Social Work Practice & Psychopharmacology: A Person-in-Environment Approach

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Social Work Practice and Psychopharmacology
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To Jack Levine

I have come to believe that intelligence consists of the knowledge that one acquires over a lifetime; wisdom, however, is something far greater. Wisdom requires having intelligence but also realizing it means nothing if it is not shared. In wisdom, there is a natural sense of giving with no fear of loss. It means realizing that the knowledge that we have is measured purely by what we can teach and share with others.

Our dearest friend, who became our beloved brother, died before the finishing of this latest revision of the book. Jack was an incredible man whose intelligence made him a “rocket scientist” in the truest sense. It was his wisdom, however, that made him our beloved brother and confidant. Knowing Jack required learning that his intelligence was always tempered deep in his sense of humor.

Both Drs. Jacinto and Dziegielewski could not let this book be published without acknowledging the passing of one of our dearest friends who became our family. He loved to take pictures and captured the spirit of all he photographed. He touched our hearts, and his spirit rests deep within our souls. Although we continue to miss him dearly, we remain comforted by the gift he left us as we continue to be touched by his photographs and his subtle reminders that he is with us now as “the bird who flies free watching over us, deep in the mountains and out to the sea.”

Sophia F. Dziegielewski
and
George A. Jacinto
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PREFACE

TAKING INTO ACCOUNT THE PERSON-IN-SITUATION

In this era of cost containment and the emphasis on behavioral health care, social work and many other disciplines have been forced to examine treatment methods and modalities with new vigor (Dziegielewski, 2015). In order for social workers to survive in the physical and mental health care arenas, it is clear that they should provide what is considered the most time-limited, effective, and accountable care. This care must incorporate awareness as well as knowledge of the medications currently used to supplement therapeutic interventions.

Many professionals as well as the lay community do not realize the important role social work can play in ensuring client intervention progress, safety, and care. I distinctly remember appearing in court as an expert witness. Soon after I started presenting mental health and family-related concerns of the client, the judge asked me with all sincere intentions: “Exactly what does a social worker do anyway?” Eager to assist my client and fully maximize the opportunity to exemplify the profession, I carefully presented a case example in which I outlined the difference between the professions and what each contributes. I explained that the main focus in each of the professions is that sociology is often related to the study of a society, psychology to the study of an individual, and anthropology to the study of a culture, but that social work is the bridge linking the individual client being served to the environment. The “person-in-situation” or “person-in-environment” has long since been the cornerstone of the profession. Clients need to be supported and the changes that occur in an individual need to be supported within the environment where the client lives and thrives. There is no magic cure or pill to cure anything without a holistic understanding of the person's support and environmental system. Once I explained this, I gave a specific example of how this perspective was critical to our recent treatment success with this client. I explained that returning the client to an unaccounted-for environment complicated and made his treatment ineffective, resulting in repeated treatment failures. Skilled in client treatment interventions and modalities, as well as discharge and case management approaches, social workers are in a unique position to ensure treatment success. When I finished with my explanation, the judge asked: “Why don't we use more social workers?” I smiled and said: “For this and every client we serve, all the decisions, including receiving the help he needs, really does start with
you as the judge. It ends, however, with social workers helping the client continue to adjust within his or her support system.”

Do not view other professionals’ lack of knowledge as derogatory to the profession of social work—just as the environment is not static, neither is the field of social work nor the interventions provided. Living in turbulent times, changing with the ebb and flow, is a part of what we do and who we are as professionals. Just as the environment is not static, neither can the profession be. What we do change relates to the needs of the client reflective of the “person-in-situation” stance. When people (including other professionals) do not understand the role of social work, it is our responsibility to help them learn what we do and what the benefits are that we can provide to all we serve. Ambiguity allows for diverse approaches needed to help a client in his or her “here-and-now” environment. Therefore, what we do today to help a client may not always be the same as what we do tomorrow. As the environment and/or situations change, so too must the strategies utilized.

In terms of changing roles, social work is not any different than the other professions. One of the greatest quotes I ever read was from Joel Paris, MD, in his book Prescriptions for the Mind (2008). Regarding the changes needed in the field of psychiatry, he stated that acknowledging the importance of “talk therapy” and supportive psychotherapy needs to be revitalized, because it can no longer be avoided in the field of psychiatry. “Unfortunately, a healthy baby has been thrown out with the bathwater” (Paris, 2008, p. xiii). For social work, avoiding the importance of having knowledge and supporting clients in taking medications used in conjunction with psychotherapy is like ignoring the baby sitting in the bathwater. Or worse yet, realizing the situation exists and leaving the baby alone in the bathwater, hoping someone else will come soon to assist. Therefore, in this volume, the authors provide what is believed to be the most important and practical information related to helping clients taking medications for mental health treatment, encouraging informed practice, and providing an overview of issues and concerns about medication that social workers will encounter in practice.

WHY DO SOCIAL WORKERS NEED TO KNOW ABOUT MEDICATIONS?

Social workers traditionally have been expected to contribute to all aspects of a client’s life. The forms of social work counseling, such as short-term therapy and cognitive behavior–based interventions, may not fully encompass the efficacy of treatment with certain mental health conditions. Therefore, medications, especially with these types of mental health conditions, are considered a viable supplement to these intervention and treatment modalities. All social workers, regardless of whether they work directly in health or mental health care, will come across clients taking medications. Social workers are expected to have some degree of understanding about the diagnostic criteria, use, and side effects of the medications provided in the context of the interventions.

The role of social workers remains complex, as they are often called upon to advise on diagnostic criteria and on which medications would be the best adjunct to the current therapy. Social workers should not shy away from learning about current diagnostic guidelines and the medications frequently used. Until recently, most of the
resources available in this area were written by professionals other than social work professionals and considered “unfriendly” in terms of correlating the information to social work treatment regimens in terms of moral and ethical issues. This is changing as social workers not only understand the importance of having this knowledge, but also utilize a social work–friendly way to help the client.

**WHICH SOCIAL WORKERS ARE INVOLVED IN USING MEDICATION INFORMATION FOR THEIR CLIENTS?**

All social workers are involved. Whether in private practice or agency settings, social workers have always been involved with medications and monitoring their effects on clients. Although social workers do not prescribe medication, few professionals would debate the need for these professionals to be well versed in the matter in order to provide ethical, efficient, and effective services to their clients. Historically, social workers have been critical of the use of medications and have actually discouraged their use. This view must now be reconsidered because many clients not only request medication to supplement psychological interventions, they expect it. As social workers will undoubtedly encounter clients who are taking medication, their knowledge will in turn affect the counseling relationship. Social workers must know the basics of medications and how these drugs can affect the time-sensitive counseling environment.

**AS A MEMBER OF A COLLABORATIVE (INTERDISCIPLINARY) TEAM, WHAT IS THE UNIQUE ROLE OF THE SOCIAL WORKER?**

Because social work professionals spend a great amount of quality time with their clients, it is likely they will be the ones on the interdisciplinary team to notice medication side effects or reactions. In this book, emphasis is placed on the role of the social worker in helping to identify the use and misuse of medication. Although this text is not meant to be inclusive of all medications, it does seek to help social workers to maximize their effectiveness and better serve their clients.

**DO SOCIAL WORKERS NEED TO KNOW ABOUT ALL MEDICATIONS AND WHY THEY ARE BEING TAKEN?**

Of course not, but all professionals should attempt to learn all they can and to utilize new information to help their clients. Medication has dramatically improved the treatment and quality of life for numerous clients who might otherwise have spent their lives in psychiatric facilities struggling with mental illness. These medications helped individuals to be responsive to everyday life as well as to psychotherapeutic interventions. Knowing how to access information about medicinal products and having a basic understanding of what they mean are critical to promoting education to clients, families, and communities.
The use of medications has increased and so has the number of medications available. The *Physicians’ Desk Reference, 2015* (PDR, 2015) lists thousands of different medications. There are innumerable over-the-counter products and herbal products. No professional can be familiar with all of them, but it is crucial to know what medications a client is taking and how to research these medications. When doing a medication history, more than just prescription medications should always be evaluated.

**WHAT TYPE OF INFORMATION SHOULD SOCIAL WORKERS KNOW ABOUT MEDICATION?**

Taking into account the vast array of medications in use today, this book will help the social worker: (a) establish a basis for understanding the use of medication with a primary focus on those used to improve mental health; and (b) provide basic information that will enable social work professionals to interpret, predict, and suggest environmental treatment strategies for clients who are taking medication as part of a therapeutic regimen.

**DO SOCIAL WORKERS REALLY NEED TO KNOW ABOUT MEDICATIONS, OR CAN THEY DEPEND ON OTHER PROFESSIONALS TO TEACH CLIENTS?**

Over 10 years ago, more than 98% of the social workers surveyed thought it was critical for successful social work practice that they be educated about medications (Dziegielewski & Leon, 1998). This view has not changed. Though all accredited social work programs generally offer at least one graduate-level course in psychopathology or clinical diagnosis, there are few textbooks available, and only two address the influence of medication from the perspective of social work treatment. Education in the use and misuse of medication and its influence on the therapeutic process is a necessity that should be incorporated into the curriculum provided by social work programs, both at graduate and at undergraduate levels.

**HOW CAN SOCIAL WORKERS BENEFIT DIRECTLY FROM THIS BOOK?**

This book can be used by social work professionals both as a textbook and as a clinical resource. Considering that most social workers receive limited training in medication during their social work program, it provides an excellent practice resource for clinicians in the field. In Part I, general information is included that will prepare social workers to address the needs of clients taking medication. The use of medication is viewed as part of social work practice, and strategies for understanding its use are highlighted. Each chapter focuses on the basic information a social worker should know, from understanding the human brain, to tips for helping the client to terminate use, to how to support the medical team with tips for taking a medication history. Another chapter is devoted to explaining the difference between generic and
brand names, presented along with medical terminology used in prescribing medications. In Chapter 3, the basic rules for monitoring medication and compliance are provided, along with tips for treatment planning and documentation.

Part II of the book outlines prescription and nonprescription medications, including herbal preparations, and a section on special populations. The first chapter in this section explains both legal and illegal drugs and the way drugs are classified and scheduled. Tips related to safety planning are highlighted, from avoiding prescription errors to handling suicidality. A chapter on complementary therapies and herbal healing is included, outlining the dangers that can occur with self-diagnosis and treatment. This chapter stresses that, as the use of herbal and medicinal products increases among clients, consumers may be lulled into thinking that these products are safe because they are “natural.” The authors remind the social worker that, if a product is strong enough to create a reaction in the body, it may produce unwanted mood changes. If it is also strong enough—whether it is herbal or chemical based—it can interact with other medications and produce undesirable side effects. In Chapter 7, consideration is given to working specifically with children and older adults as well as pregnant women or women who may become pregnant.

Part III of the book addresses specific mental health conditions such as schizophrenia, mood disorders, depression, bipolar disorders, and specific anxiety disorders. Each chapter provides a case example, characteristics of the disorder, and the treatment interventions utilized. Medications used to treat these disorders and relevant psychosocial interventions are outlined. Each chapter emphasizes the need for accurate treatment planning and documentation, and offers suggestions to facilitate this process.

Appendices A and B provide resources to help social workers find useful information that can be shared with their clients about medications, and a sample assessment form to facilitate taking a medication history. Appendix C provides a glossary that serves as a quick reference for what may initially be unfamiliar terms. Appendix D is a medication glossary that lists the brand names and generics of the most popular mental health prescription and herbal medications. Appendix E has several treatment plans to assist social workers when working with clients taking mental health medications. An Instructor's Manual is an ancillary to this text. Qualified instructors can request this ancillary by e-mail: textbook@springerpub.com.

In closing, the use of medication as a therapeutic modality constitutes a growing and changing field of science. Social workers must keep up to date with new trends and with how these medications can affect the therapeutic relationship. To complete the advocacy and broker functions basic to the field of social work, an accurate assessment and referral process must be initiated with regard to medication. Social workers must assess the various types of medications a client is taking, be they prescription, alternative remedies, or over-the-counter medicines. All social workers should be familiar with side-effect profiles and dosage routines in order to assist clients in maintaining the most therapeutically productive interventions possible. They must be able to recognize potential problems and correspondingly refer the client for adequate or revised treatment.

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Social workers in the areas of health and mental health need to be aware of several factors that can assist in monitoring their clients who are taking medications. Most important, social workers can empower clients to ask questions of their prescribers in order to verify that the medication prescribed is the best one for them. Often clients rely on the professional judgment of their physicians, pharmacists, and other professionals who prescribe or dispense medications but forget that these prescribers cannot always account for individualized reactions as well as the client’s unique situational factors.

It is critical that professionals listen carefully and encourage clients to express what they are experiencing. Clients may feel intimidated in these situations and may need reminding that they are the true “experts” and the best source of information when it comes to their own bodies and reactions. After all, it is the consumer who will either reap the rewards or suffer the consequences of the medication treatment provided. If a client is well educated and aware of the properties and possible side effects of medications, he or she can be the first to identify adverse reactions. Information that can avoid medication errors can also be provided (Archer, 2015).

The purpose of this chapter is to help social workers become aware of situational factors and medication issues key to improving the well-being of the client being served. Armed with this information, social workers can help their clients make the best personal decisions empowering them to take an active role toward the betterment of their own health and well-being.

HOW MEDICATIONS ARE NAMED

Every drug has at least two names, and sometimes a third name, referred to as the “chemical name.”

The first name is the trade name (also known as the “proprietary” or “brand” name), which will be attached to the drug as long as the pharmaceutical company’s patent (exclusive right to manufacture the drug) is in effect. This name is chosen primarily for marketing and sales purposes, so it is often short, memorable, and unique.
The second and usually longest-lasting name is the **generic name** (also referred to as a “nonproprietary” name). The drug has this name as long as it is on the market. The generic name is formulated after the initial clinical trials and from that point on is used to describe the drug (even though the patent may not be expired). Many professionals prefer to use the generic name because it will be used long after the brand-name patent has expired.

Before a trade or generic name is chosen, it must be submitted to the U.S. Food and Drug Administration (FDA) for approval. This process is rather involved as the name must be checked to make sure it does not closely resemble that of any other medicines. Also, the trade or generic name cannot resemble the purpose of the medication or what it is supposed to do (Ipaktchian, 2005). The need to avoid similar names is important because between 1995 and 2000 alone, 15% of all medication errors were attributed to name confusion (Ipaktchian, 2005). Similar names are just one area where medication errors can occur. Therefore, when medications are dispensed, complete distraction-free attention needs to be given to the task being completed. If the professional responsible for dispensing a medication is distracted, mistakes can be made that could lead to serious health-related risks. The safe use of medications and the prevention of medication errors require a collaborative team approach where all staff is aware of the medications a client is taking (Archer, 2015).

The last name is the **chemical name**, based on the drug’s structure, which is given to a medicine by the International Union of Pure and Applied Chemistry (IUPAC). As you can see in Figure 3.1, this name is often very long and so complicated that it is rarely used, unless accompanied by the brand or generic name.

One of the most confusing issues for social workers and clients alike is the use of these three different names for the same medication. Many clients, as well as social workers, get used to seeing the catchy brand name, which is the manufacturer’s trademark. When a drug is first introduced, the brand name is everywhere in the marketing material. The generic name (and sometimes the chemical name) is often listed next to it, but because this is typically longer and hard to pronounce it is often ignored. For this reason, drugs in this text are listed brand name first, as many social workers and the clients we serve find it the easiest name to recognize.

The use of a generic name can cause confusion because the introduction of a generic means the chemical name now has two meanings. The chemical name represents the brand name as well as the generic name. To confuse this further, the original brand name is generally discarded and may not appear on the label at all. For clients usually familiar with the brand name, switching to a generic name can cause them to question whether they have the proper medication.

**Example:** antidepressant

Generic name: fluoxetine (pronounced flew-OX-e-teen) or fluoxetine hydrochloride

Brand name: Prozac, Prozac Weekly, Sarafem

Chemical name (IUPAC name): N-methyl-3-phenyl-3-[4-(trifluoromethyl)phenoxy]propan-1-amine

**FIGURE 3.1** Three names for a medication.
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APPROVAL OF NEW MEDICATIONS

Before a new drug can be placed on the market, an elaborate testing procedure must determine its safety and effectiveness. To help the consumer, the FDA has a helpful website that gives information related to all new drug approvals with another website that offers specific instructions on how to complete a search for a particular medication.

To look up the drug simply enter the name at: www.accessdata.fda.gov/scripts/cder/drugsatfda/index.cfm

The instructions for using the search can be located at: www.fda.gov/Drugs/InformationOnDrugs/UCM079874

This website is particularly helpful for the consumer as the sale of unlicensed or unapproved drugs can result in substantial penalties (Miller, 2006). The FDA handles this responsibility and is the first U.S. agency tasked with protecting the safety of the consumer in this area (FDA, 2015a). Many in the lay community believe the FDA actually conducts the testing of medications. However, the FDA is an oversight agency and does not do the actual testing, which is the responsibility of pharmaceutical manufacturers. They develop a drug and then initiate testing in three phases (Miller, 2006).

A clinical trial begins this process. The purpose of the clinical trial is to determine with some certainty that the product is effective. (To do this, users of the product are compared to users in a control group, who do not use the product.) In addition, it is expected the clinical trial will identify common serious adverse events. The first phase involves determining the action of the drug, the side effects, and the maximum tolerated dose. Generally, this phase of the study utilizes normal (healthy) volunteers.

The second phase of drug testing is a controlled study. The focus at this level is to look for indications that the drug is helpful and to continue to monitor and identify potential side effects. The controlled study involves a smaller group of testers.

The third phase is a broad-based study (either controlled or uncontrolled) that further focuses on effectiveness and safety, risks and benefits, and the type of labeling to best represent the pharmaceutical. Once the company data is submitted, a team of professionals reviews the data provided and the labeling that is proposed. The primary purpose of the FDA review is to ensure that the drug’s health benefits outweigh any known risks (FDA, 2015a).

If a failure occurs at any level of the trial, the creation of the drug becomes an expensive mistake for all involved. In addition, some companies engage in a fourth phase, which is primarily used for postapproval and marketing.

In the past, there have been concerns related to the timeliness, cost, and consistency of the testing process, as well as the time allowed for a patent. Since the FDA is responsible for balancing cost, safety, access, and other factors, it has become the focus of critical attention. Over the years, this process has improved, and it is believed the FDA is indeed reviewing drugs more quickly and carefully. The FDA sometimes allows treatment use prior to full approval when a drug is needed for a serious or immediately life-threatening event where no satisfactory alternative is
readily available. There are also some rules that permit humanitarian use of a drug (Miller, 2006).

A reason for this improvement and faster reviews is that the FDA has more people working within the review process. Relman (2007) believes this is a result of the fees drug manufacturers pay to the FDA when they submit a drug; this financial assistance helps pay the salaries of the staff who conduct the studies. This additional support staff enables shorter drug-review time periods. Furthermore, representatives of the FDA argue this faster turnaround time does not harm drug quality, as the actual testing period is now longer.

Manufacturers are also expected to ensure their trials include representative populations for which the drug is intended, such as women, older adult patients, people with kidney-filtering problems, and other population groups that were overlooked in the previous testing processes. This began in 1998, when the FDA mandated that studies take into account gender and race; pediatric-based studies also had to be conducted with children. Although this pediatric mandate, in its original form, was struck down in 2002, Congress amended the law to give the Department of Health and Human Services the ability to reward manufacturers with patent extensions for some pediatric studies (Miller, 2006).

Regardless of these improvements, critics such as Epstein (2006) claim the limitations placed by the FDA—including the excessive number, length, size, and cost of clinical trials drug manufacturers are required to complete—are creating a logjam. He believes this process delays potentially important pharmaceutical developments. Relman (2007) disputes this claim, however, saying much has been done both legislatively and administratively to expedite and simplify the process. Recent changes have resulted in a streamlined process where only one or two good clinical trials are required to support an application for approval. Furthermore, concerns about long-term complications or rare, although serious, side effects are not allowed to delay approval. To address this, manufacturers are asked to conduct follow-up studies on patients using the drug over a longer period. Relman (2007) warned, however, that this “commitment” often goes unfulfilled, as this type of formal follow-up is simply not conducted.

Another concern with the approval process is that some manufacturers have been allowed to extend patents on the grounds that more extensive and lengthy testing periods are required. Serafini (2000a) warned this appears to go against the Drug Price Competition and Patent Term Restoration Act (the Hatch–Waxman Act). Extending patent-protection periods for brand-name medications might lead to higher medication costs because there will be no competition from generic drugs (Banta, 2000).

Clinical trials clearly have benefits and limitations. One of the most common limitations is the size of most drug trials, which are often limited to less than 3,000 participants. Also, clients who have complicated medical conditions or those taking other types of medications are often excluded. Last, trials are limited by the brief testing period, which prevents monitoring latent or long-term effects. To remedy this, programs such as MedWatch (explained later in this chapter) provide valuable information for social workers and other supportive professionals. The steps required for medication approval are outlined in Figure 3.2.
CREATING GENERIC DRUGS

More than 80% of the prescriptions written in the United States are filled with generic versions of a brand-name drug (Tavernise, 2015). Generic drugs are said to be the same as their more expensive brand-name counterparts, but many people are not aware what makes them equivalent or how the process works. Generic drugs are merely less expensive copies of brand-name medications (Stoppler, 2009; Watson-Heidari, 2000). They can be thought of as knock-offs—similar to a designer handbag, but without the designer name and frills. Generic drugs are created only after the patent for the brand-name medication has expired.

As discussed earlier, the creation of a brand-name medication involves original research, testing, and marketing investments that can be quite costly for the manufacturer (Watson-Heidari, 2000). In recognition of this, the FDA designates a time period for the patent when it approves the medication. Generally a patent can extend as long as 20 years. During this period, no generic drugs can be created utilizing the same ingredients as the original patent. This time period is an important incentive for the brand-name manufacturer, as it allows that manufacturer an exclusive market as a reward for the time, effort, and expense involved in creation and testing.

For a drug to be approved as a generic drug, the FDA requires three key elements be met:

1. The generic drug needs to have the same active ingredient, strength, dosage form, and route of administration as the brand-name drug.
2. The generic drug must be established to be the bioequivalent of the brand-name drug by the new manufacturer.
3. All manufacturing of the drug must meet the same quality standards of the brand-name drug. (FDA, 2012)

The Federal Trade Commission reports that since 1984 more than 10,000 generic versions have been available for about 80% to 85% less cost than the brand-name medication. There is an estimated cost savings of approximately $3 billion each week by switching to the generic version (FDA, 2012). Since the production cost of a generic drug is much less, several different manufacturers may seek approval for generic medications when the brand-name patent expires. Often the generic drug may be made by the same manufacturer or in the same plant as the brand-name drug, which helps to further ensure consistency (FDA, 2012).
Creating the generic is much less expensive because the FDA requires only that the generic have the same active ingredients, strength, and dosage of the brand-name medication it duplicates (Watson-Heidari, 2000). Almost all initial testing and marketing carries over to the generic manufacturer because the generic drug is a copy, and duplicate testing on a biochemically similar drug is not nearly as intensive or expensive. In this case, so do the original warnings for adverse reactions and side effects. Therefore a generic drug manufacturer is not required to warn consumers whenever health risks are discovered (Tavernise, 2015).

The comparison for equivalence between the generic and brand-name drugs is a statistical one. A generic drug must be similar to the standard drug when measuring plasma levels (Public Citizen's Health Research Group, 1993). In general, there should be an overall deviation of not more than 10% between generic and brand-name products, and most professionals agree there is no difference between generic and brand-name drugs. Odds are slim that something will be found wrong with the amount of active ingredients or the purity of a generic drug when compared to the brand name (Public Citizen's Health Research Group, 2009). For a helpful website that provides more information on specific generic drugs, go to www.fda.gov/cder and click on Consumer Education.

From a statistical perspective, brand-name and generic medications are equivalent. Generic drugs are required to have (see previous list) the same active ingredients, dose, strength, side-effect profiles, route of administration, and safety as the brand name they replicate (Stoppler, 2009). Furthermore, as the patent expires, the brand-name manufacturer can apply to the FDA to also make the generic equivalent; it is estimated that 50% of all generic drug production is actually by the original manufacturer and therefore made in the same manufacturing lab (Stoppler, 2009).

Although the cheaper price on generic medication is attractive, many health care prescribers still prefer to use brand-name medication whenever possible. Unfortunately, this preference can have consequences for the client; not all clients can afford brand-name medications, which may not be covered by medical insurance. It is critical for social workers to encourage clients and family members to talk with their prescribers about budgetary restrictions, so an informed decision can be made about whether brand names or generics are better for the client.

Furthermore, clients should be aware of some of the differences with no-frills generic medication. Since the FDA requires that the chemical composition of active ingredients be the same, there are only limited requirements on the size, color, shape, and taste of the generic medication, so differences can still exist (U.S. Department of Human Services Food and Drug Administration Center for Drug Evaluation and Research [CDER], 2015). These inactive ingredients hold the pill together or maintain its shape (Watson-Heidari, 2000). Inactive ingredients can add flavor or color, make the medicine last longer, or make the tablet dissolve more quickly. According to the FDA, problems with the active ingredients related to a generic medication are tracked (FDA, 2012), but not inactive ingredients. Therefore, batches can differ, and manufacturers may change the inactive ingredients, and problems related to this may go unnoticed or underreported. To address the issue where these uncontrolled features of a drug may affect continuance, in
2015 the FDA did implement stricter guidance. For example, if the size of a pill is too large, the consumer may stop taking the medication, and some regulations to get generic manufacturers to follow certain guidelines in this area have now been put into place (CDER, 2015).

Furthermore, trademark laws do not allow the generic drug to look exactly like the brand-name preparation (Stoppler, 2009). These differences may be visible to the client, so switching from a brand-name to a generic medication could actually cause confusion or even trigger a severe reaction unanticipated by the intervention team. Other clients may be upset by the switch (whether it was with or without their consent) and might worry about different or additional side effects. If a pill looks or tastes different, which is common, the client may be concerned, leading to noncontinuance.

Professionals should educate their clients about the differences between generic and brand-name medications. Clients should not think of generic medications as different or less effective than their brand-name counterparts. There are laws in virtually all states allowing pharmacists to substitute generic drugs for many brand-name products (Tavernise, 2015). Some states actually require that a generic must be substituted if it is available (Watson-Heidari, 2000). If a client does not want a generic medication, or if the provider does not want the client to have one, the prescription should state this specifically. The social worker should check that the prescriber has written the words “dispense as written” or “do not substitute.”

Asking clients or their family members questions about insurance and medication reimbursement is critical. This generally means helping clients read pamphlets outlining their insurance coverage or helping them call their insurance benefits office. Simply helping clients determine what, when, and under what circumstances medication will be covered by insurance will help them make informed self-care decisions. However, finances should never be the primary consideration for prescribing decisions. To let cost completely determine prescribing patterns is contradictory to the purpose of medication. As a practice reality, however—and no matter how disturbing it may be to take cost into consideration—it is relevant to a client’s decision. If clients cannot afford to pay for medication, they will cut corners or avoid taking the medication altogether.

New legislation related to the size, shape, and other physical attributes related to the production of generics may help to clear up some of the confusion between generic and brand-name medications and thereby increase medication continuance (CDER, 2015). Yet, there are still many other aspects such as dyes and fillers that could still remain a concern for clients. For clients, cost alone can be the deciding factor as to whether to use the generic version of a medication or the brand name. These issues may not be central to the efficacy of the drug prescribed, but they are important to the client. To improve client outcomes, whether to use a generic or a brand name should always be considered within the therapeutic decision-making process. If a prescriber writes a prescription to be filled with the brand name only, and the client’s insurance will not cover it, this needs to be discussed with the client and the prescriber. Many clients may not feel comfortable discussing this with their provider and may not get the prescription filled.
MEDICATION AVAILABILITY AND PRICING

In 1992, pharmaceuticals were a $40-billion-a-year enterprise in the United States, with an additional $7 billion spent on over-the-counter (OTC) drugs (Wilson, 1992). This rose sharply in 2009 according to the IMS, a leading global information and technology services company in the health care industry, when this industry was at $291 billion (IMS, 2009); with a 2014 update, U.S. spending has soared with its biggest jump since 2001 at $374 billion, an increase of over 10% taking into account growth and inflation (Johnson, 2015). According to the IMS, the number of prescriptions dispensed was 4.33 billion in 2014, up from 4.24 billion prescriptions dispensed in 2013 (Johnson, 2015). What these numbers do not tell you, however, is how many clients were forced to leave their prescriptions after being filled at the pharmacy counter because they could not afford the insurance copay. In 2014, the spending growth was controlled by the efforts made by insurance companies to hold back expenses with plans that had higher copayments and deductibles. According to the IMS, this left 8.4 million fewer prescriptions actually being filled compared to 2013 by consumers with limited insurance or health exchange plans (Johnson, 2015).

In addition, the use of herbal medication has also continued to increase and grows each year by approximately 25%, with an estimated $1.5 billion in preparations, extracts, and teas (Khatta, 2007), and according to a new report by Global Industry Analysts, Inc. (2015), it will reach $93.15 billion in 2015.

Of the 10,668 FDA-approved pharmaceuticals, there are more than 7,000 generic versions (FDA, 2004a, 2004b; Pal, 2007). In the United States, half of all prescriptions are filled with generic versions (Stoppler, 2009), although they account for only approximately 16 cents of every dollar spent on prescription medication (Long, 2003).

The cost of medication is not only a personal issue but also a political one. According to some policy makers, the cost of medications has become so high that desperate measures are needed to combat these costs (Serafini, 2000b). Limiting prescription costs is further complicated by the fact that the pharmaceutical industry is an unregulated market; manufacturers can charge whatever they want for new medications (Relman, 2007). The United States is the only developed nation that does not control this pricing. Some professionals are horrified when clients are able to purchase their own prescription medications for a lower price at a veterinarian's office rather than at a pharmacy because the companies charge less if the same medication is for animals (Fourneir, 2000).

Pharmaceutical costs are rising and insurance reimbursement is increasingly limited, and social workers must help their clients decide what is best for them in their fiscal situations.

THE COST OF GENERIC VERSUS BRAND NAMES

A sweet-spoken elderly woman describes what it is like to live on a fixed income of $658 a month. She relates how she places her six pill bottles on her kitchen table, then decides which ones she can afford to refill, which pills
Chapter Three  Practice Tips and Helping the Client

she will have to take every other day, and which ones she will do without.
(Serafini, 2000b, p. 86)

It is easy to see how clients are often unable to determine whether there is an effective difference between brand-name and generic medications. For many clients, this complicated decision is based on the fact that they cannot afford brand-name medication, or else they are simply given the generic without being consulted. Since many health care organizations (such as the Veterans Benefits Administration and military-based pharmacies) now buy medications in bulk, replacing brand-name medication with cheaper generic alternatives is becoming common practice.

The rationale is simple if one accepts the cost-saving incentive to switch from a brand name to a generic. On the surface, it is clear that generic medications are less expensive and considered as equally effective therapeutically. However, it is crucial to make sure the decision to switch reflects informed choice and best practice rather than just fiscal concerns.

EXPIRATION DATES

Clients who ask about using expired medications should be advised to call the pharmacy before discarding the medication. Many times pharmacists stamp their own expiration date, which generally expires before the one assigned by the manufacturer (Prufer, 1996). This practice can be costly for clients who cannot afford to purchase new medication when the old one appears to have expired. At the same time, clients should be reminded that old medications could prove ineffective and might need to be discarded after consultation with the pharmacist. If there are two dates on a prescription bottle, the latest is the one most likely put there by the drug manufacturer and should be followed. Care should always be taken when disposing of medications. Remind clients to properly dispose of medications by bringing them to the pharmacy or disposing them in receptacles provided rather than flushing them down the toilet or throwing them in the trash.

COMMON MEDICATION TERMINOLOGY

Some common terms in medication dosing and monitoring that the professional social worker should be aware of include medication half-life, drug potency and toxicity, the therapeutic index, and drug tolerance. The glossary in Appendix C also defines other commonly used medical terms.

Half-Life

A medication’s half-life is the amount of time it takes for one-half of a drug’s peak plasma level to be metabolized and excreted from the body (Sadock & Sadock, 2008)—in other words, the time it takes the amount of the drug in the body to be decreased by half (Schwartz, 1998, p. 311). If the half-life of a medication is estimated to be 4 hours, the peak concentration of the medication occurs within
4 hours of ingestion. After 4 hours, the level of medication continues to decrease by another 50% of the original amount. In 8 hours, the medication in the client’s system is reduced by another 50%, and so on. The original 50% that was left continues to be divided; 12 hours after taking the medicine, 87.5% would be eliminated. See Figure 3.3, which outlines the elimination schedule of a medication with a half-life of approximately 4 hours. Although this calculation may be confusing, the basic point is that many medications remain in the system long after the medication is taken. This has serious implications for clients who combine medications or who begin another medication before the first drug has left the system, which creates the potential for hazardous reactions.

A computation of medication half-life can assist the health care team in determining how much medication is actually left in the client’s system and how this residual amount can affect presentation and subsequent treatments. A distinction is made between a short-acting medication that is eliminated more quickly and a long-acting one, which stays in the system for a much longer period. Furthermore, medications with a short half-life are more likely to result in “discontinuance syndrome,” or the withdrawal symptoms that result after a medication is stopped.

For a medication to have an effect, a certain level of medication must be obtained. Generally it takes approximately four half-lives of a medication to reach what is identified as a “steady state.” The steady state is achieved when there is a consistent level of the medication in the body. The medication described in Figure 3.3, which has a half-life of 4 hours, would take approximately four doses every 4 hours to reach the correct level. This is why a prescriber might recommend a client double the dose when starting a new medication. When done under proper supervision, this would cut in half the time needed to attain the steady state.

There are also ways to slow down or achieve a longer half-life. For example, some drugs may be coated to slow their breakdown. Hulatt (2009) warned, however, that this is only relative to how long the medication stays in the body. Another way, which may have a more lasting effect, is to use a “chemical intermediary.” The entire dose of the medication is released into the bloodstream, and the intermediary remains in the system for a period of days, breaking down the original substance.

**Drug Potency and Toxicity**

Drugs, whether legal or illegal, can affect the nervous system and, thus, a person’s mood and behavior (Millhorn et al., 2009). Potency refers to the relative dose needed
to achieve a certain effect (Sadock & Sadock, 2008): The greater the potency, the easier it is to bind to a specific group of neuron receptors in the brain (see Chapter 2 for a discussion of medications and their interaction with neuron receptors). The more potent the drug, the lower the amount needed to achieve the desired therapeutic effect (Hogarty, 2002).

Potency has a close relationship with toxicity. Toxicity is the level of medication that does not help the body, but rather upsets or destroys normal body functions (Hanson, Venturelli, & Fleckenstein, 2005). Most professionals agree, for example, that heroin is potent and at toxic levels more lethal than many prescription and OTC medications. This does not eliminate the risk, however, that can result from underestimating the issues related to toxicity and prescription medications.

For example, Haldol (haloperidol), a drug used to treat psychosis, is a high-potency medication because the dose needed to produce a therapeutic effect (5 mg) is much lower than its counterpart, Thorazine (chlorpromazine), which requires a much higher dose (100 mg) to achieve the same effect. Understanding medication potency helps explain why doses are given in different levels for different medications. Dosages can be very confusing and difficult for the layperson to predict. Family members can also be confused when the dosage requirements for a loved one vary from a high-potency to a low-potency medication or vice versa. The social worker can assist clients by pointing out these types of medications and getting clients to ask their prescribers any specific questions they have related to dosage.

**The Therapeutic Index**

How a drug works is described as its action (Becker, 2007). Knowledge of the action of a medication, including information related to the *therapeutic index*, is essential for social workers because it outlines how to utilize a drug safely. The therapeutic index is the relative measure of a drug’s toxicity or safety. This index, also referred to as a “therapeutic ratio,” provides the mathematically calculated range between a therapeutic and a toxic dose of a drug, thereby outlining when a previously safe dose can become toxic.

**Drug Tolerance**

Clients may also develop *drug tolerance*, or lower levels of responsiveness to a medication over a period of time. The development of tolerance is associated most often with the client’s physical or mental dependence on a medication. The term “tachyphylaxis” relates to the rapid occurrence of drug tolerance. Some drugs, such as painkillers, may bring this about quickly. In these cases, clients must take the drug regularly in order to prevent the usually uncomfortable symptoms of withdrawal (Sadock & Sadock, 2008). With drug tolerance, larger doses of a drug are required to receive the same response that earlier occurred with a lesser dose. Tolerance can involve both physiological factors as well as psychological ones. *Physiological tolerance* results when clients build up a resistance to a medication after repeated exposure. They may physically need more of the medication to get the desired effect. The
psychological aspects can also be problematic and may lead a client to visit multiple prescribers seeking the medication he or she so desperately desires.

Central to a comprehensive assessment is to look for cues in a client's environment that may bring out the desire for a drug when tolerance is suspected. For example, most social workers are familiar with the issues that surround recovery efforts and the problems that clients can experience when trying to avoid alcohol. Most professionals realize the danger of relapse, which can occur by simply being near a place where alcohol is present, triggering an intense desire to drink. How many, however, have made the same connection with legally prescribed drugs?

Some clients, for example, may miss the “buzz” from benzodiazepine; for others, the smell of a hospital may trigger an uncontrollable desire for a painkiller. Social workers need to be aware of drug tolerance and what medications are most likely to cause problems after discontinuance. Staying aware and informed of the triggers that can potentiate a response can help the social worker anticipate and possibly prevent a potential relapse.

**MEDICATION MONITORING: COMMON DOSING MISTAKES**

Professional social workers are often involved in establishing and monitoring a client's medication regimen, as well as educating clients and their families on basic issues related to medication use. Therefore, a working knowledge of medications helps the social worker prepare for potential problems related to medication use and misuse.

One common problem noted by social workers regarding clients is a lack of awareness related to the medications they are taking. Many clients are simply not aware of the commonsense principles of medication use (Dziegielewski, 2006). For example, some clients may be unaware that a time-release medication should never be chewed or broken into halves. These medications are coated so part of the medication is released first, while the remainder is released when the additional coating breaks. Chewing this type of medication defeats the purpose of a time-release dosage, yet clients are seldom reminded of this because it is assumed they know.

If a medication is in a capsule, it should not be split, as this defeats the purpose of the capsule as a mode of delivery. The medication may not be evenly distributed in the capsule, and the capsule may also contain fillers and other ingredients. Splitting a capsule could easily result in the client getting all the medication at once—or none of it.

A more common example of misdosing can occur when a client is not instructed how to take a nonscored tablet. Many medications are expensive, particularly those required for maintaining mental health. In a desperate attempt to save money, a client may try to split tablet medications in half, thinking to get half the prescribed dose. Yet there is no uniform dose distribution in a nonscored tablet; the amount of medication in each side cannot be determined. Clients should be instructed to split only medication tablets that have been scored. Such a simple mistake could cause serious
problems that might remain undetected by the client, the prescribing professional, and the interdisciplinary health care team.

Liquid medications may also cause dosing problems. Most clients will simply use a kitchen spoon to measure a dose, but all spoons are not the same size. For example, the average teaspoon holds 5 mL (Kurtzweil, 1994); yet common tableware teaspoons come in various sizes from 2.5 to 9.5 mL. Thus, using everyday tableware does not guarantee accurate dosages. To assist consumers, there are various types of standardized measuring devices available, including hypodermic and oral syringes, oral droppers, cylindrical dosing spoons, and plastic medicine cups.

A simple explanation or demonstration of how to measure liquid medicines could prevent dosing problems. Also, instruments such as oral syringes are generally placed in the mouth to release the medication; be sure to remind the client and family members to remove the cap to avoid swallowing it (Kurtzweil, 1994).

Consumers and professionals have been led to believe that the dosing cup used in inpatient or residential settings is an accurate and effective way to ensure the client is receiving the correct medication. In the past, however, there have been several cases of dosage cup mislabeling that have caused the FDA to survey drug companies and recall those products that have not met the standard (Kurtzweil, 1994). The role of the health professional is essential in educating the consumer about potential dosing problems and helping to identify problems related to manufacturer error that need to be reported to the FDA for correction.

Social workers should never assume clients are clear about how to take medications and that clients will follow commonsense procedures. Oftentimes, the prescriber does not have enough time to explain all aspects of dispensing, especially when it is assumed to be well-known information. It is helpful to review with clients how they were instructed to take a medication and why it is crucial to take as directed (see Figure 3.4).

Last and probably most important, many people take more than one medication daily. For example, in the case of older adults, four out of five people over the age of 75 take medication daily, with 36% taking at least four or more different pills (Archer, 2015). Taking this many medications makes it easy to see how medication mistakes can occur. For clients taking multiple medications each day, at different times during the day, it is easy to see how confusion can occur especially in regard to what to take when and what has already been taken. Furthermore, when a medication is dispensed by a professional, a similar problem can also occur. For those who dispense

1. Before starting or taking any medication, be sure proper cleaning and handling techniques are used.
2. Remove caps from hypodermic (injected below the skin) and oral syringes and throw them away properly in needle-safe disposal containers.
3. Be sure to use only the dosing cap that comes with the product. Do not use common kitchen teaspoons etc. that could lead to inaccurate measurement.

**FIGURE 3.4** Tips for helping clients who take liquid medications.
the medication, the following principles proposed by the Centre for Policy on Ageing (2012) may be helpful. They recommend that for professionals, before giving a medication, the following should be determined: (a) the medication is given to the right patient/resident; (b) the patient is given the right medication; (c) the right dose of the medication is given; (d) the medication is being given by the proper route (oral, inhalation, injection, etc.); (e) the medication is given at the right time.

From the client's perspective, multiple medications can complicate medication regimes and be difficult to follow. As part of a collaborative team, social workers should remind clients of the importance of keeping track of their medicines and developing some type of a “check” system. The weekly pill storage containers may be one way to help clients and families get organized, allowing the consumer to track what needs to be taken and when. Helping to ensure that consumers develop a flexible system, as medication prescribing and dosing often change, is central to medication continuance while avoiding the potential for negative health consequences from taking too many or missing recommended doses.

MEDICAL TERMINOLOGY AND THE OFFICIAL “DO NOT USE” LIST

Social workers need to stay abreast of medical terminology and jargon. To read and interpret medical records, social workers need to be aware of the symbols and abbreviations commonly used in the medical profession. Table 3.1 provides examples of some abbreviations often used in the health care environment.

To protect clients, make sure all clients are aware of the “do not use” abbreviation policies and that they are followed. For example, to confirm dosing accuracy, each prescription dosage should be written with a leading zero (rather than a trailing zero) to avoid confusion. This official “do not use” list applies to all handwritten medication orders and all printed forms. Soon, it may be extended to preprogrammed health information technology systems as well. See Figure 3.5.

<table>
<thead>
<tr>
<th>TABLE 3.1 Selected Medical Abbreviations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abbreviation</td>
</tr>
<tr>
<td>A</td>
</tr>
<tr>
<td>Ad</td>
</tr>
<tr>
<td>ad lib</td>
</tr>
<tr>
<td>Add</td>
</tr>
<tr>
<td>Aq</td>
</tr>
<tr>
<td>Bid</td>
</tr>
<tr>
<td>BP</td>
</tr>
<tr>
<td>C</td>
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<td>F</td>
</tr>
</tbody>
</table>

[continued]
### TABLE 3.1 Selected Medical Abbreviations (continued)

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>General Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>fl dr</td>
<td>fluid dram</td>
</tr>
<tr>
<td>fl oz</td>
<td>fluid ounce</td>
</tr>
<tr>
<td>Gtt</td>
<td>a drop, drops</td>
</tr>
<tr>
<td>Hs</td>
<td>at bedtime</td>
</tr>
<tr>
<td>Liq</td>
<td>a solution</td>
</tr>
<tr>
<td>mg</td>
<td>milligram</td>
</tr>
<tr>
<td>ml or mL</td>
<td>milliliter (mL is preferred)</td>
</tr>
<tr>
<td>Mm</td>
<td>millimeter</td>
</tr>
<tr>
<td>Os</td>
<td>mouth</td>
</tr>
<tr>
<td>Oz</td>
<td>ounce</td>
</tr>
<tr>
<td>Pr</td>
<td>through the rectum</td>
</tr>
<tr>
<td>Prn</td>
<td>as needed</td>
</tr>
<tr>
<td>Pt</td>
<td>pint</td>
</tr>
<tr>
<td>Pv</td>
<td>through the vagina</td>
</tr>
<tr>
<td>QD, qd</td>
<td>old abbreviations; now just write “daily”</td>
</tr>
<tr>
<td>Qh</td>
<td>every hour</td>
</tr>
<tr>
<td>q2h</td>
<td>every 2 hours</td>
</tr>
<tr>
<td>q3h</td>
<td>every 3 hours</td>
</tr>
<tr>
<td>Qid</td>
<td>four times a day</td>
</tr>
<tr>
<td>Qt</td>
<td>quart</td>
</tr>
<tr>
<td>S</td>
<td>without</td>
</tr>
<tr>
<td>Sc</td>
<td>subcutaneously</td>
</tr>
<tr>
<td>Sig</td>
<td>write; let it be labeled</td>
</tr>
<tr>
<td>Tab</td>
<td>a tablet</td>
</tr>
<tr>
<td>Tid</td>
<td>three times daily</td>
</tr>
<tr>
<td>Tin</td>
<td>three times a night</td>
</tr>
<tr>
<td>Tm</td>
<td>tomorrow morning</td>
</tr>
</tbody>
</table>

This symbol, mg (milligrams), can be mistaken for mcg (micrograms), which could result in a one-thousand fold overdose.

---

**Do not use:** trailing zero (i.e., X.0)

**Instead Use:** X mg

**Do not use:** omitted leading (i.e., .X mg)

**Instead Use:** 0.X mg

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**FIGURE 3.5** Official “Do Not Use” list.

Social workers are not generally responsible for documenting this type of information, but the more they know the more helpful they can be to the client. The more knowledgeable eyes monitoring a situation, the less likely errors will go unnoticed. In fact, some states are now requiring social workers to complete continuing education hours on reducing medical errors and client safety (Allen, 2008). The need for this type of education is fueled by the at least 44,000 deaths related to medical errors that occur each year in hospitals. This trend is so alarming that, in 2001, the Florida legislature made it mandatory that all health care professionals in the state, including social workers, complete a 2-hour course on the topic (Florida Statutes, 2001). Preventing common abbreviation errors can increase compliance for all involved while decreasing the possibility of medical errors (Joint Commission Perspectives on Patient Safety, 2009).

IDENTIFYING REACTIONS AND ADVERSE EFFECTS

All health care professionals are expected to monitor side effects and report significant adverse events to the FDA in a system known as “voluntary reporting.” All clients need to be aware of the risks and benefits of taking medications, including potential side effects. To cover all side effects from every drug is beyond the scope of this chapter; however, there are some key factors that apply to medication knowledge and use.

One of the biggest weaknesses of clinical trials is they provide isolated results at one point in time. In reality, clients often take more than one medication, and it is unclear how medications may interact with each other. In addition, results may be complicated by “off-label use.” Off-label use is when a prescriber recommends a drug for a health condition or symptom for which the FDA has not approved its use. For all these reasons, a clinical trial is only one measure of what can be expected from a particular medication. We can learn more about a medication when it is prescribed to an individual than we can from a clinical trial. This makes the role of the social worker, and other professionals who view the client from an environmental perspective, critical.

Social workers should be aware of the expected general reactions and precautions that apply to each drug. This means a basic knowledge of referencing medications in sources such as the *Physicians’ Desk Reference (PDR)* is recommended. This book provides manufacturer data on testing and side-effect profiles as well as pictures of each medication (PDR, 2015). For simpler client-friendly language, a call to the local pharmacy will yield information on prescription medications as well as bottle or package inserts. Clients must be encouraged to read these inserts completely before beginning their medication regimens. *Physicians’ Desk Reference for Nonprescription Drugs and Dietary Supplements* (2003) may also be helpful. Similar to the *PDR*, it provides pictures and clear explanations of nonprescription medications.

THE MedWatch PROGRAM

MedWatch, sponsored by the FDA, is responsible for postmarketing surveillance. This program assumes all medications need to be monitored on an ongoing basis for
safety (MedWatch, 2015). Through this program, health care professionals can share information and identify safety concerns that may require formalized action. Since initial testing for side effects during clinical trials may be limited, programs such as MedWatch allow for follow-up once a medication is on the market.

MedWatch has four purposes: (a) it is designed to increase awareness about serious reactions caused by drugs or medical devices; (b) it makes it easier to report adverse drug reactions; (c) it gives the health community continuous feedback; (d) it provides a postmarketing mechanism for reporting product safety issues (Henkel, 1999).

There are three types of reports the FDA, under MedWatch, is most interested in. The first (and most relevant to this book) is the reporting of suspected serious adverse events related to drugs (prescription and OTC), medical devices, biologics (except vaccines, which are reported to another program), cosmetics, and special nutritional products (dietary supplements, infant formulas, and medical foods).

The second is the quality of the product and whether serious adverse events are related to how the product was created or distributed. Special attention is given to whether a drug may be counterfeit or contaminated, packaged or labeled incorrectly, made of defective components, or therapeutically different from the clinical ingredients originally approved by the FDA.

Last, MedWatch monitors issues of medication errors, such as incorrect dosage or use.

Health care professionals may supply spontaneous reports at any point during patient care. MedWatch also has a toll-free phone number. The major criterion for filing a report is belief or evidence a serious adverse reaction has occurred (Henkel, 1999). There is no consequence if a report is made in good faith and proves to be unfounded. Generally, reactions to report are those that were not evident during initial drug trials and were not expected to be a common side effect and, therefore, do not appear in the product handout. The reporter is not required to demonstrate or substantiate an actual reaction, yet the reporter needs to believe it has occurred and that future incidents are possible. Since the FDA will probably ask for technical follow-up information on a report, it prefers that a trained health care professional, rather than a client, make the actual report. A postmarketing safety evaluator examines information from MedWatch reports, and, according to Henkel, once an adverse effect has been substantiated, the FDA can take the following actions:

- Issue medical alerts: These alerts can provide valuable product safety information to physicians, pharmacists, and other health professionals, as well as to trade and media groups.
- Require label changes: The manufacturer may have to add or change product information on all current product labels.
- Create warnings on packaging and product information: The FDA can require these warnings be prominent so that physicians, health care professionals, and consumers are aware of their existence.
- Withdraw products: When warranted, the FDA has the power to require a company to permanently withdraw its product from the marketplace.
An immediate report to MedWatch is warranted if one or more of the following occur:

- **Death:** If you believe using a medication or medical device is the suspected cause of a client's death.
- **Life-threatening hazard:** If a client is at risk of death due to an adverse reaction, or if it is suspected that continued use of a product could cause death (e.g., possible pacemaker failure).
- **Hospitalization:** If a client is admitted to a hospital because of a severe reaction to a prescribed medication.
- **Disability:** If an adverse reaction results in a significant or permanent change in a person's previous level of functioning.
- **Birth defects, stillbirth, miscarriage, or birth with disease:** If a client is exposed to a medication or medical device that leads to any of these problems in the birthing process.
- **Intervention:** If a client needs intervention to avoid permanent damage (see Figure 3.6).

**TAPERING MEDICATIONS**

Clients often ask how they can reduce or cut back on the medications they are taking. It is always best to refer this question immediately to the prescriber because of complications that can result from discontinuing or reducing the level of certain drugs. Clients should be cautioned on the perils of stopping medication abruptly or weaning off medication without sound medical advice and monitoring. For example, Xanax, which is used to control anxiety, should never be discontinued suddenly because of the risk of seizures (PDR, 2015). If a social worker is unfamiliar with the effects of discontinuing or tapering off a medication, competent supportive practice

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**FIGURE 3.6** How to file a MedWatch report.

A MedWatch report can be filed by mail, fax, or online.

- **By mail:** Use a postage-paid MedWatch form, which includes the address. To get a copy of the form, call MedWatch at 800-FDA-1088.
- **By fax:** Fax the form to 800-FDA-0178. Any serious or adverse reaction can also be reported to the product manufacturer who by law is required to report it to the FDA.
- **Online:** Go to the MedWatch website at www.fda.gov/medwatch/ and follow the directions for submitting a report electronically.

To learn more about MedWatch, visit the MedWatch Tutorial at: www.accessdata.fda.gov/videos/MedWatch/tutorial/tutorial_video_flash.htm
is to refer the client appropriately before encouraging reduction or discontinuance of any medication.

Tapering a medication requires constant monitoring, and there are no standard rules for all medications. If the client states he or she is going to discontinue a medication without seeking medical advice, it is best to recommend a slow tapering process (Harper, 2009). This slow decrease can help avoid severe side effects and make withdrawal symptoms tolerable. When a plan for tapering is established by the prescriber, the social worker can assist the client in identifying any side effects that may occur.

Case Example: Joan

Joan, a 30-year-old single parent with little free time or extra money, began to experience flu-like symptoms. Her body ached, and she was tired and depressed. The symptoms were not severe enough to keep her home from work, and she decided against a trip to the physician because she was concerned about the copayment required by her insurance company. She started by going to the Internet and searching for flu-like symptoms and treatments, which led to 2,340,000 search results. There were numerous websites that offered everything from diagnosis tips and strategies to testimonials from individuals recommending what worked best for them. She felt overwhelmed and too sick to start reading each of the entries, so she shrugged her shoulders, turned the computer off, and went to the drugstore.

At the drugstore, she looked at the shelves and tried to decide what type of cough-and-cold medicine might relieve her headache and runny nose. She did not see any clerks to ask, and there was a line outside the front window of the pharmacy. She also hoped whatever medication she chose might have a bit of a stimulant effect to “pick her up a little.” She looked at all the different choices on the shelf and finally chose the cheapest OTC cough preparation she could find.

When she finally got home she was feeling tired, and she decided increasing the dosage of the new medicine might help her sleep. She took two full tablespoons of the medication and went to bed, but about an hour later she started feeling sicker. Her head throbbed, she began feeling nauseous, and then she vomited. She could not fall asleep, her palms were sweating, and her heart raced. Afraid of what was happening, she went into the kitchen and re-read the label. The directions read two teaspoons, and she realized she had taken more than double the prescribed dose. There was also a warning of drug interaction with certain types of antidepressants and advice to contact a physician before using the medicine. Joan was taking such a medication—Prozac. Her physician had prescribed it for her depression and to suppress her appetite. She called her neighbor to help with the children and was taken to the hospital for assessment and treatment.

Fortunately for Joan, there were no serious repercussions, but cases like this are not uncommon. She probably experienced a serious side effect: first by overdosing, and then by combining the cold preparation with another medication it specifically warned against. She had not read the directions carefully and compounded
the problem by using a common household tablespoon, which is not standardized. Unfortunately, many people like Joan are lulled into a false sense that OTC preparations are safe because they are sold without a prescription and are available at any pharmacy. In addition, many are not aware that OTC preparations can produce interactions with other medications. The FDA is aware of the concerns that can occur when using OTCs and the public's perceptions of the safety of using these medications and has started to examine the approval process for OTCs much more carefully (Burton, 2014).

According to the FDA, 50% of all consumers do not take medicine as prescribed or take them without proper professional supervision. One reason cited for this trend is that too many people (primarily women) neglect their own health because of busy schedules and lack of time (Friebert & Greeley, 1999).

MEDICATION INFORMATION AND THE INTERNET

As in Joan’s case, the abundance of information now available to the nonprofessional can empower clients to learn more. The Internet can help interested consumers investigate whether a particular medication is appropriate for their specific situation, and it allows them to do this privately and comfortably in their own homes. It can also help the consumer avoid the trip to the local drugstore. This convenience factor may be central for people when determining how and where drugs are purchased. Some sites, termed “rogue sites,” can offer a prescription without seeing a medical provider and the process may be as simple as filling out a questionnaire (Henkel, 2011).

The sheer volume of information, however, can prove overwhelming; there is much contradictory, conflicting, and simply untrue information that may appear credible. The sheer abundance of information available to the lay public increases the possibility of misinterpretation.

The Internet has become a major resource for individuals using prescription, nonprescription, and herbal remedies. For the most part, this type of access reinforces the consumer's right to control his or her own health and mental health. On the negative side, however, having all this information so readily available can challenge professionals seeking to provide both competent and effective use of medications. Although client self-determination is always encouraged, this overload of uncensored information and the possibility of encountering a “rogue site” should always be utilized with caution—especially unsubstantiated claims from newspapers, television, or the Internet.

There is a massive amount of information available to the consumer describing the risks and benefits of medication. Technology provides easy access to information, and the public has an interest and desire to find out more. Clients ask complicated questions, and those supporting them are expected to have the answers. Social work professionals must be able to help clients and their families view the information they receive objectively. It is essential to question the reliability of information retrieved...
online. The FDA does monitor and provide Internet surveillance, targeting sites that promote unapproved drugs, health fraud, and prescription drugs without a valid prescription (Henkel, 2011). To assist clients further in determining the reliability of information gathered from various sources, Desselle and Zgarrick (2004) and Larkin (1996), among others, suggest the following guidelines:

1. Who maintains the site? Government or university-based websites are recommended for the most scientifically sound information. Private sources may have their own entrepreneurial agendas for promoting or marketing a product not appropriate for every client. This is particularly important when searching for information on herbal remedies that are offered for preventive or therapeutic purposes, such as foods or dietary supplements. The FDA does not generally monitor these products and their claims (Zink & Chaffin, 1998). In addition, can you determine who owns the site? This will help the client determine if there are some biases or promotional aspects that override the content.

2. Is there a professional body responsible for reviewing the site’s contents? Do the professionals who review the site have a direct connection to the site (i.e., employees at the site) or are they independent professionals? Who reviews content from a more objective perspective? Are references made to professional journals or researchers to support the claims being made? Can the professionals, researchers, or scientists who review the site be contacted for additional information or clarification? Does the site give the credentials of the reviewers and authors of the material? What are the credentials of the writers, and where are they getting their sources?

3. Are there links to other sources that can support or supplement what is provided on the site? Does the site list where the information comes from and give credit so that you can check the accuracy? Be sure these referral sources are reputable and well established, because many companies set up professional-looking web pages but may not accurately represent the product they are advertising.

4. How often is the site updated? Within the rapidly changing mental health field, all sites that discuss medications or medical information should be updated at least monthly.

5. Does the site supplement medical information with any type of multimedia presentation that facilitates understanding of the product? Be careful, however, as a sophisticated and impressive presentation does not always mean the information is accurate. If it is from a nonreputable site, there may be a hidden message or agenda.

6. Does the site charge a fee for access? Before paying such a fee, determine if the service is more worthwhile than the many sites that are free of charge. Paying for information does not guarantee the information is proven, worthwhile, or appropriate for the client.

It is not surprising that technological advances have resulted in a surge of self-help interventions, particularly in the area of health and wellness; this trend will continue. What is most frightening is that many clients will act upon the information they get from the Internet—for example, by taking OTC medications or herbal treatments—without informing their health care worker.
It is common to think herbal preparations are natural, safe, and therefore harmless, and clients frequently take these preparations to improve their health. This can be problematic because many of these products can interact with prescription medications. For example, some herbal preparations can become toxic when taken with certain drugs, and fatal herb–drug interactions can occur (Fugh-Bergman, 2000; Mayo Clinic, 2000b). All social workers are reminded to encourage clients to write down all their medications and treatments and the sources of their information on these products. This information should later be shared with the health care provider or interdisciplinary team to determine whether the product is compatible with the client's medical, mental, social, and environmental situation. Social workers should warn clients to be cautious of products that advertise a miracle cure or a solution to all their problems. Any claims of this nature should be scrutinized thoroughly.

There are other disadvantages to the overwhelming amount of medical information available online. Adolescents, for example, are using the Internet to learn more about prescription medications—and then are using them illegally. As of 2006, prescription medications were among the drugs most heavily abused by teenagers, surpassed only by marijuana (Substance Abuse and Mental Health Services Administration [SAMHSA], 2008). Therefore, when assessing for medication use and abuse in adolescents, social workers are recommended to assess for legal as well as illegal medications (Dziegielewski, 2006).

Some adolescents create what is often referred to as “trail mix” or “skittles” and then distribute it at “pharming” parties. These small plastic bags filled with random pills from the medicine cabinets in their homes are passed around at parties and taken indiscriminately (Prosser & Nelson, 2008). Many young people are using the Internet to determine which medications to include in these bags. They can read about the medications in the medicine cabinet and select which ones might be of greatest interest for either personal or financial gain.

Furthermore, some adolescents who want prescriptions to pain medications for illegal use will even learn the symptoms of a disease that requires a certain medication; they can then fake the symptoms in order to get a prescription from their provider. Parents unaware the Internet is being used for such purposes may not know the symptoms are faked.

Most social workers who have worked for any length of time on an adolescent inpatient unit can give an example or two of a young client who tried to feign symptoms for increased or decreased dosing. This is just one more reason why parents need to monitor their children’s Internet activity. Also, parents need to be aware of what medications are in their medicine cabinet, what happens to them if they are not used, and the safest way to destroy them.

Despite the positives and negatives of this increased and easily accessible information, the role of the social worker remains central to helping clients secure and interpret accurate and relevant product information. Social workers should make it their responsibility to help clients obtain the most up-to-date and credible information. This empowers clients to self-determine if a medication in question is appropriate for them. Social workers also need to address the person-in-situation and person-in-environment issues other professionals may neglect. For example, are there others in the home who may use or abuse these medications? If so, what are some of the ways this can be addressed and possibly avoided?
BUYING MEDICATIONS ON THE INTERNET

Many websites make it easy to purchase medications. Purchasing online appeals to many individuals, especially those who cannot leave their homes or who live in rural areas (Henkel, 2011). With a simple faxed prescription or online request, a client can have medicines delivered the next day to his or her own home.

Although this is a convenient way for clients to receive medications and treatments, it can be problematic for the professionals who treat the individual. For example, a consumer can obtain a prescription without ever seeing a health care professional at some Internet sites by simply filling out a questionnaire (Henkel, 2011). This type of purchase can result in problems ranging from misdiagnosis to purchasing or receiving incorrect medication (Carey, 2000). To demonstrate the negative effects that can result from this practice, Chen (1999) described an official crackdown on one such site when it was found the person authorizing the prescriptions was a veterinarian in Mexico. The Clinton administration had allocated $10 million to crack down on illegal drug sales online. This fund was designed to identify and punish site owners; however, this cannot stop foreign-based sites from engaging in the same practices (Carey, 2000). The rules and regulations for sites located in other countries are not the same as in the United States, but the sites are available to anyone with Internet access (Henkel, 2011). Unfortunately, cases such as these give a bad name to reputable electronic pharmacies that provide valuable service.

In a later example, Henkel (2011) described the case of a 52-year-old male from Illinois with a history of heart disease who died of a heart attack after buying the impotence drug Viagra (sildenafil citrate). The consumer was able to buy the drug from an online source after only filling out a questionnaire with some basic health information to secure the prescription.

If clients decide to purchase their medications online, social workers can help them establish the credibility and reputation of an electronic pharmacy. For example, remind clients that reputable pharmacies will always verify a prescription with the physician who wrote it and provide the client with clear information about the risks and side effects. Advise clients to get the name, phone number, and professional license number of the online pharmacist and to keep this information in a safe place in the event of any problems. In addition, it is helpful to determine whether a site is approved by the National Association of Boards of Pharmacy (NABP; www.nabp.net), which has developed a seal of approval for sites that meet the appropriate standards (Henkel, 2011). This seal of approval supports a program referred to as Verified Internet Pharmacy Practice Sites (VIPPS). VIPPS membership is part of a voluntary certification program designed to ensure that, if the seal is displayed prominently on the website, it adheres to the following standards: maintaining all state licenses in good standing; allowing information about the pharmacy to be posted and maintained on the VIPPS website and periodically allowing an NABP-sanctioned team to inspect its operations; and last, displaying and maintaining the VIPPS seal with a link to the VIPPS website (NABP, 2015).

In summary, regardless of where clients get a medication, before use they should be sure it has been dated and that outdated medications are not being used. Furthermore, helping the client to be informed of programs such as VIPPS can bring awareness about a quick and convenient way to secure medications that, if not utilized
wisely, can have devastating effects. Henkel (2011) gives four general expectations of how Internet pharmacies operate that might be helpful to share with consumers:

- Users open an account with the pharmacy, submitting credit and insurance information. The pharmacy is licensed to sell prescription drugs by the state in which it operates and in those states to which it sells, if an out-of-state license is required.
- After establishing an account, users must submit a valid prescription. Doctors can call it in or in some states e-mail it or users can deliver it to the pharmacy by fax or mail. The site then verifies each prescription before dispensing the medication. A written verification policy is usually posted on the site.
- Some online pharmacies send products from a central spot, while others allow users to pick the prescription up at a local drugstore. Prescriptions usually are delivered within 3 days, often for no shipping charge. For an extra fee, many sites will deliver overnight.
- Sites typically have a mechanism for users to ask questions of the pharmacist, either through e-mail or a toll-free number. (Henkel, 2011)

**SUMMARY AND CONCLUSIONS**

Social workers often work with clients who are taking medications, and the more knowledge they have, the better equipped they will be to handle potential problems. The role of the social worker in working with clients who are using medication is essential; social workers serve as part of a collaborative team and, when necessary, serve to educate clients about issues and concerns that might otherwise be neglected. One problem often noted by medical social workers is that clients lack awareness of how to take medications properly (splitting tablets, not measuring liquid doses appropriately, and/or stopping a medication without notifying a medical professional).

Also, when taking multiple medications, it is easy to confuse what is to be taken and when. Taking medication is a personal choice, and every effort should be made to assist the consumer to get the information that is needed to make the best choice for him or her. Ensuring safety when taking medication needs to extend beyond the client, and the more professionals involved in monitoring the situation, including family and caregivers, the better. Since the individual dispensing the medication can also make mistakes, the avoidance of medication errors should always be given careful attention (Archer, 2015).

The role of the social worker in helping to understand, communicate, monitor, and document issues surrounding the use of medications is an important one. Social workers need to be aware of medication interactions and help clients prepare for and avoid negative reactions. It is also important to help the client develop his or her own system for monitoring the medications taken; this system should be flexible enough to incorporate repeated changes in medication type and dosing. It is unrealistic to expect social workers (or any health professional) to know about every medication a client is taking. It is not unreasonable, however, to expect them to find the necessary medication information and become familiar with effects and adverse reactions.
Using the *PDR* and similar resources provided by the FDA consumer website (provided earlier in the chapter) can assist in gathering available manufacturers’ data on testing and side-effect profiles (*PDR*, 2015). If this is not available, or the client is intimidated by using the computer to access a website, a call to the local pharmacy can provide package inserts.

The social worker is essential both as a supportive direct provider and as a member of the collaborative team verifying information about the client's medications and helping to establish safety and efficacy; although careful monitoring of drug therapy is not considered the primary role of the social worker, assisting in the verification process is. Social workers can identify medications that might be unnecessary or inappropriate and assist in documenting the efficacy of drugs, because many clients do not explore the appropriateness of their medications.

As part of the treatment planning process, it is not uncommon for social workers to take an initial medication history, clearly relating how taking these medications can affect the client's activities of daily living (ADLs) or supportive counseling efforts. An accurate and responsible history should also explore the possibility for medication misuse or abuse. When the potential for abuse is high, social workers can note this and prepare the team to be aware, thus avoiding possible problems for the client. When a medication history is completed, be sure the assessment is complete and includes all of the prescription and nonprescription medications and other drugs taken for chronic conditions. Be sure to document all medications and substances that a client has taken, including caffeine, nicotine, and OTC medications (Dziegielewski, 2006). In the future, social workers will probably not only complete this task regularly but also could be held solely accountable for this very important responsibility.
Understanding the medical aspects of psychopharmacological interventions can be intimidating for many social work professionals. This can be further complicated by a client’s misunderstandings about a medication prescribed or resistance to the behavioral changes needed to maximize benefit (Lampert, Haefeli, & Seilding, 2014). Similar to other nonmedically trained professionals, social workers generally have limited course work on medications in their undergraduate or graduate education; thus, any skills acquired in this area must be derived from on-the-job training or through continuing education (Dziegielewski, 2007). Although continuing education might indeed be beneficial, it often is not provided by professional social workers. The benefits of receiving training from experienced social workers are many, including that social workers are more likely to be sensitive to the person-in-situation or person-in-environment stance that has long been the foundation of social work (Dziegielewski, 2013). They are also very much aware of client self-determination, dignity, and worth, as well as how cultural mores and expectations may influence medication routines and continuance.

Despite the lack of formal training in medication use and misuse, social workers frequently provide services to clients who are on psychotropic medications. They are also required to integrate medication information into the assessment, working, and termination phases of the helping relationship. This chapter is designed to examine the issues most relevant to social workers serving clients who are taking prescription or nonprescription (over-the-counter [OTC]) medication. Topics covered include the labeling, regulation, and scheduling of drugs in terms of both prescription and nonprescription medications.

DRUGS, PHARMACEUTICALS, AND MEDICATIONS: LEGAL AND ILLEGAL

The United States makes up 5% of the world's population, yet it consumes 75% of the world's prescription drugs (National Institutes of Health [NIH], 2014). Statistics like this serve to confirm that drugs are very much a part of our society, whether taken for medicinal reasons, as a lifestyle choice, or to satisfy a desire or an addiction.
The word “drug” itself can have different meanings and, based on the context in which it is used, different policy implications (Battin et al., 2008). One derivation of the word “drug” comes from the Middle Dutch “druge vat,” or “dry-vat,” which is related to dried plant medicinals. In the United States, the word “drug” can have several meanings, but when used as a label for an illegal substance, it is particularly problematic and stigmatized.

To avoid these value-laden assumptions, prescription and OTC drugs are often referred to as “medications” and herbal and dietary substances are often called “remedies.” Social workers and other professionals often avoid the word “drugs” when there is concern the term could be confused with illegal drug use. (No doubt members of the pharmaceutical industry would be upset if they were referred to as the most profitable drug dealers in the U.S. and global markets.) Consumers may have a false sense of security that a legal drug is safe or the potential for abuse diminished.

Drugs, medications, and remedies are classified differently, and a basic knowledge of this process can help the social worker understand some of the classification issues.

**DRUG CLASSIFICATION SCHEDULES**

The Comprehensive Drug Abuse Prevention and Control Act was first enacted in 1970 and provides the legal foundation for narcotics identification and enforcement in the United States. It, along with subsequent revisions made over the years, requires strict record keeping on certain types of drugs. In addition, the Controlled Substance Act (CSA), which is Title II of the Comprehensive Drug Abuse Prevention and Control Act, oversees the possession, manufacture, movement, and distribution of drugs in the United States.

In the United States, drugs are identified and placed in five separate categories referred to as “schedules.” Each schedule is updated regularly and new substances are added on an annual basis (Drug Enforcement Administration [DEA], 2015). Each schedule has varying qualifications that determine whether a particular substance falls within it.

The two U.S. agencies that determine what substances are added or removed are the DEA and the Food and Drug Administration (FDA). Where a drug is classified depends on several characteristics: its determined medical use, the potential for abuse or physical and psychological dependence, and whether there are any international treaties to take into account. The lists are not all inclusive and focus on the parent chemical, not other isomers, salts, esters, and other derivatives (DEA, 2015).

“Drug abuse” refers to excessive drug use that does not have a medically determined purpose. “Physical dependence” or “psychological dependence” is when an individual needs a substance to continue functioning and uses the substance even when he or she knows negative circumstances could result. The terminology in terms of labeling a mental disorder, however, has changed when using official nomenclature such as the Diagnostic and Statistical Manual of Mental Disorders (5th ed., DSM-5; American Psychiatric Association [APA], 2013). In this book, the disorders
Figure 5.2

**Drugs Schedules—Selected Examples**

**Schedule 1: High Abuse, No Recognized Medical Use, Lack of Safety**
- Heroin
- LSD
- MDMA
- Marijuana
- Methaqualone

**Schedule 2: High Abuse, Medical Utility, High Dependency Risk**
- Amphetamine
- Codeine
- Cocaine
- Hydrocodone
- Methadone
- Methamphetamine
- Methylphenidate (e.g., Concerta, Ritalin, Methylin)
- Morphine
- Oxycodone

**Schedule 3: Lower Abuse, Medical Utility, Moderate Dependency Risk**
- Anabolic Steroids
- Barbiturates (some in this class)
- Codeine (e.g., combination products)
- Ketamine

**Schedule 4: Limited Abuse, High Medical Utility, Limited Dependency Risk**
- Alprazolam (e.g., Xanax)
- Chloral Hydrate
- Dextropropoxyphene dosage forms (e.g., Darvon, Darvocet)
- Diazepam (e.g., Valium)
- Paraldehyde
- Phenobarbital

**Schedule 5: Minor Problems**
- Typically includes preparations of the scheduled drugs in limited amounts (e.g., Codeine preparations such as Robitussin A-C) and others.

*Source: United States Drug Enforcement Administration (2015).*
it is taken. For example, heroin is a Schedule I drug whether it is injected, smoked, or snorted, whereas phencyclidine (PCP), and analogs of it such as PCPy, PCE, and TCP, can be in Schedule I or II (DEA, 2015). Also, Telazol (tiletamine HCL and zolazepam HCL), another PCP analog, is a Schedule III drug when used as a large-animal tranquilizer. On the other hand, dextromethorphan, a product often found in OTC cough-and-cold preparations, is not regulated, although this may change due to its potential for abuse (Cooper, 2013). When this medication is used recreationally at high doses it can result in pronounced side effects such as euphoria and hallucinogenic or dissociative symptoms.

Schedule II drugs also have the potential for abuse and severe psychological and physical dependence. The drugs or substances in this area have a currently accepted medical use in the United States but need to be monitored with severe restrictions. Today, updates to the CSA now separate each of the drug schedules (I–V) into two subcategories: narcotic and nonnarcotic controlled substances (DEA, 2015). Narcotics are generally considered pharmacy only; therefore, these substances are highly regulated, purchased, and stored in a pharmacy. Schedule II drugs are generally available by prescription. For example, methamphetamine (a central nervous system [CNS] stimulant whose use is increasing throughout the United States) is included in Schedule II (DEA, 2015).

Schedule III includes drugs or substances with the potential for abuse, although less than the substances identified in Schedules I and II. Drugs in this class can lead to low or moderate physical dependence or high psychological dependence. The Schedule III substances have currently accepted medical uses in the United States and (like Schedule II) are referred to as pharmacy-only medicines. Many of the prescription medications used for mental health are found here. Other drugs placed here include Tylenol with codeine (Tylenol number 3) and Vicodin, both of which are used in pain relief and require a prescription.

The Schedule IV substances are generally said to have a low potential for abuse relative to the substances in Schedule III. They have currently accepted medical uses in the United States but the concern remains for limited physical or psychological dependence. Substances in this area usually require a prescription. Some medications used for animals are classified in this schedule and also require a prescription. Substances in this schedule include Xanax and Valium, two antianxiety medications discussed further in Chapter 10.

The last classification is Schedule V. Compared to the drugs or substances in previous schedules, the potential for abuse is relatively low. These drugs have accepted medical uses although abuse may still lead to limited physical or psychological dependence.

In the United States, drug classification is very important. It can affect everything from whether a drug requires a prescription to determining the ease with which research can be conducted. There are also varying prison sentences for possession or use of substances depending on their classification (Battin et al., 2008). This gives the DEA a great deal of power by determining where a drug will be classified. For example, some experts question why marijuana is a Schedule I drug, rather than a Schedule II, where it could be recognized for its medical uses and benefits (Eustice & Eustice, 2008). Leaving it as a Schedule I drug is extremely unusual because, as
of February 2015, marijuana has been legalized for recreational use in 5 states and another 23 states have legalized it for medical use (Arenas, 2015).

Additionally, Battin and colleagues noted that some commonly used substances, such as alcohol, nicotine, and caffeine, are inconsistently defined in the federal code, even though these substances have many addictive properties. When unsure of where a substance is classified it is always best to look it up, as at times the classifications may not seem obvious.

Classification can help the social worker understand how use of a substance, either legally or illegally, is viewed in the medical community. Since regulatory schemas could change every year, what is Schedule I medication today could change in a year. Most of the prescription and OTC medications discussed in this chapter generally fall in the Schedules III–V range.

Where a medication is placed can also depend on use or dosage. Some drugs are regulated differently if they are used in dietary supplements or by professional athletes. For example, Battin and colleagues (2008) described how dextroamphetamine (a prescription drug and a controlled substance) is often banned from competitive sports yet is allowed in certain herbal substances in an analog form. In addition, ephedrine requires a prescription, yet, when previously marketed as ephedra (an herb with the active substance ephedrine), it was classified as a dietary supplement and therefore exempt from oversight. (The FDA banned the sale of ephedra-containing supplements in 2004.)

With the wide array of medications available and the varied processes for classification, regulation, and approval, a broad knowledge of the types of medications a client is taking, and how they can affect the therapeutic process, is essential. Knowing only prescription medications, however, can be shortsighted. Clients take multiple medications, including OTC and herbal products. In addition, many people may be illegally taking what are considered prescription medications, especially young adults (Stewart & Reed, 2015). This is further complicated by the trend for individuals, primarily young adults who engage in doctor shopping, to gain access to prescription medication illegally (Cepeda et al., 2015).

**PRESCRIPTION MEDICATIONS**

Compared to other forms of mental health treatment, psychotropic medications are relative newcomers. Social workers must have knowledge of these types of medications, which can help in the fight against mental illness and its subsequent emotional, psychological, and social problems. The increasing reliance on medications over the past 30 years has been fueled by controlled-medication–based studies that assert medication alone can be a viable treatment. This assumption has been called to question because the FDA often does not report clinical studies with negative findings in favor of the ones with positive outcomes (Arden & Linford, 2009).

In a recent study (Kirsch, Doerfler, & Truong, 2015) of 540 college students referred to counseling centers for a psychopharmacological interview sought treatment for depression, anxiety, and attention deficit hyperactivity disorder (ADHD).
What is most concerning is that, of these referrals, many reported suicidal thoughts and 12% reported that they had tried at least one suicide attempt in the past.

As prescription use and misuse increases, it is obvious social workers cannot be expected to be familiar with all medications (Karch, 2009). However, they should be well versed in those most commonly used to treat specific problems in client populations and should have a basic knowledge of the effects of medications on the human body. Social workers must also know their own limits and should be expected to practice within their competency. When unsure how a medication may affect an assessment, intervention, and treatment plan, the social worker should look up a medication or refer to another interdisciplinary team member (NIH, 2014).

In 1999, statistics showed at least three out of every four visits to a physician resulted in a prescription, with approximately 2.8 billion prescriptions dispensed that year (Friebert & Greeley, 1999). In 2014, in the United States a new concern has emerged as prescription drugs are not always obtained from a physician with approximately 54% of prescription drugs being obtained from a friend or a relative (NIH, 2014). A large number of people in the United States are taking prescription medications; so it is no surprise that, although the United States makes up only 5% of the world’s population, it takes 75% of the world’s supply of these drugs (NIH, 2014). Regardless of how many or how obtained, medication use remains an essential part of a doctor’s visit. Furthermore, the dangerous effects of improperly obtained or misused prescription medications, whether obtained legally or not, continue to be problematic.

Deaths from drug overdoses are occurring in staggering numbers (Goldberg, 2014). According to the Centers for Disease Control and Prevention (CDC, 2007), over 20,000 overdose fatalities occur annually nationwide, second only to car crashes for unintentional injury deaths in the United States. In 2010, the CDC reported that deaths from prescription painkillers in general had reached epidemic levels with painkiller overdoses killing four times as many people than in 1999 (Kane, 2013). This rise is clearly related to the use of prescription drugs mostly for nonmedical purposes. According to the CDC, this rapid increase in prescription drug poisoning appears highest in the Appalachian states, the southwestern states, and New England. Therefore, it comes as no surprise that in 2006, 295 West Virginians died from unintentional overdoses of painkillers. While the majority took them illegally, approximately 37% of the deceased had prescriptions (Reinberg, 2008). Furthermore, a 2007 Virginia chief medical officer’s annual report shocked many when it reported that prescription-drug-related deaths accounted for more than double the illegal-drug-related deaths (388 versus 152) in the state (Shenk, 2009).

Today, pharmaceutical companies find it distressing that sales related to prescription medicines are slowing and profits of $291 billion a year are not as high as they would like (IMS, 2009). For example, IMS (2009), which compiles pharmacy industry market data, reports the following prescription variable increases in drug sales between 2006 and 2010: 2006 (8%), 2007 (3.8%), 2008 (1.3%), and 2009 (1%–2%), with the number of prescription drug abusers in 2010 placed at 7 million (NIH, 2014). Two possible reasons for this slow incline may be an increased emphasis on generic drugs and some people avoiding medication due to economic restraints. Either way, when looking at painkillers alone, current statistics indicate...
painkillers are prescribed in such large quantities that there are enough prescriptions to medicate every American adult every 4 hours for a month (Kane, 2013).

The fact that the United States is the only major industrialized nation that does not regulate prescription drugs makes this a lucrative market (“U.S. Prescription Drug Sales Tumbled in 2008,” 2009). The sheer number of prescriptions and the profit factor make many observers wonder whether some medications are developed for public good or simply profit. Other professionals have questioned whether the pattern of prescribing medication for symptom relief has undermined the critical rapport needed between the provider and the client (Arden & Linford, 2009). The Physicians’ Desk Reference (PDR, 2015) lists thousands of these preparations, and with the FDA approving drugs faster than ever, this number will surely increase.

Today, the top-selling medications are cholesterol medications, followed by codeine and other drugs containing narcotic painkillers, antipsychotics, antidepressants, and blood pressure medications. According to IMS (2009), antipsychotic medications led all therapy classes in mental health prescription sales in 2008. In 2010, prescription medication abuse was listed at 8.76 million with most of the abused drugs being painkillers (5.1 million), tranquilizers (2.2 million) and stimulants (1.1 million) (NIH, 2014). Yet what is most concerning is that 62% of teens say these drugs are easy to obtain from their parents’ medicine cabinets, and 52 million people over the age of 12 have used prescription drugs for nonmedical reasons at least once in their lifetimes (NIH, 2014). The sheer abundance and availability of prescription medications have been linked to a number of deaths (Reinberg, 2008); the CDC (2007) clearly supports this contention with its warning that more information is needed to truly understand and accurately assess current and future drug-poisoning information.

Experienced social workers need to be familiar with the PDR or other online references and how to use them. In all cases, effective helping requires practicing within your competence and admitting to the client if you are not familiar with a drug. There is no stigma attached to looking up a medication—in fact, there can be negative consequences for not doing so. Most clients may not know how to use the Internet to find reputable sources (see Chapter 3 for explanation of the Verified Internet Pharmacy Practice Sites [VIPPS] seal, which ensures some level of standardization and oversight). Besides, the side-effect profiles listed for each medication may frighten even the most experienced professional and cause the client unnecessary anxiety.

When a client requests additional information, it is best to help him or her gain access to more user-friendly resources. For example, pharmacists can provide easily read and understandable literature that explains a medication, directions for use, and potential side effects. Clients should be reminded to read and save these descriptions, which can be used to explain medications to their families and friends and to professionals trying to assist them. In addition, some pharmacies utilize computer support to analyze potential drug interactions (De Angelo, 2000).

The National Institute of Mental Health (NIMH) publishes “Mental Health Medications,” a booklet for clients and professionals with basic information about numerous mental health conditions and medications (NIMH, 2015a). It can be downloaded online (www.nimh.nih.gov/health/publications/mental-health-medications/index.shtml). Social workers should help clients access this type of information.
as well as answer questions and interpret it. You can order the booklet from NIMH Public Inquiries, Room 8184, MSC 9663, 6001 Executive Boulevard, Bethesda, MD 20892-9663, or fax a request to 301-443-4279.

AVOIDING PRESCRIPTION ERRORS

Social workers do not prescribe medications; however, their role in helping consumers to protect themselves and protect clients who use prescription medications is crucial. Approximately 125,000 lives were lost over the past 10 years to legal drugs such as Vicodin, OxyContin, and methadone (Kane, 2013).

Lampert et al. (2014) state the major reason for medication errors is the lack of knowledge about medications by the consumer. After conducting interviews with 20 prescribers about their communication with clients, McGrath (1999) reported several key themes. The first was how much information should be given to clients. Prescribers mentioned time constraints as the most important reason for not sharing information. They also said sharing information depended on the client—whether the client wanted the information, and whether knowing the side effects of a medication would have an impact on the client’s willingness to take it. Lampert et al. (2014) warn that asking the question as to whether the client has any queries about a medication is simply not enough.

Another theme was the sources of information available to clients. Most prescribers felt that the more questions a client asked the better and that much of the necessary information could be shared by other health care professionals (pharmacists, nurses, and other members of the health care team). These prescribers also expressed concerns about clients believing available information, particularly television advertisements and promotional pamphlets. Lampert et al. (2014) go further, stating that the provider needs to work on ways to motivate the client to bring about the behavioral changes that are supported within the questions answered. These authors suggested using a transtheoretical model that identifies five stages for behavioral change: precontemplation, contemplation, preparation, action, and maintenance. From this perspective, once the questions are asked, the answers become the building blocks for initiating behavioral change. From this perspective, the social worker can be particularly helpful in prompting the client to not only ask the questions of the prescriber but, once answered, how to best process and incorporate the response into his or her daily activities.

Social workers need to take a more active role to protect and educate their clients. McGrath’s (1999) earlier study highlighted prescribers’ interests in increasing medication continuance and the importance of availability of medication information for clients. The question that still remains is: Who is actually responsible for counseling patients on the negative results of a drug interaction? In the past, physicians and pharmacists often said they did not have the time (Barnes, 1999), yet, with the increase in prescriptions and subsequent medication errors, this climate is changing. All prescribing and dispensing professionals as well as all supporting practitioners need to assume this role, helping the consumer to get the best results from the
medication regiment while also protecting them from harm. Medication continuance is clearly a collaborative team responsibility.

Medication errors can be reported (see Figure 5.3). Generally, errors are related to the wrong drug, the strength or dose of a drug, incorrect routes of administration, mistakes in prescribing or transcribing, and errors from a client taking the wrong medication because of a sound-alike or look-alike name (Karch, 2009).

BLACK BOX WARNINGS

The strongest warning the FDA can provide on a prescription drug is the black box warning (Karch, 2009), where the boxed text is displayed prominently. A black box warning on a drug means the drug carries a significant risk of serious and sometimes life-threatening adverse events and needs to be monitored. Once the FDA approves a warning, the pharmaceutical manufacturer is required to put it on all literature and labeling related to the medicine (U.S. Food and Drug Administration, 2013).

Adverse effects can vary and are medication dependent. Types of serious adverse effects that justify a black box warning include the possibility of suicidal tendencies, loss of bone marrow, and risk of heart attack or heart failure. These warnings often include adverse reactions that are observed, expected, or may occur when the medication is used off label. The warning notes additional considerations along with drug interactions and special considerations for caregivers. To date, this type of warning has been placed on all antidepressant medications related to suicidal attempts and stresses the importance of monitoring a consumer in the first few weeks of treatment. This warning is specifically applied to children, adolescents, and young adults (ages 18–24) (NIMH, 2015a).

This warning can be issued before the drug is officially released and, therefore, included on all supporting information. On the other hand, if the potentially adverse effects are not uncovered during the initial marketing phase, the warning may not be posted until the drug has been on the market for quite some time. Lasser and colleagues (2006) reported that this postmarketing component is critical, as many serious adverse effects are not known with any degree of certainty until a medication has been on the market for years; the longer the medication has been on the market, the more we know about it. This makes keeping updated on the latest information essential. See Figure 5.4 for the location of free FDA medication guides. These include the latest updates on serious adverse effects to assist with patient decision making and adherence to the proper use of a product.
HANDLING THE SUICIDAL CLIENT

Of all the reliable mortality data available, suicide is possibly the most underreported cause of death worldwide (DeLeo, 2015). There are many potential reasons for this underreporting including: the avoidance of stigma; religious, social, or political pressures; life-sustaining medical efforts available; and a lack of standardization with attribution to the cause and standardized certification processes. DeLeo (2015) reminds us that the simple fact of determining whether something is a suicide is complicated further by the dubious circumstances that surround the death (i.e., drowning, falls, motor vehicle accidents, etc.).

Taking into account the possibility of underreporting, the current statistics related to suicide are staggering.

According to the CDC: FastStats in 2013, suicide is ranked the 10th cause of death in the United States, with the greatest number of deaths \( n = 41,149 \) related to firearm suicides \( n = 21,175 \) (website updated in 2015). Furthermore, it was estimated in 2013 that the number of visits for self-inflicted injury was 836,000. In 2004, the Office of Applied Studies (OAS, 2006) estimated 106,079 emergency room visits involved drug-related suicide attempts in adults aged 18 and older, and 41%, or 43,176 individuals, were diagnosed with depression. Because of these earlier linkages between antidepressants and suicidal thoughts, on September 14, 2004, the FDA voted to add black box warnings to all antidepressant product labeling. Furthermore, on December 17, 2008, this warning was extended to include suicidal thoughts and behaviors that could occur with antiepileptic drugs (FDA, 2009c), which will be discussed further in Chapter 8. (See Tables 5.1 and 5.2 for these warning lists.) For a more detailed reference examining studies and data related to whether certain classes of medicines, particularly antidepressants, increase suicidality, see Koslow, Ruiz, and Nemeroff’s (2014) recent book *A Concise Guide to Understanding Suicide: Epidemiology, Pathophysiology, and Prevention*.

Regardless of the substance a client is taking, all clients under the influence of a substance or who suffer from a substance addiction should be screened for the possibility of danger to themselves or others. As social workers, assessing for suicide is an important part of the diagnostic assessment (Dziegielewski, 2015).

Prior to starting any type of intervention, the importance of establishing a trusting and accepting relationship is at the forefront (Moerman, 2012). Once efforts to establish this foundational relationship have been made, the first step is to screen for suicidal thoughts or plans. If the individual makes references to suicide, appears seriously depressed, is starting to feel better after experiencing a sincere depression, or has a history of suicide attempts, be sure to assess for the possibility of dangerous

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**FIGURE 5.4** U.S. FDA medication guides.

A site where medicine updates can be accessed: [www.fda.gov/Drugs/DrugSafety/ucm085729.htm](http://www.fda.gov/Drugs/DrugSafety/ucm085729.htm)
actions. For the most part, regardless of whether the client is a child, adolescent, or adult, assessment for suicidal thoughts requires asking direct questions and directive language (Moerman, 2012). In asking direct questions, clients need to be heard, not just listened to (Papadatou, 2009). A social worker speaking clearly, slowly, and paraphrasing what is said will foster a connection with the client.

### TABLE 5.1 Medications That May Cause Suicidal Thoughts and Behaviors

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Generic Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anafranil (clomipramine)</td>
<td>Asendin (amoxapine)</td>
</tr>
<tr>
<td>Aventyl (nortriptyline)</td>
<td>Celexa (citalopram hydrobromide)</td>
</tr>
<tr>
<td>Cymbalta (duloxetine)</td>
<td>Desyrel (trazodone HCl)</td>
</tr>
<tr>
<td>Effexor (venlafaxine HCl)</td>
<td>Elavil (amitriptyline)</td>
</tr>
<tr>
<td>Etrafon (perphenazine/amitriptyline), Lexapro (escitalopram hydrobromide)</td>
<td>Luvox (fluvoxamine maleate)</td>
</tr>
<tr>
<td>Limbitrol (chloridiazepoxide/amitriptyline)</td>
<td>Ludiomil (maprotiline)</td>
</tr>
<tr>
<td>Marplan (isocarboxazid)</td>
<td>Nardil (phenelzine sulfate)</td>
</tr>
<tr>
<td>Norpramin (desipramine HCl)</td>
<td>Pamelar (nortriptyline)</td>
</tr>
<tr>
<td>Parnate (tranylcypromine sulfate)</td>
<td>Paxil (paroxetine HCl)</td>
</tr>
<tr>
<td>Pexeva (paroxetine mesylate)</td>
<td>Prozac (fluoxetine HCl)</td>
</tr>
<tr>
<td>Remeron (mirtazapine)</td>
<td>Sarafem (fluoxetine HCl)</td>
</tr>
<tr>
<td>Serzone (nefazodone HCl), Surmontil (trimipramine)</td>
<td>Sinequan (doxepin)</td>
</tr>
<tr>
<td>Symbyax (olanzapine/fluoxetine)</td>
<td>Tofranil (imipramine hydrochloride)</td>
</tr>
<tr>
<td>Tofranil-PM (imipramine pamoate)</td>
<td>Triavil (perphenazine/amitriptyline)</td>
</tr>
<tr>
<td>Vivactil (protriptyline)</td>
<td>Wellbutrin (bupropion HCl)</td>
</tr>
<tr>
<td>Zoloft (sertraline HCl)</td>
<td>Zyban (bupropion HCl)</td>
</tr>
</tbody>
</table>

Adapted from FDA (2011).

### TABLE 5.2 Antiepileptic Drugs That Now Include Warnings

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Generic Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carbatrol, Equetro, Tegretol, Tegretol XR</td>
<td>Carbamazepine</td>
</tr>
<tr>
<td>Depakote, Depakote ER</td>
<td>Divalproex sodium</td>
</tr>
<tr>
<td>Felbatol</td>
<td>Felbamate</td>
</tr>
<tr>
<td>Neurontin</td>
<td>Gabapentin</td>
</tr>
<tr>
<td>Lamictal</td>
<td>Lamotrigine</td>
</tr>
<tr>
<td>Keppra</td>
<td>Levetiracetam</td>
</tr>
<tr>
<td>Trileptal</td>
<td>Oxcarbazepine</td>
</tr>
<tr>
<td>Lyrica</td>
<td>Pregabalin</td>
</tr>
<tr>
<td>Topamax</td>
<td>Topiramate</td>
</tr>
<tr>
<td>Gabitril</td>
<td>Tiagabine</td>
</tr>
<tr>
<td>Zonegran</td>
<td>Zonisamide</td>
</tr>
</tbody>
</table>

Adapted from FDA (2009c).
Critical questions to ask are the following:

- Have you considered harming yourself or someone else?
- If so, what would you do?
- How would you do it?
- Have you ever tried to do this before? What did you do that time?
- What would stop you from harming yourself?
- Have you ever considered harming anyone else? If so, what would you do and why? (Determine if they have access to the means or a plan for action or self-harm.)

If the potential for suicide is suspected, regardless of whether the client has a formal plan, a clear safety plan to address the potential for self-harm or harm to others should be addressed. All documentation must include an acknowledgment of the symptoms and a clear safety plan.

The strength of supportive intervention is in the planning and preparation for a client’s return to his or her environment or previous living situation. The effectiveness of a no-harm no-risk agreement is only as strong as the safety plan attached to it. If this type of formalized agreement helps, clearly outline the safety plan and then use it. Be sure, however, that you also use referrals as needed and seek inpatient treatment as part of a clear safety plan. Regardless of how the safety plan is formulated or implemented, be sure you have documentation that the questions have been asked and the client’s responses addressed.

When arranging for discharge planning, the absence of visible depressive symptoms may give the client and family members a false sense of total recuperation. Family members, employers, and coworkers may expect the client to resume normal family and occupational activities, resulting in an emotional overload for the client. Many times clients do not respond as actively as they did in the past, which may result in frustration for the client and other members of the environmental support system. There are inherent risks that clients may want to discontinue their medication once symptoms of depression lift. While all clients have the right to self-determination in medication and other aspects of treatment, social workers can help educate them about the triggers and risk of relapse (Dziegielewski, 2006). Grief and the interpretation of life circumstances can change across the life span; for more in-depth reading in this area consider the work of Walter and McCoyd (2009).

HONORING CONFIDENTIALITY AND WHEN TO TAKE PROTECTIVE ACTION

Many social workers struggle with what can and cannot be revealed when working with a suicidal or depressed client. Although statutory laws differ across the states, Gamino and Ritter (2009) described eight exceptions that allow the release of confidential information: client-authorized release of information, danger to self, danger to others, neglect or abuse of children and vulnerable adults, complaints or litigation against the counselor, litigation concerning emotional pain and suffering, court-ordered or statutory requirements to disclose, and requirements of third-party
payers. For a complete discussion of these instances the reader is referred to Gamino and Ritter, as only the ones most relevant to this discussion will be addressed here.

The first exception, and the most relevant here, is a client-authorized release of information. On any safety plan, get the client’s permission to contact the family and make sure they are aware of the situation, any intervention efforts, and the safety plan.

The second and third exceptions involve assessing for danger to self or others. It is crucial to make sure assessments include not only what clients might do to themselves, but also whether others could be at risk. Social workers often struggle to evaluate vague threats and wonder whether a person will actually act on what he or she says. Gamino and Ritter (2009) identified a number of factors particularly relevant to the seriousness of the threat:

■ Is the client male?
■ What is the client's current marital status and is he or she recently divorced or separated, single, or widowed?
■ Is the client White or Native American?
■ Is the client over the age of 60?
■ Does he or she lack social support (especially no young children in the home)?
■ Does the client or other family members have a history of attempted suicide?
■ Is the client recently unemployed or experiencing a recent decline in financial assets?
■ Is there a history of abuse (sexual, physical, and emotional)?
■ Is there a mental or medical illness (particularly depression) with a recent admission and discharge from a hospital?
■ Is there alcohol use and abuse?
■ Are firearms present?

When dealing with danger to self and others, and duty-to-warn issues, factors surrounding the case of Tarasoff v. the Regents of the University of California (1976) are often stated. In this landmark case, an individual and her family were not warned of a potential threat made against her by a client in a therapeutic session. In this situation, the threat to the victim's life was told to the offender's psychologist but no warning was issued to the victim. Sadly, the client acted on the threat and took the victim's life. It is not known whether reporting this threat could have saved her life. Since the threat was held in confidence and not reported, we will never know if revealing it could have helped to save her. Based on lessons learned in this case, precautions are often taken to avoid such situations by invoking “duty to warn.” This tragedy and the lessons learned from this case alert us to the importance of keeping up-to-date information about the duty-to-warn law in your particular state and how it relates to the protection of all within our professional code of ethics. Also, always consult with a colleague or supervisor before you act in good faith to protect another from harm. In addition, always ask yourself this question:

■ If I was brought before a jury of my peers, would they arrive at the same decision? Be sure to outline the rationale for your decision.
Once a potential threat is ascertained, it is expected that notification of the individual(s) at risk, the police, and those involved may need to be implemented. Gamino and Ritter (2009) remind the counselor to ask two critical questions before taking any action to protect others:

1. Is there a previous history of violent behavior toward people or animals?
2. Does the individual have possession of a firearm?

Last, if a client threatens to harm someone vulnerable, such as a child, an older adult, or a mentally impaired adult, mandatory reporting requires it be immediately addressed and the local protective agency called.

**PRESCRIPTION DRUGS USED ILLEGALLY**

After alcohol, tobacco, and marijuana, psychoactive prescription medications are among the most frequently abused substances (Goldberg, 2014). Furthermore, a 2007 National Survey on Drug Use and Health found that first-time drug users started off with prescription medication abuse as opposed to marijuana, which is often referred to as the “gateway drug” (Shenk, 2009). In 2011, the United Nations Office on Drugs and Crime (UNODC, 2011) published a discussion paper stating that the use of prescription medications for nonmedical purposes has reached global proportions and is clearly a worldwide concern. Of particular concern is the use of opioids, benzodiazepines, and synthetic prescription stimulants (UNODC, 2010).

Traditionally, acquiring legal drugs illegally was accomplished by visiting multiple physicians—a process known as “prescriber shopping.” It is not uncommon for social workers to hear stories of someone losing a medical insurance card only to find it had a lot of unauthorized activity. Although this pattern continues, we now see a rise in Internet pharmacies (discussed in Chapter 3), which may not have physician/prescriber oversight. In addition, these drugs can be acquired from family or friends. In the addiction field, many professionals joke that the new drug dealer is not the person selling drugs on the street corner—it is the one with access to your medicine cabinet.

Some people believe a medication cannot be harmful if a family member or friend is taking it under medical supervision. Furthermore, some teenagers now hold “pharm” or “fishing” parties, where a bowl of medications collected from participants’ homes is passed around. The bag of pills may be referred to as “trail mix” or “skittles” and pills are often shared as part of the celebration. With behaviors such as this on the rise (Prosser & Nelson, 2008), it is no surprise that the most prominent and deadly abused drugs are prescription medications (CDC, 2007). The most commonly abused prescription drugs are depressants, opioids and painkillers, and stimulants (FDA, 2015b). There has also been an increase in other compounds of abuse, such as anabolic steroids (National Institute on Drug Abuse [NIDA], 2006).

**Depressants**

Depressants are legal drugs that suppress the CNS. Antidepressants work to modulate and in turn normalize naturally occurring brain chemicals called “neurotransmitters”
The most commonly discussed neurotransmitters related to mood regulation are: serotonin, dopamine, and norepinephrine. These drugs have therapeutic value when prescribed by a physician and used as directed. See Table 5.3 for examples of depressants often abused. CNS depressants are used to create a calm feeling and can make an individual drowsy and tired. The prescribed medical uses for these medications include the treatment of anxiety, tension, panic attacks, and sleep disorders.

Depressants come in two classes: barbiturates and benzodiazepines. Barbiturates are hypnotics that suppress CNS activity; some of these drugs have fast-acting and long-lasting effects. Amobarbital, pentobarbital, and secobarbital are a few barbiturates preferred by abusers. Barbiturates often cause sedation, drowsiness, irritability, poor judgment, and slurred speech.

Benzodiazepines, traditionally referred to as “antianxiety” medications, provide a calming effect and induce a more relaxed state or even sleep. Some examples of benzodiazepines include Xanax, Valium, Klonopin, and Ativan. Overdosing on these drugs can result in drowsiness, respiratory depression, unconsciousness, and coma. Benzodiazepines cause the same symptoms as barbiturates with the addition of dizziness.

One particular benzodiazepine often associated with sexual assaults and referred to as the “date rape drug” is flunitrazepam (brand name Rohypnol), which generally causes temporary memory loss.

### Pain Relievers

Pain relievers (also referred to as “painkillers”), usually opioid or morphine derivatives, are also commonly abused. Approximately 21.5 million Americans reported that at least once in their lifetimes they had used prescription pain relievers for non-medical reasons (FDA, 2015b). When taken as directed, these medications can help relieve the discomfort from chronic pain. They are also used in preparations to help control coughs (i.e., codeine) and diarrhea. Drug addiction and misuse of opiates has been recognized as a global concern causing major public health concerns (UNODC, 2015c).
2011). The use of these medications is so problematic that in 2013 the FDA required prescription label changes to promote better prescribing and the safer use of opioids (FDA, 2013). “Five million people in the United States are chronic drug abusers, and 20% are opiate addicts . . . only 2.1 million receive treatment, 179,000 of whom are in methadone treatment” (McCaffrey, 2000, p. 1). These numbers illustrate a social obligation to close the gap between the need for and the availability of appropriate drug addiction services (NIDA, 2001).

Oxycodone is a synthetic opiate used in many prescription pain medications, including Percodan, Vicodin, and OxyContin. OxyContin was introduced as a pain relief medication by Purdue Pharma in 1995. It is a potent time-release pill that has become popular with drug abusers, who chew the tablet or melt it down and inject it. According to Meier (2002), abuse of OxyContin has grown faster than abuse of any prescription drug in decades. To combat these rising concerns, new clinical guidelines were suggested in 2009 based on the recommendations of a panel of pain-management experts for the treatment of noncancerous pain. This expert group, sanctioned by the American Pain Society and the American Academy of Pain Medicine, outlined how decisions about chronic opioid therapy must weigh the benefits of these medications with the risks of side effects and abuse (Gandey, 2009); see Table 5.4.

<table>
<thead>
<tr>
<th>Pain Relievers</th>
<th>Brand Name</th>
<th>Street Name</th>
<th>Schedule; How Administered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codeine</td>
<td>Empirin with Codeine, Fiorinal with Codeine, Robitussin A-C, Tylenol with Codeine</td>
<td>Captain Cody, doors and f ours, pancakes and syrup</td>
<td>Schedules II, III, and IV; swallowed</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>Actiq, Duragesic, Sublimaze</td>
<td>China girl, dance fever, murder 8, TNT</td>
<td>Schedule II; injected, smoked, snorted</td>
</tr>
<tr>
<td>Morphine</td>
<td>Roxanol, Duramorph</td>
<td>Miss Emma, monkey</td>
<td>Schedules II, III; injected, swallowed, and snorted</td>
</tr>
<tr>
<td>Opium</td>
<td>Laudanum, paregoric</td>
<td>Guma</td>
<td>Schedules II, III, and V; swallowed, smoked, injected</td>
</tr>
<tr>
<td>Other opioid pain medications (oxycodone, meperidine, hydromorphone, hydrocodone, propoxyphene)</td>
<td>Tylox, OxyContin, Percodan, Percocet, Demerol, Vicodin</td>
<td>Oxycotton, hillbilly heroin</td>
<td>Schedules II, III, and IV; swallowed, injected, suppositories, chewed, crushed, snorted</td>
</tr>
</tbody>
</table>

Adapted from DrugAbuse.com (2015); NIDA (2005b).
Stimulants

The third category of frequently abused prescription drugs is stimulants. According to the FDA (2015b), approximately 21.2 million Americans have used stimulant preparations at least once for nonmedical reasons; additionally, almost 13 million people reported using prescription methamphetamines at least once in their lifetimes (FDA, 2015b). These medications are desirable as they produce increased brain activity, resulting in greater alertness, attention, and energy. When they are used incorrectly, however, they can result in increased heart rate and blood pressure, even heart failure. According to a recent epidemiological review of 43,093 cases by Huang and colleagues (2006), it appears that prescription drug abuse and resultant dependence was greatest for amphetamines (classified as stimulants) and nonmedical prescription drugs when comorbid with a mental disorder as defined in the previous version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; APA, 2000).

In addition, prescription drug abuse involving amphetamine effects such as those occurring with Ritalin (methylphenidate) is on the rise (Prosser & Nelson, 2008). Since amphetamines have a pronounced abuse and dependence liability, the recent increase in the potency of illegally manufactured amphetamines has taken a toll on adolescents (Drug Abuse Warning Network [DAWN], 2006). Those who take methylphenidate illegally often take it orally, intravenously, or intranasally. The reason for taking these medications without a prescription is generally a desire to capture their stimulant effect, believing they help the client stay awake or improve school performance (Prosser & Nelson, 2008). Furthermore, the increase in the abuse of prescription pain relievers leaves many prescribers feeling they have to practice defensively, scrutinizing clients and the potential for manipulation and abuse. Additional negative effects include product theft, crimes committed to earn money to obtain the drug, and law enforcement costs (Manchikanti, 2006). See Table 5.5 for a list of often abused prescription stimulants and Table 5.6 for commonly abused steroids.

<table>
<thead>
<tr>
<th>Substance Category</th>
<th>Brand Name</th>
<th>Street Name</th>
<th>Schedule; How Administered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amphetamines</td>
<td>Biphetamine, Dexadrine</td>
<td>Bennies, black beauties, crosses, speed, uppers</td>
<td>Schedule II; injected, swallowed, smoked, and snorted</td>
</tr>
<tr>
<td>Cocaine</td>
<td>Cocaine hydrochloride</td>
<td>Blow, candy, coke, Charlie, crack, snow, toot</td>
<td>Schedule II; injected, smoked, and snorted</td>
</tr>
<tr>
<td>Methamphetamine</td>
<td>Desoxyn</td>
<td>Chalk, crank, crystal, ice, meth, speed</td>
<td>Schedule II; injected, swallowed, smoked, and snorted</td>
</tr>
<tr>
<td>Methylphenidate</td>
<td>Ritalin</td>
<td>Vitamin R, skippy, R-ball</td>
<td>Schedule II; injected, swallowed, and snorted</td>
</tr>
</tbody>
</table>

Adapted from DrugAbuse.com (2015).
Anabolic Steroids

The last area of prescription medication abuse is other compounds, such as anabolic steroids. Anabolic steroids are lab-created (synthetic) versions of the male hormone testosterone. The term “androgenic” (related to male characteristics) is given to this category of drugs, and the term “anabolic” refers to the tissue building that occurs. “Steroids” is the term that refers to the specific class of drugs. Thus, these drugs are known as “androgenic anabolic steroids” (DEA, 2004). When they were first introduced in the 1930s, these drugs were intended to assist with hypogonadism, a condition in which the testes do not produce enough testosterone and normal sexual development is delayed. Thus, these medications are often used to treat delayed puberty or to counteract conditions that cause wasting, such as HIV infection (NIDA, 2005).

Abuse of these drugs has historically been associated with athletes and fitness enthusiasts. Today, steroid abuse is one of the most severe problems in sports (Shen, Xaing, Shen, Bu, & Wang, 2009). Its popularity, however, is spreading among the general public, as many see these drugs as a way to create a perfect body. The side-effect profiles from these drugs can be dangerous. Physical side effects include high blood pressure, severe acne, thinning of hair and baldness, fluid retention, liver disorders, and sexual and reproductive disorders. There is also a high risk of HIV and other blood-borne diseases if these substances are injected with shared needles (DEA, 2004). Psychological reactions include mood swings that can lead to violence, impaired judgment, depression, extreme irritability, delusions, and aggression.

### TABLE 5.6 Anabolic Steroids Often Used Illegally

<table>
<thead>
<tr>
<th>Substance Category</th>
<th>Brand Name</th>
<th>Street Name</th>
<th>Schedule; How Administered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anabolic steroids</td>
<td>Anadrol, Oxandrin, Deca-Durabolin, Testosterone, Equipoise</td>
<td>Roids, juice</td>
<td>Schedule III; injected, swallowed, and snorted</td>
</tr>
</tbody>
</table>

Adapted from DrugAbuse.com (2015).

### TREATMENT OF SUBSTANCE ABUSE OR DEPENDENCE

Segal, Gerdes, and Steiner (2004) noted that some individuals are more vulnerable to developing addiction or prescription dependence while others may be able to use the same substance with no problematic effects. Prescription abuse that leads to dependence can be difficult to address. Successful intervention efforts require familiarity with psychotropic medications as well as supplemental psychosocial interventions effective in treating prescription substance abuse. A multidisciplinary or interdisciplinary team approach incorporates the following:

1. Recognition of the potential problems with this type of abuse
2. Understanding how belief in the safety or necessity of these substances can easily lead to addiction
3. Use of brief treatment using cognitive behavioral modification (including skills training and systematic desensitization)

4. Including social support in the form of professional encouragement and assistance (Dziegielewski, 2005)

An individualized, time-limited model is suggested for addressing potential problems associated with prescription medication abuse (Dziegielewski, 2005). Furthermore, it is worth noting that many individuals do not use just one drug. For example, Skarberg, Nyberg, and Engstrom (2009) warn that substances such as alcohol and other drugs significantly raise the danger for adverse effects, particularly with anabolic steroid abuse.

Treatment for people with addictions to these substances is complex. An individual must first recognize he or she is addicted, which generally starts with a change in mood, weight, or interests. An abused drug is continually used even though there is no medical need. In physical or psychological dependence, an individual needs a substance to continue functioning and uses the substance even though he or she knows negative circumstances could result. When abuse becomes dependence, careful evaluation for withdrawal—what is commonly referred to as “abstinence” or “discontinuance syndrome”—is expected. Due to the severity of withdrawal symptoms, detoxification can be dangerous and demands close monitoring.

For example, Rassool (1998) outlined a management plan for withdrawal from benzodiazepines. The client must be advised of the benefits of becoming clean and educated on the symptoms of withdrawal. Psychopharmacology is recommended to curb the extreme anxiety the client may feel (Ciraulo & Nace, 2000; Substance Abuse and Mental Health Services Administration [SAMHSA], 2001, 2002). Alternative medications include buspirone, trazodone, venlafaxine, nefazodone, and paroxetine (Ciraulo & Nace, 2000). Rassool described the next step as a gradual decrease of the addictive substance with close monitoring of the reduction. He stressed the importance of implementing coping skills and support for the anxiety. Complementary therapies, including aromatherapy, acupuncture, and reflexology, can also be used to assist with pain management when addressing benzodiazepines.

Cognitive behavioral therapy, in combination with a 12-step program, is recommended for treatment of addiction to benzodiazepines (Ciraulo & Nace, 2000). Furthermore, a well-integrated, individualized program that includes individual, group, and family counseling, as well as contingency management, appears most effective for those addicted to prescription medications (NIDA, 2001). In terms of psychotherapeutic strategies, cognitive behavioral interventions are considered the primary supportive intervention for those who suffer from anxiety-related conditions.

NONPRESCRIPTION OR OVER-THE-COUNTER MEDICATIONS

A nonprescription medicine, also known as an “OTC medication,” is any drug that can be purchased without a prescription. Some of the most common OTCs include antacids, laxatives and stool softeners, antidiarrheals, cold and allergy medications, and pain relievers (PDR for Nonprescription Drugs, 2009; FDA, 2015d). To date, there are
hundreds of products available without a prescription (PDR Network, 2014). These medications can be purchased off the shelf in most pharmacies or convenience stores.

There are over 80 therapeutic categories of OTC medications that fall under the oversight of the Center for Drug Evaluation and Research (CDER) under the FDA. According to the FDA (2009b), a medication must have several characteristics to be considered for OTC status. First, the benefits of the medication must outweigh the risks, with only a low potential for misuse or abuse. Second, the consumer must be able to use them for self-diagnosable conditions—where independent action is warranted and a health practitioner’s advice is not needed for safe and effective use of the product. Last, the labels need to provide clear and easy-to-follow instructions.

The FDA periodically reviews its policies on OTC products. During a review in 1972, more than 600 drugs were changed from prescription to nonprescription status, and similar results are expected from hearings that started in 2000 (Cauchon, 2000). These constant changes and updates have resulted in the reclassification of some prescription medicines as general sales. These updates continue to provide the public with greater access to medicines for self-care (Watson, Bond, Grimshaw, & Johnston, 2006). For example, on May 4, 2011, the FDA issued guidance to manufacturers of OTC liquid medications to ensure that directions and markings on any dosage cups were easy to read (FDA, 2015e). With increased availability, consequently, sales of OTC medications have also increased (Bond & Hannaford, 2003). Many Americans feel the convenience of purchasing OTC medications is important for immediate access to products that can provide relief for minor medical problems. This demand and the expected profits have encouraged drug manufacturers to switch from prescription to nonprescription medication development.

Although many social workers acknowledge the importance of understanding prescription medications, little emphasis is placed on knowing nonprescription medications. More nonprescription medications become available to clients every day, and for many a trip to the pharmacy has become a substitute for a trip to the physician (Colino, 2000).

The use of OTC medications is complicated because many clients believe they are not harmful. They may also not be aware that the abuse potential related to OTC medication has been recognized as an international concern (Cooper, 2013). It is critical for the social worker to remember that the interactions between OTC and prescribed medications can produce powerful effects; in fact, many OTC medications were once available only with a prescription.

Many of the concerns expressed in this chapter related to prescription medications often apply to nonprescription medications as well.

All OTC medications are required to have a Drug Facts label; this resource can help inform clients about their medications. Each medication also has warnings listed. The warnings are reminders of what a client should and should not do while taking the medication as well as how he or she might expect to feel.

The reason for choosing an OTC medication instead of a prescription medication should not be based on strength or implied safety. OTC medications can be just as powerful as prescription ones, so the consumer should always talk with a medically trained professional on what and how much to take (FDA, 2015d). Social workers need to be aware of and dispel the myth that increased amounts of a medication are more effective, as they can actually be worse.
The use of OTC medications can be a significant problem with older people (FDA, 2015d). Two-thirds of adults over 65 use one or more drugs daily and older persons use an average of three prescription and nonprescription drugs at any given time (Cohen, 2000). “Start low and go slow” is a well-known medication dosing precaution when working with older individuals because of adverse drug reactions. In patients 60 and older, more than half used five or more prescription medications, OTC medications, or dietary supplements (Qato et al., 2008).

The social worker’s awareness of the effects OTC medications can have on the therapeutic environment is crucial for competent and efficient practice. Use of these medications continues to rise and compels social workers to fully appreciate these medications, their potential toxic interactions with other drugs, their effects on mental disorders, and their impact on the treatment process.

In addition, as clients make more self-help OTC purchases, medication storage can become problematic. Clients should be warned that OTC and prescription medications should not be kept in bathroom medicine cabinets, which are frequently hot, humid, and subject to temperature variations. A dark, dry place such as a linen closet is a better place for storing both prescription and nonprescription medications.

**ADDITION TO OVER-THE-COUNTER MEDICATIONS**

Clients do not become dependent only on prescription drugs; dependence and addiction can also occur with OTC drugs. Many individuals take OTC drugs regularly, perhaps even daily, without thinking about the relationship between these drugs and other health factors. Because these medications are easy to purchase and readily available, there is a misconception that they cannot harm. Nonsteroidal anti-inflammatory drugs (NSAIDs) such as aspirin or ibuprofen are among the most frequently used and can cause stomach bleeding, ulcers, and can disrupt normal kidney functioning (Mayo Clinic, 2000a).

There is one major difference between OTC and prescription drugs: With OTC drugs, addiction does not involve getting high from the medication, but rather stems from taking the medication longer than expected and developing a need to continue taking it. Addiction can be defined as “abstinence syndrome.” If an individual experiences physical or psychological withdrawal symptoms upon discontinuance, addiction has occurred. In the case of caffeine, for instance, an individual who has not had a morning coffee or tea develops a headache. Chances are this person is addicted (Dziegielewski, 2005). Ingesting a caffeinated beverage will reduce the pain more quickly than an aspirin because the body craves the drug and will be satisfied only by taking it. See Figure 5.5 for OTC medications that have the greatest potential for addiction.

The social work professional who understands medication use and misuse can also help clients integrate situational or environmental concerns that may not be listed in the PDR. For clients, use of the Internet (drugs.com) may offer an easy-to-use resource that can provide information on more than 24,000 prescription, OTC, and natural products. Inclusive resources such as this can provide easy access to all of these products in one convenient place. Being aware of the role of nonprescription medications and their effects on the body is essential, especially in terms of the potential for addiction.
The words of wisdom from Wilson (1992), supported by the FDA (2015d), still remain relevant in terms of advice for using medications wisely:

1. Always read the label on a new bottle or package and help the client understand it (FDA, 2015d). Always check the list of ingredients (manufacturers frequently update ingredients), the warnings, and the expiration date. Expiration dates are important to note because the ingredients may not remain in an active state after that date. If there are two expiration dates, follow the latest one. If the product is outdated it should be discarded immediately following proper disposal procedure.

2. Warn clients to limit their dose to the amount specified in the product directions (FDA, 2015d). This is of particular importance for those who practice self-medication. Clients should have simple, written, easy-to-use directions. Some clients, especially older people, may find a chart or table to accompany written directions useful. It could indicate when the medication is to be taken and allow the client to check off the doses as taken. Social workers can also advise clients to use egg cartons to dispense their daily doses. Remind clients never to skip a dose, share medicines, or take other medications without considering their effects and what they are currently taking. Social workers need to remind their clients to keep records of all their medications, including herbal preparations and OTC and prescription medications. Clients may not remember every medication, especially when they are nervous, ill, or under pressure. Be sure your clients have a list of the medications they are taking and update it regularly.

3. It is important to empower clients and their families by either asking or helping them ask relevant questions related to medication use. Clients should know the name of the medicine, why they are taking it, and how it should be taken. They should also know how long to continue the medication and what foods or beverages to avoid while taking it. In this rapidly changing field with a vast number of drugs available, social workers are encouraged to help clients seek additional information on side effects and the potential for adverse reactions between medications.

4. When clients suspect they are taking too much of an OTC preparation, they probably are. Advise them that it is possible to become addicted to a nonprescription medication. Clients should consult their primary physicians when physiological symptoms of dependence are suspected and should work...
toward terminating use of the medication. Oftentimes, convincing them to stop buying the product or to place it out of reach is the most simple and effective solution. Social workers should encourage clients to keep a log indicating the frequency, dosage, time of day, and the stresses that precipitate use of the medication. In this way, clients will become more aware of the habits and patterns that trigger their dependency.

5. Educate your clients about addiction. If they find it difficult to give up or if they justify why they are using a medication frequently, explain that the problem can become more serious and they should not be embarrassed to ask for help. This is especially important with OTC remedies because many clients do not know they can be addictive. Integrating basic education and support into the therapeutic relationship can help address the concerns of the client and family and can facilitate the intervention process and help medications work more effectively.

LESSONS FROM THE PAST

Listening to lessons learned in the past can help to improve and anticipate problems in the future. Consider fenfluramine (approved in 1973), Redux (approved in 1996), and other potentially deadly diet pills. These pills were distributed and prescribed repeatedly even after numerous warnings that not enough was known about them.

The FDA approved fenfluramine as safe for short-term use in 1973 under the assumption it would be prescribed for individuals who were severely obese and not responding to other forms of treatment. However, many physicians dispensed prescriptions to individuals who were not obese but rather seeking a quick fix for their weight problems. Furthermore, studies suggested the combination of two drugs—fenfluramine and phentermine (called “fen–phen”)—would help shed pounds faster with fewer side effects. Although the FDA never approved the combined use of these drugs, it became one of the hottest selling remedies for weight control in the drug industry (Golden, 1997).

Redux was approved in 1996, and soon 2.5 million prescriptions were written and the number of people exposed to the drug rose to 60 million worldwide (Golden, 1997). In July 1996, Mayo Clinic researchers reported serious heart-valve damage in fenfluramine and Redux users. Eventually 30% of the 291 users of the drug combination fen–phen reported the same problems (Golden, 1997); combination use of the drug was prohibited, and Redux was recalled. Golden asks who should be held accountable for errors of this type. Golden believes the primary responsibility should rest with the FDA for approving Redux, given that it received five votes in favor of approval and three against, and considering that researchers had serious misgivings.

The drug companies that produced, tested, and marketed these drugs while knowing that more research was needed are responsible, too, as well as physicians and weight-control programs that eagerly dispensed them to individuals for whom the drugs were never intended. Some blame can be placed on the media, which advertised and promoted the drugs as a miracle, and on the clients, who so desperately wanted to lose weight. Regardless, consumers were harmed, and professionals
who were supposed to act in the best interests of their clients lost credibility. Social workers need to look carefully at the benefits and limitations of medications, always remembering and reminding their clients that medication prescription is not an exact science. This requires that social workers become more aware of how medications work, the effects they can have on individuals, and ways to more effectively educate their clients about the use and misuse of these drugs.

**SUMMARY AND CONCLUSIONS**

Social workers are often involved in medication regimens, and the more knowledge they have in the area, the more equipped they will be. Awareness of drug scheduling and medication classification can help the social worker stay abreast of classification changes and the reasons for such modifications. The presumption that medications (whether OTC or prescription) are safe is false and increases the likelihood of abuse, dependence, and withdrawal. According to the FDA (2015b), millions of Americans utilized painkillers for a nonmedical use, and prescription medication abuse ranks second only to marijuana use. The latest DAWN (a public health surveillance system) statistics (2007 Report) stated that opiates and opioids were most commonly associated with drug-related deaths, followed in prevalence by cocaine and benzodiazepines, respectively (SAMHSA, 2009, updated 2015).

The role of the social worker in helping to understand, communicate, monitor, and document issues surrounding the use of prescription and nonprescription medications is an important one. Social workers need to be aware of medication actions and interactions and help clients prepare for and avoid negative reactions. When a client appears to be using a prescription or nonprescription drug improperly and when dependence may result, a medical exam must determine the degree of intervention needed. A social worker must be prepared to question and address client assumptions that prescription and OTC medications are neither harmful nor addictive. A comprehensive medication history will facilitate the intervention team in prescribing appropriate treatment protocols and should include past substance abuse history and all drugs used by the client (including OTC prescriptions, herbal remedies, and prescribed medications). Medication continuance will be enhanced if the social worker can identify abuse patterns and practice defensively, watching for dependence and the dangers of nonmedical use of prescription as well as OTC medications. Social workers should recognize potential problem areas related to the use of prescription and OTC drugs and relate them to information provided in other chapters, incorporating effective psychosocial interventions as part of the recommended course of treatment.