Standards for Psychology Services in Jails, Prisons, Correctional Facilities, and Agencies

Second Edition

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AMERICAN ASSOCIATION
FOR CORRECTIONAL PSYCHOLOGY

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Contents

INTRODUCTION TO REVISED STANDARDS

This first revision of the *Standards for Psychology Services in Jails and Prisons* (American Association for Correctional Psychology [AACP], 1980) has retained, inasmuch as possible, both the spirit and content of the original 1980 standards. The 1980 *Standards* was an extremely thoughtful, indeed visionary, product of the task force of the American Association for Correctional Psychology, reflecting information provided by correctional and mental health organizations—including the Federal Bureau of Prisons, the American Correctional Association (1990), the American Medical Association, the American Psychological Association (APA), and AACP—with one goal: providing functional enduring standards for psychological services to inmates in adult jails and prisons that raised correctional psychology "above ground level."

Under the leadership of Robert B. Levinson, the task force named in the original *Standards* did such an outstanding job that the challenge facing our task force, formed by AACP President David Glenwick, Ph.D., and consisting of Sally Wing, Ph.D., Ina Haugen, Psy.D., Leonard Morgenbesser, Ph.D., and me, was perhaps less daunting, but certainly no less important. Our challenge was to review the original standards and align them with current professional standards, practices, and correctional system needs. Accordingly, we have recommended changes in keeping with American Psychiatric Association's (1989) *Psychiatric Services in Jails and Prisons*, the American Psychological Association's practice standards and ethical code of conducts (APA 1987, 1992), APA's *Specialty Guidelines for Forensic Psychologists* (Committee on Ethical Guidelines for Forensic Psychologists, 1991), the *National Commission on Correctional Health Care* (1997), legal rulings, the fact that we are now living in a computer age, and the significantly increasing need for mental health services by our adult and juvenile inmates as well as those on correctional supervision in our communities.

Generally, our ultimate goal was no different than that of the original task force. Through our revisions of the original AACP (1980) *Standards*, we hoped to contribute to raising correctional psychology to a level that guides and inspires legislators, psychologists, corrections administrators, staff, and the public to understand that offenders

entrusted to the custody of our correctional facilities and probation/parole agencies merit and benefit from the highest quality mental health services. By doing so, we collectively recognize both the intrinsic worth of each individual and collaborate in realizing the potential of their contributions to the communities in which they live and/or to which they will return.

The essence of the proposed changes involved expanding the scope of the AACP standards to include juvenile facilities and implications for mental health services for offenders on community supervision; increased emphasis on legal, APA, and licensing standards (especially as applied to informed consent, confidentiality, and "duty to warn"); and broader roles for correctional psychologists (e.g., policy making, psychological screening of security staff, advocacy work, and consultation). However, in proposing these changes, we also attempted to recognize the real differences between the arena of practice of a correctional psychologist and the needs of the agency by which they are employed. More detailed changes will be discussed in the Preamble.

At this time, it seems propitious to close with some comment about the distinction between a correctional psychologist and a psychologist providing mental health services within a correctional setting. At one level, a correctional psychologist is distinguished by specific academic and/or program training in correctional philosophy, systems, offender management, forensic report writing, treatment aimed at reducing recidivism, and outcome research. At another level, however, this is not a particularly useful distinction. Ethical and practice standards provide an umbrella under which the same levels of professional practice are mandated irrespective of the service setting (e.g., adult, juvenile, or community) and training level/educational background of the service provider.

The APA ethical standards are very clear that psychologists be familiar with the characteristics of their clients and their own biases regarding their clients. Regardless of their background, psychologists who provide mental health services to offenders who do not also take into account the stressful exigencies associated with their incarceration or community supervision and/or who have not come to terms with their own beliefs/feelings about offenders and their offenses may, at best, be less effective and, at worst, do harm. Providing psychological services in a correctional setting is a stressful undertaking for both

provider and client, and we owe each our uncompromising best. Our hope is that these revised AACP standards will continue to assist in that endeavor.

Richard Althouse, Ph.D.
Chair, AACP Standards Committee
May 1999

PREAMBLE TO REVISED STANDARDS

Since the 1980 publication of the original AACP *Standards for Psychology Services in Adult Jails and Prisons*, our national inmate population has almost quadrupled, from 328,695 in 1980 to 1,224,554 at the end of 1997 (Proband, 1998). It has been reported that the average daily population for both jails and prisons has been increasing at an average of more than 9% and 8% per year, respectively, since 1983 and much higher in certain states. As a result, facilities that used to house 50 offenders may now house hundreds. Those that used to contain hundreds may now house thousands. Incarcerated offender estimates by the year 2000 have ranged from 2 million to 4 million, based on the outcomes of incarceration for a wider range of crimes, longer sentences, truth in sentencing, and modifications of our federal, state, and county penal systems in the face of increasing overcrowding.

Similarly, the number of offenders on parole or probation has dramatically increased. It has been reported that at the end of 1997, nearly 4 million individuals were under correctional supervision in the United States, compared with 1.25 million in 1985. This number represents a 30% increase just from 1990 (Bureau of Justice Statistics, 1997).

Continuing deinstitutionalization of the mentally ill, combined with increasing incarceration/supervision rates, may be contributing to the growing number of incarcerated mentally ill and developmentally disabled adult and juvenile offenders, many of whom are released back into our communities on probation and parole still needing mental health services. Percentage estimates of mentally ill and developmentally disabled inmate populations have ranged from 6% to well more than 65% depending on the study and the facility. Percent-

ages of inmates needing mental health or related specialized services are much higher if drug disorders are included and higher still if a dual diagnosis criterion is used. In addition, research continues to show that the need for mental health services may be intensified by iatrogenic psychological stresses induced by incarceration and overcrowding, stresses that may result in severe depression, psychosis, and even suicidal behavior among offenders who may not have had a diagnosable emotional disturbance prior to or upon admission.

In contrast to the increased percentages of incarcerated mentally ill and developmentally disabled, since the late 1970s, there has been a decrease in social, political, and economic support for rehabilitation and mental health services and programs for offenders, especially incarcerated offenders. Resulting state and federal litigation led to legal decisions that, based on the Eighth and Fourteenth Amendments of the U.S. Constitution, have clarified the rights of inmates to receive professional mental health services as well as the minimal parameters of those services (*Americans With Disabilities Act*, 1997; see Cohen, 1998, for discussions of the following example cases: *Estelle v. Gamble*, 1976; *Bowring v. Godwin*, 1977; *Ruiz v. Estelle*, 1980; *Langley v. Coughlin*, 1989; *Farmer v. Brennan*, 1994; *Madrid v. Gomez*, 1995; *Coleman v. Wilson*, 1995; and *Youngberg*, 1992). So, at this time, there is no doubt that correctional systems and facilities have been legally mandated to provide humane living environments in their prisons and jails that include (a) providing for the mental health needs of their inmate populations and (b) ensuring that these mental health services meet certain legally and professionally defined standards.

As a partial result of this litigation, there has been a significant increase in the number of correctional psychologists over the past decade—in both the public and private sectors—as correctional organizations, facilities, and agencies have been legally mandated to comply with both constitutional and humane mental health care standards. In the face of this professional growth, ethical and practice standards are critical to corrections administrators and psychology staff for the provision of psychological services to offenders, in sufficient quality and quantity so that compliance with federal, state, and professional mandates is achieved and maintained.

In our revision of the original 1980 standards, we acknowledge that not all persons in our criminal justice system have some type of developmental disability, emotional disturbance, or mental illness requiring specialized or intensive psychological services. We also recognize that as in the original 1980 AACP standards, the 1999 revision provides the minimum acceptable levels for psychological services for offenders—regardless of the category of client (i.e., adult or juvenile, or male or female), jurisdiction (county, state, or federal), or location (jails, prisons, or community). Nonetheless, we have made every effort to reflect the applicable ethical/practice parameters and standards supported by legal decisions, as well as those of the American Psychological Association, the American Psychiatric Association, the American Correctional Association, and the National Commission on Correctional Health Care. Our full expectation is that the psychologist practitioner/supervisor will advocate for and provide mental health services in compliance with these professional guidelines regardless of their client or work setting.

The guiding purpose of these revised AACP standards is to augment the APA ethical and practice standards and apply these concepts in the corrections arena. The intent continues to be the improvement of advocacy, accessibility, integrity, quality, and measured effectiveness of mental health care for all offenders—adult or juvenile—who require or may benefit from it. To that end, we intend that the scope of the standards includes juvenile offenders and community correctional agencies providing mental health services to offenders on probation/parole. We reordered some of the original sections and paragraphs and separated or created sections. Consequently, there are now 66 standards in contrast to the original 57. We also eliminated the "general to essential" continuum. In our collective judgment, all the guidelines were viewed as essential.

As in the original 1980 standards, each section is followed by a brief discussion. The purpose of such discussion is only to clarify the standard's intent. Consequently, the discussion section should not be viewed as part of the standard or as required for compliance.

We understand that the promulgation of AACP standards does not guarantee compliance. Because these standards are not intended to

offer legal advice or substitute for legal consultation, compliance does not guarantee protection from or successful outcome of litigation. Nonetheless, a psychological practice or service in a correctional context not in compliance with these standards strongly implies an ethical or practice violation. Such a violation could result in litigation with civil and/or criminal consequences. Therefore, AACP strongly encourages the highest possible level of compliance with our standards as well as performance exceeding the standards whenever possible.

I. ADMINISTRATION

MISSION STATEMENT

1. The mission of psychological services and the work of its personnel are governed by a current written statement of mission, objectives, job descriptions, policies, and procedures approved by the facility's or agency's administration (and the headquarters staff person responsible for psychology services in multisite or agency systems).

Discussion

An overriding principle contained in this mission statement is that psychological services personnel should be guided primarily in the direction of promoting human welfare through providing these services in a considerate, effective, economical, and humane manner.

In addition to the mission statement and objectives, providers of psychological services should also have available to them a current compilation of procedural guidelines that describe (but are not limited to) forms, methods, techniques, and other procedures that contribute to the mission and are used to attain the objectives. These should be kept in a psychological services procedural manual or handbook available to both staff and administration. These documents should provide direction in at least the following areas: evaluation, diagnosis, therapy, habilitative services, research, quality improvement oversight, consultation, staff training, and professional development.

There should be evidence that the mission statement is reviewed annually and updated as appropriate.

SERVICE GUIDELINES, LICENSURE

2. All aspects of psychological services conform to provider and ethical guidelines established by the American Psychological Association, specialty guidelines for forensic psychologists, and state and federal laws and regulations.

   Specific state licensure and/or certification requirements are also applicable. Verification of necessary and current credentials is on file in the facility (or at central headquarters in multisite organizations or agencies).

Discussion

This standard is intended to ensure that psychological services in correctional settings are in keeping with the highest ethical and provider standards, regardless of the level of training or certification of the psychologist provider.

This standard also recognizes that although the admission to the independent practice of psychology is regulated by state or federal statute, not all public sector psychologists are required to be licensed or license eligible. However, employing less than licensed or license-eligible psychology staff for the delivery of psychological services is not sanctioned by APA or by our organization. This same standard applies to other disciplines providing psychological services (e.g., clinical social workers or crisis workers). Compliance with this licensing/certification standard is intended to ensure the same high level of training and competence of all psychology staff, regardless of where or by whom the psychological services are rendered.

Documentation sufficient to determine whether a particular psychological unit is in compliance with this standard would show that at least one psychologist was licensed and any additional staff psychologists and other psychological service staff were either in the process of gaining the requisite experience to apply or already in applicant status.

3. There is a current formal organizational chart that shows psychological services as a separate entity and details lines of authority in the chain of command. Such an organizational chart exists and is implemented at the institutional (or at headquarters) level and shows a full-time qualified psychologist as the individual responsible in a

prison setting for overseeing psychological services. In a jail or agency setting, the psychologist may be less than full-time as the service needs of the setting and offender population dictate.

Discussion

The efficient functioning of psychological services is based on its operation as a responsible entity within the system, facility, and/or agency. Role clarity is enhanced when lines of authority are made explicit.

Although it may be argued that good managers can be effective regardless of their degree of knowledge of the area being managed, this standard rejects such a contention. Efficient management is predicated on both demonstrated/documented expertise concerning psychological services and management skills. Consequently, this standard requires that a properly credentialed full-time psychologist (except as noted in relation to small jails) be in charge of psychological services.

There should be evidence that the organization of authority and responsibilities is reviewed annually and updated as appropriate.

4. The facility has a designated qualified psychologist with responsibility for the organization and operation of psychological services pursuant to a current written agreement, contract, or job description. Similar documentation exists describing the duties of other psychological services personnel.

Discussion

This individual shall direct, review, and supervise the psychological services provided; have authority and participate sufficiently to assess the need for such services; and assume professional responsibility and accountability for them. Psychologists accept responsibility for the consequences of their work and make every effort to ensure that their services are used appropriately.

Written job descriptions are essential for the effective delivery of services. They provide a basis for job performance evaluations and a

response to, or protection from, lawsuits. The written agreement, contract, or job description shall describe and delineate the duties of each employee such as the range and types of services to be provided, the limits of independent action and decision making, and the individual's place in the chain of command. Work schedules shall be specified that will be compatible with the institution's total program.

The chief psychologist provides adequate timely evaluations to employees, trainees, students, and others whose work is supervised. Related responsibilities include (but are not limited to) activities involved with recruiting qualified staff, directing training and/or research activities, maintaining a high level of ethical practice, and assuring that psychology staff members function only within the scope of their areas of psychological competency.

The role of a psychologist in a jail setting should include, at a minimum, functioning in the following areas: crisis intervention; the identification, management, and treatment of severely mentally disturbed inmates; and referral for immediate and/or follow-up community treatment services.

Annual job description reviews and updating will be maintained at the appropriate facility or agency site or headquarters.

PROFESSIONAL AUTONOMY

5. Within the constraints of appropriate security regulations applicable to all institutional personnel, psychologists have professional autonomy regarding psychological services and psychology staff activities for which they are responsible.

Discussion

Psychological services personnel need to be granted sufficient autonomy to practice their profession to make the most appropriate psychological judgments. Their practice should include all functions identified by the jurisdictional licensing board and practice standards as being within a psychologist's scope and sites of practice.

Psychological services should represent a separate and discrete entity—department—within the institution's (and/or agency's in a

multisite organization) organizational structure and be provided with a separate budget for staff, support staff, supplies, and training resources. Within such a structure, psychological services staff can make their own unique contributions to the broader, nonmedical mental health and human services provided at the facility or agency at the highest professional level.

SUPPORT SERVICES

6. When psychological services are provided by a facility or agency (as opposed to contracted services), adequate space, support staff, and funds for equipment, supplies, training needs, and materials—as determined by the chief psychologist (and in accordance with headquarters directives in multisite organizations)—are provided for the delivery of those services.

Discussion

The environment in which psychological services are delivered affects the quality of what is being offered. Physical arrangements should be conducive to human dignity, self-respect, and promotion of the optimal functioning of both the inmate clients and the professional staff members.

Regardless of the provider source, the following equipment is deemed necessary to ensure the efficient delivery of psychological services: a desk, a desk chair, a desk lamp, adequate overhead lighting, at least one comfortable chair (preferably with armrests) for clients, a telephone with both an outside line and interoffice capability, adequate stationery supplies, dictating equipment and/or computer with printer access, and adequate ventilation (heat and air conditioning). Offices should meet both confidential and safety needs of staff, client, and facility, with walls to the ceiling and windows with drapes that can be drawn for privacy if permitted. There should be lockable file and storage cabinets, a sufficient number of current editions of psychological test materials, appropriate manuals and reference books, and stopwatches. Preferable, but not essential, are a clock, a bookcase, and lamps. A guideline for adequate secretarial support would be a full-time secretary for every two full-time (or equivalent) psychologists.

INTEGRATION OF SERVICES

7. At least monthly, administrative meetings are held that include the chief psychologist and the facility administration (and preferably, other institutional heads of departments) to provide a forum for general discussion, including the operation of psychological services.

Discussion

Face-to-face administrative meetings are important for a successful program in any field. At such meetings, problems are identified and solutions sought. The availability of other discipline representatives at such meetings enhances the likelihood that the agreed-upon resolutions will be smoothly integrated into the institution's ongoing total effort.

At facilities or agencies where psychological services consist of more than one staff member, it is strongly suggested that psychological services staff meetings be held on a regular basis—at least twice a month. In addition to discussion of administrative concerns within the psychology department, these meetings will help promote quality care and the efficient appropriate use of resources. Psychological services staff meetings can also serve a professional development function by scheduling some time for training and other informational opportunities including meeting and problem solving with nonpsychological staff.

8. There is a periodic (at least quarterly) and annual report on the psychological services delivery system. These reports include workload demand and delivery figures, diagnostic and treatment trend analysis, comparative analyses with prior data, and other issues of importance or concern.

   These reports are provided to the facility or agency's administration and other interested management personnel by the chief psychologist (in a multisite or agency organization) or by the on-site supervisor psychologist.

Discussion

In general, there is an ongoing need for reliable information—particularly for jails—upon which psychological staffing, program, and

budget requests can be based. The availability of basic information, which these reports should supply, will put the facility's or agency's administration and funding bodies in a better position to defend appropriation requests and facilitate continuing psychological services at a level appropriate for the mental health needs of the ongoing offender population.

QUALITY ASSESSMENT/IMPROVEMENT OVERSIGHT (INTERNAL)

9. The quality of psychological services is assessed at least annually, and the results are reported to appropriate management and professional staff in writing. The chief psychologist is responsible for overseeing the internal quality assurance and improvement review.

Discussion

There should exist at each facility (and at central headquarters in a multisite agency) a quality improvement plan that includes (but is not limited to) both an internal and external semiannual/annual audit or assessment of psychological service goals, procedures, clients and client contacts/services, resources, outcomes, research, recommended changes, goals for the following year, and information distribution. Because quality improvement plans and reviews require specialized knowledge and training, such training should be obtained prior to the design of a plan and implementation of a review.

The intention of a quality improvement evaluation is to provide the facility's or agency's administration and staff (including psychological staff) timely information concerning the level of performance of psychological services and the existence of any barriers that prevent more efficient and effective functioning. Under no circumstances should the chief psychologist permit an annual external audit without a prior internal one.

Each review or audit should result in a comprehensive report that is distributed to administrative, psychological, and other staff on a need-to-know basis.

QUALITY ASSESSMENT/IMPROVEMENT OVERSIGHT (EXTERNAL)

10. A formal documented annual review (with a subsequent report to the facility's chief executive and copies to the chief psychologist and other appropriate headquarters staff) is conducted by an outside agent to monitor conformity to these standards and established policies.

Discussion

Psychological service program reviews may be conducted by appropriate headquarters personnel (in multifacility organizations) or by an appropriate member(s) of an advisory committee at an independent facility (e.g., a county jail; see Standard 48, Section IVC). Psychological services personnel have an ethical obligation to encourage and cooperate in the evaluation of the services being provided.

The program review should follow a structured outline and should include (but not be limited to) an assessment of effectiveness (what the service accomplishes), efficiency (cost of the service), continuity (linkages to other human services, both inside and outside the facility or agency), availability (staff/inmate ratio/needs), accessibility (days and hours of work schedule), and adequacy (ability to meet identified needs). Specific recommendations should be reported and written response made by the facility or agency with input from the chief psychologist; these are followed up during subsequent reviews.

II. ROLES, SERVICES, STAFFING, AND PROFESSIONAL DEVELOPMENT

ROLES AND SERVICES

11. The roles and services of correctional psychologists shall be directly related, or contribute to, mental health services, treatment, and programming for offenders.

    Appropriate roles for correctional psychologists may include (but are not limited to) the following: consultation to correctional adminis-

tration for mental health program design; psychological screening of security staff employed in specialized mental health units; classification for mental health program assignments; training of institutional and agency staff; assessment, diagnosis, and treatment of mental illness; crisis intervention; and both advocacy for and evaluation of correctional mental health programs and services.

Discussion

In the context of steadily increasing incarceration rates, the need for, and the roles of, psychologists in correctional systems have significantly expanded. In addition to the traditional assessment and treatment of mental disorders (e.g., depression, anxiety, sleep disorders, suicide, and psychosis), the emergence of new mental disorders (e.g., post-traumatic stress disorder), additional assessment and expert testimony roles (e.g., risk assessment for parole boards, involuntary commitment for treatment, and forensic assessment of sex offenders for civil commitment), and consultation services (e.g., psychological screening of security staff) have created new professional dimensions and consultation and training requirements.

Whereas it is important to consult and collaborate with other services, it would not be appropriate for correctional psychologists to assume roles not consistent with and/or directly related to the provision of psychological mental health services to the offender and/or the correctional system such that (a) the scope of psychological services becomes blurred or blended with other services (e.g., security or social services) and (b) needed mental health treatment resources are decreased. There should be no doubt among offenders or nonpsychological staff (e.g., correctional administrators, security staff, and social workers) what the scope of psychological services entails; how they contribute to the correctional agency, system, and offender; and the ethical/professional standards that apply to and guide them.

STAFFING REQUIREMENTS

12. At the facility (and at the headquarters level in multisite organizations), there is at least one person responsible for psychological services who has a doctoral degree from a regionally accredited univer-

sity or professional school in a program that is primarily psychological in nature, who is licensed/certified for the independent practice of psychology by the state where the facility is located, and who has training/experience specific to the field of correctional psychology.

Discussion

The intent of this standard is to set the minimum credential level for psychology supervisory staff. Psychological services provided by psychology staff who do not meet this credential standard (e.g., psychology interns, trainees, students, and paraprofessionals) will be supervised by a qualified (e.g., licensed) psychologist who retains final responsibility and accountability for the decisions and services provided. Such supervision will be documented and occur at least once weekly at the rate of 1 hour of direct, face-to-face, individual supervision for every 40-hour workweek, or as required by state licensing boards. Supervisory documentation will be maintained in the staff's supervisory file for the duration of the supervisory relationship.

If the supervision is for the purposes of credentialing or licensing, then the supervisory documentation shall be maintained as required by the credentialing authority.

13. The minimum ratio of full-time psychology staff to adult inmates is 1 for every 150 to 160 inmates. In specialized units (e.g., drug treatment and special management units for mentally ill inmates), the minimally acceptable ratio is 1 full-time psychologist for every 50 to 75 adult inmates. The minimum ratio in facilities for juvenile offenders is 1 full-time psychologist for every 60 to 75 juveniles in general population and 1 full-time psychologist for every 20 to 25 juveniles in a special management unit.

    For jail facilities, there will be sufficient access to psychological staff to meet the crisis and mental health needs of the inmates. To the greatest degree possible, staff composition shall reflect ethnic, racial, gender, and linguistic characteristics of offenders.

    In jail settings, the following minimum staffing pattern applies:

    A. average daily population fewer than 10—psychologist on call;
    B. average daily population between 11 and 75—contract psychologist in the facility at least 8 hours per week;

C. average daily population between 76 and 125—contract psychologist in the facility at least 16 hours per week;
D. average daily population more than 125—at least one full-time psychologist.

Discussion

It is understood that as the mental health needs and characteristics of our offender populations change, it becomes difficult to define "average." Nonetheless, the intent of this standard is to ensure that the number of available psychological services staff will meet the general and specific psychological assessment, program, and treatment needs of an average adult or juvenile inmate population. Such a mental health service level should be sufficient to be in keeping with legally defined and community guidelines (see Preamble). Except as noted in the jail standards, these ratios assume that the staff member is a full-time staff member at the facility.

There is an expectation that the number of psychological services staff will increase if the level of special needs and/or program intensity differs from average. Furthermore, each correctional facility, organization, and agency is expected to have an affirmative action plan that requires that staffing be reflective of the cultural characteristics of the offender population.

PROFESSIONAL DEVELOPMENT

14. A written plan, approved by the chief psychologist and facility, organization, and/or agency administration, requires psychology staff to receive orientation training as well as regular continuing education appropriate to their psychological activities. Documentation of these training experiences will be maintained by both the individual psychology staff and the employing agency.

Discussion

Providing psychological services in correctional facilities is a unique task and often requires particular prior experience or, for new

psychology personnel, specific orientation and training. Nevertheless, the provisions of psychological services in correctional and community settings will be in conformity with the current APA ethical and practice standards and specialty guidelines (e.g., forensic) and the individual's state licensing/certifying agency when applicable.

In general, there are three levels of orientation: (a) to the correctional facility or agency, (b) to the correctional organization (in multifacility organizations), and (c) to the functioning of psychologists in a correctional setting. At the facility level, this should occur within the first month of employment and be managed by the chief psychologist (for other psychological services staff); at the organizational level, this may occur within the first 4 months of employment and should be addressed in a formal orientation to the correctional service as a whole; specialty training should commence within the first 5 months and continue as appropriate.

Staff members at all levels of psychological skill require ongoing continuing education to maintain optimum skill levels and to ensure the highest quality of psychological services. They may require additional training to meet and/or maintain state licensure or certification standards. Each psychologist should have a documented training plan consistent with his or her training needs, and the employing agency should provide adequate training time and funding to meet those needs.

III. ETHICAL GUIDELINES

GENERAL PRINCIPLE

15. All psychological services (e.g., screening, assessment, treatment, referral, transfers, expert testimony, and forensic reports) will comply with the current American Psychological Association and forensic specialty principles and guidelines as well as federal law, state statutes, and licensing and administrative codes in the jurisdiction of the facility or agency. In the event that there is a conflict among or between practice standards, the standard that provides for the highest level of professional practice shall be followed.

Discussion

It is important that no ethical or practice distinction be made between offenders (adult or juvenile) and nonoffender individuals in the provision of psychological services.

16. To the greatest extent possible, psychological resources are used only for clearly defined psychological and mental health purposes. (See Section II, Standard 11.)

Discussion

The clear need for institution and community safety, as well as a collaborative, multidisciplinary team model in a multisite, institution, or community agency, may result in instances when psychological staff may be called upon to provide services to both administration and offenders that are not clearly "psychological" in nature. This may involve participating in administrative, disciplinary, and/or programming services and/or helping institutional or agency staff manage disruptive/noncompliant and/or dangerous inmates. To the greatest extent possible, psychological resources should be used only to provide psychological services. Psychologists should resist, as much as possible, participating in these processes to the detriment of clearly defined and needed mental health services.

COMPETENCE

17. Psychologists shall limit their functioning to their demonstrated areas of professional competence.

Discussion

In the face of demands for psychologists in correctional/forensic settings to perform a variety of psychological and forensic services for which they may have not received prior or sufficient training, it is important to the institution, facility, or agency and the client that psychological staff not provide services outside their documented/demonstrated area of expertise. The agency may be assuming legal

liability, the psychologist may be in violation of ethical and/or licensing codes, and the psychologist may harm the client.

Prior to extending services beyond the range of their usual practice, psychologists shall obtain pertinent training or arrange for appropriate supervision. This may involve (but is not limited to) a different theoretical orientation, a change in the modality or techniques employed, or a change in type, race, or gender of client or kinds of problems for which services are to be provided. Psychologists have an obligation to educate themselves in the concepts and operations of the criminal justice system in which they provide psychological services.

DOCUMENTATION

18. All psychological services, significant contacts (e.g., resulting in clinically important information), and mental health information will be documented and/or maintained in a psychological services file specific to the offender in compliance with current professional and legal standards and guidelines.

Discussion

The importance of psychology files and documentation cannot be overemphasized. Both are essential for the purposes of accountability for, and continuity of, mental health services to the offender. Such documentation should include, but not be restricted to, offender requests for services and other communication with psychology/mental health staff, limits of confidentiality and informed consent forms, screening and assessment reports, a chronology of direct and collateral clinical contacts and outcomes, diagnoses, treatment plans, treatment summaries and terminations, program status, participation/completions, referrals for consultations, consultation reports, and consent to release information forms, including to whom and for what purpose.

Documentation should be maintained in such a manner that psychological information, although confidential, can be accessed easily and efficiently. Standard forms should be used whenever possible, especially within a multifacility organization. Documentation main-

tained in computer databases and files should have a hard-copy back-up in the client's primary psychological services file.

CONFIDENTIALITY (FILES AND RECORDS)

19a. All psychological services files and records will be confidential to the inmate in accordance with current American Psychological Association and forensic guidelines as well as statutes, licensing, and administrative codes of the jurisdiction. If there is a difference in the levels of required confidentiality, the highest level will be followed.

19b. A documented policy and process to ensure confidentiality of all psychological files, records, and test protocols will be in place, including clearly labeling confidential files and records as "confidential" and keeping psychological services files/information in secured physical and/or computer storage separate from general institution or agency correctional/incarceration files or other information. A documented access process/policy for nonpsychological services staff for access to, and interpretation of, confidential psychological records only on a "need-to-know" basis will be on record at the agency, institution, and central headquarters (in a multsite organization). This process will be supervised by an on-site psychological services staff member designated as the psychological records custodian. All staff will be trained regarding this policy.

Discussion

This section recognizes that mental health information within a correctional system is subject to a variety of needs and constraints not applicable in a general community-based mental health setting. Nonetheless, the confidentiality of all psychological records will be ensured and maintained at the highest possible level, including secured separation from other institutional nontreatment records, a process of review that provides maximum and timely access to the client, and access to other institutional staff limited to a need-to-know basis and under the supervision of a designated psychological services staff person. Releases of Confidential Information forms and processes will be followed when psychological services information is released to third parties. Such releases will be documented in the inmate's psychological services file.

NOTE: With the advent of centralized computerized records and databases, the confidentiality of inmates' computerized psychological services records must be adequately safeguarded.

Psychological staff must remember that e-mailed documents, notes, and communications about an inmate may be stored in a central database or records server at another location, are not confidential, and may be accessible by other nonpsychology staff. Safeguards (such as passwords) will be in place to ensure confidentiality of these communications. (Practitioners should be reminded that in many jurisdictions, a violation of confidentiality statutes and/or ethical guidelines is subject to grievance and/or civil and criminal prosecution.)

LIMITS OF CONFIDENTIALITY

20. All inmates will be informed, both verbally and in writing, regarding the limits of confidentiality and legally or administratively mandated "duties to warn" prior to any psychological service that places confidentiality at risk. This information is provided on a form that fully discloses these limits, possible uses of information the offender provides, to whom that information may be provided without the offender's consent, and recognition that the offender has been provided this information in advance of any participation in assessment, treatment, or other psychological service. The form will be signed and dated by the offender and/or the psychologist if the offender refuses to sign. (**NOTE:** An offender's signature is not an attestation to accepting the limits, only that he or she received the information.)

Discussion

All involved parties shall be informed, in advance, of any limits to confidentiality, and the offender should be told, "You will have to trust my judgment concerning what information I have to release." Nevertheless, in the most basic sense, confidentiality is a right of the *client*, not the psychologist; privileged communication, if it exists at all, obtains only in a treatment relationship.

It is imperative that, just as in the community, inmates understand limits of confidentiality as it applies to any information they provide in the course of psychological testing, assessment, treatment, and pro-

gram participation. This understanding must be documented in the inmate's confidential psychological services file on a form specifically for that purpose.

Confidentiality is an ethical/legal principle that protects the client from disclosure of confidences entrusted to a professional during the course of treatment or service unless the professional is required by law to reveal the information to protect the welfare of the individual or the community. In a correctional setting, such a requirement may include potentially life- or security-threatening situations such as escape plans, physical injury, or hostage taking. The psychologist's professional judgment will play a heavy role in making decisions of this nature.

The ideal level of confidentiality for therapeutic information in correctional facilities and agencies should be the same as the level that exists in voluntary noninstitutional settings. However, in light of court decisions (e.g., the *Tarasoff* case, see Cohen, 1998) and the need to maintain the security and orderly administration of a correctional facility and provide for community safety, all staff should have explicit policy/procedural guidelines and training that facilitate a comprehensive understanding and management of the issues (e.g., due process, confidentiality, and duty to warn) and information involved in this sensitive area.

The correctional psychologist works *with* the offender, but *for* the department, facility, or agency, and must be able to differentiate and balance the ethical/legal obligations owed to the correctional organization or agency and the community and the offender client. Nonetheless, it is essential that psychological service providers be given the authority to maintain the confidentiality of their clients' records. To continue an effective working and treatment relationship and to satisfy professional and ethical obligations, psychology staff should not be required (except in life- or security-threatening emergencies or as required by administrative code or statute) to disclose their records or treatment information to correctional staff or officials without the documented informed consent of the client.

INFORMED CONSENT

21. All psychological screenings, assessments, treatments, and procedures (e.g., audio/video recording, observation of treatment for training, and research procedures) shall be preceded by an "informed consent" process and documented on the appropriate form. In the case of assessment and treatment, such consent shall include an explanation of the diagnosis, available treatment options, risks of treatment (including nontreatment), anticipated outcomes, and time frames. The form(s) shall be signed by both client (or designated guardian in the case of minors or adults with a legally designated guardian/custodian) and psychologist(s) and placed with the offender's psychological services file.

Discussion

Informed consent is the permission granted by the offender to the psychology staff member for the performance of a specified assessment, treatment, or procedure after receiving the material facts regarding the nature, consequences, risks, alternatives, and level of confidentiality concerning the process.

The documentation of informed consent is essential, including the circumstances and condition of the client at the time of the consent process. Documentation must exceed simply acknowledging that such a process occurred. It is advisable that specific informed consent forms be used for specific processes that require the client's signature and date and that these forms be maintained in the client's psychological services file.

INVOLUNTARY COMMITMENT/TREATMENT

22. Involuntary treatment, including the administration of psychotropic medication, placement in an observation status, and the use of restraints, will follow the ethical and practice guidelines of the American Psychological Association as well as federal laws, state statutes, and jurisdictional administrative codes. The role of the psychologist in these procedures will be clearly defined in written policies and proce-

dures. Such procedures will be advocated and/or maintained only after initial and ongoing assessments to determine the necessity of their use.

Psychologists should refuse to participate in such processes if they are inconsistent with legal, professional, or ethical standards.

Discussion

Unless it has been formally established to the contrary, the competence of offenders to make their own treatment decisions is assumed.

In general, mentally competent offenders (or their guardians in the case of juvenile offenders) have a civil right to refuse intrusive physical or chemical treatment without punishment, restraint from programs, and/or community supervision (unless there is convincing clinical documentation that such program participation or community supervision would pose a danger to them or to others). Therefore, the decision to impose mental health treatment upon a competent nonconsenting offender requires complex ethical and legal judgment and procedures. It is expected that administrative codes and statutory and other legal guidelines will be followed and documented in the offender's psychological services file.

In those instances when an involuntary psychological treatment technique is applied, it should be one that has evidence of being effective, without deleterious side effects, is of the least restrictive nature appropriate to the problems being managed, and productive of changes that a more rational client would have sought.

Examples of involuntary psychological treatment include, but are not limited to, some types of behavior modification techniques and group pressure/confrontation. Other examples of such techniques are physical restraints, which include but are not limited to locked rooms, handcuffs, and leather restraints. The use of these devices is appropriate only as part of a psychological treatment regimen.

All involuntary treatment procedures should be thoroughly documented in the offender's treatment plan, including pretreatment due process hearing results, the process implemented, the reasons, client responses, duration, outcomes, and benefit.

Psychological services staff should not be responsible for the administrative restraint of disruptive inmates when such behavior is

not part of a mental disorder (also see Standard 16). However, psychological services staff should be involved in attempts to deescalate the disruptive offender and the psychological assessment of the disruptive offender placed in seclusion or physical restraints. Such an assessment process should follow the procedural/administrative guidelines of the facility or organization in multifacility systems and should be reviewed on an ongoing basis established in consultation with psychological services.

This standard does not preclude psychological services staff from advocating a treatment program for an offender (e.g., sex offender, domestic violence, or anger management) even if the offender denies a need. However, we must keep in mind that the application of any legal or civil penalties for treatment refusal under such circumstances is a statutory mandate and outside the jurisdiction of psychological practice.

EMPLOYER AND ETHICAL/PRACTICE STANDARDS CONFLICTS

23. There is a documented and implemented policy regarding the resolution of ethical/professional conflicts between the employing correctional facility, organization, or agency and psychological services staff.

Discussion

It is expected that psychologists strive to avoid engaging in activities not in keeping with ethical, practice, and licensure standards, but without violating the work rules of his or her employer. Nevertheless, there may be occasions when correctional employer needs/expectations conflict with ethical and practice standards of psychological services staff. When that occurs, both the employing agency and the psychology staff should make every effort to resolve such conflicts in keeping with ethical psychological practice and jurisdictional licensure standards, especially when a practice complaint, loss of licensure, and/or the potential for litigation may be present. It should be understood that regardless of any liability for the employer, a psychologist who violates the ethical, practice, and/or licensure codes also may be individually at risk for legal consequences.

When avoidance is not possible without a possible work rule violation leading to a disciplinary action and/or potential loss of job, the psychologist should first seek resolution by consulting with colleagues, supervisory staff, the employing agency administration, his or her licensing agency, professional associations (e.g., state psychological association, APA, or AACP), and his or her representing union. Circumstances and references related to the conflict should be completely documented, including possible outcomes that may place the psychologist in violation of legal, ethical, and professional practice and the efforts that were made to resolve the conflict. These should be provided to the employing agency, union, and other professional agencies that have jurisdiction in the matter.

If the conflict is unavoidable or unresolvable, such as when time does not permit following the above direction or the nature of the conflict is not clear, the psychologist may comply in accordance with organizational or agency work rule policy, document the circumstances of this decision, and then pursue whatever professional/legal actions are possible to resolve the conflict and avoid such conflicts in the future.

If compliance appears to lead to the possibility of a practice complaint, then the psychologist might refuse to comply and then address any disciplinary action through the appropriate grievance and/or employment relations channels.

IV. MENTAL HEALTH SERVICES/PROGRAMS

STANDARD OPERATING POLICIES/PROCEDURES

24. Current written standard operating policies and procedures approved by the chief or supervisor psychologist are maintained and are implemented for all activities carried out by all psychological services personnel.

Discussion

Written policies and procedures for all psychological services and programs are maintained on-site, and copies are maintained at agency

or administrative headquarters in multifacility or agency organizations. These policies and procedures should be organized and accessible such that quality assessment/improvement audits and reports are facilitated and updates are easily inserted.

Psychological services are seen as a varied multiplicity of programs whose delivery is governed by standard operating procedures. The goal is to provide standardization of processes related to detection, diagnosis, treatment, crisis intervention, and referral of offender clients with psychological problems and to provide a supportive environment during all stages of each offender's period of incarceration (see Section II, Standard 11).

Although a list of standard policies and procedures will vary with facility, agency, and organizational needs, such needs might include (but are not limited to) due process procedures, intake screening, initial diagnostics and diagnostic updates, psychological assessments, crisis interventions and restraints reviews, client contacts and communications, treatment and program interventions, referrals and referral processes, court-ordered treatment, postrelease planning, research, program evaluations, suicide assessment and interventions, management of confidential storage and destruction of records, advocacy, administrative confinement, affirmative defense assessments (reduced discipline of offenders unable to control their behavior because of their mental illness), training, and professional development.

25. At least one staff member per shift within sight or sound of all inmates has training sufficient to recognize symptoms of mental disturbance most common to the facility and knows how to rapidly contact psychological services staff.

Discussion

It is the responsibility of the correctional department's or facility's administration to ensure that nonpsychological staff trained in the identification of serious mental illness and suicidal risk are available on each shift within sight or sound of all inmates.

It is the responsibility of the chief psychologist to facilitate, provide for, and document the training of institutional or agency staff respon-

sible for inmate care (e.g., security, social workers, and probation/parole agents) such that they have an understanding of basic mental health care and the process for expeditiously contacting and referring inmates to psychological or other mental health services staff. The facility or agency will maintain documentation for such training for each employee

IVA. ACCESS TO PSYCHOLOGICAL SERVICES/PROGRAMS

RECEPTION

26. At the time of admission to the facility, inmates receive a written communication explaining the procedures for gaining access to psychological and mental health services, possible limits of confidentiality, and information regarding informed consent to treatment.

Discussion

Access and due process procedures should be explained orally to inmates unable to read. If the facility or agency frequently provides services to non-English-speaking offenders, access procedures should be written and/or orally provided in their preferred language. Signs posted only in the booking, admission, or reception area do not qualify as compliance with this standard.

Psychological services will not be withheld from a potential offender client on the basis of race, color, religion, sex, sexual orientation, disability, age, or national origin except in those documented instances in which differences of this nature might impair the effectiveness of the intervention. When such is the case, every effort should be made to accommodate the difference as quickly as possible to ensure effective intervention.

In addition, basic psychological services (e.g., screening, assessment, treatment recommendations, and referrals) will not be withheld on the basis of custody status, nature of psychological symptoms, criminal offense, or as punishment for rule infractions.

27. There is a written and implemented policy approved by the chief psychologist regarding offender access to psychological services for (a)

postadmission inmates with emergency problems and (b) daily referrals of nonemergency problems covering both scheduled and unscheduled psychological care.

Discussion

A policy, procedure, and printed referral form should be in place to ensure that institution, facility, and/or agency staff refer offenders who are suspected of emotional disturbance or suicidal risk to appropriate psychological services personnel.

Correctional officers and jailers should be trained in the recognition of symptoms of mental disturbance, provide 24-hour-a-day observation, and be available to receive requests and complaints of psychological distress from inmates. This is to ensure that information is passed on to psychological staff to facilitate screening/triaging or assignment of treatment priorities, followed by referrals for treatment.

The policy should identify time frames in which a response is mandated, with feedback to the referral source briefly indicating the nature of the outcome.

Printed referral forms should require at least the date, time, inmate's name, identifying number, location, reason for referral, space for additional comments, and name of staff member making the referral.

IVB. SCREENING/EVALUATION

RECEPTION SCREENING/EVALUATION

28. The collection of psychological evaluation/screening data is performed only by psychological services staff personnel or facility/agency staff trained by them. Written intake/screening reports, recommendations, and treatment plans are reviewed by a qualified psychologist. All such information is recorded on data forms approved by the chief psychologist (in a multisite system) or supervising psychologist (in a single-site facility or agency).

At no time is the responsibility for test administration, scoring, or filing of psychological data given to inmate workers.

No screening or psychological evaluations will be implemented without first informing the offender of the need for this information,

providing information regarding the limits of confidentiality, and obtaining informed consent. This process will be documented, including obtaining the offender's signature and date. This documentation will be placed in the offender's psychological services file (see Section II, Standard 21).

Discussion

Intake psychological screening and history taking may be performed by properly trained correctional officers, jailers, or agency intake staff. Collection of any other assessment/evaluation information is performed only by psychological services personnel. Under no circumstance should an offender be involved in this process.

All personnel involved with psychological testing procedures shall adhere to the APA's current *Standards for Educational and Psychological Tests* (1974) and *Ethical Principles of Psychologists and Code of Conduct* (1992). In cases where nonlicensed or noncertified psychological services staff are involved in this process, it is the responsibility of the supervising psychologist to ensure that these standards are promulgated and followed.

29. Reception screening is performed on all inmates upon admission to a facility before being placed in the general population or housing area. The findings are recorded on a printed screening form. This form is placed in the inmate's psychological services file. Inmates identified by the intake screening as having mental health problems are referred for a more comprehensive psychological evaluation. The screening will include inquiry into (a) past and present mental health difficulties including suicidal ideation, suicide attempts, psychiatric hospitalizations, and psychotropic medications and (b) current mental status including behavioral observations, stressors, measures of daily functioning (e.g., appetite, sleeping, and activity level), and psychotropic medications.

Discussion

Documented reception screening consists of a structured observation/assessment designed to (a) prevent newly arrived inmates who pose a threat to themselves or others from being admitted to the facil-

ity's general population and (b) rapidly provide them with appropriate mental health care. The reception screening can be performed by psychological services personnel or by an appropriately trained correctional worker.

Initial assessment of the general condition of the offender at this crucial point may prevent further complications, rapid deterioration, suicide, and assaults. The welfare of the inmate, other prisoners, the correction facility's staff, and the community is thereby protected.

"Upon admission to the facility" requires that receiving screening be done immediately at the time of booking or admission. Placing two or more inmates in a holding cell/room pending screening several hours later or the next morning fails to meet the standard.

The reception screening process should include (a) a review of papers or records accompanying the inmate, (b) completion of the reception screening form with the help of the inmate (i.e., a review of the inmate's mental health history concerning suicidal behavior, sexual deviancy, alcohol and other substance abuse, hospitalizations, seizures, and patterns of violence and aggression), and (c) visual observation of the inmate's behavior (i.e., observing for signs of delusions, hallucinations, communication difficulties, peculiar speech and/or posturing, impaired level of consciousness, disorganization, memory deficits, depression, and evidence of self-mutilation).

Psychological screenings shall contribute to cell placement (e.g., single-celled or double-celled) recommendations, with an implemented documented process that provides for single-cell placement for mentally ill, mentally retarded, or developmentally disabled inmates for whom double-celled placement might exacerbate their mental illness or disability or might endanger the inmate or cellmate. Documentation of psychological reviews for cell placements should be placed in the inmate's psychological services file.

30. In a prison setting, all newly committed inmates with sentences longer than 1 year shall be given a psychological evaluation within 1 month of admission. Such routine evaluations should be brief and include (but not necessarily be limited to) behavioral observations, record review, group testing to screen for emotional and intellectual abnormalities, and a written report of initial findings. Referral for more intensive individual assessment is made on the basis of these results.

Discussion

The intent of this standard is to ensure that all newly admitted inmates be given a brief psychological evaluation to provide documentation of the nature of psychological problems existing within the facility's population and to ensure that inmates needing additional psychological assessment are referred. Such testing should be purposeful, respectful, minimally intrusive, and conducted in a manner that will encourage cooperation.

In keeping with current affirmative action and legal standards, psychological screening and referral provisions should be made for non-English-speaking offenders.

31. The individual assessment of all inmates referred for a special comprehensive psychological evaluation is completed within 14 days after the date of the referral unless otherwise required.

    As applied in a jail or to offenders diagnosed with a major mental illness and/or placed in a mental health treatment program, this standard includes

    A. reviewing earlier screening information;
    B. contacting prior psychotherapists or the individual's family physician regarding any history of mental symptomatology;
    C. conducting an extensive diagnostic interview;
    D. writing and filing a brief report;
    E. if evidence of mental disturbance is found, placing the individual in a separate area where closer supervision is possible; and either
    F. referring the individual to an appropriate mental health resource or to his or her family physician (if indicated and when release is imminent); or
    G. beginning appropriate care in the jail by staff members of the psychological and/or psychiatric services.

    This standard as applied in a prison setting includes

    A. reviewing earlier screening information and psychological evaluation data;
    B. collecting and reviewing any additional data to complete the individual's mental health history;
    C. collecting behavioral data from observations by correctional staff;

D. administering tests that assess levels of cognitive and emotional functioning and the adequacy of psychological coping mechanisms;
E. writing a report describing the results of the assessment procedures, including an outline of a recommended plan and treatment that mentions any indication by the inmate of a desire for help;
F. communicating results to the referral source; and
G. writing and filing a report of findings and recommendations.

Discussion

The intent and purpose of this standard is to ensure that the mental health status of offenders is known, recorded, and used to guide the provision of mental health services, treatment, and other correctional decisions (e.g., cell, housing, and activity assignments). It also ensures that the offender's mental status is known to the appropriate correctional staff and authorities.

We realize that this standard presumes sufficient staff and resources, that such resources may not be available, and that the provision of resources is often not within the purview of any individual psychologist. That notwithstanding, compliance with psychological ethical and practice standards requires that any mental health service that is status dependent be preceded by a mental health evaluation and/or diagnosis. When that practice suffers from lack of resources, the psychologist should advocate for the necessary resources.

When sufficient resources are not available for a thorough intake assessment, the information obtained should be prioritized to maximize the safety of the inmate, other inmates, and staff and rapid referral to psychological/psychiatric resources.

CRISIS EVALUATIONS

32. Prisons and jails should have criteria and a procedure that ensures rapid notification of qualified psychological services staff of inmate crises needing consultation or intervention during both working and nonworking hours.

Psychological staff should conduct and document crisis evaluations as soon as possible, but no later than 24 hours after the staff member has been notified and/or the inmate seen.

Discussion

Qualified psychological services personnel conduct crisis evaluations. However, facility or agency staff should have sufficient training to provide adequate supportive and protective care (i.e., placing the inmate in a protective status) until the evaluation can be made.

Documentation should be expeditious and facilitate follow-up by other psychological services personnel after the crisis evaluation. Such documentation should include the date and time the referral was made, the referral reason, when the evaluation was initiated, the type of intervention, the outcome, and recommended follow-up procedures. The documentation should be routed or copied to personnel on a need-to-know basis.

IVc. INMATE TREATMENT AND MANAGEMENT

33. Diagnostic and treatment mental health services are provided to inmates of the facility as part of the facility's total program.

Discussion

Compliance with this standard entails both outpatient (office) services as well as services provided to inmates in disciplinary or special management or crisis segregation, the facility's infirmary, or wherever else the inmate might be held, unless there is a clear and documented security or safety risk. When such is the case, every effort must be made to reduce the risk and render services to the inmate.

Inmates requiring psychological diagnostic/treatment services beyond the resources of the institution should be transferred to another facility with adequate mental health services.

34. If mental disturbance is identified in pretrial and/or presentenced detainees, the court and/or the inmate's attorney are notified according to a written policy or procedure approved by the facility's and/or organization's chief executive. Such notification will be documented and placed in the inmate's psychological services file.

Discussion

Every effort should be made by the chief psychologist to notify the offender's pretrial counsel of any mental disturbance because the condition may have a profound impact on the individual's status at trial and at sentencing. The psychologist is not expected to provide forensic testimony (e.g., regarding competency and/or plea of insanity), but rather, to render appropriate care while the pretrial prisoner remains in the facility. The court has the obligation to provide/request forensic experts to testify at the trial or during sentencing procedures.

35. Inmates held for emergency evaluation and/or treatment are housed in a specially designated area with close staff or trained volunteer supervision and sufficient security to protect these individuals.

Discussion

In collaboration with the correctional facility's administration, it is the responsibility of the psychological services staff to make the necessary provisions that will ensure the safety and security of inmates suspected of being mentally disturbed. Such individuals are particularly vulnerable to abuse in jail and prison settings. Small jails with only one staff person on duty can train volunteers to provide needed supervision, keeping in mind that the staff person will be responsible for the actions of the volunteers.

36. Only those treatment methodologies recognized and accepted by the state and general psychological community are employed in a facility unless specifically prohibited by facility or organizational administration policies. When such prohibitions apply, the reasons for the prohi-

bitions will be documented and incorporated in the psychological services policies and procedures.

Discussion

Only recognized treatment technologies/methods as applied in the community should be used in detention and correctional facilities. It is also necessary to avoid the misuse of inmate clients without stopping the exploration of effective techniques for helping inmate clients cope with their mental disturbance.

This does not imply that everything psychologists do in the community is acceptable within a prison facility; for example, aversive therapy may be used in the community but would be inappropriate in any correctional setting. Psychological services personnel should use extreme caution when using an uncommon or quasi-experimental approach that has received scant peer review. Generally, such approaches should be avoided. If used, complete documentation should be maintained (including notes regarding consultation with competent authoritative staff) and maintained in the inmate's psychological services file.

The requirement that there be a reasonable number of alternative psychological treatment programs is intended to recognize the complexity and uniqueness of each inmate client and to prevent exclusive reliance upon any particular treatment modality such as group or milieu therapy. This is not intended to mandate that every facility provide every conceivable treatment program; it does require a reasonable number of alternatives based upon the institution's resources and its inmates.

INFORMED CONSENT TO TREATMENT

37. Prior to the initiation of any treatment protocol, the offender is assessed, diagnosed, and reasonably informed regarding the nature, length, expected duration, and expected risks and outcomes of the proposed treatment as well as professionally recognized/reasonable treatment alternatives (the offender's legal guardian must be contacted according to jurisdictional standards).

    This process will be documented on an *informed consent* form signed and dated by the offender (or legal guardian) and placed in the offender's psychological services file.

Discussion

It is a matter of professional ethics and legal practice to provide for the informed consent of any individual prior to the initiation of any treatment process. Informed consent consists of providing information regarding the goals of treatment, forms of alternative treatments, risks and advantages of various treatments, duration of treatment, and expected outcomes to the client and/or legal guardian.

This process should be documented on a clearly identified Informed Consent for Treatment form, signed and dated by the offender or legal guardian, countersigned by the psychologist (or designee), and placed and maintained in the offender's psychological services file.

TREATMENT PLANS

38. A written treatment plan exists for all offenders requiring psychological treatment (e.g., individual, group, and specialized treatment such as sex offender treatment) and related services. This is developed by a psychologist and, when necessary, in collaboration with other personnel. It includes directions for nonpsychological services staff regarding their roles in the care and supervision of these offenders. This plan is maintained in the offender's psychological services file.

    When the offender is enrolled in a treatment or a psychoeducational program, an outline of the treatment or program including (a) its start and end date, purpose, and methodology; (b) chronological attendance record; and (c) notes will be maintained in the offender's psychological services file.

Discussion

Treatment plans and program notes are a widely recognized and professionally mandated part of mental health care and treatment. A professional treatment plan is a series of written statements that organize and specify the specific nature and course of interventions/therapy designed to address identified conditions (in keeping with specific diagnoses when appropriate) or problem areas, with interim and final time frames and expected measurable progress, goals, and outcomes. The roles of all involved personnel are identified.

There are a variety of professionally recognized treatment plan formats. The plan may be as brief or as long as necessary to identify the

process of proper care and should provide for interim progress notes and a termination summary report.

39. Inmates requiring acute, chronic, and/or convalescent mental health care receive these services either at the facility or a more appropriate mental health care facility to which they are referred.

Discussion

Generally, jails and prisons are inappropriate places to house mentally ill and mentally retarded individuals. Offenders needing acute mental health care should be transferred to a facility designed for that level of service. Similar consideration should be given to individuals needing chronic (long-term care) or convalescent (assisting recovery from illness or injury) care. Psychological services staff may be appropriately consulted when questions of care arise.

40. Prison systems will have their own resources for managing and providing mental health care and services for severely psychologically disturbed inmates, either in specifically designated on-site special management units or a separate facility. If a transfer to a separate mental health facility is necessary, such transfer will be carried out expeditiously.

Discussion

There are some inmates whose special mental conditions dictate close supervision. Such individuals are characterized (but not exclusively) as inmates whose mental problems result in their being a danger to themselves or others or who are unable to meet basic needs to care for themselves. The facility must provide an adequately staffed program to meet these needs.

Acutely psychotic inmates should be transferred to mental health institutions designed to care for such inmates. Procedures should be in place, and evidenced by practice, for such transfers to occur in keeping with the acuity of the inmate's condition. For example, inmates who are seriously decompensated and self-injurious should be transferred within a day.

41. Correctional facilities must ensure that security staff who are assigned to special management units are screened and trained to interact with mentally ill offenders.

Discussion

Ideally, all security staff in correctional settings are screened to ensure their psychological suitability and compatibility for working in such settings. However, this is especially true of security personnel assigned to special management units for acutely or chronically mentally ill and/or developmentally disabled offenders. The attitudes, behaviors, and interactions of correctional staff may intentionally or inadvertently exacerbate problems among inmates, resulting in possible danger on the unit.

Such screening processes might include psychological assessments provided by, or in consultation with, the facility's correctional psychology staff or coordinated through central headquarters in a multisite/multifacility organization.

The implementation and results of such screenings shall be held at the same level of confidence as any other psychological and personnel process and undertaken only by those psychology staff who are trained to use specific screening tools for this purpose. Such screening records should be stored and maintained separately from other facility or agency personnel records to avoid inadvertent access by those involved with other personnel matters. Access to these files should be controlled by the chief psychologist or designee.

42. Transfers that result in offenders being involuntarily placed in facilities that are specifically designated for the care and treatment of the severely mentally ill shall comply with due process procedures as specified in state/federal statutes.

Discussion

A recent Supreme Court decision indicated that before an individual can be involuntarily committed for treatment, there must be clear and convincing evidence that the person is mentally ill and dangerous. Furthermore, the Supreme Court decided that the possible substantial

adverse consequences of such a transfer require that the inmate's civil rights be protected through a "due process" protocol that meets jurisdictional and constitutional requirements (Cohen, 1998; *Vitek v. Jones*, 1980). Therefore, except for the constraints required due to the criminal status of the individual, inmates transferred for this reason should be accorded the same procedural rights as civilly committed persons within their jurisdiction.

This requirement is not obviated by the receiving institution being in the same jurisdiction or the special management unit being within the same correctional facility. In the absence of a governing statute, the civil commitment process should provide the guiding protocol.

This protocol includes written notice to the inmate, a hearing at which evidence is presented that supports a transfer, testimony of both supportive and defense witnesses, an independent decision maker from outside the facility, qualified and independent assistance for the inmate, and timely notice of these rights.

Documentation of this process is maintained and kept in the inmate's psychological services file.

43. There are written and implemented policies and procedures that require the responsible psychologist be consulted prior to taking the following actions with respect to emotionally disturbed inmates: housing assignment changes (including cell status), program assignment changes, disciplinary sanctions, and transfer in and out of the facility.

Discussion

The appropriate responsible mental health professional is the staff member who either has the inmate currently in treatment or who is most knowledgeable about the individual under consideration. Jail facilities with high turnover and much movement of inmates within the institution may find it necessary to prioritize certain prisoners with special mental health treatment needs or vulnerabilities.

Inmates being considered for voluntary or involuntary protection or disciplinary sanctions involving isolation (e.g., disciplinary or administrative segregation) will have access to psychological assessment procedures that take account of psychological information regarding

their mental status and effects of segregation, to be provided to the disciplinary committee during the due process hearing. There should be a disciplinary administrative policy that provides allowances for inmates who because of their mental illness are unable to conform their behaviors to the requirements of the facility. Continuity of psychological and psychiatric care should be maintained for inmates with mental health needs during their placement in segregation status, with accompanying documentation.

44. Inmates in segregation must be accorded crisis, psychological/psychiatric assessment, diagnosis, and treatment opportunities, irrespective of their segregation status.

Discussion

Because of the interaction of the stresses associated with incarceration and mental disorders, mentally ill inmates—especially those with serious mental disorders (e.g., schizophrenia, bipolar, depression with psychotic features, and post-traumatic stress disorder)—may find it difficult to conform their behaviors to the rules of a facility or institution. Consequently, rule violations may result in their frequent placement in disciplinary segregation status. The stresses associated with segregation/isolation status may result in further decompensation, resulting in a cycle of even longer segregation placements. It is essential that these inmates continue to be provided opportunities for daily contact with psychology, crisis worker, or psychiatric staff and to receive their medication. Adequate mental health care may prevent inmate injury to staff or self or suicide attempts or completions.

There should be an implemented policy and process for inmates who decompensate under these conditions to be transferred to a designated mental health facility for stabilization and treatment purposes.

45. Inmates who are mentally retarded or developmentally disabled are referred to appropriate specialized resources for care, training, and treatment according to a written plan approved by the chief psychologist (and in accordance with departmental administrative policy in multifacility organizations).

Discussion

Partially as a result of deinstitutionalization and changes in criminal legislation, many more developmentally disabled individuals than previously are being incarcerated. These individuals are often vulnerable to inmate abuse and lack of staff understanding, and/or they may find it difficult to navigate institutional and supervision rules. Consequently, they may be subject to repeated discipline and/or revocation. However, despite their disabilities, the Supreme Court (*Youngberg v. Romeo*, 1982; see Cohen, 1998) ruled that such individuals are entitled to training adequate to provide for their institutional safety while providing freedom from undue restraint. Whenever possible, such individuals should be referred for placement in settings appropriate to their level of mental and behavioral functioning.

The current definitions of mental retardation or developmental disability includes reference to *professionally measured* subaverage general intellectual functioning and deficits in adaptive behaviors such that the individual is unable to meet the standards of personal independence and social responsibility expected of individuals in his or her age and cultural group.

For those borderline individuals found to be legally competent but limited in their level of intellectual functioning, special programming care needs to be taken in making classification and training decisions. The results of consultation with appropriate community resources should be given serious consideration. Programs for these individuals ought to provide for their continued intellectual, social, and emotional growth and should encourage the development of skills, habits, and attitudes that are essential for living in the free society. Furthermore, when they are incarcerated in general correctional settings, allowances should be made for their deficits in intellectual and behavioral functioning when disciplinary processes are invoked by their behavior.

DISCHARGE AND TRANSITIONAL CARE

46. There is a written, implemented procedure that provides for the orderly discharge of inmate clients from psychological treatment. It includes (but is not limited to) the writing and filing of a treatment summary report within 30 days after treatment termination.

Discussion

The need for a termination summary arises to preclude interminable treatment (e.g., intermittent treatment that continues until the offender is released) and to make clear who is in a treatment relationship. What constitutes psychological services treatment needs to be clearly specified to avoid confusion with activities conducted by nonpsychology staff.

The termination report should be a logical extension of the individual's treatment plan and include a brief identification of the problem, the treatment methodology, the length and frequency of treatment, and the course and outcomes of treatment. The report should be filed in the offender's primary psychological services file, with copies distributed to appropriate facility or agency correctional staff as needed (e.g., social workers and parole agents).

47. There are written, implemented policies and procedures that require psychological services personnel to ensure that provisions are made for appropriate postrelease follow-up care in the community. Such policies will include a due process procedure for offenders whose treatment, including psychotropic medication, is a condition of their probation or parole.

Discussion

Mental health needs for offenders should result in a continuum of services and should not stop just because the offender is released from a facility. When inmates having a continuing need for psychological services are released to the community, the treating psychologist (or designee), in collaboration with the social worker, shall ensure that follow-up treatment services are arranged as part of the individual's release plan. Transitional mental health care should involve consultation with the supervising agent and other community agencies that are responsible for such care.

When it is determined that an inmate is sufficiently mentally ill that community supervision and/or follow-up should include involuntary treatment, detention, and/or civil commitment procedures to ensure the offender's and/or community safety, there will be a release process that interfaces with the state's statutory provisions for due process for

emergency detention, involuntary treatment, and assessment for civil commitment for mental health care and/or treatment.

QUALITY ASSESSMENT

48. There are written policies and procedures that require formal evaluations of the quantity, efficiency, compliance with professional/agency standards of psychological services, and the effectiveness of psychological treatment programs. Such evaluations shall be made at least annually. The results are submitted to the psychology staff, the chief psychologist in a multisite system or regional system, and to the administration in a single-site facility or correctional agency.

Discussion

Quality assessment and improvement procedures should be an integral part of any correctional psychology service delivery and treatment program. Such procedures can include a variety of data and approaches from agency supervisors through quality improvement committees that span multisite organizations.

A treatment program consists of an orderly sequence of psychological procedures/techniques designed to achieve a stated measurable goal agreed upon in advance by both client and therapist. Such programs, when initiated, need to be assessed in light of prior efforts to achieve the stated goals to determine whether the new program is an improvement over the previously employed approach.

IVD. CONSULTATION

49. A written policy exists and is implemented outlining the purposes and procedures for hiring contract, part-time, and consultant staff, which requires these individuals to participate in screening and documented orientation sessions conducted by the chief psychologist.

Discussion

The use of community resources should be viewed as an integral part of any correctional psychological service. It serves to enrich men-

tal health program offerings to the benefit of offender clients, professional staff, and the community.

When such utilization involves a bidding process with a provider contract going to the lowest bidder, there is a temptation to award a contract to save economic resources rather than efficiently use credentialed services and to simply presume the adequacy of those services. Such presumptions may result in inadequate facility, organization, or agency oversight of the contracted psychological services, often to the detriment of the offender client and the community.

We highly recommend that any consulting or service contract for psychological services should include, but not be limited to, the following: the frequency and length of a consultation period(s), the basis for and the amount of compensation, the specific services contracted, a termination clause that details that after appropriate notification the contract can be terminated by either party, and a renewal clause that states the conditions and requires a new contract every year.

Contract, part-time, and consultant agencies and/or staff should be screened prior to establishing their initial contract and held to the same ethical/practice standards and professional qualifications (including licensing and/or certification) for rendering independent psychological services as they would in their community.

To maintain communication and quality monitoring, it is strongly suggested that there be regular and continuing oversight contact, at least monthly, between these contract employees and the full-time staff member who is responsible for the contract.

50. The psychological services staff coordinates and consults on a regular basis with the facility's advisory committee (if any), administrative staff in multisite organizations and agencies, and other professional, administrative, and technical groups both within and outside the facility.

Discussion

The psychological services personnel should make themselves available as consultants to all levels and classification of staff at the correctional facility or agency. Such consultation may be of a formal, scheduled nature or conducted on an informal as-needed basis.

An advisory committee helps fulfill an important need to involve the best talent in the community to assist in resolving a variety of institutional problems. Its size and composition should reflect the character of the institution and include (but not be limited to) representation by mental health, medical, legal, and consumer advocates.

51. The psychological services staff coordinates and consults with other facility/agency staff regarding psychological services referrals and care of inmates.

Discussion

The intent of this standard is to help ensure optimal and appropriate use of psychological services resources. It is the responsibility of psychological services to collaborate with and support other facility staff in the development of appropriate mental health programs.

The correctional psychologist should not function in an institutional setting as if in private practice. Rather, what is being advocated is an outreach model—one in which the total correctional facility is seen as a "client." The psychologist needs to be visible, to be seen in areas throughout the facility and by staff at all levels, bringing psychological services to wherever the inmate clients are.

Examples of procedures that would fall under this guideline would include facilitating the identification and referral process for offenders in need of psychological and/or psychiatric services, developing checklists and/or guidelines for the suicidal and/or self-abusive offender, and providing information regarding commonly used psychotropic medications.

IVE. IN-SERVICE TRAINING

52. Written standard operating procedures are implemented that provide for and require psychological services staff to participate in training facility and community staff (e.g., probation and parole agents) with respect to the following: (a) types of potential psychological emergency situations, signs, and symptoms of various mental disturbances and (b) procedures for making referrals to psychological services and program areas (e.g., drug treatment and counseling).

Discussion

Because the number of staff psychologists always will be too small to meet offender demands for their services, the training of correctional institutional and community staff provides a useful enhancement of the psychologists' availability. Care must be exercised to include in-service programs, continuing staff psychologist supervision, and instruction in the recognition of signs that warrant referral to the professional psychologist.

Institutional and community agency personnel must be made aware of potential emergency situations and their specific responsibility for the early detection of mental disturbance.

Emergencies such as suicidal behavior (especially among alcoholics and drug abusers), acute psychosis, changes in reality contact and/or consciousness, disorientation, acute regression states, and self-abuse warrant additional staff training.

IVF. PSYCHOLOGY INTERNSHIPS

53. Correctional organizations, facilities, or agencies that sponsor or provide for psychology internships shall follow current jurisdictional and professional psychology internship program and supervisory guidelines.

Discussion

As the need for correctional psychologists increases, correctional facilities and organizations may offer psychology internships to psychology students from a diverse array of psychology and counseling college programs. Such internships may provide a resource for recruitment of psychology staff to work in correctional settings.

When psychology internships are offered, there should be a credentialed psychology director of the internship who is responsible for the recruitment, screening, and development of the internship program as well as for providing a liaison with the student's graduate school supervisor. In a multisite organization, each site at which a psychology intern is placed will have a credentialed psychologist supervisor (i.e., licensed or certified per jurisdictional standards) who will

oversee the intern's training at that site and report to the agency's or organization's internship program director. When there are multiple site placements during the course of an internship program, the supervisors will meet periodically during the year to assess the intern's program progress. At the termination of the year, a summary report should be provided as required by the intern's graduate school and be made available to the correctional facility's or organization's administration.

Internship programs, supervisory responsibility, practices, and quality of training will be in compliance with the same professional guidelines (e.g., APA) and current professional practice standards as apply to other psychology staff. Offenders receiving psychological services from interns should be informed of the intern's status and the supervisor's role. Such notification will be documented on the appropriate Informed Consent and Limits of Confidentiality forms. Interns should not be used as a substitute for psychology staff, nor should they be requested to provide psychological services to offenders for which they are not adequately prepared or competently supervised.

IVG. VOLUNTEERS

54. Psychological services personnel use volunteers in a variety of programs under the supervision of the chief psychologist. The implemented written policies and procedures include a system for selection and training and specifying term of service, level of supervision, definition of tasks, responsibilities, and level of authority. Documentation is required that will indicate that the volunteer has participated in an appropriate orientation session conducted by the chief psychologist.

Discussion

Volunteers can be an important personnel resource for the provision of human and mental health services. As demands for these services increase, volunteers can be trained to become an increasingly important part in providing psychological services in prisons and jails.

For example, volunteers might assist jailers on a "suicide watch," assist inmates with family and community problems, and help conduct and oversee leisure activities.

To make the experience for volunteers productive and satisfying for everyone involved—inmates, staff, administration, and the public—procedures and goals must be clearly stated and structures well defined. Consequently, volunteers should be screened by psychological services staff, given any needed security and policy/procedures orientation and training, and assigned to a specific staff member for supervision and direction of the volunteer's activities. This supervisor will be responsible for the volunteer's behaviors and activities.

IVH. OTHER PROGRAMS

55. The psychological services staff participate in the preparation and implementation of facility-wide planning—for example, the institution's master plan, facility design, disaster plan, staffing, and staff screening.

Discussion

It is important that psychological services view itself and be seen by other facility and organizational personnel as part of the total operation. This enhances the possible impact that psychological services can have on the correctional environment and milieu and improves the environment for the incarcerated offender.

Psychological services staff should strive to become involved in the challenges of making the total facility/agency function more effectively in keeping with the facility's, agency's, or organization's mission and goals. Thus, not only should psychological services staff members be involved in direct offender care, but they also should be involved in processes that affect external environmental change to help bring to bear a positive habilitative influence on individual offenders.

V. RECORDS

PSYCHOLOGICAL SERVICES RECORDS: ACCESS, DISSEMINATION, SECURITY, STORAGE, AND DESTRUCTION

56. There are written and implemented policies and procedures approved by the chief psychologist (in a multisite or agency organization) or on-site psychology supervisor and coordinated by the chief psychologist, site supervisor, or designee that specify the process of access, dissemination, security, storage, and destruction of psychological material and mental health records. This process will be in compliance with current professional and legal standards.

Discussion

All staff and offenders should be advised that an offender's mental health record is ethically and legally confidential to the offender and/or to the offender's guardian or custodian and that just as with other health records, this confidentiality is protected by federal, state, and possibly county laws with potential civil and criminal penalties for violations. Staff, offenders (both adult and juvenile), and their guardians/custodians should be informed about, or have available in writing, the policies and procedures regarding access, review, copying, distribution to third parties with and without their written consent, and correction and destruction of psychological and other mental health information.

Psychology and nonpsychology staff who are responsible for maintaining and releasing psychological or other mental health information are ethically and legally responsible for being aware of and following policies and procedures. In each facility or agency, there will be a designated records custodian who ensures compliance with professional and legal standards regarding psychological and mental health records. Ordinarily, it would be the on-site supervising psychologist (or designee in his or her absence). In a multisite system, this process would be coordinated by the chief psychologist, who ensures that the appropriate standard is followed in each facility or unit agency. In either case, except where the facility is exempt by administrative code or statute, the highest possible level of confidentiality will

be maintained, and the need to know will be determined by the chief psychologist, on-site psychology supervisor, or designee.

As in any agency or system, employees with different levels of psychological sophistication may be permitted access to an offender's mental health/psychological records on a need-to-know basis. These staff members should be aware of the location of this information, the process for accessing this information, their mandate to maintain the limits of their confidentiality, and the restrictions on their use of the information.

In cases where there may be some dispute, consultation with legal and psychology licensing authorities should be sought and their recommendations implemented whenever feasible.

DOCUMENTATION

57. There is a written and implemented policy, approved by the chief psychologist in a multifacility organization or on-site psychology supervisor, regarding standardized documentation and organization of psychological/mental health information in the offender's psychological services file including format, content, and time frames for entry. This policy will conform to current professional, administrative, legal, and forensic guidelines.

Discussion

This guideline may seem almost to "go without saying" in our document-oriented profession. Documentation is the lifeblood of communication among mental health staff, provides both a means of accountability and protection against litigation, and is therefore often subject to important ethical, legal, and forensic guidelines.

In an age of increased forensic interest, psychological services providers should anticipate that their documentation may be used in court and forensic proceedings and that it should meet current forensic standards. Therefore, it is essential that psychological services' communications to offenders be legible, dated, and signed; written documentation be legible; and all documentation indicate what service was provided when, to or about whom, who provided it, and the provider's degree and place of employment.

File and treatment plan documentation should be formatted and organized in a standardized way such that changes in mental status, diagnosis, treatment, programming, chronological progress, termination, referrals, consultations, and other contacts with psychology staff are easy to follow and assimilate by both the offender and by another psychologist who is unfamiliar with the offender but may need to provide an interim service. This may be especially important in the event of a crisis.

All documentation should be made in a timely manner, but generally not to exceed 10 working days following the service or contact. In instances of crisis, documentation should be as soon as is practical, preferably within the same day if it is anticipated that other psychological staff will need to follow up within the next working day.

PSYCHOLOGICAL SERVICES FILE: CONTENTS AND STORAGE

58. The offender's psychological/mental health record is maintained in a psychological services file. This file contains, but is not limited to, historical mental health information, the completed admissions psychological screening form, test results (excluding raw data and/or protocols), findings, diagnoses, referral and consultation information, treatment plans and dictations (both psychological and psychiatric), dispositions, confidentiality, consent and release of information forms, terminations from treatment, and plans for community follow-up.

    This psychological file is stored separately from the offender's primary incarceration/correctional record and is located at the facility in which the offender is incarcerated.

    Files containing raw data will be stored separately but in a manner that facilitates both confidentiality and easy access by trained psychology staff.

    If the offender has been released to community supervision, the psychological services file will be kept at a central location that facilitates access by correctional agency psychology staff.

Discussion

The importance of accurate and complete psychological documentation cannot be overemphasized. Not only do such records provide a sound basis for assessment, interventions, and postrelease continuity

of treatment, but they also facilitate protection for psychological, institutional, and organizational staff from litigious offenders.

Following the initiation of a psychological services file, a problem-oriented record structure is highly recommended. Although a psychological services file may not be established for each offender, the completion of a psychology screening process should initiate the creation of a psychological services file. This file should be at the same facility as the offender and should be accessible to psychologists and other postrelease correctional agency staff (e.g., probation and parole agents) as allowed by administrative codes, statutes, and organizational policies in keeping with established ethical practice.

CONFIDENTIALITY

59. Prior to an offender receiving any significant psychological service or entering into a screening, assessment, or therapeutic or treatment relationship or program, the offender is informed, verbally and in writing, of the limits of confidentiality. This shall be documented on a form designed for that purpose, signed by the offender and the psychologist, and placed in the offender's psychological services file. Ideally, this should be done during initial mental health screening upon reception into a facility or agency and periodically thereafter as circumstances dictate (e.g., entering into a specialized program such as sex offender treatment where self-disclosure is a high priority). If the offender's mental status precludes this process, it shall be done at the earliest possible time following stabilization.

    Should the need arise, the offender will be provided the opportunity to document any refutation or correction of information obtained from these contacts, relationships, or programs.

Discussion

The offender client has an important stake in what is stated in any psychology report. Psychological services personnel, like any other professionals, are capable of errors, and client reviews may correct mistakes. These procedures also may serve as assurance that initial agreements regarding confidentiality are being followed.

Offender clients left to imagine what a therapist's report contains may conjure up the worst, destroying an ongoing (or future) therapeutic relationship. Keeping clients knowledgeable can enhance the qual-

ity of the therapy interaction by making it more honest. Having been dealt with fairly, offender clients may more readily respond to psychological services.

INMATE PSYCHOLOGICAL SERVICES FILE REVIEW/COPIES

60. There are written, implemented policies and processes that provide for an offender to review and/or receive copies of his or her psychological services file records in a timely manner. This should not exceed 10 days and should be expedited when requests involve a legal matter. When such a request involves reviewing test or assessment results, a qualified psychology staff person should be present for consultation.

    Policies and procedures exist to provide for correction or refutation of psychological information in the offender's psychological services file.

Discussion

It is legally mandated that offenders have access to their psychological services file through a timely and convenient process and have access to a qualified mental health professional during this review if it involves assessment or test interpretation.

Offenders should be advised how to access their psychological services records and make copies of any records that are ethically/professionally approved (e.g., excludes copies of test protocols).

A 10-working-day response time following such a request is the minimal standard for file reviews unless unusual circumstances necessitate expediting or delaying such a response. If a delay is unavoidable, the offender will be notified and a time arranged as soon as practical.

TRANSFER OF RECORDS

61. There are written policies and procedures providing for the transfer of the offender's psychological services file that are implemented when the offender is transferred from one facility to another, from a facility to the community, and from the community to a facility.

    When an individual is to be transported to another facility, the offender's psychological services file arrives at the receiving institution either before or with the offender.

Discussion

When an inmate, especially a disturbed individual, is transferred, every effort shall be expended to ensure the implementation or continuity of treatment while avoiding unnecessary duplication of tests and evaluations. Therefore, it is important that the transfer of psychological information occurs smoothly and rapidly and that all involved staff members know the procedures.

In cases of a nonroutine transfer (e.g., acutely disturbed, suicidal, or decompensated offender) to a specialized treatment or special unit facility, the supervising psychologist (or designee) at the sending facility should (a) contact the receiving institution and give advanced notice of the impending transfer, by e-mail, fax, or telephone in an emergency, to be followed by written documentation; (b) ensure that the inmate's psychological records are forwarded in order to reach the receiving institution before or at the same time as the offender; and (c) provide for receiving staff to acknowledge receipt of the information and records if they have not had personal contact with staff at the receiving institution.

RELEASE OF PSYCHOLOGICAL INFORMATION

62. There is an implemented policy and process that both informs offenders regarding the limits of their control over the release of psychological information from their file to a third party with and without their consent and provides for their (or their custodian/legal guardian) documented authorized release of the information. A release of information form will be designated that meets the following minimal standards: (a) to whom and by whom the information is to be sent, (b) specific purpose, (c) the date the release is effective or withdrawn, (d) signature of offender (or custodian/guardian), and (e) date approved. The original will be placed in the offender's psychological services file and a copy provided to the offender.

Discussion

The release of psychological information, both with and without authorized and written consent, is ethically and legally protected through codes of professional conduct, mental health statute, and licensing law. As part of their being informed regarding the limits of

confidentiality of their mental health record, offenders will be advised of the process and limits for releasing information to a third party and have the proper forms provided to them for releasing their psychological information to a third party.

DESTRUCTION OF RECORDS

63. There will be a written policy in keeping with federal/state law regarding length of storage and the destruction of the offender's psychological/mental health file, which will be implemented following his or her release from correctional or department of justice jurisdiction (e.g., when the client has been found "not guilty" or the offender has completed his or her sentence).

Discussion

Staff and offenders will be aware of the ethical/legal guidelines, time frames, and documentation process for destroying psychological records. These vary from state to state and should be incorporated into the general records policy.

VI. RESEARCH

64. Psychological services personnel are encouraged to conduct applied and/or basic research that will improve the delivery of psychological services and contribute to the development of theory and practice as related to correctional psychology.

Discussion

Due to the increasing demand for psychological services, it is becoming more difficult to set aside time to conduct research projects. Nevertheless, within reasonable time boundaries, all full-time psychologists should be afforded the opportunity for and be engaged in at least one evaluation project having practical relevance for correctional psychology.

It is important to increase the body of knowledge related to the practical application of psychological theory to the corrections area.

The information developed should be disseminated in a professional manner consistent with the best interests of the offender, the science and profession of psychology, and the general public.

65. All psychological research in correctional facilities or agencies will be in compliance with the ethical standards proposed by the National Commission for the Protection of Human Subjects and the current standards of the American Psychological Association.

Discussion

The National Commission has identified three broad categories of research that are conducted in correctional facilities: (a) studies that hope to improve institutional or program effectiveness, (b) studies relating to confined persons in the broad context of gaining a better understanding of the effects of such confinement, and (c) research that uses prisoners because they are available individuals. These are listed in decreasing order of desirability and reflect the need for an increasing level of justification before receiving prior approval of a research advisory committee (see Section VI, Standard 66).

There is considerable reason to believe that category (c) research should never be conducted with incarcerated offenders. The need is to balance protection of human beings with the pursuit of scientific knowledge. The foreseeable consequences of a prisoner's participation should not involve undue physical or emotional stress; rather, research should respect the rights, health, and human dignity of the individuals involved. Furthermore, incarcerated offenders should be free to refuse to participate in such research without any negative consequence.

66. There are written and implemented policies and procedures for reviewing and processing research proposals that comply with the current professional and legal standards of the *Ethical Principles of Psychologists and Code of Conduct* of the American Psychological Association (1992) and are in accordance with department and institutional policies.

    Research must require prior approval by a designated research advisory committee and institution/agency review board prior to commencing. Such a review board shall be composed of professionals

with appropriate educational credentials to determine ethical/legal compliance and importance of the research. Potential researchers will be advised of the research policies and procedures prior to commencing their research.

Offender participants in research will be appropriately advised regarding their freedom to decline to participate in research without disciplinary or other negative consequences. The limits of confidentiality need to be fully disclosed, documented, and placed in their psychological services file. Offenders and third parties will be informed, in advance, that they will not receive any compensation for their participation in department- or correctional-agency-approved psychological research.

Discussion

The existence of formal procedures to obtain prior approval of all research studies is essential to protect inmates from being exposed to inadvisable, poorly controlled, and/or inhumane research conditions. These procedures shall be documented and available for review prior to the implementation of any research.

These procedures should include (a) the availability of a research advisory committee at the facility that includes administrative and psychology personnel competent to evaluate the proposed research based upon their own training, experience, and academic credentials; (b) the review of any proposed research by this committee; and (c) an administrative and legal review (when research standards suggest a legal review) by the administration in a multisite organization including the chief psychologist.

Information submitted for a review of proposed research should include (but not be limited to) the following:

A. The title of the project;
B. The name, address, and vita (including relevant research experience, capabilities, and publication list) of the researcher or researchers;
C. A summary that briefly describes what will be done, how it will be done, intended purposes, anticipated results, and benefits to psychological and correctional knowledge;
D. The anticipated duration of the project, with beginning and ending dates;
E. The project's methodology;

F. The project's resource needs (including personnel, supplies, and materials), equipment, and any other resources that will be supplied by either the researcher or facility; and
G. A description of offender involvement by number, type, time, incentives being offered, risks involved, process of obtaining informed consent, limits of confidentiality, assumed liability, management of research and postresearch risks, and proposed presentations and/or publications.

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