# PSYCHOTROPIC STORM: AN ANALYSIS OF PSYCHIATRIC OVERPRESCRIPTION AND THE LAW

*Sofia Wyman*

TABLE OF CONTENTS

## I. INTRODUCTION

Imagine: After a series of stressful weeks at work and bickering with her partner and relatives, Jane Doe schedules an appointment with her local psychiatrist. During a standard forty to sixty minute initial session,[1] Jane tells the psychiatrist what has been going on professionally and at home.[2] She then tells the psychiatrist that she has not been sleeping well, generally feels fatigued, has been experiencing bouts of melancholia and anxiety, and thinks that an antidepressant (i.e., Prozac), sedative-hypnotic (i.e., Xanax), or a combination of both prescriptions, would help her feel better.[3] The psychiatrist jots down a few notes and asks for more details about Jane's symptomatology and general physical health.

After making sure Jane does not have allergies, other illnesses, or concurrent prescriptions that might contraindicate her use of the requested psychotropic medications,[4] the psychiatrist writes a prescription for the lowest recommended dose of each drug, and schedules Jane for a follow-up in a few weeks.[5] Later that day, the psychiatrist will be flown out by a pharmacology company to speak at a conference about that company's psychotropic drugs.[6] The psychiatrist will speak about reported effects on patients, doses that seem most effective, and other relevant topics.[7] The pharmacology company will pay the psychiatrist for speaking at this

---

1. *See A Guide to Your First Visit with a Psychiatrist*, LIGHTHOUSE HEALTH GRP. (May 16, 2018), https://lighthousehealthflorida.com/a-guide-to-your-first-visit-with-a-psychiatrist/ (describing standard length of initial psychiatric consultation).

2. *See id.*; *see also What to Expect at a Psychiatry Appointment*, HOLINER PSYCHIATRIC GRP., https://holinergroup.com/blog/psychiatry-appointment-expectations/ (last visited May 23, 2023) (describing the psychiatric appointment process).

3. Malini Ghoshal, *What Is a Psychotropic Drug?*, HEALTHLINE (Nov. 6, 2019), https://www.healthline.com/health/what-is-a-psychotropic-drug ("Psychotropics are a broad category of drugs that treat many different conditions. They work by adjusting levels of brain chemicals, or neurotransmitters, like dopamine, gamma aminobutyric acid (GABA), norepinephrine, and serotonin. There are five major classes of legal psychotropic medications: anti-anxiety agents, antidepressants, antipsychotics, mood stabilizers, and stimulants."). Notably, controlled substances such as benzodiazepines and stimulants fall under the "psychotropic" umbrella, *see id.*

4. *See id.*

5. *See A Guide to Your First Visit with a Psychiatrist*, *supra* note 1; *see also What to Expect at a Psychiatry Appointment*, *supra* note 2.

6. Robert Whitaker, *Anatomy of an Industry: Commerce, Payments to Psychiatrists and Betrayal of the Public Good*, MAD IN AM. (Sept. 18, 2021), https://www.madinamerica.com/2021/09/anatomy-industry-commerce-payments-psychiatrists-betrayal-public-good/ (describing how pharmacology companies pay psychiatrists directly for services related to their medications, despite federal Open Payments legislation).

7. *See id.*

conference and has already compensated her for past talks and consultations regarding its psychotropic products that she regularly prescribes.[8]

Now imagine a different scenario: John Doe downloads a psychiatry app on his phone. He connects with a licensed psychiatrist via a chatroom and describes his struggle with depression and panic. Remotely and facelessly, the psychiatrist asks John a few questions about his symptoms, mental and physical health records, and medication, family, and allergy history. When asked about his relationship with alcohol and drugs, John lies and tells the doctor he has never had an issue with alcohol. John walks away from the encounter with prescriptions for antidepressants and sedative-hypnotic medications.[9] A week later, John still is not feeling better. Notably, antidepressants generally take a few weeks to build up enough in one's system to elicit noticeable effects, and sedative-hypnotics work in the moment to quell feelings of intense anxiety, wearing off within a few hours.[10] He reaches out to his psychiatrist via the app's chatroom, explaining that he feels very low and anxious. Unable to ascertain how severe John's condition is, the psychiatrist simply increases John's antidepressant dose.[11] As John's mood continues to deteriorate, he goes to a local bar and drinks heavily after taking multiple doses of his prescribed medications.[12] He dies from the fatal interaction between his sedative-hypnotic and high blood alcohol content.[13]

These scenarios may sound too extreme to be realistic. The truth is, both are inspired by the very real state of the psychiatric system[14] and inadequate regulation

---

8. *See id.*

9. *See* Caleb Melby & Polly Mosendz, *Telehealth Giant Drew People with Addiction. Deaths, Overdoses Followed*, BLOOMBERG (Nov. 10, 2022), https://www.bloomberg.com/news/features/2022-11-10/addicts-signed-up-for-telehealth-giant-that-prescribed-drugs-online-deaths-ove?leadSource=uverify%20wall. This scenario is inspired by real life case of Greg Grant, a 51-year-old Texan who used telehealth psychiatric service, Cerebral, to help him with his mental health for approximately two months before he committed suicide, *id.* Grant struggled with substance abuse, depression, and suicidal thoughts, *id.* Psychiatric personnel at Cerebral prescribed him an antidepressant but failed to flag Grant's alcoholism, even though he reported "drink[ing] a can of beer before heading to his job" to cope with "crippling anxiety attacks" that caused "his hands to shake," *id.* In response, the nurse practitioner in charge of his care did not make moves to reassess Grant, instead upping his antidepressant dose, *id.* That was the last time Grant interacted with the Cerebral nurse, prior to embarking on a binge-drinking episode and ultimately committing suicide, *id.*

10. *See id.*

11. *See id.*

12. *See id.*

13. *See id.* Note that Grant's circumstances are different; the article does not state that he committed suicide by overdosing on the medication prescribed to him by Cerebral, *id.* However, Grant did commit suicide after his mental health provider failed to reassess Grant's symptoms and instead attempted to remedy them by increasing his antidepressant dose, *id.*

14. *See id.*; *see also A Guide to Your First Visit with a Psychiatrist*, *supra* note 1; *see also What to Expect at a Psychiatry Appointment*, *supra* note 2.

surrounding psychopharmacology. The government and psychiatric system alike have implemented regulations and rules regarding proper psychiatric practice, medication classifications, and subsequent medication accessibility.[15] However, these authorities remain ambiguous concerning actual psychiatric *prescribing* practices, allowing mental health providers to hold interests in big pharmacological companies (take positions on their boards, speak and consult other psychiatric professionals regarding prescription of their products), despite the bias created by such pecuniary relationships.[16] Additionally, mental health practitioners are afforded significant freedom to judge medications' appropriateness and make such judgments even when there has been little to no in-person contact with patients, despite the "emotional leanness" of virtual forums.[17]

This paper's goal is to suggest possible legal and disciplinary solutions to psychotropic overprescription. Thus, it begins with a discussion about the danger posed by current psychopharmacological practices, with particular emphasis on the monetization of psychopharmacology, climbing psychotropic prescription rates in the United States, and potential harm posed by improper psychotropic prescription. Then, the paper describes the roles played by the current psychiatric treatment model and regulatory framework in perpetuating the status quo. Finally, it ends with an exploration of possible solutions, as well as the obstacles hindering their implementation.

## II. PSYCHOTROPIC MEDICATION: FRIEND AND FOE

> There is a huge financial incentive for psychiatrists to prescribe instead of doing psychotherapy . . . You can make two, three, four times as much money being a prescriber than a therapist. The vicious cycle here is that as psychiatrists limit their practices primarily to prescribing, they lose their therapy skills by attrition and do even less therapy.[18]

Notably, as of January 2022, approximately one out of every four people in the United States were taking some form of mental health medication.[19] This number

---

15. *See* Jacqueline Landess, *State Medical Boards, Licensure, and Discipline in the United States*, 17 FOCUS 337, 337–42 (2019); *see also How Electronic Prescribing Can Help Psychiatrists Manage Controlled Substance Prescriptions*, VERADIGM (July 21, 2021), https://veradigm.com/veradigm-news/how-psychiatrists-prescribe-controlled-substances/; *see also* Ghoshal, *supra* note 3.

16. Whitaker, *supra* note 6.

17. *See* Noam Ebner, *Negotiation via (the New) Email*, *in* NEGOTIATION EXCELLENCE: SUCCESSFUL DEAL MAKING 407, 410-11 (Michael Benoliel ed., 2d ed. 2014) (discussing the "leanness" of virtual communication forums).

18. Brendan L. Smith, *Inappropriate Prescribing*, 43 MONITOR ON PSYCH. 36, 39 (2012).

19. Nick VinZant, *Pandemic Fuels Rise in Mental Health Prescriptions*, QUOTEWIZARD (Jan. 6, 2022), https://quotewizard.com/news/mental-health-prescriptions.

is nearly 20% higher than it was in early 2021, with the most increased states being New York, New Mexico, and Arkansas.[20] Some attribute this growth to the ongoing psychological effects of COVID-19 but recognize that it coincides with a trend that was already growing prior to the pandemic,[21] at which point one out of every six people in the United States reported using mental health medications.[22]

According to a 2016 study by Daniel Tadson and Mark Olfson, the percentage of United States psychiatrists *not* administering psychotherapy to patients during sessions greater than 30-minutes increased from 27% throughout 1992–2002 to 53% throughout 2010–2016.[23] Most troublingly, psychiatrists administering psychotherapy prescribed medications in 66% of visits while psychiatrists *not* administering psychotherapy prescribed medication in 90% of visits.[24] Psychotherapy is key to mental health treatment, allowing both psychiatric professionals and patients to get in touch with the underlying drivers of patients' mental health issues.[25] Psychotherapeutic treatment often reveals nonmedical solutions to life circumstances causing negative psychiatric responses.[26] It also facilitates medical treatment by addressing symptom triggers and allowing psychiatric professionals to understand *why* a patient needs medication, for how long, and in what circumstances.[27] Notably, however, the doctors who engaged least in therapeutic remedies were the most likely to prescribe medications during patient visits.[28]

Further, many psychotropic medications are being prescribed by nonpsychiatrists[29] or through remote psychiatric services.[30] In fact, "the percentage of visits in

---

20. *Id.*

21. *See id.*

22. Susan Scutti, *One in Six US Adults Takes Psychiatric Drugs, Study Says*, CNN HEALTH (Dec. 12, 2016, 7:48 PM), https://www.cnn.com/2016/12/12/health/psychiatric-drug-use.

23. Eugene Rubin, *How Often Do Psychiatrists Provide Psychotherapy?*, PSYCH. TODAY (Apr. 20, 2022), https://www.psychologytoday.com/us/blog/demystifying-psychiatry/202204/how-often-do-psychiatrists-provide-psychotherapy.

24. *Id.*

25. *See generally What is Psychotherapy?*, AM. PSYCHIATRIC ASS'N, https://www.psychiatry.org/patients-families/psychotherapy (last visited Dec. 23, 2023); *see also Mental Health Treatments*, MENTAL HEALTH AM., https://mhanational.org/mental-health-treatments (last visited Aug. 31, 2023).

26. *See What is Psychotherapy?*, *supra* note 25.

27. *See id.*

28. *See* Rubin, *supra* note 23.

29. Chris Fleming, *Patients Getting Antidepressants More Often from Nonpsychiatrists Without Psychiatric Diagnoses*, HEALTH AFFS. (Aug. 8, 2011), https://www.healthaffairs.org/content/forefront/patients-getting-antidepressants-more-often-nonpsychiatrists-without-psychiatric.

30. Lisa S. Mazur & Ryan B. Marcus, *Understanding the Implications of Federal Remote Prescribing Laws on Telemedicine's Role in Behavioral Health Treatment*, BLOOMBERG L. (Feb. 7, 2018, 2:45 PM), https://news.bloomberglaw.com/health-law-and-business/understanding-the-implications-

which antidepressants were prescribed to patients by [nonpsychiatric] doctors who didn't record a specific psychiatric disorder increased from 59.5 percent of all visits in which nonpsychiatrist physicians prescribed antidepressants in 1996 to 72.7 percent in 2007."[31] According to Ramin Mojtabai, an associate professor in the Department of Mental Health at the Johns Hopkins Bloomberg School of Public Health, "[m]any of the patients who are receiving these medications are dealing with the stresses of life or physical illness, and there is no evidence that antidepressants are effective in these groups of patients."[32] He points out that direct-to-consumer advertising plays a role in heavy-handed psychotropic prescribing, as patients request medications according to symptoms that advertisements claim these medications alleviate.[33] Such symptoms tend to include fatigue, headaches, and abnormal body sensations, which relate to many mental and physical conditions, as well as everyday, circumstantial feelings of stress.[34] This indicates that many psychotropic medications are likely being used to mollify symptoms of non-psychiatric issues, in some cases delaying the diagnosis and proper treatment of other health problems.

Remote services such as the controversial Cerebral have also been on the rise, offering individuals psychiatric assistance without any in-person contact.[35] Remote psychiatric platforms have gained popularity largely because they allow individuals quick, on-the-go, stigma-free help for mental health issues, particularly those requiring medical intervention.[36] Additionally, these services are relatively cost-effective and mitigate the need posed by a health system dealing with low supply for a high demand of mental health professionals.[37] Although remote services seem great for facilitating patients' access to much needed psychiatric services, there is a huge catch: quality suffers as quantity increases. Reduction in psychiatric care quality is not a minor nuisance or aggravation, but, instead, a matter of happiness or depression — and sometimes, life or death.

Remote services, by their virtual nature, breed impersonal care. In numerous telepsychiatry applications (apps), a patient simply joins a chat with psychiatric personnel, describes his or her symptomatology, and is able to walk away from

---

of-federal-remote-prescribing-laws-on-telemedicines-role-in-behavioral-health-treatment; *see also* Melby & Mosendz, *supra* note 9.

31. *See* Fleming, *supra* note 29.

32. *Id.*

33. *Id.*

34. *Id.*

35. *See* Mazur & Marcus, *supra* note 30; *see also* Melby & Mosendz, *supra* note 9.

36. *See* Mazur & Marcus, *supra* note 30.

37. *See id.*; *see also What is Psychotherapy?*, *supra* note 25.

these faceless meetings with a prescription.[38] Even with telepsychiatry services that require some level of face-to-face communication via video, the mode limits symptom monitoring by allowing for only a narrow window of observation, controlled by what the patient wants the psychiatrist to see. In turn, lower quality therapeutic measures are used to address circumstantial stressors, as body language and demeanor cannot be fully gauged via only chatroom and video-based communications.[39] Although more people may access mental health services in a way that frees them from judgment and logistical burdens (transport to and from a mental health professional's office),[40] they also sacrifice physicians' observation-based guidance about detectable side effects[41] and medication fit.[42]

One might think that this ease of prescription indicates that psychotropic medications are safe. In reality, most psychiatric medications, similar to opioids, are habit-forming and alter neurotransmitter and hormone functionality.[43] Additionally, many are contraindicated with other medications and alcohol — at times having fatal consequences.[44] Notably, 2020's list of "most prescribed" psychiatric medications includes various antidepressants, benzodiazepines, and antipsychotics in its top twenty.[45] Although antidepressants are "not consider[ed] . . . addictive in the 'traditional' sense," they are known to "cause physical dependence[—]evidenced

38. *See* Melby & Mosendz, *supra* note 9; *see also What is Psychotherapy?*, *supra* note 25.

39. *See* Zara Abrams, *How Well is Telepsychology Working?*, 51 MONITOR ON PSYCH. 46, 52 (2020).

40. *See What is Psychotherapy?*, *supra* note 25.

41. *See* Chethan Basavarajappa et al., *Perceived Advantages and Disadvantages of Telepsychiatry – An Online Survey of Psychiatrists in India*, 64 INDIAN J. PSYCHIATRY 93 (2022); *see also* Michael F. Gliatto & Anil K. Rai, *Evaluation and Treatment of Patients with Suicidal Ideation*, 59 AM. FAM. PHYSICIAN 1500 (1999) (describing the in-depth interview process for adequately determining whether a patient is considering suicide). Note that some drugs intended to mollify depression can actually provoke suicidal ideation in a small percentage of people; if a patient is concealing such ideation, a psychiatrist is much more likely to pick up on the signs in-person v. via remote communication, *see id.*

42. *Antidepressants: Selecting One That's Right for You*, MAYO CLINIC (Sept. 23, 2022), https://www.mayoclinic.org/diseases-conditions/depression/in-depth/antidepressants/art-20046273 (discussing the multitude of alternate treatments available if one antidepressant doesn't work). Note that psychotropic prescription is a bit of a guess-and-check system — there are certain drugs that tend to be prescribed first and if a patient does not like the effects of that drug or feel the drug is not helping, then mental health providers generally redirect the treatment plan according to a predetermined list of follow-up medications, *see id.*

43. Jeffrey Juergens, *Antidepressant Addiction and Abuse*, ADDICTION CTR. (Apr. 17, 2023), https://www.addictioncenter.com/stimulants/antidepressants/.

44. *A Day to Remember: International Overdose Awareness Day*, CTRS. DISEASE CONTROL & PREVENTION (Aug. 20, 2021), https://www.cdc.gov/drugoverdose/featured-topics/ioad-benzo-overdose.html (discussing effects and risks of benzodiazepines).

45. John M. Grohol & Stephanie A. Wright, *Top 25 Psychiatric Medications for 2020*, PSYCHCENTRAL (Nov. 1, 2022), https://psychcentral.com/blog/top-25-psychiatric-medications-for-2020.

by . . . withdrawal symptoms . . . [like] nausea, hand tremors, and depression" upon sudden stop.[46] Benzodiazepines, on the other hand, are classified as Schedule IV controlled substances because they are known to be addictive, with intense physiological effects and fatal contraindications with alcohol and opioids.[47] In fact, they "were involved in 6,982 (16.8%) of 41,496 overdose deaths during January 2019–June 2020 reported by 23 states," according to a Centers for Disease Control and Prevention (CDC) study.[48] Rather than cause addiction, antipsychotics tend to heavily depress the body, sometimes leading to development of arrhythmias and epilepsy.[49]

Due to the intensity of psychiatric medications and varying levels of danger they pose when improperly used, it is concerning that prescribing standards do not stipulate psychiatric diagnosis requirements, much less face-to-face contact. In order to understand why the psychiatric system allows for overprescription of these potentially dangerous drugs, one must first understand how the psychiatric system is structured and regulated.

## III. THE PSYCHOLOGICAL TREATMENT MODEL

The field of psychology functions differently from other medical areas in that clinical psychology personnel must be equipped to diagnose and treat intangible symptomologies with limited concrete biological indicators.[50] Put simply, psychiatric work centers around fixing feelings, not body parts, and building trust and connectedness with patients—fundamental to effective treatment. The Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM 5) is at the center of

46. *See id.*

47. *See Controlled Substance Schedules*, U.S. DEP'T JUST., DRUG ENF'T ADMIN., DIVERSION CONTROL DIV., https://www.deadiversion.usdoj.gov/schedules/ (last visited Aug. 29, 2023). Benzodiazepines are Schedule IV Controlled Substances, meaning that they have a low potential for abuse relative to Schedules I-III, but higher than Schedule V controlled substances and other drugs not considered controlled substances, *see id.* A controlled substance is a drug or other substance that is tightly controlled by the government because it may be abused or cause addiction, *see Controlled Substance*, NAT'L CANCER INST., https://www.cancer.gov/publications/dictionaries/cancer-terms/def/controlled-substance (last visited Aug. 29, 2023). The control applies to the way the substance is made, used, handled, stored, and distributed, *see id.*

48. Stephen Liu et al., *Trends in Nonfatal and Fatal Overdoses Involving Benzodiazepines – 38 States and the District of Columbia, 2019-2020*, 70 MORBIDITY & MORTALITY WKLY. REP. 1136, 1139 (2021).

49. *Antipsychotics*, RETHINK MENTAL ILLNESS (Feb. 2023), https://www.rethink.org/advice-and-information/living-with-mental-illness/medications/antipsychotics/.

50. *See What is Psychiatry?*, AM. PSYCHIATRIC ASS'N, https://www.psychiatry.org/patients-families/what-is-psychiatry (last visited Dec. 23, 2023).

psychiatric treatment protocols—outlining symptom requirements for various diagnoses and the approved treatment guidelines for certain disorder profiles.[51]

The DSM 5 lists recommended screening, therapy, and medication procedures, providing a roadmap for mental health professionals attempting to navigate nuances within disorder profiles, which result in some individuals reacting very well to recommended treatment options and others requiring atypical action.[52] Unlike an appendix rupture, for instance, disorders like major depression can be treated in several ways, but with varying levels of success depending on the patient's unique hormonal and environmental characteristics.[53] This is largely because hormonal imbalances and situational factors are constantly in flux, making them difficult to quantify; thus, psychiatric treatment is as much an art form as it is a science. The unique challenges presented by the complexity of the human psyche make in-person communication about symptom experience and treatment effectiveness crucial to finding and maintaining appropriate psychiatric remedies.

### *A. Psychotherapy at the Center*

Sensibly, psychotherapy is at the center of clinical psychology, as it allows both mental health professionals and patients to better understand the circumstances, thoughts, and actions that drive pathologies.[54] Medications, although extremely useful for treating psychiatric symptoms related to hormonal imbalances, are rarely the "end-all, be-all" of effective psychiatric treatment.[55] They are, of course, very necessary for certain patients, namely those with moderate to severe symptom profiles.[56]

For these individuals, hormonal imbalances can result in emotional states that prevent them from openly communicating about underlying feelings and discomforts, blocking the remedial benefits of therapy.[57] By mitigating patients' physiological reactions to emotional stimuli, medication allows many patients to enter a

51. *See What is Psychotherapy?*, *supra* note 25.

52. *See DSM-5*, CLEVELAND CLINIC, https://my.clevelandclinic.org/health/articles/24291-diagnostic-and-statistical-manual-dsm-5 (last reviewed Oct. 14, 2022).

53. *See* Pim Cuijpers et al., *Treatment Outcomes for Depression: Challenges and Opportunities*, 7 LANCET PSYCHIATRY 925, 925–26 (2020); *see also* Navneet Bains & Sara Abdijadid, *Major Depressive Disorder*, NAT'L LIBR. MED., https://www.ncbi.nlm.nih.gov/books/NBK559078/ (last updated Apr. 10, 2023).

54. *See generally What is Psychotherapy?*, *supra* note 25; *see also Mental Health Treatments*, *supra* note 25.

55. *See What is Psychotherapy?*, supra note 25; *see also Medication*, MENTAL HEALTH AM., https://mhanational.org/medication (last visited Sept. 22, 2023).

56. *See What is Psychotherapy?*, *supra* note 25; *see also Medication*, *supra* note 55.

57. *See What is Psychotherapy?*, *supra* note 25; *see also Medication*, *supra* note 55.

calm and content enough state to reflect on triggers and solutions—opening the door to therapeutic remedies.[58] However, psychotropic medications tend to wear away in effect over time as patients grow "tolerant" and require higher doses in order to maintain emotional functionality.[59] This makes therapy very important, as therapy, unlike medication, helps patients retrain deleterious schemas and perceive the world more positively, as through cognitive behavioral therapeutic (CBT) tools, and use action to force positive changes in behavior and ultimately, mindset, as through dialectical behavioral therapeutic (DBT) tools.[60]

Further, while medication is most useful for treating "biological symptoms," therapy is useful in most psychiatric circumstances—the most effective treatment on its own in mild to moderate symptom profiles marked by "psychological and interpersonal deficits" and of great utility when administered in conjunction with medications for moderate to severe profiles of any psychiatric diagnosis variety.[61] In fact, according to numerous studies, "the combination of psychotherapy and medication is better than either treatment alone (primarily in severely ill or chronic patients) . . ."[62] As one can imagine, determining whether an individual's symptom profile is "mild," "moderate," "severe," or "chronic" requires nuanced, thorough analysis. Patients with moderate profiles sometimes benefit significantly from medical intervention and, at other times, do just as well or better with only therapeutic measures, depending on how much of that patient's symptomatology is related to biological versus interpersonal factors.[63] Responsiveness to medication and therapeutic treatments varies by patient.[64] It also varies according to a patient's current life and health situation: as individuals evolve, so do their needs.[65]

Due to the variable nature of the human psyche, it would make sense for the same mental health professional to administer therapy and drug prescriptions, as that person tends to have the best idea of a patient's baseline display and evolving

58. *See What is Psychotherapy?*, *supra* note 25; *see also Medication*, *supra* note 55.

59. *See What is Psychotherapy?*, *supra* note 25; *see also Medication*, *supra* note 55; *see also The Dangers of Untreated Mental Illness*, HIGH FOCUS TREATMENT CTRS. (May 22, 2018), https://www.highfocuscenters.com/dangers-untreated-mental-illness/.

60. *See What is Psychotherapy?*, *supra* note 25; *see also Medication*, *supra* note 55.

61. *See* Mantosh J. Dewan, *Making Combined Therapy Work*, PSYCHIATRIC TIMES (July 1, 2002), https://www.psychiatrictimes.com/view/making-combined-therapy-work.

62. *Id.*

63. *See id.* Note that if more "biological," then treatment involving medication is likely better; if more "interpersonal," then likely that just therapy is preferable, *see id.*

64. *See Mental Health Treatments*, *supra* note 25.

65. *See What is Psychotherapy?*, *supra* note 25.

symptomatology from his or her own direct monitoring during therapy sessions.[66] However, therapy administration and drug prescription are bifurcated.[67]

### *B. Who Prescribes*

As with all medical fields, the ability to prescribe is limited to medical personnel with MDs (or to psychologists with MPs, depending on the state).[68] However, the vast majority of therapeutic treatment is administered by psychologists (non-MPs) and social workers, neither of whom generally has the authority to prescribe or even recommend medications to patients.[69] These professionals may refer patients to psychiatrists and MPs (if state law allows) to obtain medical prescriptions, but they are unable to make such calls themselves due to their respective levels of training.[70] However, as noted in the previous section, a growing number of psychiatrists are trading in their "therapist" role for that of "prescriber," rather than acting as both simultaneously.[71] This presents a conundrum, given the highly personal nature of finding the right psychological treatment for a patient: the person prescribing the medications lacks the symptom knowledge and understanding of the person conducting psychotherapy with the patient.

It is true that some psychiatry practices have teams of therapists (generally psychologists or social workers) and psychiatrists who work closely with one another to determine the best treatment routes for their shared patients.[72] Although not as ideal as having prescribing professionals administer therapy themselves, this system of shared information and direct communication between therapist and psychiatrist ameliorates some of the issues presented by the bifurcated psychiatric practice model. According to Dr. Mantosh J. Dewan:

> Collaboration between disciplines has many advantages for the patient and the collaborators. The patient receives greater amounts of time and expertise, which may lead to better adherence to medications. Collaboration

66. *See* Lizzie Duszynski-Goodman, *What Does a Mental Health Counselor Do?*, FORBES HEALTH (July 7, 2023, 12:35 PM), https://www.forbes.com/health/mind/what-is-a-mental-health-counselor/.

67. *See What is Psychotherapy?*, *supra* note 25; *see also Mental Health Treatments*, *supra* note 25.

68. *See* Kendra Cherry, *Can Psychologists Prescribe Medications?*, VERYWELLMIND, https://www.verywellmind.com/can-psychologists-prescribe-medications-2795756#:~:text=1%20Psychologists%20can%20prescribe%20in,Illinois%2C%20Iowa%2C%20and%20Idaho.&text=In%20such%20cases%2C%20psychologists%20are,the%20treatment%20of%20mental%20disorders (last updated May 5, 2020).

69. *See id.* In a few states, psychologists with MPs can prescribe and recommend medications, but this is rare, *id.*

70. *See id.*

71. *See* Smith, *supra* note 18, at 39.

72. *See* Dewan, *supra* note 61.

> provides an invaluable opportunity for professional and emotional support of each other on an ongoing basis, especially in times when the patient is in crisis or when treatment has a disastrous outcome such as a suicide.[73]

However, in many cases, therapists and psychiatrists engage in "split treatment."[74] This means that they do not communicate directly with one another in a shared practice. Rather, a therapist will conduct therapy from his or her own individual practice, and then, if a patient requests, or that therapist thinks necessary, the therapist will tell the patient to see a psychiatrist for official psychiatric diagnosis and medication.[75] Therapists generally refer patients to psychiatrists, but patients have total autonomy in who they choose to go to for official psychiatric diagnoses and prescriptions.[76]

Further, a psychiatrist will only have access to a therapist's notes about a particular patient if that patient signs a release, approving the transfer of his or her medical information between professionals.[77] Even given these notes, a psychiatrist does not have the benefit of direct information sharing and collaboration with the patient's therapist about an individualized treatment plan for that patient.[78] This means that many psychiatrists prescribing medications to patients do not have a working understanding of those patients' mental or physical health histories; rather, they are giving medication to practical strangers, who they know in so far as an initial forty to sixty minute meeting and brief skimming of mental health records can allow.[79]

This method is so often employed due to common perceptions that "split treatment" is more cost-effective than "combined" or "integrated" treatment.[80] However, Dewan found that:

---

73. *Id.*

74. *See id.*

75. *Id.* Note that, in most states, a psychologist is able to diagnose, not medicate, and would refer a patient only for medication purposes. *Psychiatrists and Psychologists: What's the Difference?*, YOUR HEALTH IN MIND, https://www.yourhealthinmind.org/psychiatry-explained/psychiatrists-and-psychologists#:~:text=Psychiatrists%20prescribe%20medication%2C%20psychologists%20can,talk%20therapy (last visited Aug. 25, 2023). A social worker, on the other hand, would refer the patient for both diagnostic and medical purposes, *What is the Difference Between Psychologists, Psychiatrists and Social Workers?*, AM. PSYCH. ASS'N (2017), https://www.apa.org/ptsd-guideline/patients-and-families/psychotherapy-professionals.

76. *See* Dewan, *supra* note 61.

77. *See id.*

78. *See id.*

79. *See id.*

80. *See id.*

> [T]here are both substantial cost and time savings with integrated treatment . . . [and that] '[w]hen time away from work or child care plus the expense of traveling are factored in, the cost benefit analysis favors integrated care from a psychiatrist even more.' . . . [T]he cost for integrated treatment was only $16 higher,[81]

even when a psychologist rather than a social worker administered the therapeutic component of the combined psychiatric treatment.[82] Further, in another study evaluating 1,517 depressed patients for eighteen months, it was found that:

> [O]nly 191 patients (13%) were in integrated treatment. Patients in split treatment needed more psychotherapy sessions (21.2 versus 10.4), more medication visits (6.3 versus four), and more total outpatient care (26.2 versus 14.7 visits). Instead of split treatment leading to savings, it cost $518 more per patient ($1,854 versus $1,336).[83]

This appears to largely be related to reductions in care quality associated with "split" as opposed to combined treatment; doctors working together in combined practice to help patients resolve psychiatric issues are able to share perspectives about patients' behavioral and biological patterns at once — allowing for a quicker, more streamlined treatment process.[84] When patients undergo "split" methodologies, their treatments are more piecemeal which often results in some symptoms being overlooked and insights not being made as quickly as they could have been in a collaborative space (if made at all).[85]

Additionally, due to a variety of factors, including time commitment, cost, and emotional strain, many individuals using psychotropic medications do not simultaneously undergo therapy.[86] A 2010 study found that "the percentage of outpatient mental health visits that involve only medication and no psychotherapy jumped from 44 percent to 57 percent between 1998 and 2007."[87] It is likely that this statistic

---

81. *See id.*

82. *See id.* Also, psychologists are more specialized than social workers (largely because they are able to diagnose, even though they are not authorized to prescribe medications), which sensibly corresponds with them generally charging more than social workers per patient visit. *See generally Social Work vs. Clinical Psychology*, BRESCIA UNIV. (Mar. 28, 2016), https://www.brescia.edu/2016/03/social-work-vs-psychology/.

83. *See* Dewan, *supra* note 61.

84. *See id.*

85. *See id.*

86. *See id.*; *see also* Smith, *supra* note 18, at 37.

87. *See* Rebecca A. Clay, *Advocating for Psychotherapy*, 42 MONITOR ON PSYCH. 48, 48 (2011); *see generally* Mark Olfson & Steven C. Marcus, *National Trends in Outpatient Psychotherapy*, 167 AM. J. PSYCHIATRY 1456 (2010).

has worsened over time, particularly given the rise of remote psychiatric services centered around psychotropic prescription.[88]

### *C. Rise of Telepsychiatry*

Notably, the telepsychiatry system's growth coincides with a trend in treatment toward "medicating" as the answer to all ails.[89] Dewan explains that many patients feel like they are not "taken seriously" or "supported" fully by psychiatrists when they do not receive prescriptions.[90] As mentioned previously, medicine is not only marketed to prescribing doctors but also directly to patients.[91] These advertisements convince many patients that their symptoms will "go away" if they "simply" take a few drugs.[92] The "quick and easy" medication "fix" promised by psychopharmacology companies appeals to an on-the-go society[93] and individuals who do not have adequate insurance and cannot afford the out-of-pocket expenses of therapy.[94]

Notably, most remote psychiatric services have very limited therapeutic and talking components, lowering associated costs; patients can sign up for a telepsychiatry plan and pay $100 per month for prescription-centric treatment, rather than the $100-$200 typically charged *per* in-person psychiatric visit.[95] Reduced costs and the ease of virtual communication make telepsychiatry low-barrier at a time when deficits in funding and personnel mitigate psychiatric institutions' capacity to care for all patients seeking mental health assistance.[96] Because telepsychiatry fulfills a need,[97] many overlook the danger that this new system poses to patients' safety.

---

88. *See* Mazur & Marcus, *supra* note 30; *see also* Melby & Mosendz, *supra* note 9.

89. *See* Michael J. Formica, *With Medication More Prevalent, Talk Therapy Trends Downward*, PSYCH. TODAY (Aug. 12, 2009), https://www.psychologytoday.com/us/blog/enlightened-living/200908/medication-more-prevalent-talk-therapy-trends-downward.

90. *See* Dewan, *supra* note 61.

91. *See* Smith, *supra* note 18, at 39.

92. *See id.*

93. *See* Formica, *supra* note 89.

94. *See* Steven Rowe, *What to Do When You Can't Afford Therapy*, PSYCH CENTRAL (May 7, 2021), https://psychcentral.com/blog/what-to-do-when-you-cant-afford-therapy#no-cost-options.

95. Meaghan Rice, *How Much Does a Psychiatrist Cost Without Insurance?*, TALKSPACE (Sept. 22, 2021), https://www.talkspace.com/blog/how-much-does-a-psychiatrist-cost/ (explaining the typical cost of an in-person visit with a psychiatrist).

96. *See What is Psychotherapy?*, *supra* note 25 (discussing telepsychiatry's utility given mental health provider shortages and growing need for mental health services); *see also* Rowe, *supra* note 94 (discussing medical apps as an alternative to psychotherapy for patients who cannot afford therapy sessions).

97. *See What is Psychotherapy?*, *supra* note 25; *see also* Rowe, *supra* note 94.

Cerebral is a prime example of a telepsychiatry app that engages in questionable practices associated with declines in users' mental health.[98] Specifically, a recent complaint was filed against the company claiming that negligence, on the part of one of its psychiatric teams, contributed to Greg Grant's (a Cerebral patient's) tragic suicide.[99] His assigned psychiatric personnel admitted that they were unable to comprehend the severity of Grant's symptoms based on his intonation via the chat forum, and they wrongly assumed that Grant's condition was not severe enough to warrant more hands-on intervention.[100] They opted to simply increase his antidepressant dose, rather than schedule an evaluation or other screening appointment, when he told them that he was not doing well.[101] Grant committed suicide later that month.[102] Had the team been able to see him in-person, it is likely that they would have been able to pick up on the extremity of the pain he was experiencing from his demeanor and body language.[103] However, with only a voiceless typeface to reference, the team understandably misjudged the patient's situation.[104] After all, they barely knew him; he was but a faceless entity, with one evaluation on the books and a brief clinical description under his name.[105]

Unfortunately, Grant's story is a red herring — demonstrating that medication alone is *not always enough*[106] (notably, numerous studies on psychotropic medications and therapeutic measures demonstrate that medication alone is *rarely* enough and is *maximized* by combined therapeutic measures).[107] Further, medications are not all the same, just as individuals' biology's are not all the same.[108] When a patient comes into a psychiatrist's office and that psychiatrist is able to see that the patient looks fatigued or unwell after a few weeks using a certain medicine, the psychiatrist is able to act immediately, based on their clinical expertise and knowledge of the patient's baseline.[109] There is no telling if Grant could have benefitted from a different type of antidepressant or psychotropic medication completely. Had a psychiatrist actually *seen* and communicated with Grant one-on-one, the psychiatrist might have been able to make that assessment. Situations like Grant's shed light on

98. *See* Melby & Mosendz, *supra* note 9.
99. *See id.*
100. *See id.*
101. *See id.*
102. *See id.*
103. *See id.*
104. *See id.*
105. *See id.*
106. *See id.*
107. *See What is Psychotherapy?*, *supra* note 25.
108. *See Mental Health Medications*, NAT'L INST. MENTAL HEALTH, https://www.nimh.nih.gov/health/topics/mental-health-medications (last reviewed June 2022).
109. *See generally What is Psychotherapy?*, *supra* note 25.

the dark side of telepsychiatry, despite its evident utility in improving patient accessibility to psychiatric resources and reducing the mental health system's burden.[110]

Further, telepsychiatry allows patients to show psychiatrists a very small picture of their lives[111] (quite literally what fits in a computer video screen, or what they wish to convey via text in a chat room, as in Grant's case).[112] Some may argue that fear of vulnerability turns many prospective patients away from therapy, making telepsychiatry services beneficial in this regard, opening the door for these individuals to pursue treatments that they otherwise would not have pursued. Yet, inadequate psychiatric treatment can have profound consequences, as demonstrated by Grant's ultimate suicide.[113] When it comes to many psychiatric disorders, particularly moderate to severe ones requiring medication, incomplete care is *not* better than no care at all.[114]

Patients can experience increased states of hopelessness if subjected to faulty treatment for a prolonged period.[115] Some medications cause patients' symptoms to worsen, others do not interact with all patients' biologies effectively, and some simply take a while to alter patients' symptoms.[116] Without medical intervention or reassurance, patients may begin believing that their conditions are "unfixable," potentially leading to severe states of despair.[117] Not being able to see what a patient is *truly* experiencing, as through physical cues only perceivable when a patient is in front of a psychiatrist for an extended period of time, psychiatrists' ability to gauge medications' effectiveness and patients' actual symptomatologies is restricted—at times, detrimentally.[118]

Further, for patients suffering from mild to moderate symptoms marked by more interpersonal characteristics, as opposed to biological ones, mismanagement

---

110. *See What is Telepsychiatry?*, AM. PSYCHIATRIC ASS'N, https://www.psychiatry.org/patients-families/telepsychiatry#:~:text=Telepsychiatry%2C%20a%20subset%20of%20telemedicine,patient%20education%20and%20medication%20management (last visited Dec. 24, 2023).

111. *See generally* J. Alexander Scott, *I'm Virtually a Psychiatrist: Problems with Telepsychiatry in Training*, 45 ACAD. PSYCHIATRY 774, 774–75 (2021).

112. *See* Melby & Mosendz, *supra* note 9.

113. *See id.*

114. *See What is Psychotherapy?*, *supra* note 25; *see also The Dangers of Untreated Mental Illness*, *supra* note 59.

115. *See generally The Dangers of Untreated Mental Illness*, *supra* note 59.

116. *See Mental Health Medications*, *supra* note 108.

117. *See generally The Dangers of Untreated Mental Illness*, *supra* note 59.

118. *See id.* (discussing how untreated or mistreated mental illnesses can have further detrimental effects on patients, namely the worsening of mental illness symptoms).

of symptoms can lead to unnecessary mental health degradation.[119] This can happen if a patient most in need of therapy is only given medication, which mainly benefits patients with symptoms spawned by biological imbalances.[120] Once again, the "leanness" of the virtual forum[121] makes ascertaining such degradation very difficult for psychiatrists; without in-person contact, gauging baseline is also complicated—which can lead to care recommendations based on the wrongful perception of an individual's symptoms being more related to biological than interpersonal circumstances, or vice versa.[122]

### *D. Issues with the Psychiatric Treatment Model in Sum*

Improper psychotropic prescription stems from a treatment model that favors prescribing over therapeutic measures, largely due to the monetary incentives associated with psychopharmacology and social perceptions that medication provides a "quick fix" for psychiatric conditions.[123] Given the proven utility of therapy in fostering communication and maximizing psychological care,[124] it is troubling that prescription is *allowed* to occur without psychiatric diagnosis[125] or therapeutic action by the prescribing professional[126] and that remote prescription methods have become so readily available.[127]

Although it of course saves patients time and money to skip the therapeutic process and keep psychiatric consultations short, it also mitigates the effectiveness of their psychological healing.[128] In some cases, incomplete psychiatric care leads people to fulfill suicidal ideations, revert to addictive habits, or develop treatment-resistant conditions.[129] Further, medication can be dangerous—at times inducing atypical psychiatric responses, such as suicidality and other times leading to intense

119. *See id.; see also* Dewan, *supra* note 61.

120. *See* Dewan, *supra* note 61.

121. *See* Ebner, *supra* note 17, at 410-11.

122. *See* Dewan, *supra* note 61.

123. *See* Formica, *supra* note 89.

124. *See generally* Clay, *supra* note 87.

125. *See* Fleming, *supra* note 29.

126. *See generally* Clay, *supra* note 87 (discussing the effectiveness of psychotherapy in treating many psychiatric conditions and the marked decline in its use, notably coinciding with a rise in the prescription of psychiatric medication).

127. *See What is Telepsychiatry?*, *supra* note 110 (discussing telepsychiatry's utility given mental health provider shortages and growing need for mental health services); *see also* Rowe, *supra* note 94 (discussing medical apps as an alternative to psychotherapy for patients who cannot afford therapy sessions).

128. *See generally* Clay, *supra* note 87.

129. *See generally* Gliatto & Rai, *supra* note 41 (noting that this occurs as medications lose effectiveness and underlying schematizations, circumstances, and coping mechanisms grow increasingly deleterious).

physiological side effects and addictive tendencies.[130] Medication is not always the optimal treatment method for patients, particularly those with issues relating to interpersonal rather than biological factors; it also tends to be less effective as a treatment on its own than in conjunction with therapy.[131]

Recent psychiatric trends promoting prescription of medication without therapy, particularly "split treatment" and telepsychiatry services, can be dangerous to patients in need of therapy and symptom monitoring for successful treatment.[132] Given the debilitating nature of incomplete psychiatric treatment, it is a wonder that just two to three percent of psychiatrists nationwide are subject to medical malpractice claims—well below the seven percent average for all physicians.[133] The following section will explore the relationship between psychiatrists' malpractice liability and their chosen role as "prescriber" over "therapist."[134]

## IV. WHY MALPRACTICE CLAIMS AGAINST PSYCHIATRISTS RARELY SUCCEED

Psychiatrist-paid malpractice claims make up only one percent of those for all United States physicians.[135] This is largely due to difficulty demonstrating that a psychiatrist's actions "breached duty" and are the "but for" cause of the patient's ultimate injury.[136] Malpractice claims against psychiatrists fall into five major categories: improper treatment, improper record keeping, improper engagement with third parties (breaching psychiatrist–patient confidentiality, which, like attorney–client confidentiality, allows for numerous exceptions), negligence with suicidal patients, and unethical conduct.[137] Even if there is substantial proof demonstrating that a psychiatrist breached his or her duty in one of the aforementioned ways, the patient must also prove that (a) an actual injury was suffered and (b) that the actual injury suffered was *because of* the psychiatrist's breach of duty.[138]

---

130. *See, e.g.*, *Mental Health Medications*, *supra* note 108.

131. *See* Dewan, *supra* note 61.

132. *See id.*

133. *See generally* Richard L. Frierson & Kaustubh G. Joshi, *Malpractice Law and Psychiatry: An Overview*, 17 FOCUS 332 (2019).

134. *See generally* Smith, *supra* note 18, at 38-39 (discussing the "drug industry" and incentivized prescribing practices).

135. *See* Frierson & Joshi, *supra* note 133.

136. *See generally id.* (describing the four elements that must be proven for a malpractice claim against a psychiatrist to succeed).

137. Brian McKeen, *5 Types of Psychiatrist Negligence That Can Lead to a Lawsuit*, MCKEEN & ASSOCS., PC (Jan. 28, 2019), https://www.mckeenassociates.com/blog/2019/01/5-types-of-psychiatrist-negligence-that-can-lead-to-a-lawsuit/.

138. *See id.*; *see also* Frierson & Joshi, *supra* note 133.

When considering the central issue of this paper, improper prescription, it is difficult to demonstrate that a patient's psychological harm was caused "but for" overprescription, or that the overprescription was even a "breach" of the psychiatrist's "duty."[139] Given the fact that patients generally go to psychiatrists with the goal of obtaining prescriptions to ameliorate preexisting feelings of stress (often manifesting as sadness, anxiety, substance abuse, and sleep problems[140]), and that medication is one of the most common treatment forms used by psychiatrists.[141] Even if a patient were to bring a claim against a psychiatrist for failing to recommend therapeutic measures better suited for the patient's symptomology or for an oversight in clinical judgment resulting from lack of face-to-face contact, that patient would likely struggle to definitively prove that "but for" the psychiatrist's inaction, the patient would not have suffered the level of psychological turmoil he or she did, rising to a level of harm compensable in damages.[142] The patient would also likely have difficulty demonstrating that therapy was the clearly better treatment option from a psychiatric perspective; such an argument would rely on expert witness testimony about psychiatric standards of care, which would increase the claimant's legal fees.[143]

Notably, malpractice claims are even difficult to prove in cases like Grant's against Cerebral, which is pending trial.[144] Grant clearly suffered an actual injury; he is now deceased by suicide.[145] However, it is not nearly as clear whether or not Grant's suicide would have been avoided "but for" the team's inaction.[146] Grant was suffering from anxiety, depression, and substance use disorder but did not outwardly express that he was suicidal when he contacted Cerebral.[147] Additionally, Grant committed suicide weeks after he contacted Cerebral about his worsening state, not immediately after.[148] Thus, it is questionable whether therapy or a change in medication would have been enough to stop Grant from making his ultimate decision. Surely the team could have followed up with Grant to cover its bases and

139. *See What is Psychotherapy?*, *supra* note 25; *see generally* Smith, *supra* note 18 (discussing the popularization of medication to treat psychiatric conditions).

140. *See Stress*, CAMH, https://www.camh.ca/en/health-info/mental-illness-and-addiction-index/stress (last visited Aug. 27, 2023).

141. *See What is Psychotherapy?*, *supra* note 25; *see generally* Smith, *supra* note 18, at 37-39 (discussing the drug industry as it relates to psychiatric treatment).

142. *See generally* Smith, *supra* note 18.

143. *See Expert Witness Fees: How Much Does an Expert Witness Cost?*, SEAK: EXPERT WITNESS DIRECTORY, https://blog.seakexperts.com/expert-witness-fees-how-much-does-an-expert-witness-cost/ (last visited Sept. 4, 2023).

144. *See generally* Melby & Mosendz, *supra* note 9.

145. *See id.*

146. *See id.*

147. *Id.*

148. *See id.*

make sure that the worsening symptoms he was describing were not indicators of suicidality, but they also had no reason to believe that Grant was suicidal based on the known facts.[149] Thus, it is unclear whether the team even made an improper judgment call, much less breached a duty, when considering the status quo of psychiatric treatment methodologies.[150]

Had the team made a different judgment call and insisted that Grant schedule a one-on-one evaluation with staff,[151] there is a chance that events would have turned out differently, but it is not certain. Further, it is not as though the team completely failed to act; they increased his antidepressant dose,[152] which is a typical action taken by in-person and remote prescribers alike when patients report worsening symptomatology.[153] The notable difference between the Cerebral team's medical judgment and that of an in-person psychiatrist is that their basis for increasing Grant's dose had nothing to do with their own personal observations of Grant's demeanor; rather, it was a response to symptoms Grant described via text.[154] Still, however, without a demonstration of "but for" causation, this line of argumentation is likely moot.

Future claims against remote providers will have different fact patterns than Grant's case but will likely pose similar obstacles concerning "breach of duty" and "but for" causation. Notably, many of the issues in Grant's case stem from questions about *what* competent practice within the remote space looks like[155]; this largely stems from ambiguity about *what* competent practice looks like for psychiatric treatment more generally.[156] Medical prescriptions are the norm[157] even in circumstances where therapy would be a better option or an extremely useful tool in conjunction with said medication.[158] Thus, a remote service that disregards face-to-face contact but still prescribes is not that much different from a brief in-person meeting with a psychiatrist who does not administer a patient's therapy or work with the therapist who does yet prescribes medication anyway.

---

149. *See id.*
150. *See What is Psychotherapy?*, *supra* note 25.
151. *See* Melby & Mosendz, *supra* note 9.
152. *Id.*
153. *See What is Psychotherapy?*, *supra* note 25; *see also Mental Health Medications*, *supra* note 108.
154. *See* Melby & Mosendz, *supra* note 9.
155. *See id.*
156. *See id.*
157. *See* Formica, *supra* note 89.
158. *See* Dewan, *supra* note 61.

Although malpractice liability serves as a deterrent for medical negligence, it is a "non-punishing" system, mainly intended to compensate patients for their losses.[159] If there is no such compensation to be had, then a malpractice claim is of limited utility as doctors will not be deterred from behaviors that rarely result in tangible consequences.[160] Further, there is a significant amount of money to be *gained* from prescription, as Dr. Daniel Carlat pointed out.[161] The Federal Government has attempted to implement a "sunshine law" to dissuade psychiatrists from biasedly prescribing medications, to no avail.[162]

## V. SHINING LIGHT ISN'T ENOUGH

Congress passed The Physicians Payment Sunshine Act (Sunshine Act) as part of the Affordable Care Act (ACA), in an attempt to discourage psychiatrists, and other prescribing professionals, from prescribing medications according to their own personal interests.[163] The legislation requires drug, medical device, and biological manufacturers to disclose, for public viewership and federal review, "certain payments and items of value given to physicians and teaching hospitals," as well as "certain ownership interests held by physicians and their immediate family members."[164]

The major purpose of this act, as its title suggests, is shedding light on the financial influence that major pharmaceutical manufacturers have on medical treatment.[165] Rather than actively limit payoffs by stipulating regulations and disciplinary standards, the legislation focuses on increasing awareness about the pervasive, inescapable effects of "big pharma."[166] According to Nick Lussier, writer for the *New York University Journal of Legislation and Public Policy*, the Act does so by bringing to light "Speaker Programs," divided into two main classifications: "Peer-to-Peer" and "Patient."[167] He explains that:

---

159. Michelle M. Mello et al., *Malpractice Liability and Health Care Quality: A Review*, 323 JAMA 352, 352 (2020).

160. *See id.*

161. Smith, *supra* note 18, at 38-39 ("'There is a huge financial incentive for psychiatrists to prescribe instead of doing psychotherapy . . . You can make two, three, four times as much money being a prescriber than a therapist.'")

162. *See id.*; *see also Physician Payment Sunshine Act*, AM. PSYCHIATRIC ASS'N, https://www.psychiatry.org/psychiatrists/practice/sunshine-act (last visited Aug. 23, 2023).

163. Genevieve Pham-Kanter, *Act II of the Sunshine Act*, 11 PLOS MED. 1, 1 (2014).

164. *See Physician Payment Sunshine Act*, *supra* note 162.

165. *See id.*; *see also* Whitaker, *supra* note 6.

166. *See* Whitaker, *supra* note 6.

167. Nick Lussier, *A Little More Sunshine: How to Improve the Sunshine Act in Light of Recent Speaker Program Fraud Cases*, N.Y.U. J. LEGIS. & PUB. POL'Y (Dec. 22, 2021), https://nyujlpp.org/quorum/lussier-little-more-sunshine/.

> Peer-to-Peer programs involve a doctor being paid to present a slide presentation, over a meal, to an audience ideally comprised of other health care providers likely to prescribe the presented drug. By contrast, Patient Programs, another form of direct-to-consumer marketing like television ads, involve a paid speaker presenting drug information to patients. For both Peer-to-Peer and Patient Programs, speakers receive a fee commensurate to their medical experience . . . . [Further,] pharmaceutical companies have abused Speaker Programs as a means of rewarding high-prescribing doctors and as leverage to make doctors maintain or increase their prescriptions of company drugs.[168]

Thus, psychiatrists who prescribe and tout psychotropic drugs the most are awarded not only with direct payment for recommending and consulting other medical entities about the utility of such drugs, but with recognition, publication, and "lavish" benefits.[169] Although the Sunshine Act makes the public aware of the *quantity* that pharmacology companies spend on physicians who promote and prescribe their medications, the *quality* of such expenditures does not have to be reported.[170] Thus, when pharmacology companies take doctors to events like the Superbowl or pay for their stays at grandiose hotels, such as the Four Seasons, disclosure of such details is not necessary.[171] Further, there is no punishment in place for the development of such contractual relationships between prescribers and pharmaceutical companies.[172] Improper disclosure has resulted in a few lawsuits,[173] but that is the degree to which the Sunshine Act holds pharmacology companies and doctors accountable. Thus, the Sunshine Act fails to do more than 'shine some light' on the ugly underbelly of psychiatric practice.

## VI. SHORTCOMINGS OF "THE CONTROLLED SUBSTANCES ACT" AND THE "SUBSTANCE USE-DISORDER PREVENTION THAT PROMOTES OPIOID RECOVERY AND TREATMENT FOR PATIENTS AND COMMUNITIES ACT"

Many of the drugs that psychiatrists prescribe are classified according to:

---

168. *Id.*
169. *See id.*
170. *See id.*
171. *See id.*
172. *See id.*
173. *See id.*

> [F]ive 'schedules,' generally based on how dangerous and addictive they are.[174] They range from Schedule I drugs, 'street drugs,' with the highest potential for abuse or dependency, either psychological or physical or both, and no federally approved medical use in the U.S.; to Schedule V drugs, which have the lowest potential for abuse or dependency.[175]

Notably, in 2018, Congress passed the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act to make accessibility to Schedule II-V drugs more difficult, given upticks in their abuse (benzodiazepines and amphetamine, found in Adderall, are examples of such "controlled substances").[176] It imposed the duty to "e-prescribe" on psychiatrists, and all other prescribing personnel, in order to create a system for monitoring and controlling prescription pick-up.[177] This legislation intended to decrease addiction by cutting off addicts' access to prescription medications.[178] However, it does nothing to deter overprescription at the outset.[179]

## VII. BEYOND DISCIPLINE'S CURRENT SCOPE

While psychiatrists are some of the least sued physicians for medical malpractice, they are among the most disciplined for ethical misconduct by state medical boards.[180] However, they are not generally disciplined for overprescribing medications to their patients.[181] Rather, according to an American Psychiatric Association (APA) article by Dr. Jacqueline Landess, studies "found that psychiatrists were more likely to be disciplined for sexual misconduct than nonpsychiatrists and comprised 34% of the physicians disciplined for such behavior."[182] Substance-related discipline mainly occurs when psychiatrists improperly prescribe

---

174. *See How Electronic Prescribing Can Help Psychiatrists Manage Controlled Substance Prescriptions*, VERADIGM (July 21, 2021), https://veradigm.com/veradigm-news/how-psychiatrists-prescribe-controlled-substances/.

175. *See id.*

176. *See id.*; *Dextroamphetamine and Amphetamine (Oral Route)*, MAYO CLINIC, https://www.mayoclinic.org/drugs-supplements/dextroamphetamine-and-amphetamine-oral-route/description/drg-20071758 (last updated Dec. 1, 2023).

177. *See How Electronic Prescribing Can Help Psychiatrists Manage Controlled Substance Prescriptions*, *supra* note 174.

178. *See id.*

179. Lindsey Vuolo, *What the SUPPORT Act Means for Providers*, PRAC. PAIN MGMT. (Apr. 1, 2019), https://www.practicalpainmanagement.com/painscan/abstract/what-support-act-means-providers.

180. Jacqueline Landess, *State Medical Boards, Licensure, and Discipline in the United States*, 17 FOCUS 337, 339 (2019).

181. *See id.*

182. *Id.*

*themselves* medications and abuse such drugs while treating patients.[183] Many psychiatrists are also disciplined for improperly prescribing medications to their friends and family members.[184] Outside of these prescription issues, psychiatrists do not tend to be disciplined for general overprescribing practices.[185]

Notably, when physicians are disciplined, it is normally for actions deemed morally reprehensible or exploitative toward patients.[186] Although overprescription of medication can be exploitative, particularly when a psychiatrist is a member of a psychopharmacology board or receives some other form of compensation for promoting certain drugs, public perception tends to favor medication's use in health-related treatments.[187] Patients ask for medications, and research does not definitively demonstrate that harms are directly related to the prescription of most psychotropic medications if they are prescribed and used properly.[188] Thus, if a psychiatrist has a DSM-5 or other clinical reason for justifying a prescription to a patient, the psychiatrist's decision to prescribe medication will generally not be deemed a behavior subject to discipline, even if it can be demonstrated that the psychiatrist has a personal interest in that medication's prescription (sits on the psychopharmacology company's board; engages in "Speaker Programs" on that company's behalf).[189]

## VIII. POTENTIAL LEGAL SOLUTIONS

This paper has drawn attention to the many medical and legal reasons that psychotropic overprescription persists. Now, it will attempt to suggest solutions to the issues presented. Notably, these solutions will not be able to completely remedy psychotropic overprescription, but they do provide a starting point for activists interested in improving mental health care.

---

183. *See id.*

184. *See id.*

185. *See id.*

186. *See id.* at 338.

187. *See id.*; Matthias C. Angermeyer et al., *Public Attitudes Towards Psychiatry and Psychiatric Treatment at the Beginning of the 21st Century: A Systematic Review and Meta-Analysis of Population Surveys*, 16 WORLD PSYCHIATRY 50, 55 (2017).

188. *See generally* Smith, *supra* note 18 (discussing how patients who request advertised drugs are 17 times more likely to receive one or more new prescriptions, the growing popularity of off-label drug prescribing in psychiatry, and how there is often a lack of scientific evidence pointing to the effects of such off-label prescribing practices).

189. *See* Lussier, *supra* note 167; *see also supra* text accompanying note 164.

*Solution A: Psychologists As Prescribers*

In the current psychiatric system, treatment is bifurcated between psychiatrists and "therapists," a category that broadly encapsulates psychologists and social workers.[190] If psychologists, who generally take a more hands-on approach to patient care, are granted prescribing capabilities, issues arising from treatment bifurcation would likely be mitigated. Simultaneous administration of therapy and medication by one professional is arguably a step up from even "combined" psychiatric treatment, as the individual with personal knowledge of the patient's symptomatology has the ability to make all treatment decisions, streamlining and individualizing the process for patients.[191] Further, having more psychiatric personnel able to perform multiple treatment functions ameliorates some of the strain currently placed on the mental health system due to lack of staff and resources.

Psychologists are legally allowed to practice medicine in five states: New Mexico, Louisiana, Idaho, Illinois, and Iowa.[192] Notably, these states require all prescribing psychologists to undergo some level of psychopharmacological training, often in the form of a master's degree.[193] These psychologists must still obtain their standard doctoral degrees via intensive educational programs, largely focused on therapeutic measures.[194] This allows psychologists to gain the training necessary to understand medications without over-burdening individuals interested in the field with the extensive time and monetary investment that medical school requires.[195] In turn, the psychiatric field becomes more accessible to personnel specialized in therapy.

Further, the need for remote services may be mitigated by an increase in the number of expert personnel able to prescribe. Given that psychologists have less training than psychiatrists, their rates will remain lower than those of psychiatrists, even if they have the ability to prescribe medication.[196] Patients will then have an affordable alternate option to psychiatrists and "split" treatment.[197] Also, having more personnel able to prescribe medications may create competition within the psychiatric professional community that will force psychiatrists to maintain their

190. *See* Dewan, *supra* note 61.

191. *See id.*

192. *See* Cherry, *supra* note 68.

193. *See id.*

194. *See id.*

195. *See* Melanie Hanson, *Average Cost of Medical School*, EDUC. DATA INITIATIVE, https://educationdata.org/average-cost-of-medical-school#:~:text=The%20average%20yearly%20of,%2Dstate%2C%20private%20school (last updated July 12, 2023).

196. *See* David P. Pingitore et al., *Comparison of Psychiatrists and Psychologists in Clinical Practice*, 53 PSYCHIATRIC SERVS. 997, 982 (2002).

197. *See generally* Smith, *supra* note 18.

role as therapist, in conjunction with their role as prescriber.[198] After all, psychologists would have both capabilities at lower rates, making their offerings very attractive for individuals interested in holistic treatment.

Of course, there are potential risks associated with psychologists gaining prescribing rights. Psychopharmacology companies may begin approaching psychologists about participating in "Speaker Programs," creating pecuniary rewards for both high-prescribing psychologists and psychiatrists.[199] Because these psychologists would not be as trained in prescribing as psychiatrists are, such incentives lead to the following concerns and risks:

> [Psychologists will overlook] side effects of medications.
> [Psychologists will be in] [d]anger of overlooking medical disorders . . .
> [and] mistak[ing] [them] for mental disorders.
> [Psychologists will overlook the fact that] [m]any patients prescribed psychotropic medications also have one or more coexisting medical conditions.
> [Psychologists will not be as adept as] [p]hysicians and psychiatrists . . . to determine when and if medications are needed.[200]

It is very important that legal activists looking to improve psychiatry work on restructuring the legal frameworks that allow for self-interested prescribing.

*Solution B: Disclosure*

The Sunshine Act could have more of an impact on the psychiatric system and medical system more generally if it (a) required more descriptive disclosures[201] and (b) stipulated caps on the pecuniary interests that physicians are allowed to take in pharmacology companies.

Disclosures should not merely be about how much money a doctor receives for participating in a "Speaker Program," but should also provide the general public with an idea of what *type* of benefit is gained by the physician for the "conference" or other type of promotional activity that the physician participates in.[202] Notably, such a requirement would also help protect against fraudulent activity by pharmacology companies looking to 'reinforce' high prescription rates by psychiatrists,

198. *See id.*
199. *See* Lussier, *supra* note 167.
200. *See* Cherry, *supra* note 68.
201. *See* Lussier, *supra* note 167.
202. *See id.*

rather than compensate them for doing actual promotional work on the company's behalf.[203]

Further, disclosures should be made directly to patients. Much like the American Bar Association's (ABA) Model Rule 1.8(a) for lawyers, stating that,

> A lawyer shall not enter into a business transaction with a client or knowingly acquire an ownership, possessory, security or other pecuniary interest adverse to a client unless:
> (1) the transaction and terms on which the lawyer acquires the interest are fair and reasonable to the client and are fully disclosed and transmitted in writing in a manner that can be reasonably understood by the client;
> . . . .
>
> (3) the client gives informed consent, in a writing signed by the client, to the essential terms of the transaction and the lawyer's role in the transaction, including whether the lawyer is representing the client in the transaction.[204]

Psychiatrists should be similarly required to "transmit [] in writing" interests in drugs and obtain "informed consent" from patients prior to prescribing drugs that a psychopharmacology company pays them for promoting.[205] Notably, violation of this ABA Model Rule is subject to disciplinary consequences if violated, as opposed to legal ones (though disciplinary violations can be used as evidence of illegal behavior).[206] For psychiatrists, stipulations similar to those imposed by this ABA Model Rule for lawyers could be incorporated into either the Sunshine Act or their state disciplinary codes, or both.

Notably, such disclosure requirements would make patients more aware of psychiatrists' self interest in prescription — allowing them to be appropriately wary of psychopharmacology companies' influence over psychiatric treatment. Further, psychiatrists would likely be careful not to engage in activities that make them appear unduly influenced by a company — accepting overly lavish gifts, etc. Also, the threat of being held legally liable for fraud (if the stipulation were added to the Sunshine Act)[207] or having their licenses revoked (if enumerated by disciplinary boards) would keep psychiatrists upfront and honest about their interests.

---

203. *See id.*

204. MODEL RULES OF PRO. CONDUCT r. 1.8 (AM. BAR ASS'N 1983).

205. *See id.*

206. *See id.*; *see also* MODEL RULES FOR LAW. DISCIPLINARY ENF'T r. 9 (AM. BAR ASS'N 2002).

207. *See* Lussier, *supra* note 167.

Additionally, requiring psychiatrists to refuse compensation and gifts above a certain amount would be helpful for preventing their interests from becoming too interwoven with those of pharmacology companies. There is obvious utility in allowing psychiatrists to promote medications that they are very experienced with prescribing and have observed work well. However, that does not mean that *all* psychotropic medications that a certain pharmacology company prescribes are of the same caliber, or that the psychiatrist can speak well to the quality of *all* of a company's psychotropic drugs.

If a psychopharmacology company provides a psychiatrist with a large percentage of their yearly income, then the psychiatrist's success becomes contingent on that company's success. This means that even if a psychiatrist begins noticing a decline in that company's products, they may still feel pressured to either continue promoting the company's brand or not speak out against it. Worse yet, that psychiatrist may feel continually obligated to *prescribe* that company's drug(s), especially since pharmacology companies tend to reward their major prescribers most generously.[208]

Notably, neither disclosure requirements nor interest caps will completely eliminate the influence of psychopharmacology companies on psychiatric practice. Medications are essential to the treatment of many moderate to severe psychiatric disorders, and psychiatrists' expert opinions on their utility is important to facilitating disorder treatments for many patients. Like lawyers' business interests are limited by the ABA Model Rules,[209] psychiatrists' business interests *also* should be promoting patient safety but still allowing psychiatrists to information-share and benefit, to a degree, from such promotional activities.

## IX. CONCLUSION

Psychiatric overprescription stems from numerous structural and regulatory factors. As psychiatrists become more deeply entrenched in the role of prescriber due to pecuniary interests in psychopharmacology companies and medication becomes increasingly accessible via telepsychiatry apps, the state legislature's legal framework needs to be adapted to mitigate patient endangerment. Namely, more states should allow psychologists to obtain prescribing licenses, reducing the mental health system's need for remote psychiatric services and increasing competition within the psychiatric treatment space—potentially encouraging all mental health personnel to maintain their therapist roles.[210] In order to mitigate the challenges

208. *See id.*

209. MODEL RULES OF PRO. CONDUCT r. 1.8 (AM. BAR ASS'N 1983).

210. *See generally* Smith, *supra* note 18, at 40 (discussing the movement toward granting prescribing privileges to appropriately trained psychologists).

presented by prescribing professionals' pecuniary relationships with psychopharmacology companies, disclosure requirements should be increased[211] and interest caps instituted to increase patient awareness about prescribers' interests and moderate those interests to avoid unsafe treatment recommendations. Although these steps will not fully remedy psychiatric overprescription, they will likely help to reduce it.

211. *See* Lussier, *supra* note 167.