

# Psychologists' Role In The Discussion Of Psychotropic Medication With Clients: Legal And Ethical Considerations

By John Preston, Psy.D. and Bruce Ebert, Ph.D., J.D. (1999)

The 1990's have seen a dramatic increase in the use of psychotropic medications. This is likely due to four factors: increased knowledge about the neurobiology of certain psychiatric disorders; the advent of newer generation psychiatric drugs that have more favorable safety and side effect profiles; increased consumer acceptance of psychiatric treatment; and health care economics (i.e. the search for more cost effective approaches to treat emotional disorders).

Studies of prescribing practices in the United States indicate that the majority (75-90 percent) of prescriptions for antidepressants and minor tranquilizers are written by non-psychiatric physicians [e.g. primary care physicians (PCP's)]. Likewise up to 60 percent of patients with mental illness in the United States are treated in the primary care medical setting (Katon, W., 1994; Beardsley, R.S., *et al.* 1988). Complicating such treatment is the incredibly brief time patients are typically seen by their PCP's. Visits with PCP's last an average of eight minutes—hardly adequate time to take a history, make a diagnosis, prescribe treatment and offer the necessary patient education. Often, treatment is inadequate, follow-up is marginal at best and compliance rates with psychotropic medication treatments are poor (Keller, M.B., *et al.* 1995; Salazar, W.H., 1996; Hirschfield, R.M., *et al.*, 1997; Katon, W. *et al.*, 1992; Kerr, P., 1994; Greden, J.F., 1993).

Psychologists and other non-medical mental health professionals are consulting more and more with both psychiatrists and PCP's regarding medical treatments for psychotherapy clients. As consumers have become more empowered and better informed, psychotherapists are hearing an increased number of questions about psychotropic medications and treatment options. Additionally, some states now mandate that as a part of informed consent for treatment, psychologists must discuss with clients all available, established treatment options (including medication treatments).

When treating clients, psychologists must be knowledgeable about the professional, legal and ethical boundaries regarding the discussion of medication-related issues with clients. More importantly, considering the brief time PCP's spend with their patients, a number of compelling reasons exist for non-medical therapists to be knowledgeable about basic psychopharmacology and to be proactive in speaking with their clients and prescribing doctors. Psychotherapists see clients more frequently than they are seen by their physicians and are privy to a good deal of important information and observations. Such information includes, but is not limited to the following:

- 1) Therapists observe clients or are told about potential or emergent side effects that may interfere with compliance;
- 2) Clients may confide to psychotherapists information that they are embarrassed to tell their physician (e.g. sexual side effects such as inorgasmia);
- 3) Inadequate adherence to medication regimen;
- 4) Patient-initiated medication discontinuations (this may be especially critical if they tell the therapist that they have decided to abruptly discontinue benzodiazepines, which may result in serious withdrawal symptoms);
- 5) Emergence of late-onset side effects such as tardive dyskinesia (neuroleptics) or emotional blunting/apathy (sometimes seen in chronic SSRI treatment);
- 6) Break-through symptoms (i.e. previously controlled symptoms re-emerge);
- 7) The therapist becomes aware of the recent onset of substance abuse or the taking of new prescription medications which may either adversely affect metabolism of psychotropic agents or cause drug-drug interactions;
- 8) The therapist may be aware of a history of substance abuse in a client who is being treated by the primary care doctor with potentially addictive, benzodiazepines or stimulants;
- 9) Inadequate medication response that may warrant dosage adjustments or augmentation.

Particular issues sometimes arise which may necessitate consultation with the treating physician, that involve expressing differences of opinions about the treatment being offered. The following are but a few examples (which of course require considerable tact and mutual, collaborative respect between physician and psychotherapist):

- 1) The physician recommends medication discontinuation in a patient who is benefiting from and tolerating the medication (and in which the therapist believes that discontinuation is premature).
- 2) A patient is being under-treated (i.e. sub-therapeutic doses) and is not improving, yet there is no action or plan on the part of the physician to increase the dose (Note: under-dosing is not rare in primary care settings).
- 3) The treatment being recommended by the physician is not successful and is not in keeping with established treatment protocols (e.g. treating major depression with minor tranquilizers or treating psychotic depression solely with an antidepressant and without neuroleptics).
- 4) A medication prescribed by the treating physician is quite toxic if taken in overdose (e.g. tricyclics) and the therapist is concerned about suicide in the particular case. Since many new-generation antidepressants are relatively non-toxic, the therapist may understandably wish to recommend a medication change.

- 5) Due to the complexity or difficulty of a case, it becomes clear that a psychiatrist should be providing the treatment instead of a primary care doctor.

Finally, the following questions are frequently encountered by the therapist:

- 1) When the psychotherapist speaks with a PCP regarding possible medication treatment of a client, the physician asks, "what do you recommend?"
- 2) Clients ask the psychotherapist's opinion or advice regarding the pros and cons of medication treatment
- 3) Clients ask the psychotherapist about medication side effects, in part, because they are having difficulty reaching the prescribing physician or the doctor either does not know or is misinformed about medication side effects.

Central to the aforementioned circumstances are concerns regarding treatment outcome and client safety. Responsible practice would necessarily dictate collaboration and open discussion of the issues. However, professional territorialism and legal/ethical issues require a careful review of current standards and case law.

### Legal Issues

Is the discussion of medication treatment by psychologists within the scope of practice and does it constitute practicing medicine without a license? At this time there is no established case law to address these questions directly. However, several cases involving allied health care professionals do shed light on these issues (litigation brought against nurses and pharmacists). In these cases, the non-medical professionals were accused of practicing medicine without a license after giving patients information about prescribed medications. In each instance the nurses/pharmacists were legally exonerated. In fact in one case, it was determined that there may actually be a duty to inform clients regarding medication issues (such as side effects or potential drug-drug interactions).

Additionally, first amendment rights appear to grant psychotherapists freedom of speech to express opinions and disseminate information regarding treatment and treatment options. As noted earlier, some states now require as a part of informed consent, advising patients regarding treatment options, including medication. The largest successful lawsuit in psychiatry was based on a case where a man was treated for more than a year with psychotherapy (for major depression) and had not been advised regarding possible medical treatment alternatives. The man suffered for a year during which time he lost his business and was divorced prior to a family member finally encouraging him to get a second opinion and medical treatment. (*Osheroff v. Chestnut Lodge*, 1984).

Clearly it is not appropriate for non-physician therapists to do any of the following: administer or dispense drugs, tell patients to stop taking medication, or to advise them to change medication dosing. Such actions obviously are beyond the scope of psychology licensure. However, no one has exclusive rights to nor ownership of knowledge. All people have a right to access to basic information regarding treatment so that they may be in the best position to make informed choices.

It is incumbent on psychologists to become knowledgeable about psychopharmacology and (if appropriately trained) to be available to share such information, as is appropriate, with psychotherapy clients. ♪

### References

Beardsley, R.S., et al. (1988) Prescribing of psychotropic medication by primary care physicians and psychiatrists. *Archives of General Psychiatry*. 45: 1117-1119.

Greden, J.F. (1993) Antidepressant maintenance medications: when to discontinue and how to stop. *Journal of Clinical Psychiatry*. 54: Supplement: 39-45.

Hirschfield, R.M., et al. (1997) The National Depressive and Manic-Depressive Association consensus statement on the under-treatment of depression. *JAMA*. 277(4): 333-340.

Katon, W., et al. (1992) Adequacy and duration of antidepressant treatment in primary care. *Medical Care*. 30(1): 67-76.

Katon, W. (1994) *Panic disorder in the medical setting*. Rockville, MD: NIMH.

Keller, M.B., et al. (1995) Treatment of chronic depression with sertraline or imipramine: preliminary blinded response rates and high rates of under-treatment in the community. *Psychopharmacology Bulletin*. 31(2): 205-212.

Kerr, P. (1994) Antidepressant prescribing: a comparison between general practitioners and psychiatrists. *British Journal of General Practice*. 44(383): 275-276.

Osheroff v. Chestnut Lodge, Inc. (1984) 490 A.2d 720.

Salazan, W.H. (1996) Management of depression in the outpatient office. *Medical Clinics of North America*. 80(2): 431-455.

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