



AMERICAN  
PSYCHOLOGICAL  
ASSOCIATION

## ADVANCING COLLEAGUE ASSISTANCE IN PROFESSIONAL PSYCHOLOGY

Board of Professional Affairs' Advisory Committee on Colleague Assistance with contributions from the Association of State and Provincial Psychology Boards and the American Psychological Association of Graduate Students

### INTRODUCTION

This monograph has been written to aid licensing boards and state and provincial and territorial psychological associations (SPTAs) to develop and provide adequate and appropriate colleague assistance to distressed or impaired psychologists. The material has been developed in a working collaboration over a several year period between the Advisory Committee on Colleague Assistance (ACCA) of the Board of Professional Affairs (BPA) of the American Psychological Association (APA) and the Association of State and Provincial Psychology Boards (ASPPB).

The intention of the monograph is to provide an understanding of the nature and extent of psychologists' competence problems within a developmental context, and to provide models and strategies (programs and processes) that can address prevention and intervention. It has been the assumption throughout this process that addressing psychologists' problems would be best accomplished through appropriate collaboration and understanding between the professional associations and the licensing boards. The material herein is not intended to be prescriptive, but to address the concerns and provide assistance to the relevant stakeholders that can be adapted to local use, respecting the existing forms and legislative mandates of each jurisdiction.

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**Disclaimer:** The views expressed in this document have not been approved by the governing or policy-setting bodies of the American Psychological Association or the Association of State and Provincial Psychology Boards and should not be construed as representing policy of either organization. This document is not intended to establish a standard of practice against which state/provincial/territorial psychological associations, licensing boards or individual psychological practice is to be evaluated. Rather, it provides one approach that psychologists may find useful in understanding, assessing, and responding to colleague distress and impairment.

## CHAPTER 1

### THE PROBLEM IN CONTEXT

It is in the nature of professional work that individuals may develop personal difficulties that impede or impair their personal and professional functioning. While the majority of professionals, including psychologists, sustain a career of competent service delivery, at various times many experience stress levels that would be aided by seeking assistance and support. In addition, a few professionals develop sufficient difficulties in behavior or competence that may require outside assistance or intervention.

Professional impairment is widely addressed in several fields (notably medicine, law, and nursing). The research in this area can be difficult to interpret because some studies include multiple professional groups while other studies focus only on mental health providers or specifically psychologists. Regardless, the findings regarding professional impairment can be generally applied to psychologists to understand the impact of impairment on professional functioning. Researchers estimate that 15% of practicing physicians will become impaired at some point in their careers (Boisaubin & Levine, 2001). In a study assessing stress and burnout in Australian rural psychiatric nurses, Pinikahana and Happell (2004) found that 10.4% of nurses suffered high levels of burnout, whereas 70.8% of nurses reported a low level of burnout. Another study examining psychiatrists that were disciplined by the California state board found that of the 75 psychiatrists that were disciplined, 16% were disciplined for drug and alcohol or mental and physical impairment (Morrison & Morrison, 2001). When assessing impairment in psychologists, optimal functioning of the person of the psychologist has been noted as critical to effective professional behavior. Clinical lore and research literature on practice have long documented the high incidence of distress that occurs in conducting psychotherapy. Guy, Poelstra, and Stark (1989) found that 74.3% of psychologists reported experiencing distress at some times in their work. Of this number, 36.7% indicated that personal distress resulted in a decreased quality of care for patients, while 4.6% admitted to delivering inadequate care. Laliotas and Grayson (1985) estimated impairment prevalence in psychologists at 5-15%, and Pope, Tabachnick, and Keith-Spiegel (1987) indicated that 59.6% of professionals reported working under distress that would affect the therapeutic relationship at some time in their career. Cushway and Tyler (1994) sampled 101 clinical psychologists practicing in England and found 75% of psychologists reported that they were moderately or very stressed as a result of their job.

Psychology as a discipline has struggled to address the issues of professional distress and impairment for many years. The Association of State and Provincial Psychology Licensing Boards (ASPPB) and their member jurisdictional boards have long adjudicated improper psychologist behavior as a function of their legal mandate to protect the public. The American Psychological Association (APA) first created a structure to address this topic with the creation of the Advisory Committee on Impaired Psychologists

in the 1980's. The early focus was on alcoholism or substance abuse, occasionally addressing the "wounded healer" (Sherman, 1996). That committee was later renamed the Advisory Committee on Colleague Assistance (ACCA). Along with the effort to provide assistance to distressed psychologists and prevent practitioners' harming others, there has also been increasing attention to professional competence (Kaslow, Collins, & Illfelder-Kaye, 2004), and to strengths and resilience, capacities that foster recovery from stress and life challenges (Bonanno, 2004; Kelley, 2005). Toward that end, a focus on self-care, prevention and early intervention have become priorities of APA and ACCA's efforts.

A universal definition of distress and impairment in professional functioning has not yet been created, although most definitions demonstrate common themes. One example of a legal definition is stated in *Michigan* law (MCL 333.16106a (2005)): "Impairment means the inability or immediately pending inability of a health professional to practice his or her health profession in a manner that conforms to the minimum standards of acceptable and prevailing practice for that health profession due to the health professional's substance abuse, chemical dependency, or mental illness." The *Virginia* Colleague Assistance Program (CAP) defines impairment "as any physical, psychological, or interpersonal condition that results in a reduction of work performance by the impaired psychologist and for which the impaired psychologist is not receiving adequate treatment, yet continues providing services of an inadequate level" (*Virginia Psychological Association*, p. 2). In *Texas*, "Impaired professional" means "an individual whose ability to perform a professional service is impaired by chemical dependency on drugs or alcohol or by mental illness" (Tex. Health & Safety Code § 467.001(3) (2004)). *Ohio* regulations describe the "impairment of ability to perform according to acceptable or prevailing standards of care" (OAC Ann. 4731-16-01, et seq. (Anderson 2005)). In addition, Lamb, Presser, Pfof, Baum, Jackson, and Jarvis (1987) developed a detailed definition of impairment specifically for trainees as interference in professional functioning in one or more of the following areas:

- (1) an inability and/or unwillingness to acquire and integrate professional standards into one's repertoire of professional behavior;
- (2) an inability to acquire professional skills to reach an acceptable level of competency;
- (3) an inability to control personal stress, psychological dysfunction and/or excessive emotional reactions that interfere with professional functioning (p. 598).

In order to be able to appropriately aid distressed or impaired professionals, the nature and prevalence of such problems needs first to be understood. Research on problems of psychologists has focused on depression, substance use, work and personal life stressors, burnout, and boundary violations (including sexual misconduct). Persons with certain impairments come under protection of the Americans with Disabilities Act (ADA, 1990), making it important to consider intervention in that light. However, the ADA does allow that if mental stability is demonstrated to be a requirement for a job or training program, denial of access may be based on mental or emotional impairment (Goodman-Delahunty, 2000). The following sections review some literature on

impairment and its impact and specific problems by topic that affect psychologists and other professionals. Stresses in graduate school prior to entering a professional career will also be addressed.

### *Impairment and coping*

Coping with distress is a natural consequence of daily living for many individuals, although the use of positive (e.g. therapy) or negative (e.g. substance abuse) coping strategies can vary dramatically both within and across individuals. In a study on coping and distress, 89% of laypeople and 82% of psychologists reported experiencing at least one episode of distress, although psychologists were found to enlist a larger and more varied repertoire of coping strategies to address this distress (Norcross, Prochaska, & DiClemente, 1986). In their study on stress and coping in psychologists, Cushway and Tyler (1994) found that 65% of psychologists used behavioral strategies to cope with stress, while 60% used cognitive strategies. For example, 54% of psychologists reported talking with other psychologists, 51% used exercise to reduce their stress level, and 43% used their spouse as a sounding board to release job stress. Studies have shown that a majority of mental health professionals seek therapy at some time, but psychologists make more use of this avenue than other professions (see Geller, Norcross, & Orlinsky for a review, 2005). Studies suggest that the primary reasons for psychologists and students in training to seek therapy include conflicts in personal life, personal and professional growth, and/or occupational work distress (Holzman, Searight, & Hughes, 1996; Liaboe, Guy, Wong, & Deahnert, 1989; Norcross & Prochaska, 1986).

***Stress & burnout--personal and professional.*** Acknowledging and quantifying professional stress within the field of psychology is important to prevent and/or cope with its effects. As persons engaged in a helping profession, psychologists strive to be sensitive to how stress may affect their lives, their colleagues, and clients/patients. Hannigan, Edwards, and Burnard (2004) identified work-related stressors for psychologists as “characteristics of clients, excessive workloads, professional self-doubt and poor management” (p. 241). Vredenburgh, Carlozzi, and Stein (1999) identified two factors that may contribute to higher levels of stress: practice setting and age, while O’Connor (2001) listed emotional and draining interactions with clients, isolation, rapid role changes, and holding in personal needs in the therapy setting. Specific working environment factors that limit decision-making authority and promote ambivalent expectations may add further stress (Ackerley, Burnell, Holder, & Kurdek, 1988). For example, results indicate that lower levels of autonomy that come with working in hospital settings and lower levels of experience may put psychologists at an increased risk of stress. In a survey of 318 psychologists Guy, Poelstra, and Stark (1989) found that during the previous three years 74.3% reported experiencing “personal stress,” which was defined as job stress (32.0%), illness in family (23%), marital problems (20.4%), and financial problems (20.9%). Perhaps as a result of stress, Wood, Klein, Cross, Lammer, and Elliot (1985) noted that 32.3% of psychologists reported depression or burnout. In addition, Mahoney (1997) noted that in a survey of 155 practitioners, 37.7% reported having problems in intimate relationships, and 42.6% stated that they had had episodes of irritability or emotional exhaustion. Finally, Stevanovic and Rupert (2004) found that

professional stress was frequently related to economic uncertainty, sense of responsibility, time pressure, and perceived external constraints on services. One of the lowest rated sources of stress was ethical conflict.

*Financial issues.* In assessing distress and impairment of professional psychologists, financial matters cannot be ignored. Economic uncertainty is a common stress for psychologists and may occur due to financial issues such as problems collecting fees, cost of malpractice insurance, and frustrations in dealing with insurance companies (DeAngelis, 2005; Kaslow & Schulman, 1987; Nash, Norcross, & Prochaska, 1984). In a survey on stress in clinical psychologists, 30% of psychologists reported lack of financial compensation as a stressor (Cushway & Tyler, 1994). Case and McMinn (2003) found 29.6% of psychologists reported that financial difficulties were at least somewhat of a concern. Financial matters are further complicated by the rapid changes occurring in the health care industry that are at least “somewhat” of a stress to 62.6% of psychologists (Case & McMinn, 2003). In their APA survey, Phelps, Eisman, & Kohout (1998) found that four out of five psychologists reported that managed care had a negative impact on their practice and more recent data collected by the APA Practice Directorate had similar findings (Bufka, Reed & Rehman, 2006). The APA Practice Directorate, in collaboration with some SPTAs, has investigated several instances of alleged abuses by managed care companies that put company profits ahead of patient care or the rights of psychologists. In some instances, these concerns have developed into test case lawsuits supported by the APA Practice Organization and those lawsuits are periodically covered in the APA Monitor. Aside from financial issues surrounding a practice in psychology, there is additional stress on practitioners and recent graduates due to the debt that many incur as part of graduate study in psychology. In 2001, the APA’s Research Office conducted a survey on doctoral employment and found that 26% of psychology doctoral graduates reported a debt of \$75,000 or higher, and the average debt for a psychology doctoral graduate was \$53,111.

*Family-of-origin issues.* Psychologists may be stressed by the major effects of family problems beginning in childhood. Pope and Feldman-Summers (1992) reported that in their sample, a third of psychologists had suffered physical or sexual abuse as children, while Elliot and Guy (1993) found childhood trauma in the background of 66.4% of women mental health professionals. Earlier research (Racusin, Abramovitz, & Winter, 1981) found child abuse and/or alcoholism in 50% of families of psychotherapists and disturbed family roles including parentified children (Minuchin, 1974). This prior experience of parentification and/or child abuse could be a factor in mental health professionals choosing their profession (O’Connor, 2001). For therapists who recognize the need to work through such personal issues, these background factors may create no problems unless reactivated by exposure to clients with similar issues. Unresolved, such background issues could result in therapists’ problems with separation-individuation or clear boundaries between themselves and clients (Twemlow & Gabbard, 1989), a frequent source of impaired behavior.

*Divorce and relationship difficulties.* Divorce rates of psychologists are rarely reported in the literature. In research studies asking for current marital status, 10-13% of

psychologists report being divorced (Borys & Pope, 1989; Sherman & Thelen, 1998). When surveying psychologists for impairment, it is more common for researchers to ask about marital difficulties than divorce. As a result, studies tend to examine variables that affect marital satisfaction, including satisfaction with parenting of children, depression, loneliness, and satisfaction with sexual desire/performance (Thoreson, Miller, & Krauskopf, 1989). In a study of 264 professionals, 82% reported having experienced relationship difficulties, and 47% had sought therapy to address relationship problems (Deutsch, 1985).

*Depression.* Depression among psychologists can heavily impact individual effectiveness and satisfaction at work and home. This research area can be confusing as depression is classified in a multitude of ways across studies, e.g., DSM-IV criteria versus vague descriptions of depressive mood. For instance, Prochaska and Norcross (1983) found that 82% of psychologists endorsed “anxious or depressive moods, somatic complaints, lower self-esteem, and feelings of confusion, and helplessness about their problems” (p. 644). This loose definition, which included depressive moods, was endorsed by a large percentage of the sample. Other studies with more defined categories of depression found percentages ranging from 11% to 61% (Deutsch, 1985; Pope & Tabachnick, 1994; Sherman & Thelen, 1998; Thoreson, Miller, & Krauskopf, 1989). This range may be related to the measurements used to measure depression or the timeframe used in the study for onset and/or duration. Pope (1994) did report that of the 61% of psychologists he studied who reported depression at some point in their careers, 85% had sought treatment. Regardless of the definition utilized, and in keeping with general population trends, a majority of the above studies found that women psychologists report higher rates of depression than men. The definitional ambiguity in the research creates a potential problem in defining depression as impairment. Is impairment tied to DSM-IV diagnosis or to the presence of a certain number of depressive symptoms at any given time, or the interference in professional functioning that results from depression?

*Suicide.* Few articles have examined rates of suicide or suicidal ideation/intent in psychologists, although this may be an area of relatively high prevalence in the profession. Pope and Tabachnick (1994) discovered that 29% of their sample of 800 psychologists reported suicidal feelings at some point during their career and 4% of professionals had attempted suicide. Similarly, Deutsch (1985) found that 2% of professionals had attempted suicide. While suicide attempts are often linked to substance abuse, as with other professions, suicide attempts are also impacted by depression, burnout, marital discord, rigid thinking/tunnel vision, ambivalence about life, recent loss, and wishes to escape pain. While, of course, the prediction of suicide is impossible (Bongar, 2002), a major depressive disorder has been identified as increasing the likelihood of a completed suicide (Peruzzi & Bongar, 1999), a finding which likely holds for clients/patients in general. Additionally, 61% of psychologists have reported experiencing clinical depression at some time in their lives (Ukens, 1995).

*Substance and alcohol abuse.* The earliest colleague assistance programs in a variety of professions focused almost entirely on drug and alcohol abuse and its effects on practice. Substance abuse is also one of the most researched areas for professional psychologists.

As with depression studies, this research is affected by the definitions and measures used in individual studies. Typically, reports of substance abuse in psychologists range from 6-11%, with higher numbers associated with studies that measured alcohol abuse as well as other substances (Deutsch, 1985; Thoreson, Miller, & Krauskopf, 1989; Thoreson & Skorina, 1986). One national survey (Good, Thoreson, & Shaughnessy, 1995) reported 20% of respondents using alcohol daily or almost daily with 1% drinking more than ½ pint per day. Reported use of drugs was 1.1% for cocaine, 2.9% for opiates, 6.4% for marijuana, and 6.2% for tranquilizers. Of the sample, 10% had been confronted about their drug or alcohol abuse, and 17% had sought help. In psychologists abusing substances, Thoreson, Budd, and Krauskopf (1986) also found evidence of nicotine use, caffeine use, and addiction to prescription medicine. What may be even more alarming are the statistics on use of alcohol before a session. Surveys have found that 5.7% of psychologists had used alcohol before session on a rare basis (Pope, Tabachnick, & Keith-Spiegel, 1987), while 80% reported having gone to work with a hangover (Thoreson et al, 1986). Substance and alcohol abuse has been linked to higher divorce rates, depression/anxiety, suicide attempts, and recurrent physical illness in psychologists (Thoreson, Miller, & Krauskopf, 1989). The impact of substance abuse on work behavior in one study includes 74% reporting decrease quality of work, 68% describing a narrowing of the scope of their work, 56% describing late or incomplete work, 54% reporting increased conflict in the workplace with colleagues, and 30% detailing complaints from co-workers regarding forgetfulness and inefficiency (Thoreson, Budd, Krauskopf, 1986). Other psychologists have described themselves while drinking as displaying embarrassing and “foolish behavior in public” (Skorina, Bissell, & DeSoto, 1990, p. 249). Of the men, 44% reported colleague feedback, while 13% of women had received such feedback. In yet another survey (Floyd, Myszka, & Orr, 1998), psychologists reported noting evidence of colleagues with alcohol problems including decrease work performance, increased sick days, and smell of alcohol.

*Vicarious/secondary trauma.* Therapists must be alert to the negative impact working with traumatized clients can have on their own functioning. This impact is often referred to as secondary traumatic stress (STS) or compassion fatigue (CF) (Figley, 1995). Some authors have suggested these are the same phenomena (e.g., Stamm, 1999), while others make a distinction. Secondary traumatic stress (also known as vicarious traumatization) occurs when therapists are “exposed” to the traumatic accounts of their clients resulting in transmission of traumatic stress from the client to the therapist (Collins & Long, 2003; Figley & Kleber, 1995; McCann & Pearlman, 1990; Pearlman & MacJan, 1995). Compassion fatigue refers to the cumulative combination of STS and burnout (Figley, 1995). By whatever name, symptoms associated with STS and CF have been found to lower the quantity and the quality of the therapist’s interactions with clients. Cyr and Dowrick (1991) found that only 16 out of 30 (54%) crisis line volunteers answered yes when asked “Have you ever felt burned out from working on the crisis line?” (p. 350). Yet, when the survey inquired about behaviors and feelings that are indicative of burnout, 29 of the volunteers (97%) indicated that they had previously or were presently experiencing symptoms of burnout. Further, in a large survey investigating the impact of 9/11 on psychologists, Eidelson, D’Alessio, and Eidelson (2003) found that the most significant predictor of increased stress was higher demands on professional time, with

change of professional focus, impact on personal life, heightened personal fear, and client distress also significant (and all positive) predictors.

### *Harm to others*

In a large, international study, Orlinsky and Ronnestad (2005) have found that managing personal stress and maintaining strong personal and professional support were central to effective practice. Earlier work suggests similar effects on practice. For example, Guy, Poelstra, and Stark (1989) found that during the prior three years, 36.7% of surveyed psychologists reported that life stressors had decreased the quality of client care they provided, with 4.6% indicating that their distress had resulted in inadequate patient care.

*Sexual/dual relationships.* Pope, Tabachnick, and Keith-Spiegel (1987) reported that 46.3% of psychologists endorsed having sexual feelings for their clients at some time. Bouhoutsos, Holroyd, Lerman, Forer, and Greenberg (1983) reported that 4.8% male and .8% female psychologist had sexual contact with clients. Gartrell, Herman, Olarte, Feldstein, and Localio (1986) found that 7.1% male and 3.1% female psychologists had sexual contact with a client, and Pope and Vetter (1991) indicated that 50% of clinical and counseling psychologists surveyed had encountered at least one patient who had been sexually involved with a prior therapist. In 2001, in a chapter on sex between therapist and client, Pope reported that current nation-wide studies suggest that 4.4% of therapists have engaged in dual sexual relationships (7% of male therapists; 1.5% of female therapists). Borys and Pope (1989) reported that 98.7% of psychologists reported never having sexual contact with patients during their therapies and 95.3% reported no sexual contact with any patient after the patient's therapy ended. Kirkland, Kirkland, and Reaves (2004) reported that 742 psychologists were disciplined for sexual/dual relationships with clients, by far the most frequent infraction.

*Sexual abuse of students/supervisees.* As with the therapist-client relationship, sexual abuse can take place in the professor-student/supervisee relationship. Although Pope, Tabachnick, and Keith-Spiegel (1987) reported that 85.1% of professionals view such behavior as unethical, they found that 3.4% of psychologists endorsed having had sex with a supervisee. While 95% of professionals called such behavior harmful, 31% of students/supervisors stated that they had received advances from psychology educators during training and 17% engaged in sexual contact with one or more educators during graduate training. More female graduate students reported having sexual relations with an educator or supervisor, in keeping with the numbers that more men have inappropriate sexual relationships with clients and students (Glaser & Thorpe, 1986).

### *Graduate school issues and training needs*

*Graduate school pressures.* Graduate training can be a time of personal and professional stress. Trainees are challenged with navigating the professional socialization process in addition to balancing academic coursework with developing the skill-set necessary to conduct clinical work competently. Although these challenges are generally

acknowledged within the field, scholarly literature is surprisingly limited as to the motivational benefits versus the hindering impact of stress specifically in graduate school. The results of one study indicated that 59% of clinical psychology trainees reported a high level of psychological distress (Cushway, 1992). In a study of graduate student stress, 133 students indicated that a majority of their stress stemmed from time constraints, difficulty working with individual faculty, and financial constraints (Cahir & Morris, 1991). Research has carefully excluded behaviors that are developmentally normal such as anxiety for beginning therapists (Chapman, Hall, & Peters, 2002). Negative student distress is reflected in a report from the APA Research Office (APA, 2005) indicating that in 2004, 2.5% of doctoral students withdrew or were dismissed across the 847 training programs.

*Training issues.* It is important to consider issues of distress and impairment in training, as problems that are either ongoing in the trainee or emerge during training or internship may continue to be problematic when the trainee graduates and enters professional career. Models of professional colleague assistance that effectively address psychologists' self-care as well as prevention and early intervention will be helpful to training programs and trainees as well.

Although the link between training and practice has been described anecdotally, and some lawsuits have been brought against training programs of a psychologist charged with inappropriate behaviors, little demonstration of that connection yet exists. One recent study from the field of medicine is noteworthy for having determined that physicians reported to their licensing board were more likely to have been noted as having problems with unprofessional behavior during medical school (Papadakis, et al., 2004).

The Guidelines and Principles of the Committee on Accreditation make clear that students are to receive timely, at least annually, feedback on their progress and performance. Problems and remediation are to be addressed on an ongoing basis. Also the APA Ethical Principles of Psychologists and Code of Conduct (2002) addresses training issues in standards 7.02 and 7.04 regarding the need to make public the possibility of intervention with impaired or problematic trainees. In a survey of programs in professional psychology, 89% of doctoral programs reported students with "professional deficiencies" (p. 50) and 34% of program chairs described some personality or emotional problems in their students (Procidano, Busch-Rossnagel, Reznikoff, & Geisinger, 1995). More recently, one half of training program directors of accredited programs reported termination of at least one student in the prior three-year period (Vacha-Haase, Davenport, & Kerewsky, 2004). Much has been done in recent years to identify and remediate trainee impairment (Bemak, Epp, & Keys, 1999; Elman & Forrest, 2004; Forrest, Elman, Gizara, & Vacha-Haase, 1999; Lamb, Presser, Pfof, Baum, Jackson, & Jarvis, 1987; Mearns & Allen, 1991) to protect the public and the profession, although intervention is often later in the process either because the problem is not identified or intervention is avoided in the hope that the problem will resolve itself.

Personal psychotherapy is by far the most common form of intervention recommended for trainees (Elman & Forrest, 2004). The APA Ethical Principles of Psychologists and Code of Conduct (2002) states that students can be required to seek therapy if the training program believes the student's personal issues are negatively impacting performance. Pope and Tabachnick (1994) reported that although 13% of their respondents were required to have therapy during their training program, 70% believed therapy while in training is necessary. Additionally, 38-75% of clinical psychology doctoral students have reported engaging in treatment (Holzman, Searight, & Hughes, 1996), and 23% of practicing psychologists have reported engaging in personal therapy (Guy, Stark, & Poelstra, 1988). In another study, Mahoney (1997) found that 22.2% of psychotherapists reported currently seeing a therapist regularly, although 32.3% expressed a desire to have access to therapy to relieve stress.

Problematic or impaired behavior by psychologists is a special challenge given that the characteristics of the psychologist directly impact and are impacted by professional work, especially psychotherapy. Pipes, Holstein, and Aguirre (2005) contribute to our understanding of both the distinction and overlaps between the personal and the professional from an ethical perspective that may inform the challenge to both the professional associations and the regulatory boards. The chapter that follows addresses the systems with both aspirational and legal responsibility for assisting psychologists who are having personal difficulties that interfere with their professional work from both a preventive and disciplinary perspective.

## CHAPTER 2

### THE RESPONSE OF THE PROFESSION

#### *Common goals*

As both the American Psychological Association (APA) and the Association of State and Provincial Psychology Boards (ASPPB) take a similar stance on a number of ethical issues to monitor the professional performance of psychologists and to protect the public, a set of suggestions for colleague assistance programs, developed in collaboration between APA and ASPPB, may add important and meaningful assistance to program development. Both the APA Ethical Principles of Psychologists and Code of Conduct (2002) and ASPPB documents, describe the type of trust necessary between psychologist and client, the responsibility of the psychologist to monitor one's own psychological health to protect the public and do no harm, and the responsibility to take action to avoid harm by self or others.

Table 1 details specific, comparative mission/ethics statements for APA and ASPPB. This table demonstrates that both organizations are concerned that psychologists' personal and work stress not adversely affect their professional functioning and relationships. Both hold psychologists to standards of professional conduct and the mandate to protect the public and seek assistance when professional functioning is or may be compromised. Further comparison of the ASPPB Code of Conduct (ASPPB, 1991), the Ethical Principles of Psychologists and Code of Conduct (APA, 1992), and the Canadian Code of Ethics for Psychologists (Canadian Psychological Association, 1991) may be found in an article by Sinclair (1996). The author concluded that all three codes strongly reflect the ethical principles of respect for the dignity of persons, responsible caring, integrity in relationships, and responsibility to society. Additionally, all three require "that a psychologist not engage in an activity if he or she is impaired in some way" (Sinclair, 1996, p. 66).

In addition, APA's Advisory Committee on Colleague Assistance (ACCA), was formed to provide information and assistance regarding problems of impairment to licensing boards and state/provincial/territorial psychological associations (SPTAs). The committee adheres to the belief that all psychologists are vulnerable to stress, distress and even inappropriate or impaired behavior, in certain circumstances, and they may tend to ignore these problem issues because they threaten their sense of competency and/or professional identity (Orr, 1997). ACCA's mission includes (1) recognizing and investigating the unique occupational vulnerabilities of psychologists and their need for colleague assistance, (2) promoting the development of and continuation of state, provincial, and territorial-level colleague assistance programs and peer assistance networks, and (3) developing proper, informed relationships between SPTAs, licensing boards, and colleague assistance programs for the benefit of both the profession and the

public. ACCA emphasizes education and prevention in addition to intervention. ACCA recognizes that unique stressors for psychologists include using the person of the psychologist as a therapeutic tool, the demands of managing the intimate and confidential nature of the client/patient and psychologist relationship, the limits of reciprocity and other conditions of a more typical working relationship, varied and often quickly shifting role demands, risk for burnout and isolation in practice, and vicarious traumatization and compassion fatigue.

Hence, it may be concluded that both organizations (1) are concerned that the public be protected from harm from psychologists by monitoring the training and credentials of psychologists, (2) are concerned that the public be protected from harm from psychologists by monitoring the professional conduct of psychologists, (3) have documented that harm to the public by psychologists is frequently caused by stress, distress or impairment on the part of the psychologist, (4) believe in the resilience and growth possibilities of all human beings, and (5) believe in the efficacy of the appropriate application of therapy, education, supervision, and other psychological interventions to restore or promote optimal professional functioning. Therefore, the most efficient and effective method for solving problems in psychologists' functioning would be collaborative between the two most concerned national organizations: APA and ASPPB and their component state, provincial or territorial organizations. This collaboration is intended to result in suggestions for colleague assistance programs that would involve cooperation between psychology regulatory/licensing boards and professional associations to promote professional growth and rehabilitation of psychologists, when possible, and protect the public from harm.

This collaboration seems to be a natural outgrowth of a common licensing board function. When a licensing board receives a sanctionable complaint, the actual sanction may include a combination of professional restrictions such as suspension or restrictions on certain activities and clients seen and rehabilitation activities such as supervision, practice monitoring, and therapeutic interventions. A Colleague Assistance Program may provide these types of rehabilitative services to psychologists entering the program on their own initiative and concern, to those referred by another psychologist before any misconduct occurs, or to those being sanctioned by the licensing board as part of their rehabilitation component. For example, in Maryland, the Colleague Assistance Program (CAP) is recognized by the Board of Examiners as a psychologist rehabilitation committee so that the Board may refer individuals to the CAP (MD. CODE ANN. § 18-318).

### *Licensing board responsibilities*

In *The Law of Professional Licensing and Certification*, Reaves and Rainer (2002) stated that the right to practice a recognized profession is not an absolute or unqualified right. This right is subject to the police power of the jurisdiction. The government's interest is to protect the public; consequently it controls various aspects of professional practice. Most states, provinces, and territories have from twenty to thirty

licensed professions. The function of licensing boards is to monitor the credentialing of appropriate professionals when issuing licenses and evaluate complaints about their professional behavior and activities. The state/province/territory is considered “the authority” for the regulation of practice. That authority means the administrative agency or board to which that authority has been delegated. The state/province/territory’s control over a professional practice often includes admission to the practice, enforcing the standards of practice, insuring continuing competency, removal from practice and readmission to practice. A professional regulatory board is an agency that operates at the will of the executive branch of government. It also has a relationship with both the legislative and judicial branches, along with other agencies within the governmental structure.

Administrative law is a body of law and procedures that evolved out of government agencies’ need for a way to enforce regulations without having to resort to a regular court of law. Administrative actions were traditionally viewed as dealing with routine regulatory matters, and the rights (e.g., restriction on an independent license to practice) were not thought to be as significant as those at stake in criminal law (e.g., liberty or imprisonment) or civil law (e.g., property, forfeiture or a money judgment).

It is important to note that the procedures regulating the practice of psychology differ widely by state/province/territory. Practicing psychologists are encouraged and expected to read, understand, and seek guidance from experienced legal counsel if they do not completely understand all relevant statutory procedures, rules and regulations prior to practicing in or facing a disciplinary action in a jurisdiction. As with the law, in general, ignorance is not an excuse for mistakes or misconduct. Psychologists are fully responsible for knowing all laws that affect them and practicing in compliance with all relevant laws and regulations.

### *The disciplinary process*

Licensed professionals charged by a regulatory board with an offense that may result in the loss of a license are entitled to certain procedural rights to ensure that they can present their case and have a fair hearing. These procedural rights are termed “due process,” and, in general, any disciplinary proceeding must afford the accused some level of due process. Due process is a legal concept that describes the balancing of fairness, accuracy, procedural efficiency and acceptability to all involved parties.

Virtually all licensing board statutes specify a typical set of sanctions that include revocation of a license, suspension for a period of time, probation for a period of time, reprimand, and voluntary surrender of a license in lieu of further disciplinary proceedings. Many licensing boards also have the authority to use rehabilitation as part of the disciplinary process. Some examples follow.

In *Texas*, “The Board may follow one or more options in devising a rehabilitation program: (1) The individual may be supervised in all or selected areas of activities

related to his/her practice as a licensee by a licensed psychologist approved by the Board for a specified length of time” during which the Board will specify the focus of supervision, the number of hours per week, and the time lines for periodic and timely progress reports with all fees being the responsibility of the supervisee; (2) “The individual may be expected to successfully complete a variety of appropriate educational programs” specified by the Board; and (3) The Board may require of the individual: (a) psychodiagnostic evaluations by a psychologist approved by the Board, (b) a physical examination including alcohol and drug screening by a physician approved by the Board, (c) psychotherapy on a regular basis from a psychologist approved by the Board; and (d) any other requirement that seems appropriate to other individual case.” These requirements may be mitigated by such variables as self-report and voluntary admissions of misconduct, implementation of remedial measures already taken, motive, rehabilitative potential, prior community service, and any extenuating relevant acts and circumstances regarding seriousness or responsibility (22 Tex. Admin. Code § 469.8(b) (2005)).

In *Colorado*, the board may require the licensee to submit “to such examinations as a board may order to determine such person’s physical or mental condition” and may require the licensee to be in therapy or “take courses of training or education as may be needed to correct deficiencies found either in the hearing or by such examinations.” Supervision of practice may also be required C.R.S. §12-43-224(3)(c)(I), (II) (2004).

In *Ohio*, the board is allowed an array of requirements depending upon the offense including psychological evaluation, psychotherapy, psychiatric treatment, remedial course of study, and practice monitoring. For practice monitoring, psychological evaluation, psychotherapy, psychiatric evaluation and treatment, and toxicological screens, the licensee must sign a release authorizing access for the Board to records and progress reports (State Board of Psychology of Ohio).

The *Massachusetts* Board may also require the licensee to submit “to such examinations as the Board may require to determine the licensee’s physical or mental condition,” “to undergo therapy and/or courses of training or education deemed necessary by the Board,” and to be supervised and/or monitored. Hence, it is common for licensing boards to require such rehabilitative experiences as psychological assessment, psychotherapy, and supervision (251 CMR Section 1.09(2)(a)--(c) (2005)).

### *Grounds for disciplinary actions*

Regulatory statutes differ across jurisdictions and among professions. Some are relatively old, while many have been recently enacted. Most have been amended on one or more occasions. Consequently it is impossible to list all potential grounds for disciplinary action. At the same time, with some degree of accuracy, it is possible to list typical grounds or categories of disciplinary actions. Reaves and Rainer (2002) cited the following:

- 1) Fraud, deceit or misrepresentation in procuring a license or attempting to procure a license;

- 2) Conviction of a felony or crime involving moral turpitude;
- 3) Addiction to alcohol, drugs, or controlled substances;
- 4) Fraudulent or dishonest conduct;
- 5) Incompetent, negligent or grossly negligent practice;
- 6) Unethical, immoral or unprofessional conduct; and
- 7) Disciplinary action in another jurisdiction.
- 8) Mental incapacity;
- 9) Sexual intimacies with clients or patients;
- 10) Violation of a specified code of ethics;
- 11) Aiding and/or abetting unlicensed practice;
- 12) Failure to obtain mandatory continuing education credits; and
- 13) Violation of a rule or regulation promulgated by the regulatory board.

Exploration of the current state of affairs with regard to colleague assistance programs led to several findings: First, a number of professions have policies and practices (in some jurisdictions) that are highly regarded and considered useful and effective. These are found in medicine (Center, et al., 2003), law, the judicial system (The Texas Amicus Curiae program for judges at <http://www.scjc.state.tx.us/>) and nursing (e.g., Texas Nurses Association at <http://www.texasnurses.org/tpapn>). For example, Alabama law mandates that it is “the duty and obligation of the State Board of Medical Examiners to promote the early identification, intervention, treatment and rehabilitation of physicians and osteopaths licensed to practice medicine in the State of Alabama who may be impaired by reason of illness, inebriation, excessive use of drugs, narcotics, alcohol, chemicals or other substances or as a result of any physical or mental condition” (Ala. Code § 34-24-400 (2005)). These programs vary in the extent to which they are focused on substance abuse as the central impairment, but some include issues of impairment that interfere with interpersonal capacity as well. Second, the 2003 ACCA survey of SPTAs revealed that several psychological associations do have models of colleague assistance that directly address both the mandates of the state/provincial/territorial association and the licensing regulations. These programs have guided the development of the model that follows in this document and have the potential to provide specific assistance to others. Although not an exhaustive list, these state programs include: Colorado, Maryland, Michigan, Oregon, Pennsylvania, New York, Tennessee, Virginia, and Washington. Materials from several of these programs are included in the Appendices to this document for illustration purposes.

### *Guiding principles*

Hence, this collaborative effort between APA and ASPPB has been developed under the assumption of a number of guiding principles. These include:

1. A set of common goals exists among licensing boards, SPTAs, training institutions, and practitioners.

2. Collaboration between SPTAs and licensing boards is desirable and possible, with shared understanding of the differences between the two in mission, authority and legal mandates, perspectives and emphasis, and governing structure. Licensing boards have a legal responsibility that derives from the protective powers of the state. Although sometimes perceived as guild organizations devoted to protecting their own members, it is a tenet of the mission and ethical standards of APA and of the SPTAs that psychologists both attend to their own wellness and address problems identified in a colleague. Thus colleague assistance in an individual state, province or territory will require an understanding of what is mandated and what is permitted in that jurisdiction.
3. Differing structures of licensing boards need to be understood to promote colleague assistance. For example, some licensing boards are composed largely of psychologists, while others have only one or a few psychologists and the remainder is composed of public members or other professionals. This composition may affect their conception of appropriate colleague assistance. Some jurisdictions participate in a multiprofessional colleague assistance process (e.g., Michigan) while others operate solely for assistance or intervention with psychologists.
4. Both licensing boards and SPTAs have as a guiding principle the promotion of the public welfare and the protection of the consumers of psychological services. This principle makes it imperative that both organizations make every effort to prevent a psychologist from doing harm. This requirement evolves from the governance mandates of the legislatures of each state/province/territory, the ethics and standards of the profession, and the demands of the public at large.
5. Both the profession and the public benefit from a competent and ethical profession. Therefore, the promotion of professionalism and professional development toward increasing and maintaining competence is essential. Finally, active involvement by both licensing boards and SPTAs may serve to generate increased trust among consumers that the profession is addressing these challenges.

#### *Current status of colleague assistance*

There is a clear need and rationale for effective colleague assistance. At this time at least half of the 60 SPTAs either have never had or no longer have a colleague assistance committee or program. This was determined by a survey published by Barnett and Hilliard (2001) and reconfirmed by a follow up survey in 2003 conducted by ACCA (ACCA, 2003). At a recent APA State Leadership Conference meeting in Washington, DC (2003), ACCA met with more than 35 SPTA executives and leaders who expressed great interest as well as frustration about how to address their perceived pressing need for effective colleague assistance. Typical concerns regarding implementation of colleague assistance programs included the physical size of the jurisdiction, the number of psychologist members, and recognition of the need for both economic and human resources. A second level of concern expressed was that there is a lack of models and/or clear strategic alternatives for interventions at various levels of need of psychologists (e.g., early intervention vs. severe and injurious impairment). A third was the perception

that the fear or threat of legal sanctions contributes to increased silence and secrecy and too little focus on ways to enhance the way that the field and the profession address colleague assistance. Similarly, during the past two years, ASPPB has devoted considerable effort to understanding better how to deal with impaired psychologists, including a prevention and early intervention perspective. Programs addressing this need were the subject of ASPPB meetings in 2003 and 2004 as well as the Third International Congress on Licensure, Certification and Credentialing of Psychologists an international licensing board conference in Montreal, Canada in 2004, at which perspectives from several nations on this topic were included, e.g., the fitness to practice criteria of the Ontario, Canada licensing board. Representatives from ASPPB and ACCA addressed the challenges of creating institutional structures that met the mandates of both professional groups and the complex objectives of both protecting the public and enhancing the competence and ethical performance of psychologists.

The educational portion of the 2004 ASPPB Annual Meeting of member boards was dedicated to the topic of “Promoting Wellness within the Profession of Psychology.” Experts in the fields of treatment, prevention and law offered informative data and lead helpful group discussions with the participants. During small group breakouts participants were asked to engage in an exercise to respond as a group/ board receiving a request to collaborate on dealing with psychologists’ impairment issues. ASPPB participants overwhelmingly affirmed that boards must remain focused on their mandates to protect the public and take proper disciplinary actions against those who breach that public trust, even if the provider is impaired. Psychologists serving on licensing boards endorsed the ideas of boards being active in encouraging prevention programs, early intervention, using continuing education opportunities to raise consciousness about the stress-distress continuum, and using any other means of taking proactive steps to intervene *before* harm is done.

## CHAPTER 3

### DEVELOPMENTAL CONTEXT

A core idea in developing a collaborative model of colleague assistance is that problematic, unprofessional or impaired behavior by psychologists is best understood from a developmental perspective. From a developmental point of view, it is important that a determination that a psychologist is in need of colleague assistance or other intervention considers the level of difficulty of the psychologist's behavior. A model that is particularly helpful in assessing this developmental context is to consider the continuum of stress-distress-impairment (ACCA, 2001) as indicated below:

Stress---Distress----Impairment---Improper Behavior---Intervention/Sanction

This model may be considered a heuristic guide to self-evaluation and assistance to others. Stress ranges from minor to more severe levels associated with everyday life and extraordinary events. Additional occupational vulnerabilities deriving from the particular nature of psychological practice creates stressors such as the demanding and one-sided nature of therapy and the therapist's relative isolation, burnout, vicarious trauma, etc. described earlier. As helpers, psychologists may resist seeking help or attending to their own stress or distress. Issues of shame and fear of stigmatization may further encourage isolation and failure to address the issues. Distress refers to an experience of intense stress that is not readily resolved, and therefore impacts well-being and functioning. Disruption of thinking, mood, and other health problems, as described earlier, may intrude on professional functioning and require care and/or repair. Impairment refers to a condition that compromises the psychologist's professional functioning to a degree that may harm the client or render services ineffective. This model suggests that there is a continuum of care from self-care, growth promoting professional and personal development (Elman, Illfelder-Kaye & Robiner, in press) to intensive treatment as part of a formal adjudication if there is a finding of psychologist improper behavior.

A developmental model of colleague assistance can facilitate self-report and/or early intervention with a colleague. While stressed or distressed psychologists may seek help independently, such as seeking self help materials on the internet (e.g. from [www.apapractice.org](http://www.apapractice.org)) or through independently seeking psychotherapy (Geller, Norcross & Orlinsky, 2005) or consultation, it is likely that many more do not do so at an early enough stage in which prevention or early intervention might prevent the descent from stress or distress into impairment and professional harm. Several state associations have reported that although they have advertised assistance and invited psychologists to seek help, the numbers who voluntarily do so are remarkably small (see Floyd, Myszka & Orr, 1998). That may mean that there are psychologists practicing and potentially doing harm to both themselves and others, even though the problem has not reached a level of severity to warrant a formal report or complaint (Guy, Poelstra, & Stark, 1989; Pope, 1988). When SPTAs and licensing boards collaboratively develop programs and educate

psychologists as to their purpose and function, then psychologists may be more likely to self-refer and obtain useful and responsible help for themselves and others.

A developmental context on colleague assistance also suggests that there are or may be several levels of intervention. These would include self-care and early/preventive intervention or might evolve from mentoring relationships that would attend to the personal stressors of both trainees and practicing psychologists. Mentoring is typically a relationship between a more senior and a more junior member of a profession in which the younger or less experienced, the protégé, is guided by and identifies with the perspective and greater expertise of the older or more experienced. A wide literature exists on mentoring relationships and their advantages and challenges (see Johnson & Campbell, 2002; Williams-Nickelson, 2004) that might facilitate developmental assistance to prevent or alleviate the emergence of distress or impairment.

Another level of intervention emerges when a psychologist determines that there is concern for the functioning of a colleague. Intervening with a colleague in difficulty is a mandate of the APA Ethical Principles and Code of Conduct (2002, standards 1.04 and 1.05), yet psychologists have reported in a number of studies that they have known of a colleague whose behavior or functioning is of concern, have been reluctant to confront the person directly, or have perhaps mentioned something in a very general way and then avoided pursuing the question further for fear of alienating a colleague, being perceived as a whistle blower, or otherwise feeling that they have crossed a boundary and are generally uncomfortable with this role (Pincus, 2003). Early intervention by a colleague involves the recognition of early warning signs, e.g., depression, missing work, negative attitude toward clients, excessive drinking, anxiety over a divorce, and being willing to approach the colleague in a supportive and caring fashion. A tone of care, concern, and helpfulness is necessary, as the colleague will react negatively to feeling criticized or shamed. Of course, if the colleague displays sufficient dysfunction to suggest impairment, there is a point at which immediate reporting to an ethics committee or licensing board may be necessary.

Psychologists often know of colleagues in distress but may show a reluctance to address the issue. For example, one survey of APA members found that 69% of psychologists have known of colleagues whom they believed were experiencing personal or emotional problems, but only 36% reported having approached a colleague with their concerns (VandenBos & Duthie, 1986). The reluctance of psychologists to respond to a distressed colleague does not seem related to a belief that a professional's impaired behavior does not impact on them or that psychologists simply do not care. On the contrary, survey data from Brigham (1989) find that knowledge of impaired behavior in a colleague is distressing and knowledge of a client's report of sexual misconduct by a previous therapist has been ranked among the highest stressors for psychologists, close to rankings for suicidal clients and phone calls at home, and more stressful than excessive workloads, frustration with poor therapy outcomes and emotional depletion (Schoener, 1998).

A number of reasons have been suggested to explain why professionals may overlook or ignore signs of distress in colleagues. These include valuing a colleague's rights to privacy and autonomy, a desire not to burden further an already distressed colleague, a desire to protect the public image of the profession (or agency or institution), fear of being sued or fear of a potentially difficult confrontation with a colleague who may be defensive or hostile (Brady, Guy & Norcross, 1995; Guy, 1987; VandenBos & Duthie, 1986).

Many professionals have not had training for effective intervention with distressed or impaired colleagues and this reduces the likelihood for effective early intervention. However, resources are available to help professionals prepare and enact such interventions. For example, VandenBos and Duthie (1986) provide a six-step model to follow in attempting to assist colleagues about whom there are concerns. They offer suggestions for documenting the suspected problem, deciding who should confront the distressed colleague, preparing for meeting with and addressing the colleague and following up with the colleague. Colleague Assistance Programs have a role to play in providing training, consultation and support to psychologists who are concerned about a colleague (e.g. Pincus, 2003; Pincus & Delfin, 2003).

The next level of intervention might be in the form of either a request for assistance from a colleague assistance program (CAP) and/or a request to the licensing board. Reluctance, fear of reprisal, a wish to help but not get the person in "trouble with the law" or interfere with their ability to earn a living may prevent a psychologist from taking these steps. Furthermore, psychologists like to perceive themselves as helpers rather than disciplinarians. This same dilemma has been reported in a number of studies of psychology trainees, who report in significant numbers that they are aware of at least one peer who is struggling or behaving in an unprofessional manner (Mearns & Allen, 1991; Swann, 2003), but who do not either directly confront the colleague or find faculty either modeling that behavior or helpful with their concerns. An understanding of the mandates and operations of CAPs and licensing boards and the belief that these two organizations will make appropriate referrals to each other depending on the developmental level of the problem and the level of severity of the psychologist's behavior will lie at the heart of this collaboration.

Collaboration between a licensing board and SPTA using a developmental perspective will need to focus on differentiating between behaviors that can be ameliorated by early intervention and those that must be reported to a regulatory agency. There is probably a significant difference between a naive and inexperienced therapist who lacks knowledge of specific procedures or behaviors and one who is practicing poorly while depressed from an ongoing situational stressor or using drugs or alcohol to excess. The literature is not clear about whether sexual misconduct can be or should be remediated, but the decision by licensing boards is that it is a sanctionable offense. However, there are early warning signs of the likelihood of offense in boundary violating behavior, in which there appears to be a slippery slope to crossing the boundary between acceptable and unacceptable behavior. Extending session times or seeing a "special" client at the end of the day when others have left the work site, for example, are known

precedents for later violations (Bates & Brodsky, 1989; Gabbard, 1991; Lamb & Catanzaro, 1998; Schoener, 1995; Rodolfa, 2003).

From a developmental perspective on the evolution of stress, distress and impairment, functioning would improve if the profession created a culture change in which self-care and discussions of occupational stress and temptations happen more normally and openly. Too many psychologists still view personal problems and strong feelings regarding clients/patients as embarrassing and fear criticism and censure from colleagues (O'Connor, 2001). They see such issues as personal weaknesses and failings. If the profession could create a climate that views the impact of personal feelings and problems on professional behavior as a normal part of life that happens to psychologists at various life stages, then the professional will have permission to discuss problems and seek assistance earlier. Damage to both consumers and professionals can then be averted with such a broad systemic shift.

Hence, as colleague assistance programs develop they will ideally contain two components: one preventive and one remedial. In addition to offering remedial services for professionals who have been reported for violations, the program would develop or work with professional groups to develop self-care resources and assessment materials. Of particular utility for trainers and professionals would be a listing of early warning signs of impending problems. Such signs as lack of interest in former activities; boredom with clientele/patients; resistance to going to work or fearfulness and anxiety about work functions; sleep disturbance; increase in use of alcohol; family stresses; increased anxiety; deceptively minor boundary crossings like hugging clients or sharing personal disclosures, inappropriate financial arrangements with clients, or contact with clients outside the work setting; and isolating behaviors among many others should be presented in training and workshops to help the individual assess problematic changes in personal functioning. The goal is to catch professionals/trainees at the top of the "slippery slope" before harm to self or others has occurred and problems are easier to treat/solve.

## CHAPTER 4

### PREVENTION AND EARLY INTERVENTION BY SELF-CARE OR SELF-REFERRAL

Prevention and early intervention by self-referral before professional functioning is compromised are perhaps even more important than remediation through colleague assistance programs. The more the profession can prevent problem behavior and dysfunction from occurring, the better it can protect both the public and individual psychologists.

#### *Self-care*

Learning about self-care and warning signs for problems can begin in graduate school and continues throughout the professional career of the psychologist. Self-care has often been a neglected topic in both training programs and professional venues. Psychology has begun to recognize that self-care creates balance in life that then promotes good physical and mental health and leads to an enhanced quality of life (Cameron & Leventhal, 2003; Pope & Vasquez, 2005). Psychologists have often defined themselves in terms of being helpers to others and have not always taken care of themselves to the extent they care for others (Grosch & Olsen, 1994; Guy, 2000; Norcross, 2000).

The self-care literature details a number of approaches and activities that can be of benefit to an individual (Baker, 2003; Williams-Nickelson, 2004). Baker (2003) described the practice of self-care as involving both self-awareness and self-regulation in the service of balancing many factors including psychological, physical, and spiritual needs; connection between self and others; and one's personal and professional lives. Physical fitness concerns include attention to diet, exercise and preventive medical care. Major factors that have been shown to prevent the debilitating effects of disease are good nutrition and basic physical fitness (Berrigan, Dodd, Troiano, Krebs-Smith, & Barbash, 2003). Obesity and a sedentary life style, in particular, have been shown to increase the risk for a variety of problematic disorders, including cancer, respiratory diseases, gall bladder dysfunctions, diabetes and cardiovascular disease (Berrigan, et al., 2003). Regular exercise, a healthy diet, and regular medical checkups and health maintenance enhance energy, combat depression and anxiety, and provide a foundation for other positive health practices.

Emotional self-care is an equally important aspect of healthy functioning. Research has established clear links between the ability to recognize and express emotions and positive health (Frederickson, 2000). If psychologists do not recognize and address the impact of their emotions and deny them instead, this may result in anxiety,

depression and negative physical consequences (Cohen, Doyle, Turner, Alper, & Skoner, 2003). In addition to issues in their personal lives, some of these emotional stressors may result from the pressures of psychological practice in a variety of work settings from clinics to hospitals to private practice to universities, etc. (Baker, 2003; Coster & Schwebel, 1997; Hedges, Hilton, Hilton, & Caudill, 1997; Mahoney, 1997; Norcross, 2000; Sussman, 1995). Dealing with the emotional problems of others may create emotional stress in the psychologist. Long-term or acute experience of client/patient trauma may vicariously traumatize the psychologist (Saakvitne & Pearlman, 1996; Stamm, 1999). Psychologists can benefit from developing appropriate networks or venues to process their emotional reactions to their work. These may include peer consultation groups, personal psychotherapy, and informal sharing with friends and colleagues. Other suggested outlets include physical activity, recreation, and creative outlets such as playing music, artwork, or cooking.

Spiritual self-care can be an additional aspect of emotional health. Spirituality may be connected to religion or it may manifest itself through connections to nature or other beliefs in human purpose (McCormick, 1994; Roof, 1993; Williams-Nickelson, 2004). Spiritual self-care can be described as developing a personal understanding about the purpose of life and meaning. Research has demonstrated that a healthy spiritual life is associated with greater self-esteem, personal happiness and life satisfaction, and less depression (Blaine & Crocker, 1995). Spiritual self-care activities may include meditation, participation in a religious group, joining a spiritual community, visiting places of great natural beauty, or attending a cultural or artistic performance. While a personal choice, involvement with a group may provide not only spiritual care but also support in community and comfort in meaningful rituals. For someone with a background that includes an emphasis on religion and communality, involvement in a religious organization may also contain a strong and positive tie to family.

Many graduate programs emphasize expertise in assessment, intervention, and research but do not adequately address the person of the psychologist-trainee and his/her emotional and family issues and struggles. Self-care and the effect of personal issues on psychological work may be addressed didactically and through discussion in such courses as professional issues and ethics. Strategies to address with sensitivity an impaired colleague also need to be conveyed (Oliver, Bernstein, Anderson, Blashfield, & Roberts, 2004). A more individual, personal approach may occur in practicum or internship supervision as the trainee's issues emerge during therapy sessions. Training in self-care is an important part of any graduate program. The March, 2005 issue of *gradPsych*, the magazine of the American Psychological Association of Graduate Students (APAGS), contains a series of articles aimed at helping graduate students develop a self-care plan for themselves (Chamberlin, 2005; Dittman, 2005a, 2005b; Greer, 2005; Holloway, 2005). Authors stressed such principles as managing your time through prioritization of both coursework and family, studying socially, keeping regular hours, exercising and meditating, developing supportive friendships, setting aside time for self, eating well, and organizing tasks.

Psychology trainees, like psychologists, may face challenging personal situations or develop problems for which self-care and assistance programs might be necessary. A milieu (Pope, Sonne, & Holroyd, 1993) that fosters graduate students' access to these programs is desirable for their current training and future professional attention to self-care. Trainers may need to remember that graduate students might need explicit encouragement to attend to self-care under times of stress. Trainees need permission to appropriately examine personal issues without fear of immediate program failure or removal.

Training programs and professional associations may provide specific, personal training on issues of occupational stress, trauma, vicarious trauma, self-care, boundary management, and self-assessment (Samuel & Gordon, 1998; Sherman & Thelen, 1998). These programs are in a unique position to teach trainees and professionals techniques of self-assessment to aid in determining needs for assistance and identifying such outside resources as personal therapy, peer supervision and mentoring (Norcross, 2005). For example, Pettifor, Bultz, Samuels, Griffin, and Lucki (1994) developed a system of self-evaluation tied to the principles of major documents related to practice standards such as ethics codes, codes of conduct, and guidelines for providers of psychological services.

#### *Self-referral and confidentiality*

The nexus of intervention between self-care and the authority of a licensing board may lie in the ability of a psychologist to self-refer for assistance in resolving distress or impairment that could interfere with adequate practice. This self-referral typically takes the form of seeking consultation with a peer or personal psychotherapy (see Geller, Norcross & Orlinsky, 2005; Gilroy, Carroll, & Murra, 2002; Kaslow, 1984).

A number of jurisdictions have colleague assistance programs that can provide additional help to psychologists, such as sources of referral to professionals with expertise in assessing and/or addressing the problems of psychologists, assistance with practice management, peer support, etc. Psychologists often eschew such self-referral because of a fear of loss of privacy or confidentiality. Protection of confidentiality varies by jurisdiction, and one of the areas in which licensing boards and SPTAs may collaborate better in colleague assistance programs is in clarifying the protection of confidentiality when a psychologist self-refers and there is no evidence of real or imminent harm to the public. If a self-referred psychologist dropped out of a planned intervention before successful completion, reporting might be required if there was a belief that harm or danger to the public would occur. This level of reporting and/or confidentiality will vary by jurisdictional law. The boundaries of confidentiality must be clearly defined and clarified among all the parties involved. In particular, the licensing board and the colleague assistance program in each jurisdiction must have a clear understanding of which problems or behaviors require reporting or regulatory action and which do not.

In ideal circumstances, self-referral for assistance via resources provided by a colleague assistance program that has successful resolution and prevents harm to self or

clientele and maintains confidentiality is the best outcome. In some instances, the potential risk of harm to self or others could preclude that level of confidentiality in that it would activate licensing board responsibility to protect the public. For example, the *Virginia* CAP policies state: “The committee members will protect the confidentiality of all materials obtained as part of committee work. However, confidentiality will be breached ‘in those unusual circumstances in which not to do so would result in clear danger to the person or others’ (*American Psychologist*, March, 1990, p. 392). Thus, confidentiality will be breached whenever there is reasonable evidence that the impaired psychologist has recently engaged in or plans to engage in any of the following behaviors:

- (a) physical or sexual abuse of minors
- (b) physical or sexual abuse of patients
- (c) any illegal activity that clearly endangers others
- (d) professional illegal activities, such as practicing psychology without a license or negligent supervision that poses a clear danger to client welfare.”

## CHAPTER 5 ASSESSMENT AND INTERVENTIONS FOR DISTRESSED AND IMPAIRED PSYCHOLOGISTS

All colleague assistance programs must define mechanisms for adequately assessing problems and designing effective interventions. These mechanisms must meet professional standards and applicable laws and regulations.

### *Assessment*

Assessment is the most critical element of a program designed to intervene with distressed and impaired psychologists when there is risk or assertion of harm. Proper evaluation will need to be global and provided by experienced, senior professionals who have been trained to evaluate psychologists identified as distressed, whether by themselves or others. The typical assessment is (1) done in response to a request from a licensing board, ethics committee, self-referral, employer, colleague assistance committee, etc., (2) done to determine the presence of distress and/or impairment, and (3) done to establish recommendations for an intervention plan as needed. Professionals who might benefit from the services of an assessment may well have complex or multiple areas of difficulty. Therefore, a global evaluation often requires consideration in one or more domains as indicated by the facts of the specific referrals or presenting problems.

The assessment may seek information concerning mental health domains, medical and physical domains, training and competency issues, office and business management practices, drug and alcohol utilization, interpersonal relationships, current stresses, motivation to resolve problems, likelihood of ability to alleviate, and self-awareness of identified problems and consequences. Outcome of the initial assessment includes a plan that might include educational remediation, practice monitoring, therapeutic interventions (psychological, drug/alcohol or medical) with specific measurable objectives, including evaluation of readiness for continuation or re-entry and feedback to the appropriate parties.

In addition the assessment might indicate impairment rendering the individual unfit to practice. When this is the case the assessor can only report to the referring parties his/her inability to recommend a treatment plan for a return to practice.

A re-evaluation is necessary once the intervention has been completed in order to determine whether the psychologist can or should return to a previous level of independent practice. Factors that should be considered include: (1) successful completion of goals based on assessment results and recommendations, (2) plans for re-entry into practice (if necessary), (3) plans for self-monitoring, (4) commitment to complete every detail of the stipulation, and (5) plan for early intervention in case of relapse.

Assessment of both personal and professional areas:

- Current stressors and personal history
- Mental health
- Medical
- Professional training and competency issues
- Office and business management practices
- Practice problems, i.e., the complaint
- Impact of personal life on professional practice
- Drug and alcohol
- Interpersonal relationships
- Motivation to resolve problem
- Likelihood of ability to remediate (essential if the plan is to go forward)
- Self-awareness of the problem and its consequences (essential for remediation)

Assessors should be licensed professionals with no history of disciplinary action taken against them in the past five years. They must have demonstrated competence in the areas to be assessed and willingness to comply with the requirements of the body requesting the assessment, especially if this is not a self-referral. Such competence may be demonstrated by attending workshops at professional conferences such as APA, ASPPB, and SPTAs. The assessor must understand the program's goals and the jurisdiction's disciplinary process and be privy to information related to the request for the assessment. Care should be taken to ensure that adequate consent (see Appendix E) procedures have been followed and professional liability coverage has been provided or that the jurisdiction requesting the assessment is able to provide immunity. Generally, an assessor would not also serve as an intervener with the same psychologist because of possible dual relationship conflict. In special circumstances, e.g. rural areas, flexibility may need to be carefully considered if one person must serve both roles. If such double roles become necessary, roles and boundaries must be clearly and carefully defined.

### Characteristics of Assessors/Interveners

The following are suggestions to consider in selecting assessors and interveners:

- They are licensed professionals.
- They have no disciplinary history within the past five years.
- They have demonstrated training and competence in the areas to be assessed (e. g. drug and alcohol expertise, neuropsychological expertise).
- They should not be biased against returning rehabilitated professionals to practice.
- They have no conflict of interest.
- They have attended a workshop or received other training in the following:
  - \* The requirements of the system (e. g. timely paperwork, confidentiality, feedback)
  - \* Understanding of the program's goals and mission
  - \* Understanding of the jurisdiction's disciplinary processes
  - \* A briefing on liability issues: Liability coverage is maintained, whether through individual liability insurance, Director's and Officer's Liability Insurance of an SPTA and/or the umbrella of immunity of the licensing board, depending upon the model on which the program is based

### *Outcome of initial assessment and intervention plan*

Upon completion of the initial assessment, a report is generated which includes a clear definition of the problem (if such is possible) leading to an intervention plan with specific measurable **goals**. (See Appendix F for example plan.) If recommendations are made in the form of a plan, components of the plan may include:

1. Education (e. g. additional coursework, continuing education)
2. Restriction/modifications on practice
3. Business practice monitoring
4. Supervision/ clinical practice monitoring
5. Treatment and monitoring drug/alcohol use (e. g. urine testing)
6. Psychotherapeutic interventions
7. Medical interventions
8. Change in therapy style
9. Vocational counseling
10. Organizational changes

The assessment is complete when the results are communicated to the psychologist involved and the source of referral, as appropriate. Feedback must also be given in a fashion to ensure confidentiality while providing information necessary to adjudicate if and when a licensing board has requested assessment.

*Interventions for distress or impairment*

*Education.* This intervention might be used when a psychologist demonstrates professional difficulties due to a skill deficit, lack of knowledge in specific practice domains, or practicing outside his/her demonstrated competence. For instance, a psychologist might have demonstrated difficulties in properly assigning the diagnoses of Axis II psychopathology and might then be required to obtain suitable coursework from an accredited institution, continuing education or professional consultation.

*Restriction/modifications on practice.* This intervention may include such restrictions as specifying whether particular patients/clients (for instance, individuals with primary Axis II diagnoses or clients of a specific gender, age, ethnicity, etc.) cannot be seen by the psychologist in practice or modifications of practice such as requiring videotaping of child therapy cases. And, while limits on an individual's practice may be suggested by the assessor, it is a determination to be made by the licensing board.

*Business practice monitoring.* This intervention involves the necessity of a monitor appointed by the licensing board having oversight of the practice of a sanctioned psychologist to ensure that the office is managed properly, records are kept confidential and maintained for required time periods, state and federal regulations are followed, etc. Assessment of a practice can be initiated by an audit of the major areas of practice governed by state statutes, licensing board rules, APA Codes, and professional ethical conduct. Thus an evaluation of this type audits business practice, professional conduct, and state regulations for compliance.

Each area of the practice is evaluated against regulations such as licensing board rules, ethical codes, and standards of ethical conduct for compliance, or noncompliance. A narrative is then generated by the psychologist and used for accountability in achieving compliance during the period of monitoring.

Such an evaluation can encompass as broad or narrow an area as the results of the investigation might require. It then falls to the practice monitor meeting regularly with the sanctioned psychologist to report progress to the licensing board at regular intervals.

*Clinical practice monitoring.* This intervention involves a contracted relationship with another psychologist to oversee the clinical competence of the psychologist and ensure safe practice. Supervision can include educative functions. When supervision occurs, the psychologist is required to comply with state regulations which typically require obtaining written informed consent from clients/patients and/or posting a notice regarding the nature of the relationship (usually on the psychologist's disclosure statement). These regulations typically appear in licensure statutes or board rules. Additionally, the supervisor may share or assume responsibility for the clinical care of the psychologists' patients/clients. Be sure to check your licensing board's definitions for the different types of supervision and the requirements for each, e.g., clinical supervision, administrative supervision and consultation.

*Monitoring drug/alcohol use.* This intervention can involve a variety of strategies to ensure compliance such as collateral contacts with family members, use of appropriate alcohol and drug monitoring services, regular use of a breathalyzer or contact with the psychologist's staff to evaluate sobriety.

*Psychotherapeutic interventions.* This intervention involves a full array of psychotherapeutic services designed to address the range of psychological problems as identified in the assessment that can contribute to professional dysfunction. A treatment plan with specific planned interventions and measurable outcomes can serve to guide the work of the therapist.

*Medical interventions.* These interventions involve strategies to address medical or psychological problems that have been identified as contributing to the psychologists' distress or impairment and require the services of a physician.

#### *Outcomes of interventions*

A re-evaluation is necessary once the intervention has been completed in order to determine whether the psychologist can or should return to a previous level of independent practice. Factors that should be considered include: (1) successful completion of goals based on assessment results and recommendations, (2) plans for re-entry into practice (if necessary), (3) plans for self-monitoring, (4) commitment to complete every detail of the stipulation, and (5) plan for early intervention in case of relapse.

#### *Assessment of ability to return to unrestricted work*

The re-assessor, in consultation with other involved professionals, gathers specific information regarding the psychologist's ability to competently return to unrestricted work, such as:

- (1) Does the psychologist acknowledge wrongdoing?
- (2) Does the psychologist understand what s/he did and why it had a negative impact on him/herself and/or others?
- (3) How is the psychologist going to prevent it from happening again?
- (4) What are the precise job duties and work challenges for the psychologist if he/she is to return to unrestricted work?
- (5) What, if anything, has changed in the workplace since monitoring began?
- (6) As a practical matter, what is possible in terms of alternatives in the work situation:
  - a. Any alterations in his/her work duties or workload?
  - b. Any changes in his/her job description, temporary or longer-term?
  - c. Any alteration in hours; which staff he/she would work alongside?
  - d. Any other accommodations that are possible?

A specific example of a return to work assessment is contained in Appendix H.

## CHAPTER 6

### OPERATIONAL STRATEGIES

#### *Systems/programs of colleague assistance*

Since this monograph recommends that each SPTA in collaboration with its licensing board identify and implement a system for colleague assistance, it is most helpful to begin this chapter by identifying what is occurring in various jurisdictions to address the needs of distressed/impaired psychologists. In some jurisdictions, the licensing board might have a statutory mandate to rehabilitate or otherwise intervene with an impaired psychologist. In other instances, SPTAs might have colleague assistance programs that operate independently of or in collaboration with the licensing board. A third approach is a colleague assistance program that is independent of both the SPTA and the licensing board and could be funded privately through a bidding procedure, or funded by the state/province/territory and contracted to a specific agency. When possible, systems that address the needs of distressed/ impaired psychologists that are collaborative efforts between the SPTA and the licensing board are optimal to the smooth functioning and interweaving of colleague assistance and adjudicative functions.

The system with the likelihood for the greatest comprehensive success would involve collaboration between the SPTA and licensing board. A number of jurisdictions have such programs already in place. The most typical examples involve a letter of agreement, memorandum of understanding (e.g., *Virginia*) or other such document that is signed by representatives of the SPTA and the board (or its super-ordinate entity in the state/provincial/territorial government) (See example in Appendix B). Such documents identify the purpose of the collaboration, the responsibilities of both entities, procedural understandings, mechanisms of contact between the parties, definitions and limitations of confidentiality and conditions for termination of the agreement. Examples of elements of collaboration include providing resources for selection and training of assessors, monitors, supervisors, psychotherapists, practice evaluators, etc. States in which such collaborative models are currently practiced include Virginia, Colorado and Pennsylvania.

Collaboration between boards and SPTAs may be multidisciplinary. For example, in *Michigan*, the State of Michigan's Health Professional Recovery Program (HPRP) was established by legislation in 1994 and is administered through the state's Department of Consumer & Industry Services, Bureau of Health Services (<http://www.hprp.org>). This program cuts across the health professions and is supported by the licensing boards and associations of the state's health professions, not just psychologists. It is administered by a 501(c)6 not-for-profit corporation jointly owned by five health professional associations and administers impaired health professional monitoring programs that include both voluntary and compulsory participation. Health professionals must participate if the related licensing board determines that they are impaired. In exchange, they can keep

their licenses under restricted conditions until they complete the recovery plan established for them. The state's Department of Consumer & Industry Services has a contract with this corporation to administer the multidisciplinary program.

Another approach that has been proposed would be a multijurisdictional model in which adjacent jurisdictions collaborate to share resources and potentially provide more services and greater confidentiality than any of the jurisdictions could on its own. This approach might be particularly helpful for smaller jurisdictions with fewer psychologists. However, there are no known examples of this model currently in practice.

Variations in state, provincial, and territorial laws, economic or geographical conditions, or other factors may make one or more of the approaches discussed above more feasible or efficient. While collaboration may be optimal, such programs may not always fit with the realities of the specific jurisdiction.

### *Diversion*

A controversial topic related to dealing with the distressed or impaired professional is the use of diversion. Diversion has been defined by O'Connor (2001) "as the act of holding certain consequences in abeyance while the impaired professional undergoes treatment or education.... Should the individual fail to meet the requirements of their program, enforcement of consequences for their professional failures then proceeds as originally defined" (p. 348). Schoener (2000) identified diversion programming as coming "out of criminal justice work. Basically, for persons who admit they have a problem and would like to undergo rehabilitation, they are given an option of treatment rather than punishment. If, however, they drop out of treatment or don't finish, they suffer swift consequences. It is a classic 'stick and carrot' approach" (p.2).

Some jurisdictions offer diversionary programs as an option while others clearly do not. For example, in Pennsylvania a psychologist may be offered a consent agreement in which the psychologist's license is suspended but enforcement of the suspension is stayed pending the psychologist's successful completion of the rehabilitation plan. Upon successful completion, the disciplinary action may be dropped (S.J. Knapp, personal communication, August 10, 2005).

Whether or not diversion, or holding consequences in abeyance, is used, the criteria must be clear and specific and fit within all jurisdictional laws and regulations. It must be very explicit that there is an appropriate and ethical reason for using diversion and it does not look like diversion is being used to protect psychologists at the expense of the public. Diversion is controversial because for many it can connote the idea of getting out of a sanction or "get out of jail free." Rather, diversion needs to be seen as an alternative solution to a problem since the rehabilitation of a psychologist might better suit the good of the public. Used in this way diversion indicates corrective action that might be ordered by a licensing board while adjudication is delayed with the licensing board retaining the authority to impose sanctions if rehabilitation is not successful.

Diversion might include self-initiated corrective action either before a complaint is filed or after a complaint is filed but before a licensing board decision is considered. Again, sanctions could always occur later if intervention does not result in successful outcome. Certainly, egregious offenses, and perhaps repeat offenses, constitute too great a risk to the public and therefore could preclude diversion options.

“As a general rule, diversion programs require:

- (1) That you have a problem which is diagnosed;
- (2) That you are motivated for treatment;
- (3) That you are willing to be monitored;
- (4) That you meet certain criteria. For example, a number of nursing programs will only allow diversion on the first offenses. Repeat offenses don't qualify.”  
(Schoener, 2000, p.3)

### *Features of the system*

Common factors that appear to cut across CAPs include a statement of mission, scope, and focus; voluntariness; confidentiality; identification of professionals served; protection of CAP members from liability; need for funding; a clear understanding of mandated reporting; duration of interventions/services; certification/qualifications of assessors and interveners; and integration of multiple rehabilitation factors.

*Structure.* A number of structural considerations are relevant in developing an effective colleague assistance system for impaired/distressed psychologists. First, it will be important to have a committee or council of professionals who serve as policy makers for the program. This group might be appointed and if the program is a collaborative one, it may consist of representatives of both the licensing board and the SPTA. Identification and specification of requisite qualifications to be a member of this committee will be needed. For example, the program of the *Pennsylvania* Psychological Association has required its members to have ten years or more post-licensure experience. The *Virginia* Psychological Association's program specifies that members of the CAP represent each of the five geographical areas around the state. The policy setting committee works with the project manager who is responsible for overseeing the implementation of the policies of the committee of professionals.

Second, it is important that an individual be identified as project manager to administer the day-to-day operations and coordinate all activities and functions. The project manager need not be a psychologist. Often, these duties may be carried out by either the chair of the committee or a designated staff person.

*Records.* The system needs to identify policies related to the creation, maintenance, retention and location of records. The system must own its own records and determine how long records will be kept and who can have access to them in compliance with

relevant laws for record retention. Mandated participation may have additional reporting requirements (See Appendix G).

*Accountability for process.* Mechanisms defined to assess whether the system is achieving its intended outcomes are helpful in evaluating the success of the program. The specifics of this determination may vary, based on a number of factors, including the type of model adopted as the basis for the program and how the psychologists enter the system (i.e. mandated or voluntary). For instance, in *Colorado*, a liaison from the State Association to the licensing board affords the opportunity for collaboration between the two entities as well as accountability and protection for the public. The liaison interacts with the board at each board meeting on issues common to the licensing board and professional association. This individual is appointed by the president of the Colorado Psychological Association and is usually the chair of the Peer Assistance Committee. The liaison is expected to attend all licensing board meetings and has a regular place on the board agenda to update the members on the activities and concerns of the state association. The liaison then reports back to the state association President and Board of Directors regarding the concerns of the licensing board and seeks to facilitate collaboration when possible. The liaison also writes or coordinates the writing of articles for the state association publications on the licensing board concerns and actions. Lastly, the liaison is responsible for coordinating with the colleague assistance committee to provide training and certification to experienced psychologists who can then serve as practice evaluators, practice monitors, therapists, and assessors of fitness for practice and for practice re-entry when the licensing board deems such resources are necessary. Between sunset years, the Licensing Board, the State Association Legislative Committee and the General Assembly collaborate in hopes of bringing to the floor responsible legislation in the best interest of the public.

*Responsibilities of the system.* The system must assume the following responsibilities and develop procedures by which they will occur:

1. Provide general information.
2. Accept referrals.
3. Provide information to identified participants (e. g. brochures, letter of inquiry, acknowledgement of referral, etc.).
4. Gain and document informed consent.
5. Choose evaluators based on identified areas of concern (to be discussed in more details below). Complex cases may require multiple evaluators.
6. Recommend appropriate interventions.
7. Plan interventions and recommend interveners.
8. Track progress and individual outcomes.
9. Evaluate compliance.
10. Evaluate system outcomes.

*Entry into the system determines procedures.* A person may enter the system voluntarily, either through self-referral or referral by a colleague. Or, an individual may be mandated to enter the system as the result of a complaint that has been filed. Depending on how a person is referred, the processes of the system may require different procedures.

*Implications for a professional referring a colleague.* In receiving referrals from third parties (e.g. a colleague calling about a colleague), a number of issues may arise and may need to be anticipated by specified policies. It is important for the system to know whether persons being referred in this manner were first encouraged to seek assistance on their own. The system should determine whether or not the program may identify the person making the referral. Even if referring persons are not willing to make their identity known, they should be informed that if an intervention proceeds, the professional being referred may be able to determine the identity from the facts of the intervention, timing of the intervention or other factors. Persons making the referral should be asked at this point if they are willing to proceed or wish to drop the referral out of concern for their own privacy. The committee needs to identify what, if any, its next step will be if the person making the referral decides not to proceed at this time.

*Consent and confidentiality.* As in the provision of any psychological services, it is essential to clarify before services are rendered the purposes of the service and who is the intended recipient of the information and limits of confidentiality. Another component of informed consent is explaining to the individual what the relationship is between the assistance system and any requirements to report individual concerns to the licensing board. This relationship varies by jurisdiction and legislation. For example, in some jurisdictions an intervener could only report amount of progress or verify sessions attended, while in others, more detail about issues related to specific referral/complaint might be disclosed. Compliance with services may be enhanced if the intervener and licensing board make it clear to the psychologist that rehabilitation is their goal.

Both voluntary entry and mandated entry into the system require informed consent at each stage of the assessment and intervention process. Psychologists may withdraw at any time but the ramifications of withdrawal may differ between voluntary and mandated entrants.

Jurisdictions clarify privilege and confidentiality issues by statute and these standards apply to all professional relationships, including psychologists assessing or treating a psychologist. For example, in many jurisdictions professionals must comply with mandatory reporting laws for such issues as child abuse, elder abuse, sexual abuse of a client by a professional, and serious suicide or homicidal intent. The potential risk posed by the professional's problem could result in interveners having to report to the licensing board being treated as an exception to confidentiality.

*Funding.* Payment for services typically is by the psychologist being assessed and receiving the intervention. Funds to manage the administrative aspects of the system may come from the SPTA or administrative services may be volunteered. One source of

funding could be a small portion of licensing fees and renewals, which may require legislative authority (e.g., Physician Diversion Program; Medical Board of California).

*Liability.* Psychologists who provide assessment and intervention to distressed and impaired psychologists must have their own professional liability insurance. Where colleague assistance programs are part of the SPTA, it might be possible for members of the colleague assistance program/committee to be covered by the SPTA's insurance policy that covers its staff and governance members. If the system is acting on behalf of or in collaboration with the licensing board, it might be possible for members of the program to have immunity or indemnification. For example, in *Maryland*, pursuant to the Health Occupations 18-318(f), a person who acts in good faith and within the scope of the jurisdiction of the Colleague Assistance Committee is not civilly liable for any action as a member of the committee for giving information to, participating in, or contributing to the function of the Colleague Assistance Committee. MPA members serving CAP functions are covered by association liability insurance in the amount of at least \$1,000,000 for individual claims and \$1,000,000 per aggregate. This work may also be covered by the psychologist's personal liability insurance. SPTAs are encouraged to seek legal counsel to evaluate their risks.

*Tracking progress through the system.* Mechanisms must be defined to track the individual's progress once the intervention has started. These procedures may vary depending on whether someone entered the system voluntarily or was mandated. The following are recommended aspects of the tracking process:

1. Identify the person responsible for monitoring the process. (This might be a CAP member, an enforcement officer of the board or some other individual, depending on the model).
2. Develop forms for facilitating communication and monitoring.
3. Sign necessary consents to release information to permit sharing of information among all components of the system. Agreement to sign necessary consents is a condition of entering the program.
4. Continue monitoring by the intervener through regular reports of the participant's compliance.
5. Develop mechanisms to provide feedback to the licensing board when the board is the source of the referral.

*Professionals involved and their roles.* The effectiveness of a colleague assistance program depends on identifying experienced psychologists who can serve in various capacities and providing training to ensure that each understands the system and their functions within it. Establishing criteria to identify these individuals is essential (see Chapter 5.) Various roles include assessor, intervener, case monitor, practice monitor, psychotherapist, educator, supervisor, practice evaluator, consultant. Attention must be paid to avoiding conflicts of interest due to multiple roles. Psychologists will likely recuse from working with another psychologist with whom they have shared office space, served on boards and committees, written books or articles, etc.

*Outcome measures.* The assessment and intervention plan should translate into specific, measurable **outcomes**. For example, one outcome measure for a drug dependence problem might include negative random urine tests over a specified period of time. Wherever possible, pre-existing measures appropriate to the problem should be used. One step in the plan of rehabilitation often skipped is a reassessment for return to practice. This step serves as an overall outcome measure in addition to individual outcome measures tied to the rehabilitation plan itself. It is important to adhere to this final step for completion of the rehabilitation plan.

In addition, outcome measures to evaluate the effectiveness of the system as a whole are highly beneficial. These could include such things as surveys of stakeholders or participants or the tracking of changes in the number of complaints over time.

*Possible dispositions.* While the focus of CAPs and licensing boards often results in recommendations for intervention and remediation, other dispositions are possible. These include but are not limited to:

- (1) The psychologist refuses the evaluation once he/she sees what is entailed;
- (2) The psychologist begins the evaluation but does not complete it;
- (3) The psychologist is evaluated but has a problem that is not able to be remediated or rehabilitated;
- (4) The psychologist initially agrees to rehabilitation, but later tries to get the requirements changed by the licensure board (or training program or employer);
- (5) The psychologist begins the rehabilitation program but is not compliant or withdraws before completion;
- (6) The psychologist becomes disenchanted with the field during rehabilitation and asks for vocational counseling into another field;
- (7) The psychologist makes all of the progress they are likely to make but are not sufficiently rehabilitated to be a competent practitioner;
- (8) The rehabilitation plan is not successful.

## SUMMARY

Both APA (via ACCA) and ASPPB are dedicated to the competent and ethical practice of psychology. Both recognize that all psychologists are subject to life stresses and may suffer varying amounts of distress at different times of life. Psychologists are expected to seek help when this stress/distress has a negative impact on their functioning.

Colleague assistance programs (CAPs) function to both educate psychologists on how to ameliorate the effects of stress through self-care and to provide treatment and support services for those who self-refer for help or are referred by others including licensing boards. It is the basic premise of this monograph that generally the most effective and efficient CAPs result from collaboration between psychology associations and licensing boards. CAPs are intended to benefit both the public and the profession. The purpose of this monograph is to provide direction and content support to a group wishing to begin or strengthen a jurisdictional CAP by citing supportive literature to provide a rationale for services and describing issues that need to be considered in the development and implementation of a CAP. Representative issues include structure of the CAP, confidentiality issues, liability, assessment strategies, interventions, selection and training of assessors and interveners, monitoring procedures and formats, rehabilitation determination, and program evaluation.

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TABLE 1

APA/ASPPB Mission and Ethics Code Comparison

APA	ASPPB
<b>PROTECT THE PUBLIC</b>	
Respect and protect civil and human rights  Establish relationships of trust with those with whom they work	The practice of psychology...is hereby declared to effect the public health, safety, and welfare
<b>HARMFUL BEHAVIOR</b>	
<p>[Psychologists] strive to benefit those with whom they work and take care to do no harm</p> <p>Be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work.</p> <p>Refrain from initiating an activity when they know or should know that there is substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner</p> <p>Become aware of personal problems that may interfere with their performing work-related duties adequately</p> <p>[Psychologists may not] exploit persons over whom they have supervisory, evaluative, or other authority such as clients/patients, students, supervisees, research participants, and employees.</p>	<p>Immoral, unprofessional, or dishonorable conduct is conduct that violates the accepted standards of practice through neglect, exploitation, harm, abuse and/or tends to bring reproach or disrepute to the profession of psychology</p> <p>[Psychologists] shall not undertake or continue a professional relationship with a client when the psychologist is, or could reasonably be expected...to be impaired due to mental, emotional, physiological, or substance abuse conditions</p>
<b>ETHICAL COMPLIANCE</b>	
[APA expects psychologists to] uphold professional standards of conduct; accept appropriate responsibility for their behavior; [be] concerned about the ethical compliance of their colleagues' scientific and professional conduct; [and] take appropriate measures, such as obtaining	[ASPPB assists] member boards in protecting the public [by] the provision of information and guidance to member boards and individual psychologists regarding ethical practice and the discipline of psychologists' licenses [and by regulating] the practice of psychology by

professional consultation or assistance, and determine whether they should limit, suspend, or terminate their work-related duties	unqualified persons and from unprofessional conduct by persons licensed to practice psychology
TRAINING AND CREDENTIALING	
[APA develops standards and guidelines for training psychologists and monitors that training through accreditation procedures]	[ASPPB protects the public by] the development, utilization, and integration of credentialing and training models, examinations, and other assessment methodologies to establish criteria for psychology licensure and certification.

Sources: APA Ethical Principles and Code of Conduct (2002)  
ASPPB Code of Conduct  
ASPPB Mission Statement  
ASPPB Model Regulations  
ASPPB Model Act for Licensure of Psychologists