

# Criminal Justice and Behavior

<http://cjb.sagepub.com/>

---

## Standards for Psychology Services in Jails, Prisons, Correctional Facilities, and Agencies : International Association for Correctional and Forensic Psychology (Formerly American Association for Correctional Psychology)

IACFP Practice Standards Committee  
*Criminal Justice and Behavior* 2010 37: 749  
DOI: 10.1177/0093854810368253

The online version of this article can be found at:  
<http://cjb.sagepub.com/content/37/7/749>

---

Published by:



<http://www.sagepublications.com>

On behalf of:



[International Association for Correctional and Forensic Psychology](http://www.iacfp.org)

**Additional services and information for *Criminal Justice and Behavior* can be found at:**

**Email Alerts:** <http://cjb.sagepub.com/cgi/alerts>

**Subscriptions:** <http://cjb.sagepub.com/subscriptions>

**Reprints:** <http://www.sagepub.com/journalsReprints.nav>

**Permissions:** <http://www.sagepub.com/journalsPermissions.nav>

**Citations:** <http://cjb.sagepub.com/content/37/7/749.refs.html>

**STANDARDS FOR PSYCHOLOGY SERVICES  
IN JAILS, PRISONS, CORRECTIONAL  
FACILITIES, AND AGENCIES**

**INTERNATIONAL ASSOCIATION FOR  
CORRECTIONAL  
AND FORENSIC PSYCHOLOGY  
(FORMERLY AMERICAN ASSOCIATION FOR  
CORRECTIONAL PSYCHOLOGY)**

**THIRD EDITION  
2010**

**Criminal Justice and Behavior** seeks contributions examining psychological and forensic aspects of the juvenile and criminal justice systems. The concepts “juvenile” and “criminal behavior” should be interpreted broadly to include analyses of the etiology of delinquent or criminal behavior, the process of law violation, the processing of criminal defendants, victimology, crime prevention, intervention, and treatment. The journal emphasizes reports of original empirical research, theoretical contributions, developing and testing of innovative programs and classification systems, and critical literature reviews of the relevant research and theoretical development.

**Manuscripts:** Electronic submissions are strongly encouraged and should be sent to [CJBehavior@aol.com](mailto:CJBehavior@aol.com). Manuscripts should be typed and double spaced, with tables, charts, and references on separate pages. The ideal length for manuscripts submitted to CJB is 25 to 35 pages. The format described in the *Publication Manual of the American Psychological Association* (5th or 6th edition) must be followed. If submitting hard copy manuscripts, please submit in triplicate to Curt R. Bartol, PhD, Editor, *Criminal Justice and Behavior*, 216 Rector Road, Glenville, NY 12302-6700. Questions concerning manuscript submission can be directed to [CJBehavior@aol.com](mailto:CJBehavior@aol.com). Book reviews and inquiries should be sent to Brent Snook, PhD, Memorial University of Newfoundland, email: [bsnook@play.psych.mun.ca](mailto:bsnook@play.psych.mun.ca) or fax 1-709-737-3101.

**Criminal Justice and Behavior** (ISSN 0093-8548) (J233) is published monthly by SAGE Publications, 2455 Teller Rd, Thousand Oaks, CA 91320. Copyright © 2010 by the International Association for Correctional and Forensic Psychology; <http://www.ia4cfp.org>. All rights reserved. No portion of the contents may be reproduced in any form without written permission from the publisher. Periodicals postage paid at Thousand Oaks, California, and at additional mailing offices. POSTMASTER: Send address changes to Criminal Justice and Behavior, c/o SAGE Publications, 2455 Teller Road, Thousand Oaks, CA 91320.

**Subscription Information:** All subscription inquiries, orders, back issues, claims, and renewals should be addressed to SAGE Publications, 2455 Teller Road, Thousand Oaks, CA 91320; telephone: (800) 818-SAGE (7243) and (805) 499-0721; fax: (805) 375-1700; e-mail: [journals@sagepub.com](mailto:journals@sagepub.com); <http://www.sagepublications.com>. **Subscription Price:** Institutions: \$889. For all customers outside the Americas, please visit <http://www.sagepub.co.uk/customerCare.nav> for information. **Claims:** Claims for undelivered copies must be made no later than six months following month of publication. The publisher will supply missing copies when losses have been sustained in transit and when the reserve stock will permit.

**Abstracting and Indexing:** Please visit <http://cjb.sagepub.com> and click on the Abstracting/Indexing link on the left-hand side to view a full list of databases in which this journal is indexed.

**Copyright Permission:** Permission requests to photocopy or otherwise reproduce copyrighted material owned by the American Association for Correctional and Forensic Psychology should be submitted by accessing the Copyright Clearance Center’s Rightslink® service through the journal’s Web site at <http://cjb.sagepub.com>. Permission may also be requested by contacting the Copyright Clearance Center via their Web site at <http://www.copyright.com>, or via e-mail at [info@copyright.com](mailto:info@copyright.com).

**Advertising and Reprints:** Current advertising rates and specifications may be obtained by contacting the advertising coordinator in the Thousand Oaks office at (805) 410-7772 or by sending an e-mail to [advertising@sagepub.com](mailto:advertising@sagepub.com). Acceptance of advertising in this journal in no way implies endorsement of the advertised product or service by SAGE, the journal’s affiliated society(ies), or the journal editor(s). No endorsement is intended or implied. SAGE reserves the right to reject any advertising it deems as inappropriate for this journal. To order reprints, please call (805) 410-7763 or e-mail [reprint@sagepub.com](mailto:reprint@sagepub.com).

**Change of Address:** Six weeks’ advance notice must be given when notifying of change of address. Please send old address label along with the new address to ensure proper identification. Please specify name of journal.

---

*Printed on acid-free paper*

**INTERNATIONAL ASSOCIATION FOR FORENSIC  
AND CORRECTIONAL PSYCHOLOGY  
STANDARDS FOR PSYCHOLOGY SERVICES  
IN JAILS, PRISONS, CORRECTIONAL  
FACILITIES, AND AGENCIES**

**Contents**

|  |     |
|--|-----|
| Introduction   | 752 |
| Preamble   | 754 |
| Definitions  | 756 |
| General Ethical Principles                                 | 757 |
| A. Administration and Operations                           | 760 |
| B. Roles, Services, Staffing, and Professional Development | 765 |
| C. Ethical Practice Guidelines                             | 769 |
| D. Mental Health Services and Programs                     | 776 |
| E. Mental Health Records                                   | 799 |
| F. Research  | 803 |
| References   | 806 |
| Index  | 808 |

## INTRODUCTION TO THE THIRD EDITION

Since the American Association for Correctional Psychology's standards for correctional mental health care were published in 1980, there have been significant changes in America's criminal justice and correctional mental health care systems. These changes contributed to a steady increase in incarceration rates, prison growth, incarceration of mentally ill offenders, and a decrease of mental health resources for inmates and offenders. Those changes led to an increase in civil rights litigation against departments of corrections for inadequate provision of mental health services. Some of those changes led to the first revision of these standards, published in 2000.

Since 2000, the American Association for Correctional Psychology became the American Association for Correctional and *Forensic* Psychology (AACFP), and in 2008 became the *International* Association of Correctional and Forensic Psychology (IACFP). This evolution reflected both the changing landscape of correctional mental health care here and abroad as well as the increasing scope of interests, activities, and contributions of our membership. It also reflected the association's growing concerns about the need for more collaborative international reviews, comprehensive standards for correctional mental health care, and international attention focused on improving the provision of mental health care services to seriously mentally ill offenders and inmates in other countries.

We should all understand that offenders, mentally ill or not, entrusted to the custody of correctional facilities and agencies, benefit in a number of ways from the highest quality of rehabilitative and mental health services that we can ethically and practically offer. First, quality mental health services contribute to maintaining institution security by reducing inmate and staff stress levels and helping to facilitate offender participation in rehabilitative programming. Second, they increase the likelihood of successful reintegration of mentally ill offenders into the community by promoting adequate community-based mental health care follow-up, thereby contributing to reduced recidivism. Third, by adhering to the guidelines of these standards, correctional organizations, agencies, and staff can reduce the likelihood of expensive civil litigation or other legal actions that can result from inadequate correctional mental health services. Therefore, correctional mental health services that ethically abide by professional standards of practice remain one of the foremost means of reducing the likelihood of civil and/or criminal challenges.

Generally, the revision committee's ultimate goal in this revision was no different than that of the original task force and the first revision committee: to continue raising correctional mental health services to a level that guides correctional administrators and mental health providers to the provision of high-quality correctional mental health care.

As with our first and second editions, this third edition is presented as a guide and reference to professionally accepted and recognized correctional mental health services practices in jails, prisons, correctional agencies, and facilities, regardless of whether or not such services are constitutionally or legally mandated or in which country they are provided.

These standards/guidelines are intended to augment, not supplant, those of national, state, or other professional psychological associations or related mental health and social work professions. Furthermore, they are intended to support standards for correctional mental health care published by the American Correctional Association (ACA, 1990), and the

National Commission on Correctional Health Care (NCCHC, 1999, 2008), with whom we share the same strong commitment to the provision of optimal correctional mental health care.

This edition contains some substantive additions to the previous set of standards. Among them is the inclusion of other correctional mental health care providers in other psychology-based professions and credential levels, including clinical social workers, certified professional counselors, and crisis intervention workers. There is an expanded section on ethics, a section on screening institution and agency staff who have direct contact with mentally ill offenders or inmates, updated standards of screening for and monitoring of mentally ill and potentially suicidal inmates, and a standard for continuing community care of mentally ill offenders.

These standards begin with general ethical principles that parallel those of the American Psychological Association (1987) as well as those of other service organizations (e.g., American Psychiatric Association, 1989, 2000; Canadian Psychological Association, 2000; National Association of Social Workers, 1999). These general principles are intended to provide the ethical structure within which all correctional mental health psychological services are provided, emphasizing client autonomy, avoiding or minimizing harm, advocating for competent mental health services and social responsibility. This opening section is followed by the specific sections on the administration, roles and services, ethical practice guidelines, standards for the various components of mental health services, mental health records, and finally correctional mental health research. In their aggregate, these standards address the legally and constitutionally acceptable components of mental health care of inmates (e.g., screening and evaluating inmates, treatment of both seriously mentally ill and suicidal inmates with sufficient numbers of qualified mental health providers, and confidential records) as well as desirable components such as access to mental health care, staff screening and training, and quality assurance (e.g., Cohen, 2009).

In closing, as chair of the revisions committee, my deepest gratitude is extended to those individuals who volunteered their time and effort to this project. First, to committee members Leonard Morgenbesser (Empire State College/SUNY and Department of Correctional Services), Patricia Orud (certified correctional health care provider, St. Paul, Minnesota), and especially to Kelly Paulk Ray (medical psychologist, Baton Rouge, Louisiana) for her reliable and ongoing editorial assistance, insightful comments, and substantive suggestions.

After the committee's preliminary work was finished, additional input and editorial guidance were provided by two noncommittee individuals, Lorraine Reitzel (University of Texas; M.D. Anderson Treatment Center) and Janet Walsh (psychology supervisor, Wisconsin Department of Corrections), both of whom provided additional thoughtful and insightful suggestions. Those who find this revision informing, authoritative, and persuasive owe their appreciation to these dedicated professionals.

We understand that these standards are aspirational and, although frequently grounded in case law and overlapping with other professional standards for correctional mental health services, carry no specific legal authority. We also understand there are different administrative and operational means by which a department, agency, or facility can successfully meet these guidelines. However, consistent with the goals of the original and previously revised AACFP standards, this revision should provide correctional administrators and correctional mental health services providers, both here and abroad, with persuasive guidance for such pursuits while upholding the highest ethical and practice standards of their professions. It is in that hopeful and collegial spirit that the International Association for Correctional

and Forensic Psychology revisions committee presents this third edition of standards for psychology services in jails, prisons, correctional facilities, and agencies.

*Richard Althouse, PhD*  
Chair, IACFP Standards Revision Committee

### PREAMBLE TO THE THIRD EDITION

When the second revision of the American Association for Correctional Psychology standards for psychology services was published in 2000, there were almost 6 million individuals under correctional supervision (Proband, 1998). Of these, about 1.5 million were housed in America's jails and prisons. Over a quarter of a million (about 16%) of these offenders were reportedly mentally ill (Ditton, 1999), over 100,000 receiving psychotropic drugs (Beck & Maruschak, 2000). Since then, five well-documented trends characterized the three previous decades of incarceration in the United States: deinstitutionalization and eventual criminalization of the mentally ill, higher incarceration rates (particularly related to the war on drugs), longer prison sentences contributing to the evolution of the "prison industrial" complex associated with increased prison-building (e.g., Dyer, 2000; Welch, 1999), the privatization of prison care, and more punitive prison philosophy and conditions (e.g., evolution of the supermax prison).

By 2004, over 2 million individuals were housed in America's jails and prisons, with up to 50% reported to have mental health problems, including mania, major depression, and psychotic disorders (James & Glaze, 2006). By mid-2007, the number of incarcerated had grown to over 2.3 million, and between 2000 and 2006 the number of mentally ill inmates in America's jails and prisons quadrupled (Human Rights Watch, 2006).

Today, America's jails and prisons now house many more seriously ill persons than our psychiatric hospitals (Cohen, 2008, pp. 1-10). The Los Angeles and Cook County jails have been referenced as America's leading institutions for housing mentally ill individuals for a number of years, and Rikers Island has recently been cited as America's leading psychiatric facility (Cohen, 2007). The increasing numbers of incarcerated mentally ill individuals have posed significant resource challenges for correctional departments and agencies as well as the mental health service providers they employ, challenges they have generally been unable to meet.

Adding to these challenges are the number of mentally ill offenders among the 5 million individuals on probation or parole (Glaze & Bonczar, 2008). Although the exact percentage of mentally ill probationers and parolees is unknown, extrapolations from available data suggest it is significant (Lurigio, Rollins, & Fallon, 2004). Moreover, emerging research suggests that recently released prisoners are at higher risk for suicide than individuals in the general population (Knoll, 2007). Often, these individuals have limited access to either community or corrections-based mental health services and little to no access to health insurance to pay for such services. Many of these individuals are likely to return to prison, sometimes intentionally, to access mental health care.

Historically, correctional mental health practitioners have faced challenges beyond the increasing numbers of mentally ill offenders and inmates. The first was a social one. Prior to the deinstitutionalization of the mentally ill in the 1950s and 1960s, crimes committed



by a mentally ill individual were often considered symptomatic of their mental illness. Consequently, these individuals were first seen as mentally ill, and secondarily as criminals. They were often diverted from the criminal justice process, with their care and treatment shifted to state or community mental health care systems. At that time, advocating for adequate mental health care for mentally ill “criminals” was socially and politically acceptable. However, as a by-product of the deinstitutionalization era, state and community mental health resources were more limited, and mentally ill individuals who committed crimes were by necessity diverted to the criminal justice system. Caught up in the evolving socio-political contexts of “tough on crime,” and the “war on drugs,” these individuals were now first considered criminals, and secondarily (if at all) as mentally ill, a reversal of the pre-deinstitutionalization era philosophy.

Advocating for adequate treatment for these “criminals” (later recognized as antisocial personality disorders and sociopaths) was now akin to being “soft on crime,” and not politically or socially sanctioned. The end result of this attitudinal shift was a socially and politically acceptable, if not desirable, negligence of the treatment needs of the seriously mentally ill offender and inmate.

The second challenge was economic. Correctional care for the growing number of incarcerated individuals over the past four decades became increasingly costly, and by 2006, America’s correctional agencies were spending well over \$60 billion a year to meet their expenditure needs (Bureau of Justice Statistics, 2007). Many state budgets were stressed by the increasing costs of meeting just the basic security and housing needs of their expanding departments of corrections. Consequently, many jails and prisons remained financially unable to meet their basic housing costs and provide adequate mental health resources and other rehabilitative programming for their inmates. Correctional agencies and their mental health care providers—particularly correctional psychologists—became increasingly ill equipped to meet the mental health care needs of the growing numbers of mentally ill offenders and inmates (e.g., Human Rights Watch, 2003).

In the United States, these trends contributed to a third resource challenge: an increased frequency of costly civil rights litigation against corrections departments, agencies, facility administrators, and mental health staff for their failure to provide adequate mental health care to the mentally ill or suicidal inmate. Because the United States’s Prison Litigation Reform Act of 1995 significantly reduced the number of frivolous inmate lawsuits, class action civil rights lawsuits alleging deliberate indifference to seriously mentally ill inmates’ mental health needs have been more likely to receive court attention.

The major thrust of these court decisions was that inmates with serious mental illness or who posed a suicide risk had a *constitutional* right to adequate mental health care by qualified mental health professionals that was consistent with professional and community standards of care (see Cohen, 1998, 2007). Adequate care components included screening, adequate staff, facility resources, records, psychotropic medication, suicide prevention and intervention programs, training, humane treatment, and quality assurance programs, among others. But adequate care was the primary concept in many of these cases, and it became clear that failure to provide adequate care for the seriously mentally ill inmate would more likely place state and corrections administrators at risk for allegations of deliberate indifference, followed by costly civil litigation and judicial oversight.

These court decisions provided some motivation for jail and prison administrators to improve their mental health services to mentally ill inmates, and they turned to professional



standards for providing correctional mental health care for procedural guidance (e.g., American Association for Correctional Psychology, 2000; American Correctional Association, 1990; National Commission on Correctional Health Care, 1999). These standards had evolved as a guide to what constitutes high-quality standards of correctional mental health care and provided a ready tool for assisting corrections administrators defend against civil rights litigation.

Unfortunately, many state and corrections administrators continue to be faced with the increasing costs of basic correctional care, the increasing costs of treating mentally ill inmates in keeping with court-mandated standards of care, and the potential costs of civil litigation for not meeting these standards. These are admittedly difficult choices.

This unfortunate state of affairs is not unique to the United States. These same difficult choices face other Western industrialized countries—Canada, the United Kingdom, Ireland, France, Germany, and Australia, among others—that have experienced parallel increases of mentally ill inmates in their correctional facilities. The results of one research study suggested that other Western countries have psychotic illnesses or major depression among 14% to 15% of their prisoners (Cohen, 2008, pp. 1-10), but remain without sufficient resources to meet their inmates' legally recognized mental health needs. Although many of their professional and legal organizations are aware of this, effective solutions remain elusive.

In summary, there are a significant number of mentally ill individuals incarcerated in jails, prisons, and communities, both in America and other countries, and the numbers grow each year. Despite civil court mandates for adequate mental health services, meeting the treatment needs of seriously mentally ill offenders and inmates remains a persistent challenge both in the United States and abroad.

While economic solutions are difficult, clear ethical and treatment standards of adequate mental health care of the seriously mentally ill offender and inmate are still the best principled mechanisms for guiding such care. The advantages are clear. Not only does adequate mental health care facilitate more effective correctional rehabilitation efforts, successful community reintegration, and reduced recidivism, providing adequate mental health care is the best defense against civil or human rights litigation. More fundamentally, however, how a society treats offenders and inmates reflects that society's moral priorities, and there is no higher priority than protecting our human rights. Deliberate indifference to offenders and inmates mental health needs should not be an acceptable moral practice. Therefore, with these concepts in mind, the IACFP standards revision committee presents this edition of the International Association for Correctional and Forensic Psychology's standards for psychology services in jails, prisons, and correctional agencies.

## DEFINITIONS

The following terms and definitions are used throughout these standards:

*Community standards:* Mental health services that meet standards comparable to state or federally certified mental health clinics.

*Deliberate indifference:* The intentional or willful disregard of the known mental health needs of a seriously mentally ill or suicidal inmate.

*Detainee:* An individual judicially detained for investigative purposes.

- Inmate*: An individual housed in a detention center, jail, prison (including military prisons or detention facilities), or other correctional facility under the jurisdiction of a correctional authority.
- Licensed clinical social worker (LCSW)*: A social worker who is licensed to independently provide mental health care services.
- Licensed psychologist*: A psychologist who is licensed for the independent practice of psychology.
- Medical psychologist (also known as prescribing psychologist)*: A licensed psychologist who by virtue of advanced training is certified to write prescriptions for psychotropic medications.
- Mental health care provider (MHP)*: A mental health care professional whose education and training permits the provision of mental health care services, but only under the supervision of a qualified mental health care professional.
- Mental health services*: For the purposes of these standards, “mental health services” refer only to psychological-based services, or services provided by a medical psychologist.
- Offender*: A person, not incarcerated, but who is under the jurisdictional supervision of a correctional authority.
- Psychologist*: An individual who has completed the education and training necessary to be recognized by the American Psychological Association as a psychologist, but is not yet licensed.
- Psychologist administrator*: A psychologist who holds the highest level of responsibility for the administration of mental health services in a department, bureau, or agency. This person must be a licensed psychologist.
- Psychology supervisor*: A psychologist who has supervisory responsibility for mental health care providers in a correctional setting.
- Qualified mental health care professional (QMHP)*: A professional who is licensed or certified at the highest level of their discipline to independently provide psychological mental health care services. Examples include a licensed psychologist, medical psychologist, or licensed clinical social worker.
- Resident*: A juvenile held in a juvenile correctional facility.
- Serious mental illness*: Psychosis, bipolar disorders, and severe depression.

## GENERAL ETHICAL PRINCIPLES

While ethics, the philosophy of morality and right and wrong conduct, informs conceptual foundations of the practice standards of many professions, there are few arenas in which the ethics of cultural morality, criminal justice, and psychology practice standards continue to clash more starkly than the arena of corrections. Correctional psychologists and other correctional mental health service providers who strive to comply with their professional standards of practice often find themselves struggling to resolve the conflicts among their professions’ ideological, conceptual, and ethical frameworks with the sociopolitical moral values and practice standards of the criminal justice system, the punitive nature of the criminal justice model as carried out in their institutions and agencies, and their own personal values. In these struggles, it can be easy to lose sight of the basic and humane ethical principles of psychological services in correctional settings.

When the American Association for Correctional Psychology’s (AACP) Practice Standards Committee revised the 1980 standards, the intent was to augment the American Psychological Association’s (APA) guidelines for forensic psychologists (Committee, 1991) and the *Ethical Principles of Psychologists and Code of Conduct* (APA, 1992) for psychologists providing services in correctional and forensic arenas. Since that committee believed that the APA’s ethical principles would suffice for correctional and forensic practice, the AACP standards (2000) were not accompanied by a separate set of ethical principles specific to its members.

In 2005, the AACP became the American Association for Correctional and Forensic Psychology (AACFP), and the Practice Standards Committee believed that providing psychological and forensic services in correctional settings was sufficiently unique that it warranted a separate section of ethical principles that guided these practices. A separate set of ethical principles was published by the committee in *The Correctional Psychologist* (Althouse, 2005). As before, these ethical principles were not intended to supplant those of the 2002 edition of the American Psychological Association's *Ethical Principles of Psychologists and Codes of Conduct*: Beneficence and Nonmaleficence, Fidelity and Responsibility, Integrity, Justice, and Respect for People's Rights and Dignity. Rather, they were intended to augment their application in correctional settings to assist correctional and forensic psychologists in ascertaining ethical courses of action and implementing the practice standards.

In 2008, the AACFP became the International Association for Correctional and Forensic Psychology (IACFP). The four ethical principles that follow are set forth with the same intentions as those previously published. They remain consistent with the ethical standards of the APA (2002), as well as those of the Canadian Psychological Association (2000) and the British Psychological Society (2006), and provide the ethical framework within which all of the standards are implemented.

It is the committee's belief that by providing mental health services in compliance with these ethical concepts and principles, association members and correctional mental health service provider colleagues will optimally contribute to the understanding and care of all offenders.

*Principle A: Recognize individual rights to dignity, respect, self-determination, and humane treatment*

In many societies, offenders are often considered and treated as "second class" citizens not worthy of the same basic human rights and dignity as nonoffenders. Psychologists and mental health service provider colleagues strive to avoid such distinctions by extending the same human rights of dignity, courtesy, professional respect and autonomy to their offender clients as they would to nonoffender clients.

*Principle B: Avoid or minimize emotional and physical harm*

Correctional mental health service providers will avoid or minimize deliberate emotional and/or physical harm—including practices recognized as torturous—to their clients, regardless of their client's religious, political, sexual, military, or civil status or orientation.

Offenders are incarcerated *as* punishment and not *for* punishment. Unfortunately, social, political, governmental, correctional administrative forces, and insufficient mental health services resources can directly or indirectly influence mental health service professionals to provide services that reflect the current culturally, socially, and politically popular models of treatment of offenders and prisoners. Such pressure can result in insufficient numbers of mental health services' staff; insufficient access to mental health services by offenders or prisoners; insufficient due process safeguards; suboptimal assessments; inappropriate, incompetent, or incomplete treatments; incomplete documentation; and/or assisting employing agencies in the deliberate infliction of emotional and physical pain, as in emotionally abusive practices or torturous interrogations. These consequences inflict unacceptable levels of emotional and physical harm to corrections clients.

IACFP members must strive to identify and resist such pressures, focusing instead on providing objectively and professionally optimal, research-based psychological and mental health services and interventions to their clients while minimizing or avoiding harm. Although the professional demands of correctional psychologists and related mental health disciplines may result in some temporary discomfort to the offender (e.g., placement in restraints, constant observation), the overriding concern should always be the safety, welfare and optimal mental health of the offender, other offenders, and correctional staff.

Under no circumstance does IACFP sanction the involvement of any of its members in the deliberate infliction of emotional or physical pain for the purposes of coercion, punishment, or torture. Not only do these actions violate an offender's constitutional right to be free from cruel and unusual punishment, they also violate international guidelines regarding the treatment of prisoners (e.g., United Nations's *Standard Minimum Rules for the Treatment of Prisoners*, 1977, and its *International Covenant on Civil and Political Rights*, 1976), and can result in prosecution.

However, harm can take less onerous and more insidious forms: avoidable delays in responding to a request for services; failure to meet due process requirements; failure to maintain an accurate treatment plan; failure to keep an accurate record; failure to practice within one's scope of competency; imposing one's political, cultural, and personal biases about offenders; providing services while psychologically impaired; sexually or emotionally abusing a client or patient; and avoiding advocating for quality mental health services and research, to name a few. Members must strive to avoid these and similar categories of harm.

*Principle C: Maximize good: Provide and advocate for competent mental health services and research*

Correctional mental health services staff will advocate for and adhere to the highest professional practice and evidence-based research standards when providing mental health care within the context of available resources.

One may easily lose sight of this ethical principle in correctional settings in which administrative and clinical supervision of mental health services may be minimal, where there is insufficient administrative, social, and financial support for qualified and competent mental health services and research, and where there is a resistant anticriminal and punitive cultural environment. These variables may compromise standards of clinical competence and autonomy, reduce sufficient and timely access to mental health services, and compromise due process.

Likewise, the correctional environment may militate against the humane, appropriate, competent, and effective treatment based on professionally recognized research standards; the confidentiality of records; or adequate release planning. At the very least, mental health services that are incomplete, ineffective, or otherwise inadequate, constitute both ethical and professional misconduct. They also render functional disservices to the offender or inmate client, the institutional or correctional agency, the community, and ultimately the society at large from which offenders come and to which they will return.

Within the context of available resources, IACFP members and other correctional mental health service providers will advocate for and provide the highest quality services possible within these limits, and advocate for adequate resources to meet their practice needs.

*Principle D: Recognize and practice social responsibility*

Correctional mental health service providers are mindful of their multiple layers of social responsibility, and manage their services accordingly. Mental health services providers in correctional settings always have multiple client and shareholder responsibilities. While primary professional obligations are owed the offender or inmate client, correctional mental health service providers must remain mindful of their professional responsibilities to their correctional agency, staff, communities, families, and ultimately, society at large. They do so by:

1. Advocating for and providing optimal psychological or other mental health services of sufficient quality and quantity to meet the professionally identified mental health needs of seriously mentally ill inmates and offenders;
2. Contributing to the staff training needs of the correctional or forensic setting or agency, including identifying and caring for the mentally ill offenders and inmates, and effectively managing suicide risk;
3. Educating policy makers and the public about the mental health, rehabilitation, and community reintegration needs of offenders and inmates;
4. Advocating for research that supports evidence-based foundations for correctional rehabilitation programs, practices, and mental health treatment.

#### A. ADMINISTRATION AND OPERATIONS

This section of standards encompasses the mission, administrative structure, operations, and quality oversight of psychological mental health services in correctional and detainee settings. The goal is a high-quality psychological services system that is well integrated into the correctional program of a department, agency, correctional facility, and community.

##### A-1. Administrative Mission

The administrative mission is to provide the highest quality psychological services to the seriously mentally ill detainee, offender, inmate, or resident, and, as possible, to other mentally ill individuals entrusted to their care, in keeping with human rights, international treaties, civil (or comparable) rights, applicable legislation, and community standards.

##### A-2. Administrative Responsibilities

*Standard (a):* Department, bureau, agency, and institutional administrators ensure that there are sufficient numbers of qualified mental health services staff to provide competent psychological services to the seriously mentally ill or suicidal detainee, offender, inmate, or resident, in keeping with legal, civil, professional, and community (or comparable) standards.

*Standard (b):* Department, bureau, agency, and facility administrators ensure that only the most qualified and highly credentialed psychological service providers are employed to provide mental health services to seriously mentally ill individuals entrusted to their care.

*Standard (c):* Mental health administrative 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 ensuring that psychological services staff function only within the scope of their areas of competency.

*Standard (d):* There is an implemented department administration policy that requires psychological screening of non-mental health services personnel, particularly security staff, to ensure they are able to work with the correctional population to which they are assigned. Such psychological screening would be done by an outside agency employed for that purpose.



*Standard (e):* The warden or superintendent of a jail ensures that the services of an independent psychology services provider includes crisis intervention; the identification, management, and treatment of severely mentally disturbed and suicidal inmates; and a referral process for immediate and/or follow-up community treatment services.

## Discussion

The mission and these fundamental administrative standards form the conceptual hub essential for the provision of adequate psychology services in criminal justice and correctional settings. Meeting the mission and Standard (a) ensures that mentally ill inmates have adequate access to and receive competent psychological treatment for serious mental illness or suicidal inclinations. For example, in the United States, Standard (a) reflects the intent of the Mentally Ill Offender Treatment and Crime Reduction Act of 2004 (S. 1194).

While there are various mental health professions that provide for the delivery of psychological services (e.g., psychology, counseling, social work), the committee understands that providing adequate psychology services to correctional clients within criminal justice or detention settings in keeping with community standards poses specific challenges to professional and institution staff alike. In the face of consistent economic and resource shortfalls, it is tempting to lower these standards as stopgap measures. However, it takes only one inadequately trained staff to create a clinical crisis for a seriously mentally ill individual that may lead to an adverse outcome, such as a mental health crisis, successful suicide, and/or to the injury of a staff, inmate, or resident. These occurrences can contribute to heightened stress levels within the institution, create unnecessary security risks, lead to negative community publicity, and risk potential litigation against both administrators and staff.

A similar argument can be made for the psychological screening of other institution staff—particularly correctional officers—working with or responsible for the safety and security of inmates, particularly mentally ill inmates or residents. Correctional officers are especially vulnerable to the stresses of working in correctional or detention settings, and it takes a psychologically stable individual to meet the challenges associated with these settings. A psychologically unstable or physically abusive correctional officer or other correctional staff can create additional security risks for other institutional staff and inmates, clinical crises for the mentally ill inmate, and an environment that runs counter to the conceptual rehabilitative mission of the agency. Therefore, psychological screening of these staff is of benefit to all and is highly recommended. A pre-hiring screening process for correctional staff has been successfully implemented by departments of corrections in numerous states, and is a process the committee highly recommends.

### A-3. Administrative Structure

*Standard (a):* There is a current and readily accessible formal administrative chart that shows mental health services as an individual entity in the department, agency, and facility, with clear lines of administrative and supervisory authority.

*Standard (b):* The department, bureau, agency, and/or facility has a licensed psychologist with administrative and/or supervisory responsibility for the organization and operation of psychological services pursuant to a current written agreement, contract, and job description.

## Discussion

Meeting these two standards ensures the professional and ethical provision of correctional psychological services within the department, bureau, agency, and/or facility. It also emphasizes that the administration and supervision of these services is at the highest professional level.

Although it may be argued that good managers can be effective regardless of their discipline and degree of knowledge of the area being managed, these two standards reject such a contention. Efficient management is predicated on both demonstrated/documented expertise in the provision of correctional mental health and psychology services and management skills. Consequently, these standards require that a licensed full-time psychologist administers and/or supervises psychology services and staff in correctional departments, agencies and facilities; assesses the need for such services; and assumes professional responsibility and accountability for them.

Written job descriptions are essential for the effective delivery of psychological 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 psychological mental health services provider such as the individual's place in the chain of command, work schedules, range and types of services to be provided, and the limits of independent action and decision making.

### A-4. Operational Structure

*Standard:* The operational delivery of psychological services is structured by a current and readily accessible written policy statement of the mission, goals, objectives, job descriptions, policies, and procedures, approved by the administrative psychologist and the department, agency, or facility administration.

## Discussion

This standard ensures that there is a written policy document that explains the purpose and operational structure of a facility's or agency's mental health and psychology services. All facilities and agencies should have a current compilation of mental health services' procedural guidelines that describe (but are not limited to) forms, methods, psychological techniques, and other procedures that contribute to their mission, goals, and objectives. These should be kept in a department or agency's mental health services procedural manual or handbook readily available to both staff and administration. These documents should provide direction in at least the following areas: psychological evaluation, diagnosis, therapy, habilitative services, research, quality improvement oversight, consultation, staff training, and professional development. There is documentation that the mission statement is reviewed annually, updated as appropriate, and implemented.

### A-5. Mental Health Services Guidelines

*Standard (a):* All aspects of mental health services conform to the ethical and standards of practice guidelines established by the provider's profession, licensing and certification regulations, state and federal laws, international agreements, and constitutional standards of care, regarding the treatment of pretrial detainees, inmates, and residents.



*Standard (b):* Within the constraints of appropriate security regulations applicable to all institutional personnel, psychology service staff have professional autonomy regarding the provision of mental health services and activities for which they are credentialed.

*Standard (c):* Verification of necessary and current provider credentials is on file in the facility (and at central headquarters in multisite organizations or agencies).

*Standard (d):* The supervising psychologist provides work performance evaluations to employees, trainees, students, and other mental health services staff whose work is supervised on an annual basis or more often if warranted.

## Discussion

These standards are intended to ensure that mental health services in correctional settings are in keeping with the highest ethical and provider standards commensurate with the training or certification of the provider.

Although the admission to the independent practice of psychology, social work, counseling, and provision of mental health services is regulated by state or federal statute, not all public sector mental health service providers are required to be licensed, certified, or license eligible. However, employing less than licensed, certified, or license-eligible mental health services staff for the supervision of or direct delivery of correctional psychology services is not sanctioned by the International Association for Correctional and Forensic Psychology. Compliance with this licensing/certification standard is intended to ensure that the delivery of psychology services to offenders and inmates is at a level commensurate with community standards.

Documentation sufficient to determine whether a particular psychological unit is in compliance with this standard would show that managing or supervising psychologist is licensed and that any other psychology mental health service providers are in applicant status or in the process of gaining the requisite experience to apply for licensure or certification.

Mental health services personnel need to be granted sufficient autonomy to practice their profession to make the most appropriate psychological judgments in compliance with their ethical and professional standards. Their practice should include all functions identified by the jurisdictional licensing board and practice standards as being within the provider's scope and sites of practice.

### A-6. Support Services

*Standard:* When mental health services are provided by a facility or agency (as opposed to contracted services), adequate space, support staff, and funds for testing and other equipment and supplies, training needs, and materials as determined by the administrative psychologists and/or psychologist supervisor (and in compliance with headquarters directives in multisite organizations) are provided for the delivery of those services.

## Discussion

The correctional or agency environment in which mental health services are delivered directly 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 arm rests) 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, including an alarm system that alerts other staff of an emergency, 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.

### **A-7. Summary Reports of Mental Health Services**

*Standard (a):* There is a periodic (at least quarterly) and annual summary report on the delivery of mental health services in the facility or agency. These reports include workload demand and delivery data, diagnostic and treatment trend analyses, comparative analyses with prior data, and other mental health care issues of importance or concern.

*Standard (b):* These reports, along with any recommendations for improvements, 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 agency's or facility's supervising psychologist.

### **Discussion**

There is an ongoing need for reliable information that provides the basis for budget and resource planning for mental health care services. The availability of basic information will be an advantage to administrators who need to make and defend appropriation requests in order to facilitate acceptable mental health services in keeping with the mental health service needs of the offender population.

### **A-8. Quality Assessment/Improvement Oversight (Internal)**

*Standard (a):* The psychologist administrator annually assesses the quality and quantity of psychological services.

*Standard (b):* Each review or audit results in a comprehensive report that is distributed to administrative, mental health, and other staff on a need-to-know basis for discussion and recommendations for improvements.

### **A-9. Quality Assessment/Improvement Oversight (External)**

*Standard (a):* A formal documented annual review is conducted by a qualified outside agent to monitor staff compliance with mental health care policies.

*Standard (b):* The program review follows 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). The results, along with any recommendations for improvements, are provided to the appropriate personnel for review and discussion.

## Discussion

The purpose of a quality improvement evaluation is to provide the agency's and/or facility's administration and staff timely information concerning the level of performance of mental health services and the existence of any barriers that prevent more efficient and effective service delivery. The psychologist administrator should resist an annual external audit without a prior internal one.

A quality improvement process that includes (but is not limited to) both an internal and external annual audit is essential to the assessment of mental health service priorities, goals, and procedures. Client contacts/services, client satisfaction, resources, outcomes, research, recommended changes, goals for the following year, and information distribution are all proper areas for such assessments. 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.

### A-10. Integration of Mental Health Services

*Standard:* There are periodic (e.g., monthly, quarterly, semiannually) administrative meetings at the department, agency, and facility level that provide a forum for, and documentation of, general discussion regarding the operation of mental health services.

## Discussion

Periodic meetings of mental health care administrative and psychology supervisory staff with other department, agency, and facility administrative staff are essential for a successful correctional mental health program. At such meetings, information is shared, 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 total correctional effort.

At facilities or agencies where mental health services consist of more than one psychology staff member or staff from different disciplines (e.g., social work, counselors), it is strongly recommended that collective mental health services staff meetings be held at least twice each month. In addition to discussion of administrative concerns within the mental health services' department, these meetings will help promote quality care and the efficient use of mental health resources. Mental health 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 non-mental health services staff, such as administrators and security personnel.

## B. ROLES, SERVICES, STAFFING, AND PROFESSIONAL DEVELOPMENT

This section highlights the roles and services of correctional mental health services staff, provides guidelines for mental health services staff-to-inmate ratios, and emphasizes the need for appropriate staff orientation, training, and professional development.

### B-1. Roles and Services

*Standard (a):* The primary roles and services of correctional mental health services staff are directly related, or contribute to, mental health services, treatment, and programming for mentally ill offenders, inmates, pretrial, and revocation detainees.

*Standard (b):* Appropriate roles for correctional mental health service staff include (but are not limited to) the following: consultation to correctional administration for mental health services' program design; administering and supervising mental health services; psychological screening of security staff employed in specialized mental health units; mental health assessment and classification for mental health program assignments; and training of institutional and agency staff.

*Standard (c):* Mental health services include screening, assessment, diagnosis, and treatment of mental illness; crisis and suicide interventions; and prerelease planning for inmates who will need mental health services following release. Additional services may include research and advocacy for and evaluation of correctional mental health programs and services.

*Standard (d):* Mental health services staff do not assume a dual role that overlaps with other functions and services (e.g., security) of the correctional agency or facility that could result in unethical dual-role relationships that risks harm to their offender or inmate clients.

### Discussion

Steadily increasing inmate and offender populations have continued to fuel the growing need for qualified mental health services professionals and providers. Department administrators and staff in prisons, jails, and other correctional facilities have been increasingly challenged and stressed by the increasing mental health service needs of the growing number of mentally ill inmates and offenders, as well as the litigation that often accompanies the failure to provide those services. In addition to the increased need for the assessment and treatment of familiar mental disorders (e.g., depression and other mood disorders, anxiety, sleep disorders, psychosis, and suicide), the emergence of stress-related disorders (e.g., posttraumatic stress disorder) associated with current military actions present new treatment challenges in correctional settings.

The past decade has also seen an increased need for forensic 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), consultation services (e.g., psychological screening of security staff), and coordinating postrelease mental health services with community mental health services agencies. These increased needs have created new professional consultation and training requirements.

Although it is important to consult, collaborate with, and support other services, it would not be ethical for correctional psychologists or other mental health service professionals to assume roles not consistent with and/or directly related to the provision of mental health services such that (a) the scope of mental health services becomes blurred or blended with other services (e.g., security, administration, medical, or social services) and (b) needed mental health treatment resources are decreased. There should be no doubt among clients or non-mental health services staff what the scope of mental health services encompasses, how those services contribute to the correctional agency, system, inmate, resident, or offender, and the ethical/professional standards that govern them.

For mental health services staff in agencies that may require them to engage in correctional or security-related duties, meeting Standard (d) may occasionally be difficult. In such cases, one should attempt to comply in a manner that optimally upholds the intent of this

standard, particularly if it involves security or control-related activities with an inmate in treatment. When the possibility of such a dual relationship exists, that should be explained prior to the implementation of any assessment or treatment process.

## **B-2. Administration and Supervision of Psychological Services**

*Standard:* At the facility or agency there is at least one person identified as responsible for directing or supervising psychological services. This individual has a doctoral degree from a regionally accredited university or professional school in a program that is primarily psychological in nature, is licensed/certified for the independent practice by the state or country in which the facility is located, and has training/experience specific to the field of correctional psychology and related mental health services.

## **Discussion**

The intent of this standard is to set the minimum credential level for on-site mental health services supervisory staff. Mental health services provided by mental health care providers who do not meet this standard (e.g., unlicensed psychologists, unlicensed clinical social workers, psychology interns, trainees, students, and paraprofessionals) will be supervised by a licensed psychologist or medical psychologist who has final supervisory responsibility and accountability for the decisions and services provided. Supervision meetings 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 or national 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.

## **B-3. Staff**

*Standard (a):* There will be a sufficient number of qualified mental health professionals (e.g., psychologists, counselors, social workers) to meet the mental health needs of the facility's inmate population.

*Standard (b):* Qualified mental health professionals are credentialed for independent practice and qualified to provide testing, assessment, diagnosis, and treatment services in keeping with professional, legal, and community standards of practice.

## **B-4. Staff-to-Inmate Ratios**

*Standard:* The following psychological staff-to-inmate ratios are presented as guidelines:

*Prisons:* The minimum ratio of a full-time qualified mental health care professional (licensed psychologist or other mental health care professional practitioner credentialed for independent practice) to adult inmates is 1 for every 150 to 160 general population inmates.

*Specialized units:* (e.g., drug treatment and special management units for mentally ill inmates), the minimally acceptable ratio is 1 full-time qualified mental health care professional for every 50 to 75 adult inmates.

*Juvenile facilities:* The minimum psychology staff ratio in facilities for juvenile offenders is 1 full-time qualified mental health care professional for every 60 to 75 juveniles in general population and 1 full-time qualified mental health care professional for every 20 to 25 juveniles in a special management unit.

*Jails:*

- A. Average daily population fewer than 10: licensed psychologist on call;
- B. Average daily population between 11 and 75: a contract licensed psychologist in the facility at least 8 hours per week;
- C. Average daily population between 76 and 125: a contract licensed psychologist in the facility at least 16 hours per week;
- D. Average daily population more than 125: at least one full-time licensed psychologist per 125 inmates.

**Discussion**

The intent of this standard is to ensure that the number of qualified mental health professionals and providers are sufficient to meet the psychological assessment, program, and treatment needs of an adult or juvenile inmate population. Ideally, professionals credentialed for independent practice and able to provide the necessary range of psychological mental health services (e.g., testing, diagnosis, treatment, suicide intervention) are preferred. This allows for more time spent in delivering services and less time in supervision of less qualified staff.

When only one professional is available for psychological mental health services, such as for jails, the most highly trained and credentialed psychology professional should be the standard. That would be either a licensed or a medical psychologist.

While the staff-to-inmate ratios provided above may appear arbitrary, they are not. During the last two and a half decades, a number of state departments of corrections have been involved in civil litigation alleging deliberate indifference to the mental health needs of their seriously mentally ill inmates, a direct result of insufficient numbers of qualified mental health services staff, particularly licensed psychologists and psychiatrists. In such cases, courts have ordered corrections departments to address deficiencies of their inmate mental health services, with expert witnesses recommending specific numbers of additional mental health services staff sufficient to meet inmates' mental health needs (e.g., Cohen, 1998, p. B-68).

A review of the literature regarding court decisions in such cases (e.g., Cohen, 2008) continues to support our proposed staff-to-inmate ratios as a *guide* for corrections departments and prison facilities to minimize the risk of such civil litigation. Jails should have a slightly higher staff-to-inmate ratio given the literature noting the higher incidence of mental illness and suicide in jails than in prisons. It is expected that the number of qualified psychology mental health services staff will increase as the level of special psychological needs and/or program intensity warrants.

Court decisions aside, periodic surveys of mentally ill inmates have consistently referenced an average of 15% or higher of general inmate populations as seriously mentally ill (e.g., Ditton, 1999; Magaletta, Diamond, Faust, Daggett, & Camp, 2009). In 1999, Kupers estimated the proportion of inmates who suffered from serious major mental disorders to be 5 times that of the general population (p. xvi). That suggests that 22 of 150 adult inmates in a general prison population would be seriously mentally ill, more than enough to keep one psychologist or other qualified mental health services provider busy, especially in addition to their other responsibilities. Such a caseload may parallel community standards for a full-time qualified mental health services provider. Therefore, we believe these ratios are reasonable in light of the known mental health needs of these various jail, prison, and juvenile populations.



## B-5. Professional Training and Development

*Standard (a):* A written plan, approved by the psychologist administrator and organization, agency, and/or facility administration, requires mental health provider staff to receive orientation training as well as regular continuing education appropriate to their mental health services responsibilities and credential status.

*Standard (b):* Documentation of these training experiences will be maintained by both the employing agency and mental health services staff.

*Standard (c):* Mental health services' staff assessment and treatment training shall reflect ethnic, racial, gender, and linguistic characteristics of their client population.

## Discussion

Providing correctional mental health services is a uniquely specialized task that often requires specialized education and experience. For newly employed mental health personnel, additional orientation and training are also required. Nevertheless, the provisions of mental health services in correctional and community settings will conform with the current ethical and practice standards of the mental health service providers' disciplines, specialty guidelines (e.g., forensic), and the individual's state licensing/certifying agency. Therefore, it is imperative that adequate orientation and professional development training be promoted and facilitated by the employing agency.

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 mental health service providers in correctional settings. At the facility level, this should occur within the first month of employment and be managed by the psychologist administrator (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.

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

The presumption that being trained in basic Westernized principles of psychological practice is sufficient regardless of a client's culture is not warranted when dealing with members of diverse cultures. Agencies should promote and support diversity training of their mental health services staff sufficient to maximize meeting the mental health needs of culturally diverse correctional populations.

## C. ETHICAL PRACTICE GUIDELINES

The following practice guidelines follow from the ethical principles presented at the beginning of these standards: *offender dignity and respect, avoiding harm, competent mental health services, and social responsibility.*



### **C-1. General Principles**

*Standard:* All mental health services (e.g., screening, assessment, treatment, referral, transfers, expert testimony, and forensic reports) will comply with the prevailing psychological association's codes of ethics as well as those of the licensing agencies of the jurisdiction, state and federal laws, and international treaties. Mental health services provided by other disciplines will also be in compliance with their respective ethical guidelines and standards of practice and applicable statutory and licensing or certification standards. In the event that there is a conflict among or between ethical principles and practice standards, the standard that provides for the highest level of ethical professional practice shall be followed. The standards of practice comply with the basic principles of recognizing offenders' rights to dignity, respect, and autonomy, avoiding or minimizing emotional and physical harm, advocating for competent mental health services and research, while practicing in ways that recognize multiple social responsibilities.

#### **Discussion**

It is important that mental health services are of the highest quality, and that no ethical or practice distinction be made between offenders (adult or juvenile) and nonoffender (e.g., pretrial or revoked detainees) individuals in the provision of these mental health services.

### **C-2. Mental Health Resources**

*Standard:* Mental health resources are provided only for clearly defined mental health purposes in compliance with the ethical principles of these standards.

#### **Discussion**

The clear need for institution and community safety, as well as a collaborative, multidisciplinary team model in a multisite, institution, or community agency, can result in instances when psychological staff may be called upon to provide services for administration and to 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 security staff physically or coercively manage disruptive/noncompliant and/or dangerous inmates. In these instances, mental health resources are used only to provide services in keeping with applicable ethical and practice standards. Mental health service providers should resist participating in these dual-role processes to the detriment of clearly defined and needed mental health services.

### **C-3. Competence**

*Standard:* Psychologists and other mental health service providers limit their services to their supervised or demonstrated areas of professional competence.

#### **Discussion**

In the face of increasing demands for mental health service in correctional/forensic settings, it is likely that some staff will be asked to perform a variety of psychological and

forensic services for which they may have not received sufficient training. It is important to the institution, facility, or agency and to the offender or inmate client that mental health services staff not provide services outside their documented/demonstrated area of expertise. To do otherwise may result in harm, and place the agency and/or the mental health service professional at risk for legal or civil litigation.

Prior to extending services beyond the scope of their competency, providers 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, gender, or kinds of mental health problems for which services are to be provided. In keeping with this standard, mental health service providers have an obligation to educate themselves in the concepts and operations of the criminal justice system in which they provide services.

#### **C-4. Documentation**

*Standard:* All mental health services, significant contacts (e.g., resulting in clinically important information), and mental health information will be documented and/or maintained in a confidential file specific to the offender in compliance with current professional, legal, and administrative code standards. Documents that require the signature of the mental health services provider shall be legibly signed, indicating the name and status of the provider, and dated.

#### **Discussion**

The importance of confidential mental health files and documentation cannot be over-emphasized. Both are essential for the purposes of accountability and continuity of mental health services to the offender. Documentation should include but not be restricted to offender requests for services, 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, completion, referrals for consultations, consultation reports, and consent to release information forms, including to whom and for what purpose.

Documentation is maintained in such a manner that mental health information can be accessed easily and efficiently in accordance with applicable standards. Standard forms are used whenever possible, especially within a multifacility organization. Documentation maintained in computer databases and electronic files should have a hard-copy backup in the client's primary mental health services file.

#### **C-5. Confidentiality (Files and Records)**

*Standard (a):* All mental health services files and records are confidential to the inmate in accordance with current professional 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 is followed.

*Standard (b):* A documented policy and implemented process to ensure confidentiality of all mental health services files, records, and test protocols are implemented, including clearly

labeling confidential files and records as “confidential” and keeping mental health 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 mental health records only on a “need-to-know” basis is on record at the agency, institution, and central headquarters in a multisite organization. This process is supervised by an on-site psychological services staff member designated as the mental health records custodian. All staff are trained regarding this policy.

*Standard (c):* Each organization/agency has its own policy regarding the transport of mental health records from one institution to another for routine and emergency facility transfers. These policies ensure the confidentiality of records during the transport and intake process.

## 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 and databases, 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 mental health services staff person. Releases of Confidential Information forms and processes are followed when mental health information is released to third parties. Such releases are documented in the inmate’s mental health services file.

*Note:* With the development of centralized computerized records and databases, the confidentiality of inmates’ computerized psychological services records must be adequately safeguarded in a manner that ensures the highest level of confidentiality.

Mental health services’ staff must remember that e-mailed documents, mental health services’ notes, and mental health services’ communications about an offender or 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 or individuals who may illegally breach a computer database. Security safeguards (such as passwords and encryption) will be in place to ensure confidentiality of these communications. Practitioners should be reminded that a violation of confidentiality statutes and/or ethical guidelines is subject to grievance, civil, and/or criminal prosecution.

### C-6. Limits of Confidentiality

*Standard:* All inmates are 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 their confidentiality at risk. This information is provided on a readable 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 mental health services’ provider 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.) This documentation will be placed in the offender’s mental health services confidential file.

## Discussion

All involved parties are informed, in advance, of any limits to confidentiality, and the offender, inmate, or resident is told what information the provider is obligated to release and to whom (e.g., duties to warn, crimes to report, endangerment to the facility). In the most basic sense, confidentiality is a *right* of the *client*, not the psychologist, other mental health service providers, or the agency. Privileged communication, when it exists at all, obtains only in a treatment relationship.

It is imperative that, just as in the community, offenders, inmates, and residents (and their guardians) understand limits and risks of confidentiality as it applies to any information they provide in the course of psychological testing, assessment, treatment, and program participation. This understanding must be documented in their confidential mental health 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 mental health services provider during the course of treatment *or* service unless the provider 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 professional's clinical 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 and the professional community. 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 mental health services provider works *with* their clients, 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, community safety, and the offender, inmate, or resident client. Nonetheless, it is essential that providers of mental health services be given the authority and responsibility to maintain the confidentiality of their clients' records. To continue an effective working and treatment relationship and to satisfy professional and ethical obligations, mental health services staff should not be required to disclose their confidential records or treatment information to correctional staff or officials or other third parties outside the agency without the documented informed consent of the client, except as required or allowed by administrative code or statute, such as a security risk to the facility or a danger to a specific individual.

### C-7. Informed Consent

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

## Discussion

*Informed consent* is the documented permission granted by the offender to the mental health services 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.

### C-8. Involuntary Treatment

*Standard:* Involuntary treatment, including the administration of psychotropic medication, placement in an observation status, and the use of restraints, is undertaken only by a qualified mental health professional under the auspices of the ethical and practice guidelines of the mental health service provider's discipline as well as federal laws, state statutes, and jurisdictional administrative codes. The role and responsibilities of the qualified mental health professional in these procedures is clearly defined in written policies and procedures. Such procedures are advocated and/or maintained only after initial and ongoing assessments to determine the necessity of their use. Mental health services professionals refuse to participate in such processes if they are inconsistent with their legal, professional, or ethical standards, utilized for disciplinary or punitive purposes, contrary to constitutional rights, or conflict with international agreements regarding the treatment of prisoners or detainees.

## Discussion

Unless it has been legally established to the contrary, the competence of both inmates and offenders to make their own treatment decisions is assumed, and these individuals (or their guardians) have a civil and legal right to refuse intrusive physical or chemical treatment without punishment, restraint from programs, and/or community supervision (unless there is convincing clinical documentation that lack of such program participation or community supervision would pose a danger to them or to others). Therefore, the decision to impose involuntary treatment upon a competent nonconsenting offender (e.g., taking medication as a condition of probation or parole) or inmate (e.g., forced feeding) requires complex ethical and legal judgment, and compliance with constitutional statutory, administrative, and professional guidelines. These processes should be clearly referenced and documented in the individual's mental health services file.

In those instances when an involuntary psychological treatment technique is applied, it should be one that is empirically derived and evidence based, that is of the least restrictive nature appropriate to the behaviors being managed without deleterious side effects, and that produces changes that a more rational or mentally competent client would have sought if he or she were mentally competent. Examples of involuntary mental health treatments include, but are not limited to, behavior modification and group pressure/confrontation techniques such as might be used in confrontive drug treatment or military-oriented boot camp programs. 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 documented and professional accepted treatment regimen and appropriately supervised in keeping with professionally recognized standards of psychological practice.

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.

Mental health services staff should not be responsible for the administrative restraint of disruptive inmates when such behavior is not part of a mental disorder. However, mental health 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 qualified mental health services staff from advocating a treatment program for an offender, inmate, or resident (e.g., sex offender, domestic violence, or anger management) even if the individual 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.

### **C-9. Employer and Staff Ethical Conflicts**

*Standard:* There is a documented and implemented policy regarding the resolution of ethical/professional conflicts between the employing correctional facility, organization, or agency and mental health services staff.

### **Discussion**

It is expected that psychologists and other mental health services staff strive to engage in activities compliant with ethical, practice, and licensure standards. Nevertheless, there may be occasions when such compliance conflicts with the needs and expectations of the employer or employing agency. When that occurs, both parties should make every effort to resolve such conflicts in keeping with ethical, practice, and jurisdictional licensure standards. This would be particularly important when there is the risk of loss of licensure, legal liability, or civil litigation. It is understood that regardless of any employer liability, mental health services providers who violate their ethical, practice, and/or licensure codes also may be individually at risk for civil and/or legal consequences.

When it is not possible to avoid a possible work rule violation leading to a disciplinary action and/or potential loss of job, the mental health services provider 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, licensing board, APA, or IACFP), and his or her representing union. Circumstances and references related to the conflict should be completely documented, including possible outcomes that may place the provider 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 but does not place the mental health services staff at risk for loss of licensure, legal or civil litigation, or endanger personal safety, such as when time does not permit resolving the ethical conflict, the staff may comply in accordance with organizational or agency work rule policy, document the circumstances of this decision, and then pursue whatever professional/legal or work-related actions (such as filing a grievance) are possible to resolve the conflict and to avoid such conflicts in the future.

If compliance appears to lead to the possibility of a practice or legal complaint that places the staff in jeopardy of professional censorship, possible loss of license, or criminal liability, then the staff might refuse to comply and then address any disciplinary action through the appropriate grievance and/or employment relations and/or legal processes.

#### **D. MENTAL HEALTH SERVICES AND PROGRAMS**

This section describes the standards for the availability and delivery of psychological mental health services in detention centers, jails, prisons, correctional centers, and juvenile facilities. The primary goal is an orderly, programmatic, and integrated process for a sufficient number of qualified mental health professionals to identify, monitor, treat, and arrange follow-up mental health care services for the seriously mentally ill pretrial detainee, offender, inmate, and juvenile resident.

For the purposes of this section, an *offender* is an individual in the community under the probation or parole supervision of a correctional department or agency. An *inmate* is defined as an individual housed in a detention center, jail, prison, juvenile facility, or other correctional agency, for the purposes of pretrial detention, serving a sentence, or receiving medical or mental health treatment.

#### **GENERAL GUIDELINES**

##### **D-1. Availability of Mental Health Services**

*Standard:* Mental health services are provided in compliance with international treaties and agreements, human and civil rights, ethical, professional, and community practice standards, and are not denied to inmates based on their offense, legal, political, military, security, or other constitutionally or nationally protected status.

##### **D-2. Availability of Interpreters**

*Standard:* Qualified interpreters are available for non-English-speaking and hearing-impaired offenders and inmates.

#### **Discussion**

In the United States, the Fourth, Eighth, and Fourteenth Constitutional Amendments provide pretrial detainees, offenders, and inmates a constitutional right to be treated for serious mental health problems and suicidal risk. Other Western industrialized countries and international human rights treaties have similar provisions. Since a significant percentage of successful civil rights litigations have resulted from failures to comply with these constitutional or legal mandates, these provisions carry significant legal weight.



These standards apply to both outpatient mental health services to general population inmates as well as to those in disciplinary, special management units, segregation, the facility's infirmary, or wherever else the inmate might be housed, unless there is an overriding documented security or safety risk. When such is the case, every effort must be made to reduce the risk and render appropriate mental health services to those individuals.

### **D-3. Standardized Operation, Policies, and Procedures**

*Standard (a):* There is a manual of standardized operating policies and procedures for mental health and support services approved and administered by the chief administrative or supervising psychologist.

*Standard (b):* The policies and procedures manual is maintained at administrative headquarters in multisite organizations and agencies with copies at associated facilities available to mental health services and facility administrative staff.

*Standard (c):* The manual should be organized and accessible so as to facilitate quality assessment/improvement audits, reports, and updates.

*Standard (d):* The manual should categorically include (but is not limited to) policies and procedures related to client contacts and communications, due process procedures, intake screening, initial diagnostics and diagnostic updates, psychological assessments, classification of mental illnesses, treatment and program interventions, crisis interventions, suicide assessment and prevention, restraints reviews, referrals and referral processes, postrelease planning, research, program evaluations, management of confidential storage and destruction of records, administrative confinement, affirmative defense assessments (reduced discipline of inmates unable to control their behavior because of their mental illness), supervision of interns, staff training, and professional development.

### **Discussion**

This standard ensures that the standardization, regulation, and implementation of mental health services are reviewed, approved, and administrated at the highest administrative level of a corrections department, agency, and facility.

### **D-4. Availability of Mental Health Services Staff**

*Standard (a):* A sufficient number of qualified mental health professionals are available to provide mental health services to inmates (see Standard B-3). Mental health services include, but are not exclusive to, mental health intake screening, assessment, treatment, crisis intervention, and postrelease follow-up services.

*Standard (b):* A facility's mental health services' policy must provide for 24/7 on-call availability of qualified mental health staff for rapid assessment of acutely mentally ill, distressed, or potentially suicidal, or self-injurious, inmates.

### **D-5. Screening and Training of Non-Mental Health Services Staff**

*Standard (a):* There is an established screening process for non-mental health services staff, particularly staff who have direct contact with inmates.

*Standard (b):* At least one staff member per shift within sight or sound of inmates under his or her supervision is trained by qualified mental health services staff to recognize signs and symptoms of potential mental illness or suicide risk and when to contact mental health services staff.

## Discussion

Working with inmates, particularly in a correctional setting, can be extremely stressful, and not everyone who applies for such employment is suitable for that work or environment. Ideally, all potential correctional staff are screened prior to hiring to ensure their psychological suitability and compatibility for working with inmates, particularly in correctional settings. This is especially true of security personnel assigned to special management units for acutely or chronically mentally ill, developmentally disabled, vulnerable, and suicidal, inmates. The attitudes, behaviors, and interactions of any correctional staff may intentionally or inadvertently exacerbate problems among inmates, resulting in possible danger to staff or other inmates, in turn raising institution acuity levels. Consequently, prehire or posthire specialized screening is becoming more desirable and widespread. These screenings may include psychological assessments provided by, or in consultation with, the facility's correctional psychology staff or coordinated with a contract provider through central headquarters in a multisite organization.

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

Regarding mental health training, it is the responsibility of the chief psychologist to collaborate with agency or facility administrators to schedule, facilitate, and document the training of institutional staff responsible 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 referring inmates to facility or agency mental health services staff.

Despite the availability of qualified mental health professionals, many interpersonal conflicts and potentially adverse outcomes can be moderated or averted by well-trained frontline staff responsible for the security and safety of offenders or inmates under their supervision. In a facility, it is the responsibility of the correction department's or facility's administration to ensure that nonpsychological staff—particularly security staff—are sufficiently trained in the identification of signs of serious mental illness and suicidal risk and that these staff are available on each shift within sight or sound of all inmates under their supervision.

### D-6. In-Service Training

*Standard (a):* Written standard operating procedures are implemented that provide for and require qualified mental health 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).

*Standard (b):* Training of new staff should occur within 2 months after their employment, with annual updates or refresher training for all staff. The facility or agency will maintain documentation for this training for each employee.

*Standard (c):* Special management units. Correctional facilities ensure that security staff assigned to special management units are screened and trained to interact appropriately with mentally ill, developmentally disabled, and suicidal offenders prior to being assigned to special management units.

*Standard (d):* Suicide prevention/intervention. There is a written and implemented training program for staff training and review of the policies and procedures for suicide assessment, intervention, and transfer. Training and review should occur at least on an annual basis, more often if staff turnover warrants.

## Discussion

Because the number of staff psychologists is frequently too small to meet offender and inmate needs 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.

It is the responsibility of the chief psychologist to collaborate with agency or facility administrators to schedule, facilitate, and document the training of institutional staff responsible 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 referring inmates to facility or agency mental health services staff in an expeditious manner.

### D-7. Collaboration and Coordination With Other Facility/Agency Staff

*Standard:* Mental health services staff routinely collaborate and consult with other agency and facility staff regarding the provision and delivery of mental health services to inmates and offenders.

## Discussion

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

The correctional mental health services provider should not behave as if in private practice. Rather, what is advocated is an outreach philosophy in which the total correctional facility is seen as a "client." Mental health services providers are most effective when visible in areas throughout the facility and by staff at all levels, bringing mental health services to wherever the inmates are.

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

### **D-8. Emergency Evaluation and Crisis Intervention Housing**

*Standard:* Inmates identified for emergency mental health evaluation and/or crisis interventions are housed in designated secure, suicide-proof cells with close supervision and sufficient security staff trained to protect these individuals from self-harm and harm from other inmates and to make referrals to mental health services staff.

#### **Discussion**

Mentally ill, acutely stressed, or suicidal individuals, are particularly vulnerable to abuse in jail and prison settings, and often experience increased stress and anxiety related to their incarceration. Incidents of self-harm or suicide attempts are often highest in this population. It is the responsibility of the department, facility, or agency, and psychological services staff to ensure the safety and security of inmates suspected of being mentally disturbed, having a serious mental illness, or posing a suicidal risk.

### **D-9. Systematic Monitoring of the Mentally Ill and Suicidal Inmate**

*Standard (a):* There is a department-, agency-, or facility-based implemented plan and procedure for systematic monitoring of the mentally ill, seriously mentally ill, and/or suicidal inmate for the duration of his or her incarceration. The procedure ensures that individuals who have been diagnosed and classified as suffering from a mental illness or are suicidal are periodically assessed by a mental health professional, the assessment is documented, and the documentation placed in the appropriate database and confidential mental health services files.

*Standard (b):* Inmates who are seriously mentally ill (psychotic, bipolar, severely depressed) are assessed minimally every 60 days; more often if their illness is acute and closer assessment and treatment is warranted. The results are documented and placed in the inmates mental health file.

*Standard (c):* Inmates who are not seriously mentally ill are seen at least every 190 days; more often if their mental status warrants. The results are documented and placed in the inmate's mental health file.

*Standard (d):* Inmates who are acutely suicidal will be monitored according to the applicable suicide prevention and intervention plan and documented accordingly.

#### **Discussion**

It is easy for offenders or inmates with a mental illness to be overlooked if they present no behavioral or program challenges and/or are not on psychotropic medications. Untreated anxiety can lead to unforeseen behavioral problems and overlooked depression can lead to a surprising suicide gesture or attempt. Both can lead to security and litigation risks. A classification process that codes the level of mental health services' needs, and utilizes that code to provide routine follow-up with offenders or inmates with identified mental health services needs can help minimize both types of risks.

### **D-10. Due Process**

*Standard:* Prior to engaging an offender or inmate in any significant aspect of mental health services (e.g., assessment, referrals, treatment, retention in observation or restraints, research), the individual is informed verbally and in writing of the nature and purpose of the process, how the information will be used, and the limits of confidentiality, and his or her informed

consent is obtained. In keeping with ethical and professional standards of practice, this process is documented, signed, and placed in the individual's confidential mental health service's file.

## Discussion

Due process is an ethical component of mental health services that recognizes and respects the autonomy of the individual. There are professional standards and ethical guidelines (e.g., American Psychological Association, Canadian Psychological Association) that inform mental health service providers regarding when and how to implement this process, and there are numerous ways and forms by which this can be efficiently accomplished. Failure to follow due process standards can lead to adverse outcomes for the provider, including complaints to licensing boards and litigation.

### D-11. Critical Incident Stress Debriefing and Review of Procedures

*Standard (a):* The facility has a written and operational plan for debriefing (such as a critical incident stress debriefing) for both staff and inmates following a serious suicide attempt or a completed inmate suicide. The critical incident debriefing is facilitated by appropriately trained staff cognizant of the advantages and disadvantages of this type of debriefing for those involved. The debriefing is not a part of any investigative or review process, and participation is voluntary. The results of the debriefing should be confidential and not shared with administrative or investigative staff. Professional and confidential referrals are made for staff and inmates needing additional assistance with psychological difficulties.

*Standard (b):* In addition to a critical incident debriefing, there is a facility or agency review of procedures following an attempted or completed suicide to ensure that proper precautions were taken and procedures followed. The results should be shared with quality assurance personnel and other staff as warranted.

## Discussion

Clearly, incarceration is a stressful experience, and incarceration in combination with serious medical and/or mental illness or other personal stress can be a precursor to suicidal ideation, gestures, serious attempts, and completions (National Institute of Corrections, 1995). These are among the reasons why the incidence of suicide in prisons and jails remains a leading cause of death, particularly among jail and segregation inmates. The constitutional scope of the Fourth and Eighth Amendments mandates a suicide prevention program in correctional facilities and agencies that have custody of inmates. A failure to do so is a leading precipitant of civil litigation alleging wrongful deaths from deliberate indifference of institutional or agency administrators and/or staff.

Beyond the constitutional mandates, however, experience has shown that many who contemplate and/or attempt suicide do so in the midst of a crisis that, given time and appropriate interventions, can be resolved. This leads the potentially suicidal person, and possibly others, to be thankful she or he had not attempted suicide or succeeded in killing herself or himself. Therefore, constitutional issues aside, there are humanitarian reasons to facilitate suicide risk assessment and intervention strategies. Inmates who contemplate suicide can often be successfully deterred by trained staff, thus saving institution staff, inmates, and/or relatives from the grief associated with a successful suicide.

An inmate suicide is also a critical incident for other inmates and staff. Because of the potential for investigations, staff discipline, and agency litigation that may follow a completed offender suicide, staff and other offenders' emotional trauma may be intensified or prolonged with negative impacts on agency morale, productivity, and security. Therefore, a comprehensive suicide assessment and intervention policy, including quality assurance program reviews and critical incident debriefings, is a necessary adjunct to any correctional facility's inmate care and treatment obligations.

#### ACCESS TO MENTAL HEALTH SERVICES

##### D-12. Policies and Procedures

*Standard:* There is a written and implemented policy and procedure approved by the department or agency's chief administrative psychologist regarding inmate and offender access to mental health service providers.

##### D-13. Routine Referrals

*Standard (a):* Request forms for offender and inmate referrals to mental health services are confidential, readily available, secured, and delivered on a sufficiently routine basis to ensure prompt (e.g., same day or next scheduled work day) delivery to appropriate mental health service staff for a response.

*Standard (b):* Request forms provide for the date, time, inmate's name, identifying number, location, reason for referral, space for additional comments, and name of staff member making the referral if not the inmate. There is a space for a response by the mental health services staff indicating the nature of the service to be provided and when an interview is scheduled.

*Standard (c):* There is an identified time frame in which a response by mental health services staff is mandated as well as feedback to the referral source briefly indicating the nature of the outcome. Time frames include both a time within which the inmate receives a response to a request and when the inmate is seen by a mental health services staff. A maximum response time of 3 working days, and an interview time of between 5 and 10 working days for nonemergency services, is recommended. Emergency services require a response within the hour to a day, depending upon the nature of the emergency.

*Standard (d):* The original referral form is placed in the inmate's confidential mental health services file and a copy returned to the offender.

##### D-14. Crisis Referrals

*Standard:* Correctional facilities have a policy, criteria, and an operational procedure that ensure rapid access to qualified mental health services staff for inmate crises (e.g., threats or attempts of self-harm or assault, escape, emotional instability, sexual assault) needing consultation or intervention during both working and nonworking hours.

#### Discussion

Only qualified mental health services providers should conduct crisis evaluations. However, facility or agency staff should be sufficiently trained to provide adequate supportive and protective care (i.e., placing the inmate in a protective status for observation) until the evaluation can be made by appropriate mental health services staff.

Documentation should be expeditious and facilitate clinical follow-up by other mental health services personnel. Such documentation should include the date and time of the



referral, the referral reason, when the evaluation was initiated, the type of intervention, the outcome, and recommended follow-up procedures. The documentation should be placed in the inmate's confidential mental health services file, and copies routed to institution or jail personnel on a need-to-know basis.

### **D-15. Inmates in Segregation**

*Standard (a):* Inmates in segregation are accorded the same access to mental health services as individuals in the general population, including a referral process, crisis intervention, psychological/psychiatric assessment, diagnosis, treatment, and appropriate mental health programming, irrespective of their segregation status.

*Standard (b):* A mental health services staff contacts all inmates in segregation at least once weekly to assess their mental health status, and twice weekly (or more often if warranted) for mentally ill inmates. Mentally ill inmates are promptly referred for additional mental health services as warranted. These contacts and referrals are documented and placed in the inmate's mental health services file.

*Standard (c):* Segregation assessments are conducted in a manner that ensures the confidentiality of the assessment process. Inmates are not interviewed in depth or provided substantive mental health services at their cell door unless adequate provisions are made to ensure the confidentiality of the assessment process.

*Standard (d):* Segregated inmates identified as acutely stressed or seriously mentally ill are afforded the same access to mental health services as those in the general population, including participating in individual and/or group therapy, and psychiatric treatment.

*Standard (e):* Segregated inmates identified as mentally ill will be scheduled for a minimum of 2 hours out-of-cell structured therapeutic activity and between 7 and 10 hours of unstructured recreation activity each week.

### **Discussion**

The interaction of the stresses associated with incarceration and mental disorders often make it difficult for mentally ill inmates, especially those with serious mental disorders (e.g., schizophrenia, bipolar, depression with psychotic features, and posttraumatic stress disorder), to conform their behaviors to the rules of a correctional facility or institution. Consequently, rule violations may result in frequent placement in disciplinary segregation. The stresses associated with segregation/isolation status can result in further emotional and cognitive decompensation, resulting in a cycle of even longer periods in segregation. However, the constitutional mandates for care of the seriously mentally ill are not suspended when a mentally ill inmate is in segregation status, and adequate mental health care may prevent inmate injury to staff or self or suicide attempts or completions, and reduce the risk of litigation. Therefore, it is reasonable that these inmates be provided opportunities for routine contact with psychology, crisis worker, or psychiatric staff, participate in warranted mental health treatment activities and programs, and reliably receive their psychotropic medication.

We recognize that providing these services in a segregation setting designed primarily to discipline inmates can be difficult. However, not to do so may set the stage for adverse events and civil litigation (e.g., memorandum of agreement between the U.S. Department of Justice and the state of Wisconsin regarding conditions at the Taycheedah Correctional Institution; U.S. Department of Justice, 2006). Consequently, every effort should be made to collaborate with security staff and provide these services in a manner that is minimally disruptive to the normal operation of segregation units.



## D-16. Billing Offenders for Mental Health Services

*Standard:* There is a policy that inmates or offenders on community supervision are not billed for access to or for receiving mental health services from department, agency, or facility mental health service providers.

### Discussion

It is becoming increasingly common to make inmates pay a copay for accessing health care services as a means of reducing frivolous or unnecessary requests, or helping to offset the expense of providing medical services. This would *not be appropriate* for inmates or offenders seeking or receiving mental health care from department or agency staff since it might reduce their motivation to access mental health services when access may avert a potentially adverse event.

### RECEPTION AND INTAKE

## D-17. Reception/Intake Screening

*Standard (a):* New admissions. All newly received inmates are briefly screened for mental illness and suicide risk as part of the admission to a jail or reception facility *prior to* being placed in a general population room or cell. Inmates in need of a more comprehensive mental health evaluation are immediately referred to a qualified mental health services provider. The screening information is entered on a standardized screening form and placed in the inmate's confidential mental health services file. (Note: "Upon admission to the facility" requires that reception screening be done as part of the booking or admission process. *It should be noted that placing two or more inmates in a holding cell pending screening several hours later or the next morning fails to meet this standard.*)

*Standard (b):* The collection of psychological assessment/screening data is performed only by qualified mental health services staff, personnel, or facility/agency staff trained by them. All personnel who use psychological tests as part of the screening procedure shall adhere to the *Standards for Educational and Psychological Tests* (American Psychological Association, 1974) and *Ethical Principles of Psychologists and Code of Conduct* (American Psychological Association, 2002). In cases where nonlicensed or noncertified mental health services staff are involved in intake screening, it is the responsibility of the supervising psychologist to ensure that the process adheres to these standards. At no time are inmates given the responsibility for test administration, scoring, or filing of psychological data.

*Standard (c):* Standard screening includes inquiries into past and present mental health difficulties including treatment and psychotropic medications, suicidal ideation, gestures or attempts, substance dependence or abuse, and current mental status including behavioral observations, mood, cognitive function, stressors, measures of daily functioning (e.g., appetite, sleeping, and activity level), and any medical concerns.

*Standard (d):* Referrals for additional mental health services shall be noted on the screening form and implemented according to policy.

*Standard (e):* All such information is recorded and stored on forms approved by the chief psychologist (in a multisite organization), or supervising psychologist (in a single-site facility or agency), and placed in the inmate's confidential mental health services file.

*Standard (f):* Transfers. The mental health status of prescreened inmates transferred from another facility is reviewed within 5 working days of admission unless pretransfer information requires a more immediate or thorough assessment. This screening may involve only a file review for transfers with no known mental health problems, or a face-to-face assessment for inmates with documented or known mental health concerns or suicide risk. Referrals for additional mental health services shall be noted on the form and implemented according to policy.

*Standard (g):* Cell placement. Psychological screenings contribute to cell placement decisions (e.g., single-celled or other-celled) with a documented process that provides for single-cell placement for seriously mentally ill, mentally retarded, developmentally disabled, or inmates vulnerable to sexual or physical assault, for whom double-celled placement might exacerbate their mental illness or disability or might endanger the inmate or cellmate. Documentation of psychological reviews and recommendations for cell placements should be placed in the inmate's mental health services confidential file and distributed as necessary to ensure appropriate cell placement.

## **Discussion**

The existence of serious mental illness in jails and prison facilities is widely known. Over the years, courts have found that the absence of a mental health screening process contributes to the failure of a correctional mental health system to meet established constitutional mandates, particularly as they pertain to the identification of inmates with serious mental disorders. Consequently, corrections administrators who fail to establish screening processes that identify mentally disordered inmates may find themselves the subject of deliberate indifference litigation.

Initial assessment of the mental health status of the inmate at this crucial point can also prevent additional complications, including assaults, suicide attempts, or rapid cognitive and emotional deterioration. The welfare of the inmate, other prisoners, the correction facility's staff, and the community is thereby protected, and legal or civil liability to institution or agency staff are better managed.

## **D-18. Mental Health Status of Pretrial and/or Presentence Inmates**

*Standard:* There is a written and implemented policy and procedure approved by the facility's and/or organization's chief executive for notifying the court and/or inmate's attorney if mental health disturbance or suicide risk is identified via intake screening and assessment of detainee, pretrial and presentence inmates. Such notification will be documented and placed in the inmate's mental health services file.

## **Discussion**

Every effort should be made by the chief psychologist to notify the offender's pretrial counsel of any mental illness or disturbance because the condition may have a profound impact on the individual's mental 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.

## **D-19. Inmate Orientation**

*Standard:* Within 1 week of admission to a facility, inmates receive a verbal and/or written communication orienting them to the procedures for gaining access to mental health and psychiatric services, limits of confidentiality, duty to warn, informed consent to screening and treatment, documentation, impact of treatment on program movement, crisis interventions, involuntary treatment, releases of information, and review of their mental health services records.

## Discussion

This standard ensures that all offenders, inmates, and residents know how to access mental health services, understand informed consent, and understand limits of confidentiality when interacting with mental health services staff. This 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. Otherwise, the services of an interpreter are utilized. Signs posted only in the booking, admission, or reception area do not qualify as compliance with this standard.

Inmates should be reassured that mental health services will not be withheld 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, they are reassured that basic psychological services (e.g., screening, assessment, treatment recommendations, and referrals) are not withheld on the basis of custody status, economic status, nature of psychological symptoms, criminal, civil, or wartime offense, or as punishment for rule violations.

### D-20. Psychological Assessments

*Standard (a):* Routine evaluations. All inmates with sentences longer than 1 year are given a standard psychological evaluation *within 1 month* of admission. Such routine evaluations may be brief and include (but not necessarily be limited to) behavioral observations, record and file review, group testing to screen for emotional and intellectual abnormalities, and brief written report of initial findings placed in the confidential mental health services' file. Referral for more intensive individual assessment is made on the basis of the results.

*Standard (b):* Comprehensive evaluations. 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 required sooner.

As applied to inmates in a jail setting diagnosed with a major mental illness and/or placed in a mental health treatment program, this standard includes the following:

- A. Reviewing earlier screening information
- B. Contacting prior psychotherapists or the individual's family physician regarding any history of mental illness
- 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; referring the individual to an appropriate mental health resource or to his or her family physician (if indicated and when release is imminent); or beginning appropriate care in the jail by staff members of the psychological and/or psychiatric services

As applied in a prison setting, this standard includes,

- F. Reviewing earlier screening information and psychological evaluation data and collecting and reviewing any additional data to complete the individual's mental health history

- G. Collecting behavioral data from observations by correctional staff
- H. Administering tests that assess levels of cognitive and emotional functioning and the adequacy of psychological coping mechanisms
- I. Writing a report describing the results of the assessment procedures, including an outline of a recommended plan and treatment
- J. Documenting any indication by the inmate of a desire for help
- K. Communicating results to the referral source
- L. Filing a written report of findings and recommendations

(Note: All personnel who use psychological tests shall adhere to the *Standards for Educational and Psychological Tests* and *Ethical Principles of Psychologists and Code of Conduct* [American Psychological Association, 1974, 2002].)

## Discussion

The intent of these standards is to ensure that all newly admitted inmates be given a *brief* psychological evaluation so that inmates needing additional psychological or other mental health services are expeditiously referred, and to provide documentation of the nature of psychological problems existing within the facility's population. This assessment should be confidential, purposeful, respectful, minimally intrusive, and conducted in a manner that will encourage cooperation.

Furthermore, these standards are intended to ensure that the mental health status of inmates 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) during their incarceration, if not their sentence. It also ensures that the offender's or inmate's mental health status is known to the appropriate correctional staff and authorities.

These standards presume sufficient staff and resources. We recognize that such resources may not be available and that the provision of resources is often not within the purview of any individual psychologist or mental health services supervisor. 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 to meet this standard.

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.

## TREATMENT SERVICES

### D-21. Informed Consent

*Standard:* In keeping with professional standards of practice, prior to the initiation or change of any treatment protocol, the offender or inmate is assessed, diagnosed, and informed regarding the nature, length, anticipated duration, expected risks, and outcomes of the proposed treatment as well as professionally recognized/reasonable treatment alternatives. The offender's or inmate's legal guardian must be contacted according to jurisdictional standards. This process will be documented on a standardized Informed Consent form, signed and dated by the offender or inmate (or legal guardian) and the mental health services' provider, and placed

in the individual's confidential mental health services file. If the individual or individual's legal guardian refuses to sign, treatment will not be initiated unless the treatment is court ordered and involuntary.

### **Discussion**

Informed consent is a critical component of due process. It is a matter of professional ethics and 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, limits of confidentiality, expected outcomes to the client and/or legal guardian, and the individual's consent to participate in her or his treatment. Even if the treatment is court ordered and thus involuntary, the informed consent process is mandatory.

### **D-22. Evidence-Based Treatment and Treatment Programs**

*Standard:* Only those evidence-based psychological treatment methodologies recognized within the general psychological community are employed unless specifically exempt by facility or organizational administration policies. When such exemptions apply, the reasons for the exemptions are documented and incorporated in the psychological services policies and procedures. When such is the case, the next best treatment option is provided.

### **Discussion**

In the face of insufficient numbers of qualified mental health services staff, lack of sufficient treatment time, and the punitive politic of incarceration, it is important to remain focused on using evidence-based treatments. Doing so helps minimize the use of treatments that may seem appropriate because of their sociopolitical appeal, but may actually be harmful to the client and produce negative individual and social outcomes. In cases where empirically supported treatment does not exist for a given diagnosis, the psychologist or other mental health services provider should extrapolate from available literature.

However, mental health services personnel should use extreme caution when such extrapolation tempts one to use an uncommon or quasi-experimental approach that has received scant peer review. Generally, such approaches should be avoided. If used, complete professional documentation should be maintained (including notes regarding consultation with competent, authoritative staff) and maintained in the inmate's mental health services file.

As an additional precautionary note, this standard does not imply that everything psychologists or other mental health services providers do in the community is acceptable within a prison facility. For example, aversive therapy may be acceptable in the community but would be inappropriate in a correctional setting.

The requirement that there be a reasonable number of alternative psychological treatment programs is intended to recognize the complexity and uniqueness of each offender or inmate client and to prevent exclusive reliance upon any particular treatment modality, such as group, community, or milieu therapy. However, 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 department, institution, or agency resources and its inmate population.

### **D-23. Treatment Plans**

*Standard (a):* A written treatment plan exists for all offenders and inmates participating in psychological treatment (e.g., individual, group, specialized treatment such as sex offender treatment, and suicide risk management) and related services. This is developed by a qualified mental health staff in keeping with recognized professional standards, and, when necessary, in collaboration with other personnel involved in the plan.

*Standard (b):* Treatment plans are reevaluated on a semiannual or annual basis (more often if warranted) and revised as necessary. Revisions are based on a change of diagnosis, the amelioration of signs or symptoms, the emergence of new signs or symptoms, or evidence that the treatment approach is not effective in addressing the diagnosis and related signs or symptoms.

### **Discussion**

A professional treatment plan is a series of written statements that organize and specify the 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. It includes directions for nonpsychological services staff regarding their roles in the care and supervision of these individuals.

This plan should be thoroughly reviewed with the offender or inmate and signed and dated by him or her or legal guardian, and the treatment provider and should be routinely reviewed, updated, and maintained in the offender's or inmate's mental health services file.

Treatment plans and program notes are a widely recognized and a professionally mandated part of mental health services, and help ensure the cooperation of the client. Furthermore, treatment plans allow other mental health staff who may need to become involved when a crisis occurs to intervene more effectively.

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 and measured outcomes of treatment, provide for and support interim progress notes, and contribute to a termination summary report.

When the offender or inmate is enrolled in a treatment or a psycho-educational program (e.g., anger management, domestic violence), an outline of the treatment program including (a) its limits of confidentiality, (b) its start and end date, purpose, and methodology signed by the client, (c) chronological attendance record, and (d) notes is maintained in the offender's or inmate's confidential mental health services file.

### **D-24. Victims of Sexual Assault**

*Standard (a):* There is a written and implemented plan for the mental health assessment and treatment of inmate victims of physical and/or sexual assault. This plan will be compliant with appropriate state and federal laws and guidelines (e.g., Prevention and Elimination of Prison Rape Act of 2003).

*Standard (b):* Psychology staff should aid in the custodial evaluation following a physical or sexual assault by contributing recommendations about the need for protective custody, special cell arrangements (single celled), or in some cases, transfer to another institution. These



recommendations are provided to minimize the risk of physical or sexual assault in the future, and should be made with input from the inmate.

## Discussion

Inmates who have been victims of physical and/or sexual assault often experience post-trauma difficulties that lead to emotional and adjustment difficulties. Federal guidelines (e.g., Prevention and Elimination of Prison Rape Act of 2003) mandate mental health and supportive services for these inmates, and mental health services should be an integrated component of this care.

### D-25. Suicidal/Self-Injurious Inmates

*Standard (a):* Policies and procedures. Correctional departments, agencies, and facilities have written and implemented suicide prevention/intervention policies, procedures, and protocols that provide for staff training, inmate screening, assessment, management, treatment, and follow-up monitoring of suicidal or self-injurious inmates, both at reception and during their incarceration.

*Standard (b):* These policies and procedures are consistent with professionally recognized suicide prevention and management standards (e.g., National Commission of Correctional Health Care, American Correctional Association, American Association for Correctional and Forensic Psychology, National Institute of Corrections), and relevant statutory guidelines. Protocols shall provide for varying levels of intervention appropriate to the assessed suicide risk including nonpunitive observation in suicide-proof cells, and restraints, with constant to randomly scheduled (at not more than 15-minute staggered intervals) observations by designated staff when full-view constant monitoring is not available.

*Standard (c):* Staff training. Qualified mental health services staff routinely train non-mental health services staff (e.g., security, administrative, social workers, teachers) in suicide risk assessment, intervention, and referral procedures specific to the institution, facility, or agency. This training is provided at least on an annual basis.

*Standard (d):* Segregation inmates. As a part of a suicide prevention plan, inmates in segregation status are assessed at least once weekly, more often if warranted by diagnosis or department or agency policy, by qualified mental health services staff who assess inmates for suicide risk and other mental health concerns. Documentation of these assessments as well as referrals for follow-up services are placed in the inmates' confidential mental health services file.

*Standard (e):* Management of suicidal inmates. The facility has an implemented policy regarding a level of humane management (e.g., availability of personal property, meal preparation and eating utensils, bedding, levels of confinement or restraint) that minimizes any potential self-harm risk until the initial mental health or medical assessment is undertaken.

### D-26. Placement in Observation or Suicide Watch Status, Pre- and Postrelease Assessments

*Standard (a):* There is a written, standardized policy and procedure for placing a potentially suicidal or self-injurious inmate, as well as the property assigned to the inmate, in a secure, safe, and visually accessible cell for observation pending a mental status and suicide risk assessment by a qualified mental health services staff.

*Standard (b):* A suicidal inmate placed in observation status by other than mental health staff (e.g., security staff) must be assessed for suicide risk, management, and intervention needs—including a psychiatric referral or transfer—by qualified mental health staff within 24 hours of initial placement. After the initial assessments, mental health status assessments will be done at least every 48 hours during nonworking days and every 24 hours during scheduled working days, until the inmate is released or transferred to an appropriate mental health care

facility. Documentation of these assessments will be placed in the inmate's confidential mental health services' file. The rationale for lowered levels of observation or monitoring and release to preplacement status are thoroughly documented and placed in the individual's mental health services file.

*Standard (c):* Postrelease assessments by mental health professionals occur at least twice weekly (more often if assessed risk warrants) until determined otherwise by qualified mental health services staff.

*Standard (d):* If inmates are utilized to maintain observation of suicidal inmates, there is a standard policy and procedure for selecting these inmates, how they are utilized, and how their observations are documented. Ideally, the selection of these inmates involves a collaboration of both mental health services and other appropriate facility staff (e.g., social workers, security staff).

## Discussion

Inmate suicide remains one of the leading causes of inmate death, and professionally recognized standardized policies and procedures for assessing and managing suicidal inmates are a critical and constitutionally mandated component of any correctional departments, agency, or facility's mental health program. A large percentage of wrongful-death civil litigations have resulted from inmate suicides, and without such policies and procedures, department, agency, and/or facility staff, including mental health services staff are increasingly vulnerable to such litigation. Litigation is a highly stressful process and settlements can be very costly and can place professional careers in jeopardy. Having standard policies and staff well trained in suicide prevention assessment, prevention, and intervention procedures can minimize that vulnerability.

### D-27. Restraints

*Standard (a):* A suicidal, self-injurious, or consistently assaultive inmate whose behavior appears out of his or her volitional control and who is placed in physical restraints, is assessed by a qualified mental health professional as soon as practical, but no later than within an hour of placement.

*Standard (b):* After the initial assessment, assessments of mental status occur at intervals no longer than every 12 hours to determine the inmate's mental health status and to make recommendations for continued restraint placement, reduced levels of restraint, or release, to the appropriate authority. Assessments occur more frequently if warranted.

*Standard (c):* Following release from restraints, the inmate is seen as warranted to assess, manage, and intervene to minimize suicide risk, but not less than once per 5 working days until otherwise decided by qualified mental health services staff.

*Standard (d):* Forms necessary for the documentation of screening, assessment, levels of intervention, monitoring, and follow-up procedures are readily available to staff for completion. This documentation is placed in the inmate's confidential mental health and medical records file in sufficient time to afford professionals an opportunity for review within 5 working days; sooner if the assessed risk and level of intervention warrants.

*Standard (e):* Transfer. When the safety of the individual cannot be ensured following release from clinical observation or restraints status, a referral and secured transfer of the suicidal or self-injurious inmate to a mental health or medical treatment facility is arranged and implemented.

### D-28. Termination of Treatment

*Standard:* There is a written, implemented procedure that provides for the orderly discharge of offenders and inmates from psychological or suicide management/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 inmate or offender is released) and to make clear who is in a treatment relationship and why. 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 or suicide risk management 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, and reason for termination (e.g., treatment goals met, transfer to another institution, release to the community). The report should be filed in the offender's or inmate's primary psychological services file, with copies distributed to appropriate facility or agency correctional staff as needed (e.g., social workers and parole agents).

## TRANSFERS

### D-29. Mental Health Care Within Multisite Agencies

*Standard:* Multisite prison organizations have sufficient resources for managing and providing mental health treatment for seriously mentally ill inmates, either in specifically designated on-site special management units or a separate mental health facility. If a transfer to a separate mental health facility is necessary, such transfer is carried out expeditiously in keeping with written policies and procedures.

## 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 chronic danger to themselves or others or who are psychologically unable to meet basic needs to care for themselves. The department, agency, and/or facility must be able to access and provide an adequately staffed program to meet these inmates' needs.

When such is not the case for acutely psychotic or chronically mentally ill inmates, they should be transferred to mental health institutions designed to care for them. Procedures should be in place, and evidenced by practice, for such transfers to occur in keeping with the seriousness of the inmates' condition. For example, inmates who are seriously decompensated and self-injurious should be transferred within a day or two.

### D-30. Mental Health Consultation for Housing, Program Assignment, Disciplinary Sanctions, and Transfers

*Standard:* There are written and implemented policies and procedures that require qualified mental health services staff be consulted prior to taking the following actions with respect to emotionally disturbed or seriously mental ill 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 inmate 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.

Housing and cell changes can be very stressful for seriously mentally ill inmates and may exacerbate their symptoms. Consequently, such changes should not be made without very good reason or without consultation with a mental health services provider. The same can be said for program assignment changes.

Inmates being considered for voluntary or involuntary protection or disciplinary sanctions involving isolation (e.g., disciplinary or administrative segregation) have access to psychological assessment procedures that take account of psychological information regarding their mental status and effects of segregation, which is provided to the disciplinary committee during the due process hearing. There should be a disciplinary administrative policy that provides disciplinary exceptions for inmates who, because of their mental illness, are not able to manage their behaviors in compliance with the standards of the facility. Continuity of psychological and psychiatric care is very important, and should be maintained for inmates with mental health needs during their placement in segregation.

### **D-31. Transfer to Another Correctional Facility**

*Standard (a):* The mental health status of inmates to be transferred to another correctional facility is assessed prior to transfer. This may be accomplished through a file review or individual assessment depending upon level of need and current mental health status. This assessment will be documented and accompany the inmate when transferred.

*Standard (b):* Prior to transfer, mental health services staff at the sending institution will notify their counterparts at the receiving institution of the pending transfer of inmates with severe mental health, suicide management, or disability needs.

### **D-32. Transfer to a Mental Health Facility**

*Standard:* Acutely mentally ill or suicidal inmates whose screened or assessed mental health treatment needs exceed those of the resources of their facility are expeditiously secured, referred, and transferred, to an appropriate mental health facility in compliance with due process and transfer procedures.

### **D-33. Transfer for Chronic and/or Convalescent Mental Health Care**

*Standard:* Inmates requiring care and treatment for serious chronic mental illness and care beyond the resources of their facility are referred and transferred to a more appropriate mental health care facility.

## **Discussion**

Generally, correctional facilities are inappropriate places to house seriously mentally ill and developmentally disabled inmates. Inmates 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 are consulted when questions of care arise.

**D-34. Transfer of Decompensating Segregation Inmates**

*Standard:* There is a written policy and implemented process for transferring inmates in segregation who continue to decompensate to a designated mental health facility for stabilization and treatment.

**D-35. Transfer of Developmentally Disabled Inmates**

*Standard:* Inmates who are mentally retarded or developmentally disabled are referred and transferred 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**

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 other age and cultural group.

Partially as a result of deinstitutionalization and changes in criminal legislation, more developmentally disabled individuals are being incarcerated than was historically the case. These individuals are often more 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.

For developmentally disabled inmates, or those with documented borderline intellectual functioning found to be legally competent, special programming care is taken in making classification and training decisions. The results of consultation with appropriate community resources are given serious consideration. Programs for these individuals 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. Ideally, a designated mental health services provider routinely consults with the disciplinary committee in making disciplinary decisions.

**D-36. Involuntary Transfers**

*Standard:* Due process. Transfers that result in offenders being involuntarily placed in facilities that are specifically designated for the care and treatment of the severely mentally ill comply with due process procedures as specified in constitutional amendments, federal law, and state 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 timely verbal and written notice to the inmate of his or her rights, a hearing at which evidence is presented that supports the proposed transfer, testimony of both supportive and defense witnesses, an independent decision maker from outside the facility, qualified, independent assistance for the inmate. A copy of the documentation of this process is maintained and kept in the inmate's confidential mental health services file.

### D-37. Transfer to the Community

*Standard (a):* There are written, implemented policies and procedures that require mental health services personnel to ensure that provisions are made for appropriate postrelease follow-up mental health care in the community for seriously mental ill inmates prior to their release and transfer.

*Standard (b):* The policy will include a due process procedure for inmates whose treatment, including psychotropic medication, is a condition of their community supervision.

*Standard (c):* Release procedures include,

- (i) Arranging contact with a qualified community mental health services provider as soon as is practical
- (ii) A prescription for psychotropic medication adequate to ensure the inmate has sufficient medication until the date of the arranged contact with the community mental health provider, or for four weeks, whichever occurs first
- (iii) Notifying the community agent of record of prescribed medication and appointment(s) with the community-based mental health services provider

*Standard (d):* 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 inmate's and community's safety, there is a prerelease process that is consistent with statutory provisions for emergency detention, involuntary treatment, and assessment for civil commitment for mental health care.

*Standard (e):* Prerelease documentation is placed in the inmate's confidential mental health services file.

## Discussion

Mentally ill inmates are often released to the community without adequate follow-up care. This is more likely now because states are ironically attempting to find ways of reducing their corrections budgets that includes the early release of inmates. This is frequently the by-product of a general community disinterest in helping offenders, limited community mental health provider and financial resources, limited health insurance and employment options making it difficult for just released inmates to pay for mental health services, and a limited number of qualified providers willing to see individuals under these circumstances.



However, mental health needs for mentally ill offenders and inmates often require a continuum of services that do not terminate because the inmate is released from a facility. Providing treatment for these individuals contributes to a more likely successful transition into the community, including the reduction of recidivism. Therefore, there should be a department or agency policy that mandates that the treating psychologist (or designee), in collaboration with the psychiatrist of medical psychologist and social worker, ensures that follow-up treatment services are arranged as part of the mentally ill inmate's release plan. Transitional mental health care should involve consultation and coordination with the supervising agent and other community agencies that are responsible for such care.

## QUALITY ASSESSMENT

### D-38. Policies and Procedures

*Standard:* 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 mental health services staff, the chief psychologist in a multisite system or regional system, and to the administration in a single-site facility or correctional agency.

### D-39. Multidisciplinary Reviews

*Standard:* Mental health services staff facilitate weekly meetings with other designated institution staff (e.g., psychiatrist, medical services, security, social services) to ensure optimal provision of mental health services by reviewing designated client cases and issues. Documentation of these meetings is maintained by the psychology supervisor of mental health services or designee.

## Discussion

Quality assessment and improvement procedures should be an integral part of any correctional psychology service delivery and treatment program process. Such procedures may 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 stated goals, and to determine whether the new program is an improvement over the previous program.

### D-40. Consultation

*Standard:* There is a written policy outlining the purposes and procedures for hiring contract, part-time, and consultant mental health services staff. This policy also requires that these individuals are properly screened for their qualifications and ability to work with inmates and offenders, and that they complete orientation sessions regarding mentally ill inmates. This training is conducted by the on-site psychology supervisor or designee, and should be properly documented.

## Discussion

The use of community resources serves to enrich department, agency, and facility mental health programming to the benefit of offender and inmate clients, professional staff, and the community. These resources should be viewed as an integral part of any correctional mental health service.

When utilization of community resources involves a bidding process with a provider contract going to the lowest bidder, there is a temptation to award a contract to the lowest bidder to save economic resources 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.

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 mental health services staff member who is responsible for the contract, whether at the department, agency, or facility level.

### D-41. Coordination With Advisory Committees

*Standard:* Mental health services staff consult 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

A department, agency, and/or facility advisory committee often helps meet an important program need by involving the best community talent to assist in resolving a variety of department, agency, or facility problems. Psychological services personnel should strive to make themselves available as consultants to all levels and classification of staff at the correctional agency or facility. Such consultation may be of a formal, scheduled nature or conducted on an informal as-needed basis.

### D-42. Psychology Internships

*Standard (a):* Correctional departments, agencies, or facilities that sponsor or provide for psychology internships follow current jurisdictional and professional psychology internship program and supervisory guidelines.

*Standard (b):* Offenders and inmates receiving mental health services from psychology or other mental health discipline interns are informed of the intern's status, the name of his or her supervisor, and the scope of the supervisor's role. Such notification is documented on the appropriate Informed Consent and Limits of Confidentiality forms.

*Standard (c):* Interns should not be used as a substitute for qualified psychology staff, nor should they be requested to provide mental health services to offenders or inmates for which they are not adequately trained or competently supervised.

## Discussion

As the need for qualified correctional mental health services staff increases, correctional facilities and organizations may offer psychology internships to qualified students from a

diverse array of psychology and counseling college or university programs. Such internships can provide a rich resource for recruiting future psychology staff to work in correctional and forensic settings.

When psychology internships are offered, there is a licensed 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., American Psychological Association) and current professional practice standards as apply to staff from other disciplines.

#### **D-43. Volunteers**

*Standard:* Mental health services personnel use community volunteers in a variety of programs under the supervision of the chief psychologist. The implemented written policies and procedures include a system for selection, 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 or on-site psychology supervisor.

#### **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 mental health 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 mental health 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 is responsible for the volunteer's behaviors and activities.

#### **D-44. Other Programs**

*Standard:* The mental health services staff collaborate in the preparation and implementation of facility-wide planning; for example, the institution's master plan, facility design, disaster plan, staffing, staff screening, mental health services, and program delivery.

## Discussion

It is important that mental health services views itself and is seen by other facility and organizational personnel as part of the total department, agency, and facility 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.

Mental health services staff should strive to become involved in the challenges of making the department, agency, and facility function more effectively in keeping with department, agency, and facility's mission and goals. In the face of limited resources, this may entail first attending to high-demand need (e.g., attending to the needs of seriously mentally offenders and inmates) at the expense of lower-demand needs (e.g., meeting the needs of less mentally ill offenders or inmates), or modifying involvement in program delivery (e.g., sex offender treatment or anger management programming for only high-risk offenders or inmates). These are the kinds of decisions and challenges that will continue to face correctional organizations and facilities, and the mental health services staff working in them. In the end, collaborative planning and discussion will yield the best outcomes.

### E. MENTAL HEALTH RECORDS

This section provides standards related to the access, confidentiality, documentation, storage, and destruction of mental health records and documents. The goal is to have a clear, standardized process for the creation, confidential storage, access to, and destruction of inmate, resident, and offender mental health records.

#### E-1. Access, Dissemination, Security, Storage, and Destruction of Mental Health Services Records

*Standard (a):* There are written and implemented policies approved by the mental health services administrator (in a multisite or agency organization) that specify the procedures for access, dissemination, security, confidential storage, and destruction of mental health records. The procedures are in compliance with current legal and professional standards.

*Standard (b):* In each facility or agency, there is a designated records custodian who ensures compliance with the procedures.

## Discussion

Department, agency, and facility staff, offenders, inmates, and residents should be informed that correctional mental health records are ethically and legally confidential to them and/or to their guardian or custodian. This confidentiality is protected by federal, state, county, and licensing laws and there are civil and criminal penalties available for violations of these laws. Staff, offenders (both adult and juvenile), inmates, residents and their guardians/custodians should have the policies and procedures regarding access, review, copying, distribution to third parties with and without their written consent, and the correction and destruction of mental health information, available in writing prior to the initiation of any mental health services.

Mental health services staff, as well as staff who are responsible for maintaining and releasing mental health information, are ethically, professionally, and legally responsible

for the awareness of and compliance with governing policies and procedures. Ordinarily, the on-site agency or facility supervising psychologist (or designee in his or her absence) would be responsible for the maintenance and release of mental health records. In a multi-site organization, this process would be coordinated by the psychologist administrator, who ensures that the appropriate confidentiality standards are followed in each facility or agency. In either case, except where the facility is exempt by administrative code or statute, the highest possible level of confidentiality is maintained, and the need to know will be determined by the psychologist administrator, on-site psychology supervisor, or designees.

Department, agency, or facility employees with different levels of psychological sophistication may be permitted access to selected information from an offender's or inmate's mental health/psychological records only on a need-to-know basis. Employees should be aware of 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 with resulting recommendations implemented whenever feasible.

## **E-2. Provision of Confidentiality Information**

*Standard:* Prior to an offender, inmate, or resident receiving any significant psychological service or entering into a screening, assessment, or therapeutic or treatment relationship or program, confidentiality information is provided in both verbal and written form. This shall be documented on a form designed for that purpose, signed by the individual and the designated mental health services provider, and placed in individual's mental health services file. Ideally, this should be done prior to initial intake 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 individual's mental status precludes this process, it is done at the earliest possible time following stabilization.

## **Discussion**

Individuals have an important stake in what is documented in their mental health records. Psychological services personnel, like any other professional, are capable of errors, and client reviews may correct mistakes. Individuals may make additions/corrections to objectionable statements in their mental health services' file record, but all documentation is included as part of the record. Individuals left to imagine what a therapist's report contains may conjure up the worst, destroying an ongoing (or future) therapeutic relationship. Keeping clients informed enhances the quality of the therapy relationship by making it more transparent, and can contribute to a more positive response to correctional mental health services.

## **E-3. Documentation**

*Standard (a):* There is a written and implemented policy, approved by the psychology administrator in a multifacility organization or on-site psychology supervisor regarding standardized documentation and organization of mental health services files. This includes the format, content, time frames, and signatures of entries. This policy conforms to current professional, administrative, and forensic guidelines.

*Standard (b):* All documentation is made in a timely manner, the timeframe not to exceed 5 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 mental health services staff will need to follow up within the next working day.

*Standard (c):* All individuals for whom correctional mental health records are available are provided the opportunity to document any refutation or correction of information in their mental health record.

## Discussion

Documentation is the lifeblood of communication among mental health staff and between mental health and other staff. Nonetheless, documentation is often subject to important ethical, legal, and forensic guidelines.

In an age of increased forensic scrutiny, correctional mental health services providers should anticipate that their documentation may be used in court and forensic proceedings. Therefore, it is essential that mental health services' communications be consistent with professional standards for forensic documents. Written documentation should be legible, and all documentation indicate what service was provided when, to or about whom, who provided it, and the provider's status and place of employment.

Documentation should be formatted and organized in a way such that changes in mental status, diagnosis, treatment, programming, chronological progress, termination, referrals, consultations, and other contacts with mental health services staff are easy to follow and assimilate by another mental health service provider who, although unfamiliar with the client, may need to provide an interim service. This may be especially important in the event of a crisis.

### E-4. Contents and Storage

*Standard (a):* Confidential mental health records are maintained in a secured area. These records contain, but are not limited to, historical mental health information, the completed admissions psychological screening form, test results (excluding raw data and/or protocols), findings, diagnoses, referral, consultation informational 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.

*Standard (b):* Confidential mental health records are secured and stored separately from other incarceration/correctional records.

*Standard (c):* Records containing raw test data are stored in a manner that facilitates both confidentiality and easy access by trained mental health service providers.

*Standard (d):* For inmates released to community supervision, the mental health services record is kept at a central location that facilitates access by department or agency mental health services staff.

*Standard (e):* For mental health records electronically stored in a central record data base, access to these records are maximally protected by access codes and encryption suitable to maintain optimum confidentiality.

## Discussion

The importance of accurate and complete mental health services 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 against possible litigation.

Following the initiation of a mental health services record, a problem-oriented record structure is highly recommended. Although a mental health services record may not be established for each offender, they should be for each inmate. The completion of a psychology screening process should initiate the creation of a psychological services record. This record should be at the same facility as the inmate 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.

### **E-5. Requests for Review and Copies of Mental Health Services Records**

*Standard (a):* There are written, implemented policies and processes that provide for a timely response to offender, inmate, or guardian/custodian requests to review or have copies of their mental health records. The time between a request and the provision of a review or copy does not exceed 10 days, and is expedited when requests involve a legal matter.

*Standard (b):* Offenders, inmates, residents, and guardian/custodians are informed of how to access mental health services records for review or have copies of any records that are ethically/professionally/legally approved.

*Standard (c):* When such a request involves reviewing test, assessment, and diagnosis results, a qualified mental health services provider is available for consultation.

*Standard (d):* Policies and procedures exist to provide for correction or refutation of mental health information in the mental health services record. Corrections and refutations are documented and filed in the mental health services record.

### **Discussion**

Since offenders, inmates, and residents have an important stake in what is stated in their mental health services record, they must have ready access to their psychological services record through a timely and convenient process. This includes access to a qualified mental health professional during this review if it involves assessment, test interpretation, or diagnoses. Clients left to imagine what a mental health services report may contain may conjure up the worst, potentially interfering with a therapeutic relationship. If therapists are aware that their clients have access to their reports, it may motivate them to write readily understandable and objective reports.

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

### **E-6. Transfer of Records**

*Standard (a):* There are written policies and procedures providing for the transfer of mental health services file that are implemented when there is a transfer from the community to a facility, one facility to another, or a facility to the community.

*Standard (b):* When an inmate or resident is transported to another facility, their mental health services file arrives at the receiving institution either before or with the inmate.

## Discussion

When an inmate or resident, especially a mentally disturbed individual, is transferred, every effort shall be made to ensure the implementation or continuity of treatment while avoiding unnecessary duplication of tests and evaluations. Therefore, it is important that the transfer of mental health 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 mail, fax, or telephone in an emergency, to be followed by written documentation; (b) ensure that the inmate's or resident's psychological records are forwarded in order to reach the receiving institution before or at the same time as the individual; 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.

### E-7. Release of Psychological Information

*Standard:* There is an implemented policy and process that both informs offenders, inmates, residents, and custodian/guardians regarding the limits of their control over the release information from a mental health services file to a third party with and without their consent, and provides for their (or their custodian/legal guardian) documented authorized release of the specified information. A legally recognized release of information form meets the standards of the current version of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) in America, or comparable standard if elsewhere: (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 the subject of the record (or custodian/guardian), (e) the date approved, and (f) when and by whom the information was released. The original is placed in the subject's mental health services file and a copy provided to the requesting party.

## 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 statutes, licensing law, and the federal Health Insurance Portability and Accountability Act. As part of their being informed regarding the limits of confidentiality of their mental health record, offenders, inmates, residents, and custodians/guardians are advised of the process and limits for releasing information to a third party and have the proper forms provided to them for releasing their mental health information to a third party.

### E-8. Destruction of Records

*Standard:* There is a written and implemented policy compliant with federal/state law regarding length of storage and the destruction of correctional mental health records.

## F. RESEARCH

This section highlights important considerations for conducting research with offenders and inmates. The goal is to provide the participants maximum protection from undue

harm by providing them with adequate due process, humane treatment, and follow-up information.

### **F-1. Contribution of Research**

*Standard (a):* Mental health services personnel are encouraged to conduct applied and/or basic research that improves the delivery of mental services and contributes to the development of theory and practice of correctional and/or forensic psychology.

*Standard (b):* Because research is imperative for improving mental health services, mental health services personnel facilitate the work of outside researchers and institutions who wish to conduct research in the correctional or forensic agency/institution.

### **Discussion**

Due to the increasing demand for direct mental health services, it is becoming more difficult for direct-services mental health staff to set aside time to conduct research. Nevertheless, within reasonable time boundaries, all qualified mental health staff should be afforded the opportunity for engaging in at least one evaluation or research project having practical relevance for correctional or forensic psychology. Moreover, mental health staff should help to facilitate research projects from outside parties when possible and in accordance with the agency/institution administrative procedures.

While it is important to increase the body of knowledge related to the practical application of psychological theory to the corrections area, the information sought should be researched and disseminated in a manner consistent with the highest ethical standards of the science and profession of psychology as well as the best interests of the offender participants and the public.

### **F-2. Compliance With Ethical Research Standards**

*Standard:* All psychological research in correctional facilities or agencies complies with the ethical standards of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (1976), the most recent standards published by the Office for Human Research Protections (2003) of the U.S. Department of Health and Human Services, the current research standards of the American Psychological Association, or comparable if in another country, and applicable international human rights agreements.

### **Discussion**

The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research 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 and potentially coercible 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.

There is considerable reason to believe that Category (c) research should never be conducted with inmates. The need is to balance protection of human beings with the pursuit of

scientific knowledge. The foreseeable consequences of participation should not involve undue physical or emotional stress; rather, researchers should respect the human rights, health, and dignity of the inmate participants. Moreover, the informed consent of the offender participants should always be obtained and appropriately documented prior to the conduct of any prospectively designed research project.

### F-3. Policies and Procedures

*Standard (a):* There are written and implemented administrative policies and procedures that require qualified mental health professionals to review and process research proposals that involve the use of offenders, inmates, or residents, and prior approval by a designated department or agency-level research advisory committee and institution review board prior to commencing.

*Standard (b):* Potential researchers will be advised of the research policies and procedures prior to commencing their research.

*Standard (c):* Participants are appropriately advised regarding their freedom to decline to participate in research without disciplinary or other negative consequences.

*Standard (d):* Participants will sign an informed consent form specific to the research project and prior to their participation.

*Standard (e):* The limits of confidentiality need to be fully disclosed, documented, and placed in participants' mental health services file. This includes informing participants that summary or aggregate data from the project may be used for research purposes.

*Standard (f):* Participants are informed prior to their participation that they will not receive any legal compensation for their participation in department or correctional agency psychological research.

*Standard (g):* Information submitted for a review of proposed research minimally includes (but not be limited to) the following:

1. The title of the project
2. The name, address, vita (including relevant research experience, capabilities, and publication list) of the researcher or researchers
3. A summary that briefly describes what will be done, how it will be done, intended purposes, anticipated results, protection of the participants from harm, and benefits to psychological and correctional knowledge
4. The anticipated duration of the project, with beginning and ending dates
5. The project's methodology
6. 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
7. 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
8. Internal review board approval, if the researcher is affiliated with a university or hospital setting that requires it

*Standard (h):* Upon completion of the research, a complete report regarding the outcomes of the research is prepared and submitted to the appropriate agencies and participants for review. Research participants must be given an opportunity to review the results of the project as well; however, this can be provided on an as-requested basis, as long as the researcher provides direction to the participant regarding how to make such a request.

### Discussion

The existence of formal procedures to obtain prior approval of all research studies is essential to protect offenders or inmates from being exposed to inadvisable, poorly controlled, and/

or inhumane research conditions. These procedures are documented and available for review by appropriate administrative and qualified mental health services staff prior to the approval and implementation of any research.

## REFERENCES

- Althouse, R. (2005). American Association for Correctional and Forensic Psychology standards for psychology services in jails, prisons, correctional facilities, and agencies: Ethical principles. *The Correctional Psychologist*, 37, 1, 4-5.
- American Association for Correctional Psychology. (1980). Standards for psychology services in adult jails and prisons. *Criminal Justice and Behavior*, 7, 81-127.
- American Association for Correctional Psychology. (2000). Standards for psychology services in jails, prisons, correctional facilities, and agencies (2nd ed.). *Criminal Justice and Behavior*, 27, 433-494.
- American Correctional Association. (1990). *Standards for adult correctional institutions* (3rd ed.). Lanham, MD: Author.
- American Psychiatric Association. (1989). *Psychiatric services in jails and prisons* (WMA512, No. 29). Washington, DC: Office of Psychiatric Services.
- American Psychiatric Association. (2000). *Guidelines for psychiatric services in jails and prisons: A task force report of the American Psychiatric Association* (2nd ed.). Washington, DC: Author.
- American Psychological Association. (1974). *Standards for educational and psychological tests*. Washington, DC: Author.
- American Psychological Association. (1987). *General guidelines for providers of psychological services*. Washington, DC: Author.
- American Psychological Association. (1992). Ethical principles of psychologists and code of conduct. *American Psychologist*, 47, 1597-1611.
- American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist*, 57, 1060-1073.
- Beck, A. J., & Maruschak, L. M. (2000). *Mental health treatment in state prisons, 2001. Bureau of Justice Statistics special report*. Washington, DC: Government Printing Office.
- British Psychological Society. (2006). *Code of ethics and conduct*. Retrieved from [www.bps.org.uk/the-society/code-of-conduct/](http://www.bps.org.uk/the-society/code-of-conduct/)
- Bureau of Justice Statistics. (2007). *Direct expenditures by criminal justice function, 1982-2006*. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics. Retrieved from <http://bjs.ojp.usdoj.gov/content/glance/exptypt.cfm>.
- Canadian Psychological Association. (2000). *Canadian code of ethics for psychologists* (3rd ed.). Ottawa, Canada: Author.
- Cohen, F. (1998). *The mentally disordered inmate and the law*. Kingston, NJ: Civic Research Institute.
- Cohen, F. (2007). Train your cops or else! *Correctional Mental Health Report*, 9(4), 64.
- Cohen, F. (2008). *The mentally disordered inmate and the law* (2nd ed.). Kingston, NJ: Civic Research Institute.
- Cohen, F. (2009). Components of a correctional mental health treatment program. *Correctional Mental Health Report*, 11(4), 49.
- Committee on Ethical Guidelines for Forensic Psychologists. (1991). *Specialty guidelines for forensic psychologists*. Washington, DC: American Psychological Association, Division 41.
- Ditton, P. M. (1999). *Special report: Mental health and treatment of inmates and probationers*. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics. Retrieved from <http://bjs.ojp.usdoj.gov/index.cfm?ty=pbdetail&iid=787>
- Dyer, J. (2000). *The perpetual prisoner machine: How America profits from crime*. Boulder, CO: Westview.
- Glaze, L.E. & Bonczar, T.P. (2008). *Probation and parole in the United States, 2006*. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics. Retrieved from <http://bjs.ojp.usdoj.gov/index.cfm?ty=pbdetail&iid=1106>.
- Health Insurance Portability and Accountability Act of 1996. (1996). Retrieved from <http://www.cms.hhs.gov/HIPAAGenInfo/Downloads/HIPAAlaw.pdf>
- Human Rights Watch. (2003). *Ill equipped: U.S. prisons and offenders with mental illness*. New York, NY: Author.
- Human Rights Watch (2006). U.S.: *Number of mentally ill in prisons quadrupled*. Retrieved from [http://hrw.org/english/docs/2006/09/06/usdom14137\\_txt.htm](http://hrw.org/english/docs/2006/09/06/usdom14137_txt.htm).
- James, J. D., & Glaze, L.E. (2006). *Special report: Mental health problems of prison and jail inmates*. Washington, DC: U.D. Department of Justice, Bureau of Justice Statistics. Retrieved from <http://bjs.ojp.usdoj.gov/content/pub/pdf/mhppji.pdf>.
- Knoll, J. (2007). Research review and commentary: Is reentry deadly? *Correctional Mental Health Report*, 9, 59.
- Kupers, T. (1999). *Prison madness*. San Francisco, CA: Jossey-Bass.
- Lurigio, A. J., Rollins, A., & Fallon, J. (2004). The effects of serious mental illness on offender reentry. *Federal Probation*, 68, 2. Retrieved from [http://www.uscourts.gov/fedprob/September\\_2004/illness.html](http://www.uscourts.gov/fedprob/September_2004/illness.html)
- Magaletta, P. R., Diamond, P. M., Faust, E., Daggett, D. M., & Camp, S. D. (2009). Estimating the mental illness components of service need in corrections. *Criminal Justice and Behavior*, 36, 229-244.
- National Association of Social Workers. (1999). *Code of ethics*. Retrieved from <http://www.socialworkers.org/pubs/code/code.asp>

- National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. (1976). *Research involving prisoners* (DHEW No. (OS) 76-131). Bethesda, MD: Author.
- National Commission on Correctional Health Care. (1999). *Correctional mental health care: Standards and guidelines for delivering services*. Chicago, IL: Author.
- National Commission on Correctional Health Care. (2008). *Standards for mental health services in correctional facilities*. Chicago, IL: Author.
- National Institute of Corrections. (1995). *Prison suicide: An overview and guide to prevention*. Mansfield, MA: Author.
- Office for Human Research Protections.(2003). *OHRP guidance on the involvement of prisoners in research*. Washington, DC: U.S. Department of Health and Human Services. Retrieved from <http://www.hhs.gov/ohrp/humansubjects/guidance/prisoner.htm>.
- Prevention and Elimination of Prison Rape Act of 2003. (2003). Retrieved from <http://www.justdetention.org/pdf/PREA.pdf>.
- Proband, S. C. (1998). Corrections populations near 6 million. *Overcrowded Times*, 9(2), 4.
- United Nations. (1976). *International covenant on civil and political rights*. Retrieved from [www1.umn.edu/humanrts/instree/b3ccpr.htm](http://www1.umn.edu/humanrts/instree/b3ccpr.htm)
- United Nations. (1977). *Standard minimum rules for the treatment of prisoners*. Retrieved from <http://www2.ohchr.org/english/law/treatmentprisoners.htm>.
- U.S. Department of Justice. (2006). *Memorandum of agreement between the United States Department of Justice and the state of Wisconsin regarding conditions at the Taycheedah Correctional Institution*. Retrieved from [www.usdoj.gov/crt/split/documents/taycheedah\\_agree.pdf](http://www.usdoj.gov/crt/split/documents/taycheedah_agree.pdf)
- Vitek v. Jones, 45 U.S. 480 (1980).
- Welch, M. (1999). *Punishment in America: Social control and the ironies of imprisonment*. Thousand Oaks, CA: Sage.
- Youngberg v. Romeo, 457 U.S. 307 (1982).



## INDEX

(letters and numbers refer to standards)

- Administration
  - meetings with, A-10
  - mission, A-1
  - responsibilities, A-2
  - structure, A-3, A-4
- Annual reports, A-7
- Annual reviews, A-8 (a), A-9 (a)
- Billing for mental health services, D-16
- Chief administrative psychologist, A-3 (b)
- Competence, C-3
- Confidentiality, C-5, C-6
- Community care (see Follow-up care)
- Constitutional standards
  - of mental health care, Introduction
  - of suicidal inmates, D-11
- Crisis referrals and evaluations, D-14
- Critical incident debriefing, D-11
- Deliberate indifference, Definitions
- Detainees, C-1, D-18
- Documentation, C-4
- Dual roles, avoidance of, B-1 (d), C-2
- Due process, D-10
- Emergency evaluations, D-14
- Ethical conflicts, C-9
- Ethical guidelines
  - general principles, C-1
  - individual rights, Principle A
  - minimizing harm, Principle B
  - maximizing good, Principle C
  - social responsibility, Principle D
- Evidence-based treatment, D-2
- Health Insurance Portability and Accountability Act (HIPAA), E-7
- Housing and housing assignments, D-8, D-17 (g), D-30
- Informed consent, C-7
- In-service training, B-4, D-5
- International treaties, Principle B, C-1, D-1
- Interpreters, D-2
- Internships, D-42
- Involuntary treatment, C-8
- Mental health services
  - administrative support of, A-6
  - availability of, D-1, D-4, D-12, D-15
  - guidelines, A-5
  - inmate orientation to, D-19
  - in segregation, D-15
  - orientation to, D-19
  - roles and services, B-1
- Monitoring of mentally ill and suicidal inmates, D-9
- Multidisciplinary reviews, D-39
- Pretrial and presentence inmates, D-18
- Prevention and Elimination of Prison Rape Act, D-24
- Professional development, B-5
- Psychological assessments, D-20
- Psychological treatment, D-22
- Psychology records
  - confidentiality of, E-1, E-2, E-4 (c)
  - contents/storage, E-4
  - destruction of, E-8
  - documentation, E-3
  - offender correction of, E-5 (d)
  - offender review, E-5
  - release of, E-7
  - transfer of, E-6
- Qualified mental health care provider, Definitions
- Qualified mental health care professional, Definitions, B-3, C-8, D-4
- Quality assessment/improvement, A-8, A-9
- Reception mental health screening, D-17
- Records management, E-1
- Records review, D-17 (f)
- Referral process, D-13, D-14
- Research, F
- Restraints, D-27
- Roles and services, B-1
- Screening and training of non-mental health service employees, D-5, D-6
- Serious mental illness, definition of, Definitions
- Supervision, B-2
- Staff training, B-5
- Staffing to inmate ratios, B-4
- Staffing requirements, B-2
- Standards of practice, Introduction, C-1
- Suicide prevention/intervention, D-25, D-26
- Supervision, B-2
- Support services, A-6
- Torture, prohibition of, Principle B
- Transfers, D-29, D-31, D-32,
  - of chronic or convalescing mentally ill inmates, D-33,
  - of decompensating segregation inmates, D-34
  - of developmentally disabled inmates, D-35
  - of involuntary transfers, D-36
  - community transfers, D-37
- Treatment plans, D-23
- Treatment termination, D-28
- Volunteers, D-4