Ethical and Professional Conflicts in Correctional Psychology

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The role of the mental health professional in a prison setting has changed to reflect the prevailing ideology of the correctional administration that deemphasizes treatment and emphasizes security and custodial concerns. As a consequence, mental health professionals who work in corrections have experienced unique ethical and professional conflicts. Standards were developed to address the conflicts and provide guidelines for professional conduct, but dilemmas continue to exist. The authors believe this can be attributed to (a) the standards being vague and (b) correctional personnel not understanding or supporting the standards or the psychologist’s role as a mental health professional. This article examines these propositions in more detail, using vignettes and discussion, and offers other approaches to resolving the dilemmas and improving the delivery of mental health services to incarcerated individuals.

Historical Perspective

Mental health professionals who work in corrections have experienced ethical and professional conflicts that are unique to these institutions. Appreciating the mental health professional’s role within a prison entails an examination of how our society has treated those who violate the law. Historically, most societies have adopted a philosophy that those individuals who commit criminal acts should be punished. Modern Western judicial systems have justified their use of punishment on four major grounds: retribution, deterrence, incapacitation, and rehabilitation (Grilliot, 1983; Kerper, 1972). Retribution has Biblical roots referring to “an eye for an eye.” Deterrence operates from the core belief that those who see individuals punished will be less likely to follow the example of offenders because of the fear of punishment. Incapacitation has as its primary goal the protection of society by rendering offenders unable to repeat the offense. Rehabilitation is conceptualized as treating or “correcting” offenders so that they can live in society and not reoffend.

The theory of rehabilitation is a relatively new objective used to justify punishment and has undergone many reformulations as our society’s attitude toward criminal offenders has changed (Travin, 1989). Early American colonists believed that rehabilitation could be accomplished through solitude, hard labor, and contemplation of one’s criminal acts. The mainstays of this rehabilitation approach became tarnished somewhat in the 1960s and much more appreciably so in the 1970s and 1980s. There were many reasons for this, not the least of which was the failure of such efforts to significantly lower recidivism rates (Roth, 1986). Consequently, the role of the mental health professional changed to better reflect the prevailing ideology of the correctional administration (viz., deemphasizing treatment of the individual and emphasizing security of the institution as well as protecting the community at large; “Board Approves,” 1989; Ochipinti & Boston, 1987).

Organizational Models

Currently, the delivery of mental health services for individuals sentenced to correctional facilities tends to fall within four basic organizational patterns. The individual may receive treatment under one of the following: (a) in a correctional setting where both the mental health services and security needs are provided by the department of corrections; (b) in a correctional setting where the mental health services are provided by a separately administered mental health agency and security needs are administered by corrections; (c) in a mental health facility (e.g., a state hospital with a forensic unit) where both the mental health services and security needs are provided by the depart-
ment of mental health; and (d) in a mental health facility where the mental health services are provided by the department of mental health and the security needs are administered by the department of corrections (Nelson & Berger, 1988). The states vary with respect to mental health services being provided by a department of mental hygiene versus a department of corrections. In those state systems where mental health services are administered by the department of corrections, the institution's warden has authority over chief psychologists and other mental health departmental heads.

A national survey was recently published regarding mental health services (i.e., 24-hr hospital mental health care, residential treatment programs, counseling/therapy, medication monitoring, and testing/assessment) for state adult correctional facilities (Morrissey, Swanson, Goldstrom, Rudolph, & Manderscheid, 1993). The results of the survey found a pattern that "as one moves from intensive to less intensive services, the more likely it is that services are provided under the auspices of the individual prison or another State department of corrections (DOC) facility" (p. 2). As a large proportion of psychologists tend to provide outpatient care (i.e., less intensive treatment), this trend suggests that their services to inmates are more likely to fall under the correctional system than the mental health system.

The delivery of psychological services within the federal system is managed by the Federal Bureau of Prisons. There is an overall chief administrator of psychology located at the central office in Washington, DC. The next level in the organization reflects a division of the states into various regions (e.g., western, eastern, southern, etc.) with a regional administrator who oversees the activities of the chief psychologists within the individual federal prisons. Each federal prison has a chief psychologist who supervises the activities of staff psychologists working at that institution. Although the organizational hierarchy in psychology is responsible for providing direction and support for general policy, the actual day-to-day administration of psychological services is directed by the chief psychologist of that prison. In turn, the chief psychologist's direct administrator of these services is the associate warden of programs who reports to the warden. The underlying philosophy was that all employees were considered correctional officers first and foremost. Such expectations of psychologists are not peculiar to the federal system but endemic to most correctional institutions ("Board Approves," 1989; Clingempeel, Mulvey, & Reppucci, 1980). Consequently, psychologists are expected to engage in custody-oriented activities that may at times undermine the traditional therapeutic goals and relationship between the therapist and the individual inmate, thus causing ethical and professional dilemmas.

In some states as well as in the federal prison system, the justification for placing mental health services under the administration of corrections is that there would be fewer problems and more available resources. For example, psychologists would not be seen as "outsiders," and departments of corrections tend to obtain resources more easily than do departments of mental health because of their priority status in getting funds (Levinson, 1985; Nelson & Berger, 1988). In addition, if mental health care were delivered within the department of corrections, legal issues regarding the transfer of individuals from the jurisdiction of corrections to mental health would be averted (Vitek v. Jones, 1980). Under these organizational contexts, staff psychologists who encounter ethical dilemmas may seek the support of their profession's departmental head. However, given that these psychology administrators do not hold ultimate authority, the dilemmas may not be resolved. This article will primarily focus on those systems where mental health does not function autonomously but under the auspices of corrections.

**Treatment Versus Security Model**

The move of correctional institutions from a treatment model to a security model has not always been a comfortable fit for psychologists working in the system. The primary role of mental health professionals as perceived by correctional administrators has evolved into that of applying their expertise and skills to custody matters (viz., ensuring a compliant and manageable inmate population). Under these conditions, the psychologist is compelled to address the needs of the institution as primary.

The United States Department of Justice, Federal Bureau of Prisons offered a good illustration of this. It was mandated that recently hired psychologists attend and successfully complete an intensive training program at Glyncyo, Georgia, site of the Federal Law Enforcement Training Center. The 3-week program was titled "Introduction to Correctional Techniques" (Federal Bureau of Prisons, 1986) and was designed to teach the new employee basic correctional concepts and tasks, which included inmate discipline review, self-defense, use of firearms, and searching for contraband. The basic purpose of this training program was to orient all employees to their custodial-disciplinary roles and duties in the Federal Bureau of Prisons. What was noteworthy about this training program is that no distinction was made between psychologists and other correctional employees. The underlying philosophy was that all employees were considered correctional officers first and foremost. Such expectations of psychologists are not peculiar to the federal system but endemic to most correctional institutions ("Board Approves," 1989; Clingempeel, Mulvey, & Reppucci, 1980). Consequently, psychologists are expected to engage in custody-oriented activities that may at times undermine the traditional therapeutic goals and relationship between the therapist and the individual inmate, thus causing ethical and professional dilemmas.

Over a decade ago, Brodsky (1980) and Clingempeel et al. (1980) described a variety of dilemmas faced by psychologists working in corrections. Some of the dilemmas they discussed were confidentiality, use of psychological assessment, and treatment interventions. The conflicting issues raised by the mental health professional's role as a custodial agent prompted the development of standards specific to correctional mental health. These standards arose from associations such as the American Public Health Association (Dubler, 1986), the American Medical Association (1979), and the American Association of Correctional Psychologists (1980). The areas of confidentiality, professional autonomy, medication, use of involuntary restraints, and licensure requirements were similarly addressed by the various standards. In addition, the standards provided guidelines for professional conduct sensitive to the needs of both mental health and corrections (Levinson, 1985; Travin, 1989). In 1991, "Specialty Guidelines for Forensic Psychologists" was developed by the American Psychological Association's Division 41 in an effort to "provide more specific guidelines to forensic psychologists in monitoring their professional conduct" when functioning in correctional and forensic mental health facilities.
as well as in other areas of forensic professional practice (Committee on Ethical Guidelines for Forensic Psychologists, p. 655). The creation of this standard plus the addition of “Forensic Activities” in the American Psychological Association’s Ethical Principles of Psychologists and Code of Conduct (1992) illustrate the growth of psychologists engaging in forensic work and the need for guidance in performing ethically and toward the “highest ideals of psychology.”

Despite the existence of the various standards, many ethical and professional dilemmas continue to plague psychologists working in corrections. This is particularly so if mental health does not function independently but under the administration of the department of corrections. We believe this can be attributed to the following: (a) the standards for psychologists are vague and (b) correctional personnel do not understand or support the standards and/or the psychologist’s role as a mental health professional. The remainder of this article will examine these propositions in more detail using vignettes and discussion.

Vignette 1

Psychologist A receives a call in his office from the associate warden, directing him to report to Unit C, where they are short of correctional officers. Psychologist A reports to Unit C and participates in the evening count. Subsequently, he is approached by the captain and directed to perform a search for contraband of the inmates’ property. The psychologist is also told he will have to “pat search” all inmates in his section. The psychologist is to seize any contraband and report all infractions to the captain.

The above vignette represents an example where the psychologist is asked to perform a correctional officer’s duties. In examining the various professional associations’ standards (American Medical Association, 1979; American Association of Correctional Psychologists [AACP], 1980; Dubler, 1986), there is no clear statement as to the circumstances under which a psychologist should or should not perform correctional officers’ tasks. Generally, psychologists who work in correctional institutions accept the importance and primacy of security (Goldstein, 1983). Further, the Bureau of Prisons Psychology Manual (Federal Bureau of Prisons, 1987) states that under emergency situations “psychologists function first and foremost as correctional workers” (Sec. 3.4). However, under nonemergency conditions, the manual cautions psychologists to avoid violations of the American Psychological Association’s Ethical Standards (American Psychological Association [APA], 1989). In that the manual does not define or describe what situation constitutes an “emergency” for psychologists assuming correctional duties, this allows a wide range of events to be interpreted as “emergencies.” The scenario we described is one where the unit is short-staffed and correctional officers’ tasks need to be fulfilled for security purposes. Does this represent an emergency situation condoning the captain’s request for the psychologist to perform various custodial activities, ranging from an innocuous count to an invasive “pat-search” and reporting of infractions?

As stated earlier, the standards do not specifically address some issues, such as (a) psychologists’ correctional versus mental health duties and (b) what is meant by an “emergency” situation for psychologists to perform correctional duties. This state of affairs places clinicians in a “no-win” position. If clinicians cannot turn to standards to guide them or use the standards to decline participation in potentially dilemmatic activities, the correctional administration may have every right to expect psychologists to cooperate with their requests. Although the “Specialty Guidelines for Forensic Psychologists” (Committee on Ethical Guidelines for Forensic Psychologists, 1991) was designed for forensic psychologists who may be working in correctional settings, no clear direction is offered to help the psychologist resolve this particular conflict. Some experts such as Clingempeel et al. (1980) have concluded that when the standards do not provide definitive guidelines, psychologists are “forced to rely in large measure on personal values... in making decisions regarding custody vs. treatment” (p. 129).

In addition, when mental health professionals engage in correctional duties, the inmates’ perception of psychologists is affected. Among the costs of engaging in correctional activities is the compromise of psychologists’ credibility and efficacy. Permitting psychologists to function in dual roles destroys their therapeutic image and thus leaves them being perceived solely as a “cop.” This is problematic beyond the perhaps esoteric issue of role distortion. Prisons by and large do not have adequate mental health staffing; hence, this practice effectively results in leaving an institution that uses a psychologist as a correctional officer with one more of many other “cops” and one less of very few clinicians.

In our vignette, the short-term gain to the institution of the psychologist who serves custodial needs does not outweigh the long-lasting detriment to rehabilitation efforts that could be initiated by psychologists working within their mental health role. We accept that all staff members should function in ways that assure the maintenance of security. It does not seem unreasonable, however, to suggest that psychologists participate in such maintenance only in a manner that is congruent with a more traditional professional role.

Vignette 2

Inmate R is scheduled to appear before the prison disciplinary board for having violated the institution’s rules. Specifically, Inmate R was verbally abusive to one of the correctional officers and refused to report to her work assignment. This is the third such incident in the last week. If the board decides to impose a disciplinary measure, Inmate R could lose a number of earned “good-time” days and possibly be placed in administrative segregation. Psychologist B is asked to serve as one of the members of the disciplinary board. The psychologist does not know Inmate R and believes there is no conflict of interest.

Many believe that psychologists’ participation on prison disciplinary boards does not pose an ethical dilemma if there is no dual-role conflict present. A common perception is that as long as the psychologist is not the inmate’s treating clinician, no dilemma arises in being a decision-maker regarding the inmate. In fact, both the American Public Health Association (Dubler, 1986) and the American Association of Correctional Psychologists (1980) accept mental health professionals functioning as members of decision-making teams when they are not the inmate’s therapist. The standards, however, do not specifically address the issue of psychologists participating in decisions that result in punishment or discipline for the inmate. For example, prison disciplinary boards could exact measures such as (a) loss
of privileges, (b) loss of earned “good time,” (c) transfer of the inmate to a high-security institution (e.g., where more hardcore inmates are housed and the risk of victimization is higher), and (d) placement in solitary confinement for a lengthy period.

The standards’ lack of specificity do not give the psychologist any support or direction in what to do when asked to serve on a disciplinary board. Should the psychologist assume a role where the sole purpose of participation is meting out punishment for the inmate? This does not appear to be in agreement with the American Psychological Association’s Ethical Standards (APA, 1989, 1992; Williams, 1986) on psychologists’ primary commitment to the welfare and protection of individuals. Although the Ethical Standards of the American Psychological Association do not specifically comment on psychologists serving in decision-making roles where an individual could be punished, the standards do endorse psychologists taking “reasonable steps to avoid harming their patients or clients...and to minimize harm where it is foreseeable and unavoidable” (APA, 1992, Standard 1.14). Psychiatrists appear to be excluded from sitting on disciplinary boards because of their credo to “do no harm.”

Further, allowing psychologists to serve on disciplinary boards leads to the breakdown of our unique position to serve only mental health needs. Permitting psychologists to make disciplinary decisions erodes the traditional professional role. This occurs both externally (e.g., losing credibility among inmates; custody personnel viewing us as primarily correctional workers) as well as internally (e.g., the psychologist beginning to adopt a “jailer’s” mentality). Vague or nonspecific guidelines on this point leave the therapeutically oriented psychologist feeling lost and thwarted. It also grants the correctional administration the ability to influence the naive and pliant psychologist into adopting a disciplinary orientation. The “Specialty Guidelines for Forensic Psychologists” acknowledges that forensic psychologists’ personal values and moral beliefs may affect their ability to practice competently, and as such, they are “obligated to decline participation or to limit their assistance in a manner consistent with professional obligations.” (Committee on Ethical Guidelines for Forensic Psychologists, 1991, p. 648). Unfortunately, without a clear prohibition against psychologists serving as punishment/discipline decisionmakers appearing in any of the standards, there is room for interpretation, with the possible result of correctional psychology drawing those attracted toward controlling and punishing inmates rather than those inclined toward understanding and treating them.

On the other hand, some might argue that if psychologists serve on a disciplinary board, they could apply their knowledge and expertise to evaluating the inmate. Conceivably then, this could be used to help the inmate. Rather than serving as board members, we believe this desired effect could be similarly achieved if psychologists acted as consultants to the board. However, in accordance with preserving psychologists’ commitment to maintaining a therapeutic role, their involvement as consultants should only occur at the request of the inmate.

Vignette 3

Inmate X has a long history of violent behavior, which has resulted in his current imprisonment. While incarcerated, he has been a model prisoner. Inmate X has now been scheduled for a parole board hearing. Upon reviewing Inmate X’s central file, the warden believes that the inmate is still a dangerous individual who should not be granted parole despite his record of no institutional infractions. Accordingly, the warden requests that Dr. R evaluate Inmate X using psychological tests. The warden would like information about the inmate’s personality relating to his continued threat to public safety, and he would like this evaluation to be performed without the inmate being informed of its purpose because he believes Inmate X might otherwise refuse to participate in the evaluation.

The identification of dangerousness by mental health professionals has remained a much-debated issue. There are, however, a sizable number of clinicians who assert that through proper training, education, and experience, they can identify those features relevant to an individual’s threat of harm. One means of accomplishing such an evaluation would be through a thorough clinical interview, review and consideration of collateral sources of information, and the administration of select psychological measures.

In this scenario, the warden’s concern revolves around the issue of release of an individual whom he considers dangerous into the community. The warden, in his quest to obtain all relevant information to the issue of dangerousness for presentation to the parole board, solicits the assistance of the psychologist. The warden’s request for such an evaluation is qualitatively no different from commonly accepted requests made by judges to forensic psychologists and psychiatrists for probation and sentencing purposes. Moreover, psychologists and psychiatrists routinely evaluate hospitalized insanity acquittees as to their readiness for release into the community on the basis of their mental condition and the threat of harm to others. Therefore, it is not unreasonable or unrealistic for the warden to anticipate this as a job responsibility for the correctional mental health worker.

The problematic element in this scenario refers to the warden’s request for a “covert” evaluation where the inmate is deprived of his right to informed consent. The application of psychologists’ skills in such an important issue as the identification of dangerousness in an incarcerated individual demands respect and adherence to this fundamental ethical principle; however, an exception to this principle exists. Standards developed for mental health professionals in corrections have defined “emergency” conditions where one does not need to obtain informed consent prior to evaluation (AACP, 1980; American Medical Association, 1979; American Psychiatric Association, 1989; Dubler, 1986). These standards define the “emergency” as limited to life-threatening circumstances where there is a risk of escape or “the creation of internal disorder or riot” (American Psychiatric Association, 1989). We believe that to allow this scenario to fall under this exception would be grossly inappropriate.

The issue of informed consent also illustrates a basic difference between the correctional administrator and the mental health worker. For the latter, professional ethics and standards strongly dictate obtaining informed consent, maintaining confidentiality, and discussing the limitations of confidentiality with the client (APA, 1989, 1992; Committee on Ethical Guidelines for Forensic Psychologists, 1991). Correctional administrators, on the other hand, may not understand the need for this because they are not expected by their colleagues or the inmates to adhere to the above principles.
It is possible that correctional psychologists in certain situations could view themselves as having to function in a role similar to that of correctional administrators and thus justifiably deviate from their professional standards. For example, in this scenario, an argument could be made that by informing the inmate of the nature and purpose of the psychological assessment, one, in essence, sabotages the evaluation. Along these lines, it could be stated that the greater good of protecting public safety outweighs the compromise of informed consent. Ultimately, these arguments would fail because they would not be accepted by the mental health community. Idiosyncratic interpretations by individual clinicians as to what constitutes an exception to confidentiality and informed consent essentially undermine the validity of the written standards and ethics. The credibility of a profession requires that those who identify themselves as belonging to the professional group must respect and adhere to its shared concept of ethical behavior. Confidentiality and informed consent are by definition the cornerstones of psychological practice and our professional identity and therefore must be vigorously protected.

**Vignette 4**

Inmate Y is a 40-year-old individual who has a reported history of suicide attempts while in the community and has obvious scars on his wrists. He is also a known substance abuser. A new policy of monthly urinalysis screens for randomly selected inmates went into effect in the prison. When asked to give a urine sample by Unit Manager S, Inmate Y refused and stated that he is being singled out because the unit manager does not like him. Inmate Y then went to his bunk area and cut his wrists. He was subsequently placed in the infirmary, where Dr. T, a psychologist, evaluated him. The unit manager told Dr. T that the inmate is a savvy convict who had cut his wrists to avoid the urinalysis. Unit Manager S also suspects that Inmate Y has been involved in smuggling drugs into the institution. The unit manager believes that Inmate Y should be punished for refusing the urinalysis because not to do so would encourage other inmates to also refuse drug testing and possibly use manipulative acts to avoid it. Dr. T identifies Inmate Y as suffering from a borderline personality disorder and recommends that he attend a group therapy program for suicidal inmates. Dr. T also recommends that Inmate Y not be selected in the near future for random drug screens. Unit Manager S informs the warden that he disagrees with Dr. T's opinions and suggests that the warden veto the doctor's recommendations.

This vignette illustrates the different explanations and reactions of correctional staff and mental health professionals to an inmate's behavior. Generally, the correctional staff's training and experience lead them to view disruptive behavior as related to criminality and requiring punishment. The clinician's perspective, on the other hand, derives from a treatment model (i.e., the disruptive behavior represents a symptom in an identifiable disorder that can be treated). Herein lies a basic conflict between corrections and mental health.

Several authors have suggested that beyond this custody-treatment dichotomy, other differences also exist. Correctional administrators and workers may view themselves as professional managers whose primary concern involves maintaining security and addressing issues of overcrowding and day-to-day activities of meals, work details, and orderly unit functioning (Smith, 1987). Corrections workers, perhaps rightly, may view themselves as the “backbone” of the prison, and mental health professionals as playing an ancillary role (Hilkey, 1988). Within this context, psychological symptoms and treatment then may be viewed either as irrelevant or as interfering with the orderly maintenance of an institution. Additionally, if correctional staff perceive disruptive conduct as a manipulative attempt by an inmate to escape punishment, the staff may have a negative reaction to mental health professionals “psychologizing” the behavior. This in turn may foster a generalization that psychological symptoms are simulated for secondary gain (Adams, 1985; Nelson & Berger, 1988).

This tendency for the correctional staff to ignore, dismiss, or misidentify problematic behavior may be a function of their lack of training. Moreover, some mental health professionals’ inclination to label such behavior as always a product of mental illness may reflect their naiveté of the prison community. Certainly not all correctional staff are insensitive to psychological symptoms, nor are all clinicians gullible to an offender’s “con games.” In our vignette, however, it appears that the staff from both professions rigidly maintained a unidimensional orientation; viz., the unit manager viewed the inmate’s behavior as manipulative, whereas the psychologist considered it a symptom of a psychological disorder.

Maintaining an inflexible and stereotypic approach does not encourage the smooth running of an institution. This issue must be remedied through education. Correctional personnel, therefore, should be trained in minimum in basic psychological concepts and symptomatology. Further, clinicians should be aware of correctional practices and priorities as well as understand offenders and their behavior in prison. We, however, are not proposing that psychologists receive training to the extent that they could assume the duties of a correctional officer, nor are we advocating that correctional staff be instructed to such a degree that they could be considered lay mental health practitioners. Rather, both professional groups should be sensitized to and demonstrate a respect for each other’s contribution and expertise.

Another important issue to consider is the basis for manipulative behavior that is so commonly seen in prison. One might concede that the inmate’s actions in our vignette were in fact “manipulative.” Simply identifying this as such does not offer the correctional staff a method for properly managing this inmate. To deal more effectively with “manipulative behaviors,” it is necessary to understand that there are various causes for such conduct. The manipulative behavior could be the product of a genuine mental illness, malingering, or a mixture of these two factors in an individual who is both disturbed and antisocial. Properly assessing the reason for the manipulative conduct is essential if we are to eliminate such acting out. If the manipulations are determined to be the result of a mental illness, then treatment is indicated and warranted. If the behavior stems from a sociopathic style, then it should be curtailed and not reinforced.

**Summary**

As the Criminal Justice System has modified its view of the role corrections should play in addressing offenders, the expectation of what psychologists can and should do within corrections has also been affected. In recent years, the sociopolitical
climate has been skewed toward harsher sentencing, with the public by and large less sympathetic toward the needs of offenders and more concerned with keeping such individuals out of the community. In response, prisons have shifted away from providing adequate rehabilitative services to inmates. Prisons have continued to employ psychologists; however, their traditional role of providing rehabilitation to prisoners has changed to include institutional concerns of security and incapacitation. Standards were developed in an attempt to offer the psychologist guidelines in making this transition, that is, being sensitive to the security needs of the institution while preserving the clinician’s therapeutic alliance. Despite the existence of these standards, ethical and professional dilemmas continue to exist as illustrated in our vignettes. Underlying reasons for these persistent dilemmas may include the vagueness of the guidelines thus far developed and the lack of correctional administrators’ understanding of and support for the therapeutic role of psychologists.

Proposed Recommendations

It is our opinion that psychologists who work under the administration of corrections within a prison setting in essence often serve as “window dressing” and frequently do not provide true clinical services. We believe that this situation cannot be remedied solely by amendments to the existing guidelines and standards, some of which are vague. Moreover, the suggestion that the psychology administration negotiate with the correctional administration regarding the type of work they will or will not perform would not appear to be a generally effective solution. We strongly believe that correctional administrators are interested in the welfare of inmates. For many, however, their current mission and goals (a smooth running of the institution) are not the correctional rehabilitative goals of the past (provide therapeutic services to address inmates’ current adjustment problems in addition to future ones they may have in the community). Thus, conflicts arise when mental health providers’ goals are not congruent with those of correctional administrators.

Given this shift of correctional administrative concerns, what solution can be offered? Some have suggested the implementation of peer review committees as a method of monitoring the clinical care given within prison and jail settings (Brodsky, 1980; National Commission on Correctional Health Care, 1987). Recommendations from peer review committees would be useful only to the extent that there would be an incentive for administration to follow the committee’s proposals. Accreditation of mental health programs could be one method for securing adequate clinical services to prisoners; however, it would be necessary that the lack or loss of accreditation result in some economic sanctions to the correctional facility if the concept of “accreditation” is to be meaningful. The imposed economic sanctions could be a reduction of funding for mental health programs and services.

It should be noted that a reduction of funding for mental health programs and services may not be a sufficient incentive for some wardens to adhere to accreditation guidelines, because they may not believe in the need for such services. Although these wardens may have the opinion that mental health treat-
Given the variety of conflicts faced by psychologists who work under the auspices of a department of corrections, we do not believe that such dilemmas can be effectively and sufficiently resolved by the following: (a) refining existing professional standards; (b) psychology administrators negotiating with their correctional administration employers about the type of work they will or will not perform; (c) implementing peer review committees; and (d) imposing economic sanctions either through a reduction of funding or lawsuits. Consequently, we strongly believe that the long-term resolution of psychologists’ role conflicts can best be achieved by placing the locus of control for mental health services under health or mental health departments. The balance between custody and treatment needs can be accomplished, as evidenced by states where mental health agencies administer both security and treatment, or security needs alone are administered by the department of corrections.

In conclusion, if mental health services provided in correctional settings do not reorganize under the auspices of mental health or health departments, the ethical dilemmas mentioned by Brodsky and his colleagues over a decade ago will continue to plague mental health professionals in the future just as they do now.

References


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167