DIVERTING JUSTICE: UNANSWERED QUESTIONS ON DIVERTING LICENSEES FROM DISCIPLINE

by Thomas O'Connor[1]

Several boards in the Department of Consumer Affairs have begun, during the last ten years, to develop and try out what are euphemistically called "diversion" programs. Generally speaking, a diversion program is one aspect of a regulatory agency's enforcement system which focuses on detecting substance-abusing or otherwise impaired licensees, securing their agreement (or requiring them, under threat of discipline) to seek treatment, and "diverting" them from the discipline track to rehabilitation. Frequently, diversion occurs with little or no interruption of a professional's practice, and it always occurs under conditions of strict confidentiality, preventing consumers from finding out about the problem even if they inquire. In my personal opinion, these unwise experiments have not received sufficient public scrutiny, are at odds with the consumer protection mandate of these boards, and are a powder keg ready to explode.

There are many unanswered questions about diversion programs, a few of which are presented as examples below.

Are licensing boards within the Department of Consumer Affairs not charged with protecting vulnerable consumers rather than diverting licensees who have harmed those consumers from justice and accountability? Efforts of professions to divert their members from established disciplinary processes hark back to the notorious "conspiracy of silence" by which professions attempted to shield their members from responsibility for heinous, harmful, and sometimes criminal behavior. "Diversion" tells the public that the licensee's record is "clean," which is hard to reconcile with the truth. Diversion is the sleight of hand by which professions can enable the most exploitative licensee to quickly regain access to vulnerable and unsuspecting consumers.

Most diversion programs seem to rest on blatant conflicts of interest. For example, several boards with diversion programs contract with diversion group facilitators who are *paid* by the licensees they monitor. Those who are conducting the intervention are also monitoring or evaluating the work (of diversion) that they are doing. What monitor is likely to judge his or own work (of diversion) as shoddy, lacking validity, and generally inadequate? How are these boards legitimately able to assure vulnerable consumers that the facilitators' loyalties lie with the consumer rather than with the person who is paying them?

Beyond the conflict of interest is the fundamental question of the statutory charge of these licensing boards—that is, to protect consumers from those who have harmed and are likely to harm again. In much more trivial matters that do not threaten the safety of citizens, we would not think of proceeding with such an experiment until there is reliable evidence that a product or procedure is both safe and effective. To take the example of therapists who sexually abuse their patients, who can name even one independently conducted study published in a scientific or professional journal showing that any rehabilitation intervention has ever worked? When someone claims to have an effective treatment, drug, or intervention, we test *first* for safety and effectiveness and *then* approve it for general use. But pressures to protect abusive and dangerous licensees from accountability may have resulted in ignorance of this fundamental principle.

If in fact there is no evidence based on independently conducted studies published in scientific or professional journals which establishes the effectiveness of rehabilitation programs for therapists who have sexually abused their patients, then are not all interventions currently used—both by definition and in actuality—*trial* interventions? Who is exposed to the harm caused by bogus or ineffective trial interventions that enable abusive therapists to return to practice? Is it not the consumers? A review of the research on consumers who are likely to be sexually victimized in therapy reveals: "The best single predictor of exploitation in therapy is a therapist who has exploited another patient in the past."[2] Even the Insurance Trust of the American Psychological Association acknowledged that "the recidivism rate for sexual misconduct is substantial."[3] Do those who place consumers at risk of harm on the basis of experimental or trial diversion methods not have a responsibility to obtain the informed consent of these consumers as they study and research their methods? According to the Nuremberg Code, the first principle of trying out procedures is to obtain the "voluntary consent" of those who are placed at risk. Consumers simply should not be used as guinea pigs, without their knowledge or consent, while diversion programs test as-yet-unvalidated procedures.

It is interesting that "diversion" of sexually abusive therapists from justice and accountability affects differentially men and women. The research on therapist-patient sexual relationships suggests that the overwhelming majority of perpetrators are men and the overwhelming majority of victims are women. In one study, for example, 92% of the sexual relationships occurred between male therapists and female patients.[4] In a more recent study of psychiatrists, 88% of the self-reported cases of therapist-patient sex involved male therapists with female patients; 7.6% involved male therapists with male patients; 3.5% involved female therapists with male patients; and 1.4% involved female therapists with female patients.[5] Under these circumstances, diverting the licensee who has sexually abused patients from the disciplinary process appears to be a sexist approach which shields mostly male perpetrators who exploit mostly female victims. Diversion also raises the question of elitism: Why should allied health and medical providers be treated any differently than the public at large when sexual offenses are committed? The extent and harm of such offenses should not be underestimated. Research evidence indicates that *half* of all therapists have treated at least one patient who has been sexually abused by a previous therapist, that about one out of every hundred of these patients takes his or her own life, and that about one out of every twenty is a minor when he or she is sexually abused by a therapist.[6]

Further exacerbating this problem is the fact that in the psychotherapy setting, the therapist typically treats patients on a one-on-one basis behind closed (sometimes locked) doors, with very strict contracts of confidentiality. It is impossible to monitor the practice of the abusing-but-diverted therapist and, therefore, impossible to protect the consumer. License revocation is the only responsible decision in such cases—certainly not diversion.

In other circumstances where rehabilitation may be possible, and where there is adequate evidence of the safety and effectiveness of the rehabilitation approach (or other safeguards, as well as informed consent for any patients who are placed at risk during trial or experimental use of inadequately validated approaches), such rehabilitation may be usefully combined with the necessary dis-

ciplinary procedures that do not undermine justice, accountability, and—of great importance—the safety of consumers. Those considering rehabilitation programs should candidly and carefully address these and numerous other questions described in the literature.[7] To avoid addressing these unanswered questions is to avoid the responsibility of protecting the consumer. Placing consumers at risk without their knowledge or consent is impossible to justify.

ENDNOTES

1. The author, who is the Executive Officer of the Board of Psychology (BOP), wrote a memorandum on diversion to the Department of Consumer Affairs on August 18, 1992. Mr. O'Connor authorized the Center for Public Interest Law to publish this amended version of his memorandum. The views he states here are his personal opinions and do not necessarily reflect official policy of the Board of Psychology.

At a recent meeting, the Board of Psychology adopted the following resolution:

WHEREAS the Board of Psychology has duly considered the various aspects of diversion programs, and

WHEREAS the Board of Psychology is a regulatory board within the Department of Consumer Affairs which is a consumer protection agency, and

WHEREAS the primary mission of the Board of Psychology is to provide consumer protection through an effective enforcement program, and

WHEREAS a diversion program, by name and definition, is a diversion away from enforcement, and

WHEREAS the offering and regulation of rehabilitation services is most properly the function of private enterprise and professional guilds, so

THEREFORE BE IT RESOLVED that it is the position of the Board of Psychology that to offer impaired psychologists entry into a diversion program in lieu of appropriate license discipline is a conflict with the Board's mandate to protect the public. Further, it is the position of the Board of Psychology that it is highly appropriate for impaired licensees to seek rehabilitation programs from the private sector.

2. C. Bates and A. Brodsky, *Sex in the Therapy Hour* (Guilford Press, 1989), 141.

3. American Psychological Association Insurance Trust, *Bulletin: Sexual Misconduct and Professional Liability Claims* (1990), 3.

4. J. Bouhoutsos, J. Holroyd, H. Lerman, B. Forer, and M. Greenberg, "Sexual Intimacy between Psychotherapists and Patients," *Professional Psychology: Research and Practice* 14 (1983): 195–96.

5. N. Gartrell, J. Herman, S. Olarte, M. Feldstein, and R. Localio, "Psychiatrist-Patient Sexual Contact: Results of a National Survey," *American Journal of Psychiatry* 143 (1986): 112–31.

6. K. Pope and V. Vetter, "Prior Therapist-Patient Sexual Involvement Among Patients Seen by Psychologists," *Psychotherapy* 28 (1991): 429–38.

7. In "Rehabilitation Plans and Expert Testimony for Therapists Who Have Been Sexually Involved with a Patient," *Independent Practitioner* 11(3) (1991): 31–39, Dr. Kenneth Pope sets forth sixteen basic questions which responsible regulators should address before creating rehabilitation programs. See also K. Pope, "Therapist-Patient Sex As Sex Abuse: Six Scientific, Professional, and Practical Dilemmas in Addressing Victimization and Rehabilitation," *Professional Psychology: Research and Practice* 21 (1990): 227–39; and K. Pope, "Therapist-Patient Sexual Involvement: A Review of the Research," *Clinical Psychology Review* 10 (1990): 477–90.