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CONNECTICUT VALLEY HOSPITAL

PSYCHOLOGY SERVICES
PROCEDURES MANUAL

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Procedures Manual

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SECTION 1

INTRODUCTION AND MISSION

The overall mission of the psychology services within Connecticut Valley Hospital (CVH) is to provide support and services to both the clinical and administrative operations of each program consistent with hospital-wide missions and objectives. In this effort, the psychology staff strives to provide the highest quality and quantity of clinical services in response to the unique and dynamic needs of the patients and programs. Furthermore, the psychology staff is dedicated to the promotion of communication, cooperation, and coordination within the hospital clinical and administrative organization.

Connecticut Valley Hospital includes three divisions: Addiction Services (ASD), General Psychiatry (GPD), and Forensic Services (WFD). The psychology staff members within these divisions serve a variety of functions based on the needs of the programs and services provided. These services and functions may include, but are not limited to, direct provision of comprehensive psychological therapies (individual, group, family, cognitive rehabilitation, behavioral management), psychological and neuropsychological evaluation and consultation, program development and direction, treatment plan development and implementation, and active membership in the interdisciplinary treatment team. Additionally, each psychologist is expected to assume at least one set of responsibilities for the discipline, such as representing psychology on a hospital-wide committee, coordinating psychology trainees, or coordinating testing materials.

Members of the CVH psychology staff are responsible for maintaining an appropriate level of current training and experience in all areas of their assigned practice.

Psychological services to patients should be effective and respectful with due regard to human, legal, and civil rights, so that each patient may achieve an optimal level of autonomous functioning.

SECTION 2

ORGANIZATIONAL STRUCTURE, ORIENTATION AND SUPERVISION

Psychological services occur within the matrix organizational structure of CVH. At the unit level, the psychologist operates within a treatment team under the clinical oversight of the attending psychiatrist. Within the team, the psychologist may function as a Unit Director, Program Director, or Unit Psychologist. As a Unit or Program Director, the psychologist is responsible for providing administrative supervision to the clinical staff including related tasks such as contributing to completion of performance appraisals. In the case where the psychologist is not the Unit or Program Director, he/she operates under the administrative supervision of the Unit Director.

Within the discipline of psychology, a psychologist receives professional supervision from another psychologist. In some instances, the supervisor and the supervisee may belong to the same job classification and peer supervision is practiced. Supervisors document the supervisory session in a supervisory log.

All psychologists receive monthly supervision from a supervising psychologist. The purview of supervision includes, but is not restricted to, review of all professional duties, quality assurance, personnel issues, personal and professional development. When psychologists encounter professional challenges they feel ill equipped to handle, they are expected to address these concerns with their supervisor. In addition to monthly meetings, supervisors also provide ad hoc supervision as needed. Supervisors document supervisory sessions.

In addition to aiming to insure the quality of the performance of psychologists, the supervisory process also aims to identify areas in need of improvement and educational goals. Supervisors provide guidance to their supervisees and ongoing feedback on their performance. These collaborative efforts are then reflected in their performance appraisal.

All supervising psychologists receive monthly supervision from the associate discipline chair of their division. Here as well, the supervisory process aims to identify areas in need of improvement and educational goals in the performance of the supervising psychologist. Associate discipline chairs provide guidance to their supervisees and ongoing feedback on their performance. These collaborative efforts are then reflected in their performance appraisal.

Associate discipline chairs receive monthly supervision from the discipline chair. Here again, the supervisory process aims to identify areas in need of improvement and educational goals in the performance of the associate chairs. The discipline chair provides guidance to the associate discipline chairs and ongoing feedback on their performance. These collaborative efforts are then reflected in their performance appraisal.

At the hospital level, Associate Professional Discipline Chairs (APDC) of Psychology represent each division. The APDCs have input in determining the number of qualified and competent psychologists required to provide care, determine the qualifications and competence of psychologists who provide patient care, provide for

orientation and continuing education of all psychologists, recommend space and resources needed, and participate in selecting outside sources for needed services. The APDCs ensure that each psychologist receives competent professional supervision and monitors this process. When unique expertise is required on behalf of a patient, but is not available within the existing pool of psychologists, the APDCs identify and address such needs for technical supervision as they arise.

The APDCs meet monthly with the Professional Discipline Chair (PDC) of Psychology for the purposes of communication and coordination among the divisions. This leadership group is responsible for planning and directing psychological services, integrating psychological services with other services provided to patients at CVH, and monitoring and improving performance. Additionally, this group reviews and approves or rejects the credentials of each psychologist during the biennial credentialing review.

The PDC develops discipline policies and procedures governing the psychological assessment and treatment of patients based on the standards of practice and care. The PDC collaborates with other hospital leaders to develop patient-care programming, decision-making structures and processes, and improve performance. The PDC ensures that discipline specific policies are revised as necessary and reviewed at least every two years.

Opportunities for professional supervision are available both in a structured and on an as needed basis. The descriptions following this text outline the supervisors and supervisees within each division's programs/units. Typically, the supervisors are at a higher level within the psychology discipline hierarchy, but this is not always the case. In those situations, the psychologist may either receive peer supervision from a psychologist at the same level, or may seek supervision outside of their program/unit. Within ASD, the counseling staff utilizes counselor supervisors as the first level of professional supervision. Beyond this level, they may seek supervision from their supervising psychologist. In addition to the informal guidance and feedback sought from a supervisor when needed, each supervisor is also expected to meet with each of their supervisees on a regularly scheduled basis, at least monthly. This supervision may occur in an individual or group setting depending on the needs of those involved. Supervision is expected to be documented with at least date, time, and names of those involved.

DISCIPLINE ORIENTATION

All new employees participate in the hospital-wide orientation program, as well as a specific orientation to the Division. The orientation program is coordinated by the service Supervising Psychologist.

New Psychologists are acclimated to the cultural environment and the mission and goals of CVH through the orientation process. The goal of this process is to enhance the new psychologist sense of efficacy and belonging. The new psychologist's immediate psychology supervisor introduces him/her to the values, goal, policies, procedures, role expectations, physical facilities, special services of CVH and of the Division in which the new psychologist is hired.

SECTION 3

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SECTION 4

ANNUAL CREDENTIALING PROCEDURE

Psychologists are credentialed by the Governing Body at the recommendation of the psychology credentialing committee to provide services within those areas in which they have demonstrated competence. Credentialing review is conducted biennially by the hospital-wide psychology credentialing committee. The credentialing committee consists of the discipline chair and associate chairs, and the chair of the credentialing committee.

Psychologists are typically credentialed in all or some of the following areas: Screening evaluation, psychological evaluation, neuropsychological evaluation, diagnostic evaluation, consultation, individual psychotherapy, comprehensive behavioral plans, group psychotherapy, family, couples, and family-support psychotherapy, psycho-education, research and program evaluation, forensic psychology, substance abuse counseling, and supervising and administration. Definitions of these professional activities are listed in Appendix A.

Psychologists apply for credentialing December 1st of odd-numbered years (e.g., 1DEC03). They do so by providing the chair of the credentialing committee with a duly completed application for credentialing form (see Appendix B), an itemized listing of their continuing education activities of the previous two years (see Appendix C), and their most recent performance appraisal. New staff and the neuropsychology post-doctoral fellows apply for credentialing upon hiring. Fellows are credentialed for one year only.

On the credentialing application, psychologists request to be credentialed either at the "under supervision" level (US), the independent practice level (IP), or the supervisory level (S). The US level applies to unlicensed staff (post-doctoral fellows) and to licensed staff in practice areas in which they lack training or experience to function independently. The IP level applies to licensed staff in practice areas in which they possess training or experience to function independently. The S level applies to staff who through their training and experience have demonstrated superior clinical competencies. The S level requires completing biennially continuing education activities in the areas of supervision.

The credentialing committee meets in January to review all applications. The committee can recommend credentialing for a two-year period, a one-year period if warranted by a psychologist's sub-par performance, or denying credentialing. Denying credentialing is warranted in egregious cases (e.g., grave ethical violations).

SECTION 5

CONTINUING EDUCATION AND TRAINING

All doctoral level psychology staff members are required to maintain Connecticut State licensure. All are required to apply for credentialing as indicated in the “Annual Credentialing Procedure”. Psychologists adhere to the Guidelines of the American Psychological Association as they apply to the psychological services provided at Connecticut Valley Hospital. In addition, each psychology staff member is responsible to keep abreast of current developments in psychology and related fields that impact on the provision of services. Finally, it is the responsibility of the individual psychologist to maintain an adequate level of knowledge and clinical skills to competently provide the psychological services that his/her duties require. In the service of these objectives, the following guidelines are offered:

- (1) Psychologists should attend at least 50 hours a year of formal continuing education activities (e.g., lectures, workshops, paper presentations, etc.), and should engage in a sufficient degree of reading and independent study to maintain competency (at least 50 hours). Sharing of important articles with colleagues is encouraged.
- (2) Psychology staff members are also encouraged to participate as presenters, lecturers, and consultants to other DMHAS services as their duties permit or require in order to both enhance his/her own knowledge base, as well as to assist in the training of other staff members.

To promote and support the above objectives, the Associate Chair of Psychological Services in the division will coordinate staff coverage in an effort to facilitate attendance at professional conferences, presentations, and other opportunities for continuing education which may be of interest and of relevance to the provision of clinical services and other professional functions.

In addition to the above professional development opportunities arranged at the discretion of the individual psychology staff member, each psychologist may be periodically directed to attend specific training. Some of this may be training sponsored by the hospital, the division, or a specific program unit for purposes of assuring competence in critical clinical functions that apply to a number of disciplines, as described in the CVH Educational Plan. In other cases, the Associate Chair for Psychology may determine that an individual psychologist requires additional training in a psychology-specific function for purposes of correcting deficiencies in performance, or in order to develop the expertise required to assume expanded or newly assigned duties. Compliance with this type of directed training will be considered a key element in that psychologist's continuing competence.

Psychology staff members will also be required to receive mandatory training in a number of areas essential to their functioning as hospital staff members including, but not limited to, Infection Control, Fire Safety, and Personnel Policies. This training will be administered through the Clinical Program in which the psychologist is involved and on a schedule to be determined by the Department of Human Resources.

These efforts and objectives are based on the belief that ongoing training and education are of the utmost importance to the maintenance of competent services, as well as being critical in promoting high levels of morale, motivation, and personal job satisfaction.

Monitoring Continuing Education

Participation in appropriate continuing education is an important element in maintaining clinical competence. To assure that each psychologist meets the minimum standards in this area, each psychology staff member will maintain a list of all workshops, conferences, presentations and other continuing educational functions that he/she attends or presents. This will be submitted biennially for the credentialing process to the Chair of the credentialing committee for placement in the respective staff member's credentialing record.

SECTION 6

PSYCHOLOGICAL ASSESSMENT REFERRAL AND ADMINISTRATION PROCEDURES

The term “Psychological Assessment” denotes an extensive examination of a patient’s psychological functioning detailing adaptive, intellectual, and personality functioning. In the following pages, the term Psychological Assessment is used generically, and is meant to include more specialized evaluations (such as neuropsychological assessments). The term does not include other specialized evaluation such as Problem Sexual Behavior Evaluations or Positive Behavioral Support Plan reports, which have different standards.

Definitions of Different Types of Psychological Assessments:

Integrated Initial Psychological Evaluation (IIPE) - The Integrated Initial Psychological Evaluation documents the initial review of psychological data available within the first few days following admission. The IIPE is completed no later than day 5 following admission. It contains the following required elements:

A description of purpose of the IIPE (usually, to gather baseline data for assessment and treatment planning), a review of available history, [including reason for admission, risk factors (including suicidality, aggression, trauma, substance abuse), presenting symptoms, and strengths/supports], behavioral observations [including appearance, cognitive processes, sensorimotor behavior, cooperation, interpersonal behavior], initial assessment (cognitive, affective, behavioral), formulation (an initial case conceptualization including goals, strengths and barriers) and a plan entailing specific recommendations for further assessment and treatment.

The IIPE is completed using CVH form # 638. The signed CVH XXX form is added to the Assessment section of the medical record by day 5. Once the psychologist presents the information from CVH XXX to the clinical team, he/she enters the date of that presentation at the bottom section of CVH XXX [*Date presented to treatment team: DD/MM/YY*].

IIPE is completed on every patient admitted to GPD and to WFD (except B4S). In ASD, the IIPF is triggered for any rehabilitation patient by any one of the following:

- (1) a positive response to items 1 [*Has current thoughts of either hurting or killing him/herself*], 2 [*Has plan to harm or kill him/herself*], 3 [*Is experiencing command hallucinations about self-harm*], 11 [*Has “ended” relationships, said good-byes, refused to see friends/visitors*], 12 [*Is giving away personal possessions*], or 13 [*Is verbalizing feelings of abandonment, hopelessness, helplessness or despair*] of the Suicide Risk Assessment
- (2) a suicide attempt within 30 days of admission
- (3) a history of trauma, aggression, and/or a nonsubstance-related Axis I or II disorder expected to interfere with a patient’s ability to benefit from treatment and/or engage in the recovery process
- (4) cognitive processing deficits
- (5) marked difficulty with emotional and/or interpersonal processes

For WFD B4S, the IIPE is triggered by the same criteria except any non-substance related Axis I or II disorder.

Psychological Evaluation - A psychological evaluation involves the assessment of those various phenomenological, behavioral, and/or cognitive components that underlie one's emotional states and personality. Psychological testing may be utilized alone or in combination with neuropsychological testing in order to better understand how affective and personality variables may affect one's cognitive skills and functions.

Neuropsychological Evaluation - A neuropsychological evaluation involves the assessment of a variety of cognitive and behavioral functions, such as intelligence, attention and concentration, problem solving, reasoning, conceptualization, planning and organization, mental speed and flexibility, verbal skills, language, academic skills, perceptual and visuospatial skills, new learning and memory, and/or motor skills. Neuropsychological evaluation is indicated whenever brain-based impairments and/or deficits in any of the above functions are suspected. Both psychological and neuropsychological evaluations are consultative/assessment procedures and do not constitute any form of treatment.

Psychological assessments of patients whose native language is not English may require a referral to a consultant. In such cases, the psychologist consults with the Associate Discipline Chair to facilitate this process.

Procedures

A request for a Psychological and/or Neuropsychological Evaluation is initiated by either (1) the unit psychologist (such as upon admission or at another point in the course of treatment) or (2) the treatment team. The request must be prescribed in the patient's treatment plan and is formally made by completing the referral form (CVH-348). The completed referral form should then be forwarded to Associate Chair of Psychology (and/or designee) within each division.

In GPD and WFD, psychological evaluations are to be completed within 28 days of initiation of testing, while neuropsychological evaluations are to be completed within 45 days of the initiation of testing. In ASD, they are completed in 14 days. Resources or clinical factors may impact on the timeline. Psychologists need to record in the medical record (1) their contacts with the patient after each testing session via a progress note as well as (2) any reasons for departure from these guidelines, should they occur (e.g., an uncooperative patient).

A psychologist receiving a referral is responsible for the completion of the evaluation. Under certain circumstances, the completion of an evaluation may be delegated to another psychologist. A psychologist may refer a patient's psychological assessment to another psychologist within a Division under the direction/approval of that Division's Associate Chair of Psychology (and/or designee) when one or more of the following criteria is met: (1) the assigned psychologist has multiple active referrals simultaneously which, in his/her judgment, cannot be completed within the required time period [i.e., within the general time limits prescribed by divisional policy and/or within the time limits imposed by the circumstances of the case, such as a court date for example]; (2) the assigned psychologist does not have the specific skills necessary to complete the evaluation [e.g., advanced neuropsychological skills]; and (3) the assigned psychologist has an involvement with the patient which does not predispose to a successful evaluation outcome or which would, in the judgment of that psychologist, compromise the administration and completion of the evaluation [e.g., when the psychologist is the focus of a paranoid delusion]. In addition, the assigned psychologist may seek consultation and assistance from another psychologist within the Division when he/she feels this reflects prudent judgment (e.g., when there is a question of objectivity or a question of expertise); if such a situation/circumstance may arise, the assigned psychologist consults with the Associate Discipline Chair to determine who will prepare the evaluation. Furthermore, the assigned psychologist may decide to pass on the referral to a doctoral-level psychology student

(i.e., post-doctoral fellow, intern, or practicum student) for the purpose of training; in that case, the assigned psychologist remains responsible for the content of the report and prompt completion of the evaluation (including signatures).

At the completion of the evaluation, the psychologist arranges to meet and present the results of the evaluation to the treatment team and documents this presentation through signature at the bottom of report.

Required report format

- Name of Patient
- Date of Birth
- Dates of Testing (list all dates on which the assessment was conducted)
- Current medications (including doses and frequencies)
- Date of Report
- Reason for Referral (describe the specific question(s) to be addressed)
- Relevant Confidentiality Limitations Statement (especially necessary in forensic cases where it is clear that the results of the report may have a bearing on the outcome of a court proceeding, but any limitations should be explained to a patient prior to the evaluation, and this explanation as well as the patient's willingness to complete the evaluation should be documented)
- Pertinent Background History (describe relevant social factors, including history of present illness, social history, familial history, substance use history, legal history and medical history; comment on factual inconsistencies in the available history and attempts made to resolve these inconsistencies)
- Testing Procedures (list all instruments administered; if an administration was unsuccessful and/or partially completed, note this in this section)
- List of documents reviewed (include date of document)
- Behavioral Observation (comment on appearance, attitude, speech, general behavior, thought processes, etc.)
- Degree of Confidence in the Results Obtained (comment on how likely it is that the results are valid measures of functioning based on various factors, such as degree of cooperation and alertness)
- Test Results – may include sections and subsections with respect to:
 - a. Cognitive functioning (describe cognitive strengths and weaknesses; report test scores as clinically indicated to enable status comparison in future assessments)
 - b. Affective/Personality functioning (describe affective factors and symptoms as well as personality strengths and weaknesses; report test scores as clinically indicated to enable status comparison in future assessments)
 - c. Adaptive functioning (describe strengths and weaknesses in social functioning including interests, likes and dislikes; report all test scores as clinically indicated to enable status comparison in future assessments)
- Diagnostic impressions (list diagnostic impressions; if qualifiers such as “*Rule out*” are used, indicate specific plan to be used to resolve the diagnostic question)
- Summary (summarize major findings and their implications)
- Recommendations (list specific treatment recommendations; if behavioral treatment is recommended, refer for Positive Behavioral Support Plan)
- Signatures (name and degree. If prepared by a trainee, the supervisor's signature follows the trainees and the clause, "Reviewed and approved by". Psychologists and trainees have the responsibility to insure the completion of their reports, including all signatures within 10 business days)
- Date of Feedback to Treatment Team (with second signature of psychologist)

Retention of records

After the evaluation is completed and included in the medical record, all raw test data as well as the completed and signed evaluation report are transferred within 30 days (90 days in GPD) to a centralized data collection locale for each Division. In ASD, the records are stored in the psychologists' office. In GPD, records are stored in the Woodward 2 North storage room. In WFD, records are stored in the neuropsychology lab. In each locale, the records are kept in alphabetical order in a filing cabinet that is locked or located in a locked room.

Additional Assessments

Additional assessments may be needed beyond the initial assessment under a variety of circumstances; these include significant changes in clinical presentation or particular changes over long periods of time (e.g., aging, treatment benefits, or disease). The same process is used to trigger a "re-evaluation" as described above (form CVH 348). Comparisons with performance on earlier assessment(s) are particularly important in additional assessments.

SECTION 7

GUIDELINES FOR IMPLEMENTATION OF POSITIVE BEHAVIORAL SUPPORT PLANS

Positive Behavioral Support Plan (or Planning) (PBSP) entails instruction designed to teach skills and competencies to facilitate behavioral change. PBSP is rooted in Applied Behavioral Analysis. PBSP involves designing environments and interventions aimed at replacing problem behaviors with adaptive behaviors. PBSP is an approach to helping people improve their difficult behavior that is based on four premises:

1. People (even caregivers) do not control others, but seek to support others in their own behavior change process.
2. There is a reason behind most difficult behavior (a function).
3. A large and growing body of knowledge about how to better understand people and make humane changes in their lives can reduce the occurrence of difficult behavior.
4. Avoid coercion - the use of unpleasant events to manage behavior.

I. Indications for PBSP

- A. A PBSP is indicated when 1) adaptive behaviors are not produced frequently enough for healthy adjustment or 2) maladaptive behaviors that harm the individual or others are produced too frequently for healthy adjustment.
- B. Examples of adaptive behaviors (target behaviors) include hygiene activities, good use of leisure time, polite interactions with peers, appropriate volume of speech, attendance at pre-vocational activities, etc.
- C. Examples of maladaptive behaviors (behaviors of concern) include behavioral excesses such as recurrent physical aggression against others, self-injurious behavior, and sexual compulsion, as well as behavioral deficits such as self-care deficit, apathy, avoidance, and treatment refusal.
- D. The purpose of a PBSP is to increase the occurrence of target behaviors. A fundamental assumption of PBSP is that behaviors of concern will decrease in frequency as target behaviors are emitted consistently. PBSP do not entail the application of aversive consequences of any sort (no response cost), because emphasizing behaviors of concern tends to inadvertently and intermittently reinforce these behaviors.

II. Components of PBSP

- A. Function of behavior

Behaviors are maintained by consequence events (function) through positive or negative reinforcement. PBSP requires identifying the function of a behavior, i.e., what need it meets. Behaviors are occasioned by antecedent events. Changing behaviors requires consideration of maintaining consequences.

B. Functional behavioral analysis (FBA)

A FBA is a systematic process to identify factors that contribute to occurrence and maintenance of problem behaviors. It serves as basis for developing proactive and comprehensive PBSP.

1. It consists of:
 - a. clear and measurable definition of behavior of concern;
 - b. complete testable hypothesis regarding the function of the behavior of concern;
 - c. integration of psychological and neuropsychological assessment findings;
 - d. data to test hypothesis; and
 - e. a PBSP based on hypothesis.

III. Definition of behavior of concern

- A. A FBA requires an objective and measurable definition of individual behaviors of concern. These may be embedded in response chains, i.e., predictable sequences of behaviors, and fall in response classes, i.e., topographically different behaviors with similar function (e.g., obtain attention, escape task request).
- B. The basic working unit of a FBA is a testable hypothesis, a “best guess” about behavior and conditions under which problem behavior is observed. It entails linking setting events (i.e., situation in which the problem behavior is more likely to occur), trigger antecedents, problem behavior, and maintaining consequences (i.e., the stimuli that follow the problem behavior and maintain or increase its likelihood).
- C. Data is then collected to test the FBA-derived hypothesis. When data do not support hypotheses, then all information is reviewed and more is collected, so that the hypothesis can be changed and the new hypothesis is tested.

IV. Teaching alternative behavior

Alternative/desired behaviors need to be identified, taught, and rewarded. This creates competing pathways to the behavior of concern. To promote his/her recovery, the individual and, if appropriate, his/her family need to be involved in this process in order to express their wishes and preferences.

IV. Eliminating behaviors of concern

Strategies to eliminate behaviors of concern include: modifying antecedents so that they no longer trigger the problem behavior; designing teaching strategies to make problem behavior inefficient (and acceptable behavior easier); designing consequence strategies to make maintaining consequences ineffective (i.e., less often present or less reinforcing); design setting event strategies to neutralize effect of setting events.

V. PBSP requirements

- A. PBSPs are devised only in the context of an inter-disciplinary treatment approach and based on multidisciplinary assessments. As with any other treatment strategy, they must have the approval of the team psychiatrist and may require in some cases a written order to ensure consistent application.
- B. A team considering the use of a PBSP contacts its psychologist. The team psychologist, if not credentialed in PBSP must, after preliminary consultation with the inter-disciplinary team, establish a peer consultation relationship with another psychologist who is so credentialed.
- C. All PBSPs include an evaluation procedure to review, modify, and, if appropriate, terminate the plan. All plans are review by the Associate Discipline Chair, who may use peer-consultation if not credentialed in PBS planning.
- D. All PBSPs are stored in the secure folder at T:Psychology_QA/PBSP Log. Once a PBSP is assigned, the psychologist contacts Ms. Ruzzo and updates the information as needed.

VI. Credentialing

PBSPs require that the psychologist who is designing the treatment be appropriately credentialed and currently competent, or if necessary, supervised by another psychologist within or outside the Division with relevant credentialed expertise. If a PBSP is used, this must be conducted in a manner consistent with the guidelines outlined in this section.

VII .Joint Commission requirements

- A. The use of PBSP is approved by the Medical Staff and the Governing Body, and is supervised by staff credentialed in the specific area of PBSP. All staff involved in carrying out PBSPs has been trained in program implementation. All PBSPs are implemented in a clear, consistent manner, and contain a continuous measurement and assessment component with adequate summary of the data into a useful form of presentation (graphs, narratives, etc.), and have methods of feedback from the client, staff or significant others in order to alter the program to meet the individual's changing needs.
- B. Strategies traditionally known as “aversion therapy”, which involve the application of a noxious stimulus to eliminate maladaptive behaviors, are not employed at Connecticut Valley Hospital.

SECTION 8

PROCEDURE FOR COMPETENCY BASED PERFORMANCE APPRAISAL

In accordance with the policies and procedures of the Department of Administrative Services (DAS), the Department of Mental Health and Addiction Services (DMHAS), and Connecticut Valley Hospital (CVH), each Psychology staff member shall have his/her job performance evaluated at least annually. (There is also provision, under special circumstances, for performance evaluations to be conducted at more frequent intervals.) It is the goal of the current performance evaluation system to have each staff member understand his/her job duties in terms of the major job functions which comprise those duties, understand the various competencies relevant to those job functions, and to have the performance appraisal reflect both the job functions and the associated competencies. This goal of a competency-based performance appraisal is approached somewhat differently for managers and non-managers.

Non-Managerial Psychology Staff

Building an individualized, competency-based performance evaluation for each Psychology staff member involves several steps. First, each Psychology staff member (in conjunction with the Human Resources Department and his/her supervisor) develops a *Competency Based Functional Job Description*. This document will define the major functions the employee performs within the Addiction Services Division and (as applicable) within the Hospital, stating in measurable terms the skills, abilities, attitudes, and knowledge (i.e., competencies) the employee needs in order to perform these functions. This document should be updated whenever appropriate to reflect any significant changes in the employee's job functions.

The next step involves transposing these job competencies onto the *Competency Based Performance Appraisal* form. This form organizes the competencies under the following categories: knowledge of work; quantity of work; quality of work; ability to learn new duties; initiative; cooperation; and judgement. There is also an additional category ("other") used for punctuality/attendance, and any other relevant miscellaneous competencies. When a performance appraisal is to be performed (at least annually), the supervisor will use this form to rate each competency on a scale ranging from 1 (unsatisfactory) through 5 (excellent). The data to be used for these ratings will include findings from: the Psychology standards of practice monitors; general medical record reviews conducted by the ASD Clinical Performance Review Committee; ASD Utilization Management monitors; supervisory observations by the ASD Psychology Associate Chair; and findings from any progressive discipline that may have occurred.

As a next step, the supervisor uses the scores on the *Competency Based Performance Appraisal* form (with input on administrative functions from the respective Unit Director) to provide ratings on the *DAS Performance Appraisal* form (PER-125). The *Performance Appraisal* form is basically a summary version of the *Competency Based Performance Appraisal* form, but also has sections to address areas that need improvement, the employee's general ability to perform required work, and to recognize contributions beyond the normal requirements of the position.

The final element in the performance appraisal process is the provision of an annual educational plan, based on an assessment of the various competencies that the employee will need to maintain, enhance, and/or acquire.

This plan outlines required training for the individual employee, addressing a wide range of both general competencies (relating to such issues as fire safety, infection control, boundaries/countertransference, etc.), and specific competencies (such as enhanced skills/knowledge relating to the employee's individual clinical assignments).

Managerial Psychology Staff

As with non-managerial positions, the first step for each Psychology staff manager is to develop a current, competency-based functional job description via the *Performance Assessment and Recognition System* (PARS) document. The PARS document defines the employee's major job functions and associated competencies under two general categories: (a) core performance functions and leadership competencies; and (b) key job functions and personal competencies. When completed, this portion of the PARS process should result in a comprehensive summary of both the employee's major job functions and the associated administrative, leadership, and clinical competencies involved in performing those functions.

The next step of the PARS process occurs at the beginning of each fiscal year. The Psychology manager, together with the supervising manager, develops a prioritized list of performance objectives for that year relating to each of the employee's major job functions. This list should be reflective of the goals and objectives set by DMHAS and CVH, as well as a needs assessment of the Addiction Services Division that pertain to the employee's job duties. Each listed performance objective should also identify performance measures and a target date for completion.

The following step in the PARS process involves a formal (documented) review by the employee and supervising manager of the progress that has been accomplished with each performance objective. This is done at least quarterly. The purpose is to review accomplishments, identify obstacles, determine appropriate future actions, and (if necessary) revise objectives. This also provides a timely method of addressing any needs or deficiencies with regard to competencies.

The final step of the PARS process is an annual review in which the supervisory manager determines, after discussion with the manager, a final performance rating for each objective and a composite rating. There are four terms used for these ratings: exceeds expectations; meets all expectations; needs improvement; unsatisfactory.

As with non-managerial employees, each Psychology manager also has an annual educational plan. Again, this is used to address both general and specific competencies that the manager will need to maintain, enhance, and/or acquire in order to achieve optimum job performance.

SECTION 9

PROCEDURE FOR INVOLVEMENT OF REHABILITATION COUNSELORS AND PSYCHOLOGY TRAINEES IN THE PROVISION OF SERVICES

Provision of Services by Counselors

Rehabilitation Counselors/Substance Abuse Counselors are permanent employees of CVH who operate exclusively within the Addiction Services Division based on their experience and training within the substance abuse treatment field. They function as members of the interdisciplinary treatment team in addition to their primary duties of case coordination, group facilitation, and milieu management. Within counseling, there exist levels I and II which are supervised (professional and administrative supervision) by the Lead Rehabilitation Counselor/Substance Abuse Counselor Supervisor. As counselors work first and second shift on each program unit within ASD, there is one Lead/Supervisor position assigned to each shift and unit. The Counselors are credentialed members of the psychology discipline. Yet, they serve a dual role in that they are also counted as part of the security coverage of the program units. In this regard, they are accountable to the nursing discipline.

Provision of Services by Trainees

The Discipline of Psychology is committed to participating in the education of Psychology trainees. There are four types of Psychology trainees.

Post-Doctoral Fellows are doctoral level trainees who are not licensed to practice autonomously. They function under the supervision and license of a psychologist. Their fellowship usually lasts one year and is non-renewable. The purpose of the fellowship is to acquire specialized professional skills while providing valuable services to the CVH community.

Psychology Interns are advanced graduate students in clinical psychology participating in a yearlong internship based at River Valley Services. They are not licensed to practice autonomously. They function under the supervision and license of a psychologist. Their internship lasts one year and is non-renewable. The purpose of the internship is to acquire professional skills while providing valuable services to the CVH community.

Psychology Practicum Students are graduate students in clinical psychology participating in a yearlong practicum experience. They are not licensed to practice autonomously. They function under the supervision and license of a psychologist. Their internship lasts one year and is non-renewable. The purpose of the practicum is to develop familiarity with applied clinical settings and begin acquiring professional skills while providing valuable services to the CVH community.

Psychology Clerks are undergraduate students in psychology participating in a six to twelve month long clerkship. They do not provide any clinical services. Their clerkship is non-renewable. The purpose of the clerkship is to develop familiarity with applied clinical settings through observation and data gathering.

PSYCHOLOGY DISCIPLINE DESIGNATED SUPERVISORS

PSYCHOLOGIST	PROFESSIONAL SUP.	ADMINISTRATIVE SUP.
Barbo	Leone	Farrell
Bellhorn	Elder	Cornell
Boylin	Hillbrand	Bouffard
Carles	Leone	Smith
Edwards	Elder	Ferrero
Elder	Hillbrand	Hyatt
Geysen	Schreer	Nicholson (interim)
Hart	Leone	Denier
Hillbrand	Conrad	DeFrancesco
Lah	Hillbrand	Bennett
Leone	Hillbrand	Wassil
Loughead	Schumacher	Heymann
Nevin	Elder	Ferrero
Niman	Hillbrand	Mullaney
Papapietro	Schreer	DiSilvestro
Rosenfield	Elder	Hyatt
Schreer	Leone	Barki
Schumacher	Leone	Salvatore
Siliman	Hillbrand	Conrad
Sommerville	Elder	Ferrero
Sondik	Elder	Ferrero
Vayalakkarra	Elder	Cornell
Ward-McKinlay	Leone	Arata

APPENDICES

Appendix A

Credentialing Domains

The professional activities for which psychologists may be credentialed include:

1. Screening evaluation.

Screening is the use of a clinical interview and chart review to assess an individual's need for psychological services.

2. Psychological Evaluation.

Psychological evaluation is the systematic assessment of an individual's cognitive abilities and deficits, personality strengths and weaknesses, character structure, and psychopathology, using standardized psychodiagnostic tests and clinical interviews. Standardized psychodiagnostic tests include the Wechsler Adult Intelligence Scale, Rorschach, Minnesota Multiphasic Personality Inventory, Millon Clinical Multiaxial Inventory, Benton Visual Retention Test, Luria-Nebraska Neuropsychological Battery, Halstead-Reitan, Peabody Picture Vocabulary Test, Vineland Social Maturity Scale, tests of memory and additional formal procedures recognized by the profession.

3. Neuropsychological Evaluation.

Neuropsychological Evaluation is the assessment of an individual's brain behavior relationships in terms of strengths and weaknesses. This is done through the use of standardized interview and assessment methods such as neuropsychological test batteries, as well as other memory tests, standardized intelligence tests, sensory perceptual and motor coordination tests, and additional formal procedures recognized by the profession.

4. Diagnostic Evaluation.

Diagnostic evaluation is the act of identifying and/or classifying mental disorder according to presenting signs and symptoms and relevant historical information. It is a summary statement of a condition: conveying clinical picture, etiology, pathogenesis, prognosis, and possible treatment. Psychologists conduct a diagnostic evaluation by means of clinical interview, observation, historical documentation, structured interview, or standardized psychodiagnostic tests as clinically indicated; and diagnose within the framework of psychological documentation (assessments, evaluations, etc.) Psychologists utilize DSM-IV Axes I, II, III and V as well as ICD-9.

5. Consultation.

Consultation is the provision of psychological expertise to staff members, programs, or community providers and consumers.

6. Individual Psychotherapy.

Individual psychotherapy is a form of verbal therapy involving regularly scheduled meetings in which a trained and experienced psychotherapist establishes a professional relationship with an individual patient. The psychotherapist facilitates exploration of problems of a psychological *and/or emotional nature* with the objective of removing or modifying behavior problems or endeavoring to restore functioning or to effect change in personality organization. Individual psychotherapy notes documenting treatment progress are entered in the chart on a weekly basis for the first month and monthly thereafter. A thorough off-service note is written at the end of a course of individual psychotherapy to summarize the course and outcome of treatment. All psychotherapy notes need to identify the Master Treatment Plan problem addressed, describe progress or lack

thereof, and be easily legible. An illegible signature needs to be followed by the therapist's printed name. Trainee notes require their supervisor's co-signature.

7. Comprehensive Behavioral Plans.

Comprehensive behavioral plans are explicit procedural strategies, based on established principles of learning theory, in which antecedent-consequence relationships are identified and implemented in an effort to increase or decrease target behavior(s). Comprehensive behavioral plans may involve multiple caregivers/treaters in their implementation but must be supervised and monitored by professionals trained in behavior therapy. These professionals are responsible for ensuring adherence to all legal, professional, and ethical standards relative to the use and application of behavioral techniques.

8. Group Psychotherapy:

Group psychotherapy is defined as the establishment of a professional and therapeutic relationship between a trained and experienced psychotherapist and a single group of identified patients. The group participants explore psychological and emotional problems on a regular schedule in a safe, supportive setting with the overall purpose of addressing, modifying, or reducing problem behaviors. Group psychotherapists may utilize a variety of evidence-based approaches and modalities. Group psychotherapy notes documenting treatment progress are entered in the chart following each session within 48 hours. All group psychotherapy notes need to identify the Master Treatment Plan problem addressed, describe progress or lack thereof, and be easily legible. An illegible signature needs to be followed by the therapist's printed name. Trainee notes require their supervisor's co-signature.

9. Family/Couples Therapy and Family Support Groups:

A specialized form of psychotherapy in which an experienced psychotherapist with specialized training in marriage and family therapy works with a family or families. Participants discuss the identified client's problems, treatment and progress, and how it effects the family and how the family influences the client. The family receives education specific to the client's illness. The goal is to reduce behavioral problems that are generated within the family system. Interns, under supervision of a psychotherapist, may provide family/couples or family group therapy.

10. Psychoeducation

Psychoeducation is the presentation of information (oral, written, videotaped or some combination) with the goal of increasing a client's understanding of a particular issue related to his/her identified treatment needs. Psychoeducation is typically conducted in a group setting to promote discussion, sharing of information and experiences among peers, and the answering of questions.

11. Research and Program Evaluation.

These activities involve systematic approaches to research and evaluation of therapeutic endeavors. The procedures include formulation of an hypothesis or problem, development of assessment methods, selection of appropriate populations, and possible control groups, collection and analysis of the data, and preparation of written reports.

12. Forensic Psychology.

Forensic psychology deals with the psychology of the law, courts and legal procedures. Forensic credentials are based upon standards of the American Board of Forensic Psychology Clinical Credentials are granted in the following areas: Expert Witness in the Judicial Setting, Pre-sentence Evaluation Expert, Psychiatric Security Review Board Expert, Probate or Civil Mental Illness Determination Expert, and Competency Evaluation Expert.

13. Substance Abuse Counseling

Substance abuse counseling requires basic knowledge in chemical dependency and recovery. Experience in working with clients with both addiction and co-occurring psychiatric and/or medical disorders is expected. Staff conducting substance abuse counseling should have knowledge of Dialectical Behavior Therapy, Motivational Enhancement Therapy, Stages of change models, 12-step recovery models, and the use of Opiate agonist treatment, in addition to an understanding of the 12 core functions identified by the Connecticut Certification Board (see attached).

14. Supervision and administration

- a. Supervision of trainees: All trainees are supervised by Psychologists, Supervising Psychologists I and II, or the Director of Psychology. Supervision consists of guidance and feedback sought from a supervisor when needed. At a minimal, each supervisor is also expected to meet with each of their assigned trainees on a regularly scheduled basis, at least weekly unless dictated otherwise by contractual requirements.
- b. Supervision of professional staff: In addition to the informal guidance and feedback sought from a supervisor when needed, each supervisor is also expected to meet with each of their supervisees on a regularly scheduled basis, at least monthly. This supervision may occur in an individual or group setting depending on the needs of those involved.

Program management: Program management entails the development, implementation, quantitative and qualitative evaluation, and day-to-day management of a program and its staff.

Appendix B

Application for Clinical Credentials

CONNECTICUT VALLEY HOSPITAL PSYCHOLOGY SERVICES

Application for Clinical Credentialing

☐ **Addiction Division** ☐ **Forensic Division** ☐ **General Psychiatry**

Name: _____

Job title: _____

Year doctorate awarded: _____ University: _____

Specialty area: ☐ General clinical ☐ Forensic psychology ☐ Substance abuse

☐ Neuropsychology ☐ Geriatrics ☐ Other (specify): _____

CT Psychology license #: _____ or Post-doctoral fellow ☐

License verified by: _____ date verified? _____

Psychological Assessment

_____ Cognitive
_____ Personality: Objective
_____ Personality: Projective
_____ Neuropsychology
_____ Psychodiagnostic

Psychotherapy

_____ Individual
_____ Group
_____ Family
_____ Behavioral

Forensic expertise

_____ PSRB
_____ Competency
_____ Pre-sentence
_____ Probate

Administration

_____ Supervision *ENTER PRACTICE STATUS:*
_____ Program management US (Under Supervision), I (Independent) *OR* S (Supervisory)

By submitting this application for clinical credentialing, I intend to abide by all standards and ethical principles of the profession of psychology as defined by the American Psychological Association, and to practice in accordance with state law.

I confirm that all information on this form is true and give permission to DMHAS and its representatives to verify the facts as I have presented them.

I confirm that I have not been convicted of a felony and that I do not suffer from a medical or psychiatric disorder that would prevent me from serving in the areas in which I seek credentialing.

_____ Date: _____
(Psychologist signature)

Approved: Date _____
Chair, Credentialing Committee

Approved: Date _____
Chair, Discipline of Psychology or designee

Appendix C

Continuing Education Monitoring Sheet

Continuing Education

Each Psychology staff member will maintain a list of all workshops, conferences, presentations, and other continuing education efforts which he/she attends or presents, and will submit this list, in early December, to the Associate Chair of Psychology. The staff member should also forward this list to the Human Resources Department for inclusion in the Psychologist's personnel record.

Psychologist's Name _____ Years _____

[illegible]

Appendix D

Ethical Principles of Psychologists and Code of Conduct

Please consult these at <http://www.apa.org/ethics/code/index.aspx> or below

Ethical Principles of Psychologists and Code of Conduct 2010 Amendments

Language of the 2002 Ethics Code with Changes Marked

Introduction and Applicability

If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists make known their commitment to this Ethics Code and take steps to resolve the conflict in a responsible manner. ~~If the conflict is unresolvable via such means, psychologists may adhere to the requirements of the law, regulations, or other governing authority in keeping with basic principles of human rights.~~

1.02 Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority

If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. ~~If the conflict is unresolvable via such means, psychologists may adhere to the requirements of the law, regulations, or other governing legal authority.~~ Under no circumstances may this standard be used to justify or defend violating human rights.

1.03 Conflicts Between Ethics and Organizational Demands

If the demands of an organization with which psychologists are affiliated or for whom they are working are in conflict with this Ethics Code, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and ~~to the extent feasible,~~ take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights.

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INTRODUCTION AND APPLICABILITY

The American Psychological Association's (APA's) Ethical Principles of Psychologists and Code of Conduct (hereinafter referred to as the Ethics Code) consists of an Introduction, a Preamble, five General Principles (A – E), and specific Ethical Standards. The Introduction discusses the intent, organization, procedural considerations, and scope of application of the Ethics Code. The Preamble and General Principles are aspirational goals to guide psychologists toward the highest ideals of psychology. Although the Preamble and General Principles are not themselves enforceable rules, they should be considered by psychologists in arriving at an ethical course of action. The Ethical Standards set forth enforceable rules for conduct as psychologists. Most of the Ethical Standards are written broadly, in order to apply to psychologists in varied roles, although the application of an Ethical Standard may vary depending on the context. The Ethical Standards are not exhaustive. The fact that a given conduct is not specifically addressed by an Ethical Standard does not mean that it is necessarily either ethical or unethical.

This Ethics Code applies only to psychologists' activities that are part of their scientific, educational, or professional roles as psychologists. Areas covered include but are not limited to the clinical, counseling, and school practice of psychology; research; teaching; supervision of trainees; public service; policy development; social intervention; development of assessment instruments; conducting assessments; educational counseling; organizational consulting; forensic activities; program design and evaluation; and administration. This Ethics Code applies to these activities across a variety of contexts, such as in person, postal, telephone, internet, and other electronic transmissions. These activities shall be distinguished from the purely private conduct of psychologists, which is not within the purview of the Ethics Code.

Membership in the APA commits members and student affiliates to comply with the standards of the APA Ethics Code and to the rules and procedures used to enforce them. Lack of awareness or misunderstanding of an Ethical Standard is not itself a defense to a charge of unethical conduct.

The procedures for filing, investigating, and resolving complaints of unethical conduct are described in the current Rules and Procedures of the APA Ethics Committee. APA may impose sanctions on its members for violations of the standards of the Ethics Code, including termination of APA membership, and may notify other bodies and individuals of its actions. Actions that violate the standards of the Ethics Code may also lead to the imposition of sanctions on psychologists or students whether or not they are APA members by bodies other than APA, including state psychological associations, other professional groups, psychology boards, other state or federal agencies, and payors for health services. In addition, APA may take action against a member after his or her conviction of a felony, expulsion or suspension from an affiliated state psychological association, or suspension or loss of licensure. When the sanction to be imposed by APA is less than expulsion, the 2001 Rules and Procedures do not guarantee an opportunity for an in-person hearing, but generally provide that complaints will be resolved only on the basis of a submitted record.

The Ethics Code is intended to provide guidance for psychologists and standards of professional conduct that can be applied by the APA and by other bodies that choose to adopt them. The Ethics Code is not intended to be a basis of civil liability. Whether a psychologist has violated the Ethics Code standards does not by itself determine whether the psychologist is legally liable in a court action, whether a contract is enforceable, or whether other legal consequences occur.

The modifiers used in some of the standards of this Ethics Code (e.g., *reasonably*, *appropriate*, *potentially*) are included in the standards when they would (1) allow professional judgment on the part of psychologists, (2) eliminate injustice or inequality that would occur without the modifier, (3) ensure applicability across the broad range of activities conducted by psychologists, or (4) guard against a set of rigid rules that might be quickly outdated. As used in this Ethics Code, the term *reasonable* means the prevailing professional judgment of psychologists engaged in similar activities in similar circumstances, given the knowledge the psychologist had or should have had at the time.

In the process of making decisions regarding their professional behavior, psychologists must consider this Ethics Code in addition to applicable laws and psychology board regulations. In applying the Ethics Code to their professional work, psychologists may consider other materials and guidelines that have been adopted or endorsed by scientific and professional psychological organizations and the dictates of their own conscience, as well as consult with others within the field. If this Ethics Code establishes a higher standard of conduct than is required by law, psychologists must meet the higher ethical standard. If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists make known their commitment to this Ethics Code and take steps to resolve the conflict in a responsible manner. If the conflict is unresolvable via such means, psychologists may adhere to the requirements of the law, regulations, or other governing authority in keeping with basic principles of human rights.

PREAMBLE

Psychologists are committed to increasing scientific and professional knowledge of behavior and people's understanding of themselves and others and to the use of such knowledge to improve the condition of individuals, organizations, and society. Psychologists respect and protect civil and human rights and the central importance of freedom of inquiry and expression in research, teaching, and publication. They strive to help the public in developing informed judgments and choices concerning human behavior. In doing so, they perform many roles, such as researcher, educator, diagnostician, therapist, supervisor, consultant, administrator, social interventionist, and expert witness. This Ethics Code provides a common set of principles and standards upon which psychologists build their professional and scientific work.

This Ethics Code is intended to provide specific standards to cover most situations encountered by psychologists. It has as its goals the welfare and protection of the individuals and groups with whom psychologists work and the education of members, students, and the public regarding ethical standards of the discipline.

The development of a dynamic set of ethical standards for psychologists' work-related conduct requires a personal commitment and lifelong effort to act ethically; to encourage ethical behavior by students, supervisees, employees, and colleagues; and to consult with others concerning ethical problems.

GENERAL PRINCIPLES

This section consists of General Principles. General Principles, as opposed to Ethical Standards, are aspirational in nature. Their intent is to guide and inspire psychologists toward the very highest ethical ideals of the profession. General Principles, in contrast to Ethical Standards, do not represent obligations and should not form the basis for imposing sanctions. Relying upon General Principles for either of these reasons distorts both their meaning and purpose.

PRINCIPLE A: BENEFICENCE AND NONMALEFICENCE

Psychologists strive to benefit those with whom they work and take care to do no harm. In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons, and the welfare of animal subjects of research. When conflicts occur among psychologists' obligations or concerns, they attempt to resolve these conflicts in a responsible fashion that avoids or minimizes harm. Because psychologists' scientific and professional judgments and actions may affect the lives of others, they are alert to and guard against personal, financial, social, organizational, or political factors that might lead to misuse of their influence. Psychologists strive to be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work.

PRINCIPLE B: FIDELITY AND RESPONSIBILITY

Psychologists establish relationships of trust with those with whom they work. They are aware of their professional and scientific responsibilities to society and to the specific communities in which they work. Psychologists uphold professional standards of conduct, clarify their professional roles and obligations, accept appropriate responsibility for their behavior, and seek to manage conflicts of interest that could lead to exploitation or harm. Psychologists consult with, refer to, or cooperate with other professionals and institutions to the extent needed to serve the best interests of those with whom they work. They are concerned about the ethical compliance of their colleagues' scientific and professional conduct. Psychologists strive to contribute a portion of their professional time for little or no compensation or personal advantage.

PRINCIPLE C: INTEGRITY

Psychologists seek to promote accuracy, honesty, and truthfulness in the science, teaching, and practice of psychology. In these activities psychologists do not steal, cheat, or engage in fraud, subterfuge, or intentional misrepresentation of fact. Psychologists strive to keep their promises and to avoid unwise or unclear commitments. In situations in which deception may be ethically justifiable to maximize benefits and minimize harm, psychologists have a serious obligation to consider the need for, the possible consequences of, and their responsibility to correct any resulting mistrust or other harmful effects that arise from the use of such techniques.

PRINCIPLE D: JUSTICE

Psychologists recognize that fairness and justice entitle all persons to access to and benefit from the contributions of psychology and to equal quality in the processes, procedures, and services being conducted by psychologists. Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of their competence, and the limitations of their expertise do not lead to or condone unjust practices.

PRINCIPLE E: RESPECT FOR PEOPLE'S RIGHTS AND DIGNITY

Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination. Psychologists are aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision making. Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status and consider these factors when working with members of such groups. Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices.

ETHICAL STANDARDS

1. RESOLVING ETHICAL ISSUES

1.01 Misuse of Psychologists' Work

If psychologists learn of misuse or misrepresentation of their work, they take reasonable steps to correct or minimize the misuse or misrepresentation.

1.02 Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority

If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists make known their commitment to the Ethics Code and take steps to resolve the conflict. If the conflict is unresolvable via such means, psychologists may adhere to the requirements of the law, regulations, or other governing legal authority.

1.03 Conflicts Between Ethics and Organizational Demands

If the demands of an organization with which psychologists are affiliated or for whom they are working conflict with this Ethics Code, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and to the extent feasible, resolve the conflict in a way that permits adherence to the Ethics Code.

1.04 Informal Resolution of Ethical Violations

When psychologists believe that there may have been an ethical violation by another psychologist, they attempt to resolve the issue by bringing it to the attention of that individual, if an informal resolution appears appropriate and the intervention does not violate any confidentiality rights that may be involved. (See also Standards 1.02, Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority, and 1.03, Conflicts Between Ethics and Organizational Demands.)

1.05 Reporting Ethical Violations

If an apparent ethical violation has substantially harmed or is likely to substantially harm a person or organization and is not appropriate for informal resolution under Standard 1.04, Informal Resolution of Ethical Violations, or is not resolved properly in that fashion, psychologists take further action appropriate to the situation. Such action might include referral to state or national committees on professional ethics, to state licensing boards, or to the appropriate institutional authorities. This standard does not apply when an intervention would violate confidentiality rights or when psychologists have been retained to review the work of another psychologist whose professional conduct is in question. (See also Standard 1.02, Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority.)

1.06 Cooperating With Ethics Committees

Psychologists cooperate in ethics investigations, proceedings, and resulting requirements of the APA or any affiliated state psychological association to which they belong. In doing so, they address any confidentiality issues. Failure to cooperate is itself an ethics violation. However, making a request for deferment of adjudication of an ethics complaint pending the outcome of litigation does not alone constitute noncooperation.

1.07 Improper Complaints

Psychologists do not file or encourage the filing of ethics complaints that are made with reckless disregard for or willful ignorance of facts that would disprove the allegation.

1.08 Unfair Discrimination Against Complainants and Respondents

Psychologists do not deny persons employment, advancement, admissions to academic or other programs, tenure, or promotion, based solely upon their having made or their being the subject of an ethics complaint. This does not preclude taking action based upon the outcome of such proceedings or considering other appropriate information.

2. COMPETENCE

2.01 Boundaries of Competence

- (a) Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience.
- (b) Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals, except as provided in Standard 2.02, Providing Services in Emergencies.
- (c) Psychologists planning to provide services, teach, or conduct research involving populations, areas, techniques, or technologies new to them undertake relevant education, training, supervised experience, consultation, or study.
- (d) When psychologists are asked to provide services to individuals for whom appropriate mental health services are not available and for which psychologists have not obtained the competence necessary, psychologists with closely related prior training or experience may provide such services in order to ensure that services are not denied if they make a reasonable effort to obtain the competence required by using relevant research, training, consultation, or study.
- (e) In those emerging areas in which generally recognized standards for preparatory training do not yet exist, psychologists nevertheless take reasonable steps to ensure the competence of their work and to protect clients/patients, students, supervisees, research participants, organizational clients, and others from harm.
- (f) When assuming forensic roles, psychologists are or become reasonably familiar with the judicial or administrative rules governing their roles.

2.02 Providing Services in Emergencies

In emergencies, when psychologists provide services to individuals for whom other mental health services are not available and for which psychologists have not obtained the necessary training, psychologists may provide such services in order to ensure that services are not denied. The services are discontinued as soon as the emergency has ended or appropriate services are available.

2.03 Maintaining Competence

Psychologists undertake ongoing efforts to develop and maintain their competence.

2.04 Bases for Scientific and Professional Judgments

Psychologists' work is based upon established scientific and professional knowledge of the discipline. (See also Standards 2.01e, Boundaries of Competence, and 10.01b, Informed Consent to Therapy.)

2.05 Delegation of Work to Others

Psychologists who delegate work to employees, supervisees, or research or teaching assistants or who use the services of others, such as interpreters, take reasonable steps to (1) avoid delegating such work to persons who have a multiple relationship with those being served that would likely lead to exploitation or loss of objectivity; (2) authorize only those responsibilities that such persons can be expected to perform competently on the basis of their education, training, or experience, either independently or with the level of supervision being provided; and (3) see that such persons perform these services competently. (See also Standards 2.02, Providing Services in Emergencies; 3.05, Multiple Relationships; 4.01, Maintaining Confidentiality; 9.01, Bases for Assessments; 9.02, Use of Assessments; 9.03, Informed Consent in Assessments; and 9.07, Assessment by Unqualified Persons.)

2.06 Personal Problems and Conflicts

- (a) Psychologists refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner.

(b) When psychologists become aware of personal problems that may interfere with their performing work-related duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance, and determine whether they should limit, suspend, or terminate their work-related duties. (See also Standard 10.10, Terminating Therapy.)

3. HUMAN RELATIONS

3.01 Unfair Discrimination

In their work-related activities, psychologists do not engage in unfair discrimination based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, socioeconomic status, or any basis proscribed by law.

3.02 Sexual Harassment

Psychologists do not engage in sexual harassment. Sexual harassment is sexual solicitation, physical advances, or verbal or nonverbal conduct that is sexual in nature, that occurs in connection with the psychologist's activities or roles as a psychologist, and that either (1) is unwelcome, is offensive, or creates a hostile workplace or educational environment, and the psychologist knows or is told this or (2) is sufficiently severe or intense to be abusive to a reasonable person in the context. Sexual harassment can consist of a single intense or severe act or of multiple persistent or pervasive acts. (See also Standard 1.08, Unfair Discrimination Against Complainants and Respondents.)

3.03 Other Harassment

Psychologists do not knowingly engage in behavior that is harassing or demeaning to persons with whom they interact in their work based on factors such as those persons' age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status.

3.04 Avoiding Harm

Psychologists take reasonable steps to avoid harming their clients/patients, students, supervisees, research participants, organizational clients, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable.

3.05 Multiple Relationships

(a) A multiple relationship occurs when a psychologist is in a professional role with a person and (1) at the same time is in another role with the same person, (2) at the same time is in a relationship with a person closely associated with or related to the person with whom the psychologist has the professional relationship, or (3) promises to enter into another relationship in the future with the person or a person closely associated with or related to the person.

A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists.

Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical.

(b) If a psychologist finds that, due to unforeseen factors, a potentially harmful multiple relationship has arisen, the psychologist takes reasonable steps to resolve it with due regard for the best interests of the affected person and maximal compliance with the Ethics Code.

(c) When psychologists are required by law, institutional policy, or extraordinary circumstances to serve in more than one role in judicial or administrative proceedings, at the outset they clarify role expectations and the extent of confidentiality and thereafter as changes occur. (See also Standards 3.04, Avoiding Harm, and 3.07, Third-Party Requests for Services.)

3.06 Conflict of Interest

Psychologists refrain from taking on a professional role when personal, scientific, professional, legal, financial, or other interests or relationships could reasonably be expected to (1) impair their objectivity, competence, or effectiveness in performing their functions as psychologists or (2) expose the person or organization with whom the professional relationship exists to harm or exploitation.

3.07 Third-Party Requests for Services

When psychologists agree to provide services to a person or entity at the request of a third party, psychologists attempt to clarify at the outset of the service the nature of the relationship with all individuals or organizations involved. This clarification includes the role of the psychologist (e.g., therapist, consultant, diagnostician, or expert witness), an identification of who is the client, the probable uses of the services provided or the information obtained, and the fact that there may be limits to confidentiality. (See also Standards 3.05, Multiple Relationships, and 4.02, Discussing the Limits of Confidentiality.)

3.08 Exploitative Relationships

Psychologists do not exploit persons over whom they have supervisory, evaluative, or other authority such as clients/patients, students, supervisees, research participants, and employees. (See also Standards 3.05, Multiple Relationships; 6.04, Fees and Financial Arrangements; 6.05, Barter With Clients/Patients; 7.07, Sexual Relationships With Students and Supervisees; 10.05, Sexual Intimacies With Current Therapy Clients/Patients; 10.06, Sexual Intimacies With Relatives or Significant Others of Current Therapy Clients/Patients; 10.07, Therapy With Former Sexual Partners; and 10.08, Sexual Intimacies With Former Therapy Clients/Patients.)

3.09 Cooperation With Other Professionals

When indicated and professionally appropriate, psychologists cooperate with other professionals in order to serve their clients/patients effectively and appropriately. (See also Standard 4.05, Disclosures.)

3.10 Informed Consent

(a) When psychologists conduct research or provide assessment, therapy, counseling, or consulting services in person or via electronic transmission or other forms of communication, they obtain the informed consent of the individual or individuals using language that is reasonably understandable to that person or persons except when conducting such activities without consent is mandated by law or governmental regulation or as otherwise provided in this Ethics Code. (See also Standards 8.02, Informed Consent to Research; 9.03, Informed Consent in Assessments; and 10.01, Informed Consent to Therapy.)

- (b) For persons who are legally incapable of giving informed consent, psychologists nevertheless (1) provide an appropriate explanation, (2) seek the individual's assent, (3) consider such persons' preferences and best interests, and (4) obtain appropriate permission from a legally authorized person, if such substitute consent is permitted or required by law. When consent by a legally authorized person is not permitted or required by law, psychologists take reasonable steps to protect the individual's rights and welfare.
- (c) When psychological services are court ordered or otherwise mandated, psychologists inform the individual of the nature of the anticipated services, including whether the services are court ordered or mandated and any limits of confidentiality, before proceeding.
- (d) Psychologists appropriately document written or oral consent, permission, and assent. (See also Standards 8.02, Informed Consent to Research; 9.03, Informed Consent in Assessments; and 10.01, Informed Consent to Therapy.)

3.11 Psychological Services Delivered To or Through Organizations

- (a) Psychologists delivering services to or through organizations provide information beforehand to clients and when appropriate those directly affected by the services about (1) the nature and objectives of the services, (2) the intended recipients, (3) which of the individuals are clients, (4) the relationship the psychologist will have with each person and the organization, (5) the probable uses of services provided and information obtained, (6) who will have access to the information, and (7) limits of confidentiality. As soon as feasible, they provide information about the results and conclusions of such services to appropriate persons.
- (b) If psychologists will be precluded by law or by organizational roles from providing such information to particular individuals or groups, they so inform those individuals or groups at the outset of the service.

3.12 Interruption of Psychological Services

Unless otherwise covered by contract, psychologists make reasonable efforts to plan for facilitating services in the event that psychological services are interrupted by factors such as the psychologist's illness, death, unavailability, relocation, or retirement or by the client's/patient's relocation or financial limitations. (See also Standard 6.02c, Maintenance, Dissemination, and Disposal of Confidential Records of Professional and Scientific Work.)

4. PRIVACY AND CONFIDENTIALITY

4.01 Maintaining Confidentiality

Psychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship. (See also Standard 2.05, Delegation of Work to Others.)

4.02 Discussing the Limits of Confidentiality

- (a) Psychologists discuss with persons (including, to the extent feasible, persons who are legally incapable of giving informed consent and their legal representatives) and organizations with whom they establish a scientific or professional relationship (1) the relevant limits of confidentiality and (2) the foreseeable uses of the information generated through their psychological activities. (See also Standard 3.10, Informed Consent.)
- (b) Unless it is not feasible or is contraindicated, the discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances may warrant.
- (c) Psychologists who offer services, products, or information via electronic transmission inform clients/patients of the risks to privacy and limits of confidentiality.

4.03 Recording

Before recording the voices or images of individuals to whom they provide services, psychologists obtain permission from all such persons or their legal representatives. (See also Standards 8.03, Informed Consent for Recording Voices and Images in Research; 8.05, Dispensing With Informed Consent for Research; and 8.07, Deception in Research.)

4.04 Minimizing Intrusions on Privacy

- (a) Psychologists include in written and oral reports and consultations, only information germane to the purpose for which the communication is made.
- (b) Psychologists discuss confidential information obtained in their work only for appropriate scientific or professional purposes and only with persons clearly concerned with such matters.

4.05 Disclosures

- (a) Psychologists may disclose confidential information with the appropriate consent of the organizational client, the individual client/patient, or another legally authorized person on behalf of the client/patient unless prohibited by law.
- (b) Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose such as to (1) provide needed professional services; (2) obtain appropriate professional consultations; (3) protect the client/patient, psychologist, or others from harm; or (4) obtain payment for services from a client/patient, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose. (See also Standard 6.04e, Fees and Financial Arrangements.)

4.06 Consultations

When consulting with colleagues, (1) psychologists do not disclose confidential information that reasonably could lead to the identification of a client/patient, research participant, or other person or organization with whom they have a confidential relationship unless they have obtained the prior consent of the person or organization or the disclosure cannot be avoided, and (2) they disclose information only to the extent necessary to achieve the purposes of the consultation. (See also Standard 4.01, Maintaining Confidentiality.)

4.07 Use of Confidential Information for Didactic or Other Purposes

Psychologists do not disclose in their writings, lectures, or other public media, confidential, personally identifiable information concerning their clients/patients, students, research participants, organizational clients, or other recipients of their services that they

obtained during the course of their work, unless (1) they take reasonable steps to disguise the person or organization, (2) the person or organization has consented in writing, or (3) there is legal authorization for doing so.

5. ADVERTISING AND OTHER PUBLIC STATEMENTS

5.01 Avoidance of False or Deceptive Statements

(a) Public statements include but are not limited to paid or unpaid advertising, product endorsements, grant applications, licensing applications, other credentialing applications, brochures, printed matter, directory listings, personal resumes or curricula vitae, or comments for use in media such as print or electronic transmission, statements in legal proceedings, lectures and public oral presentations, and published materials. Psychologists do not knowingly make public statements that are false, deceptive, or fraudulent concerning their research, practice, or other work activities or those of persons or organizations with which they are affiliated.

(b) Psychologists do not make false, deceptive, or fraudulent statements concerning (1) their training, experience, or competence; (2) their academic degrees; (3) their credentials; (4) their institutional or association affiliations; (5) their services; (6) the scientific or clinical basis for, or results or degree of success of, their services; (7) their fees; or (8) their publications or research findings.

(c) Psychologists claim degrees as credentials for their health services only if those degrees (1) were earned from a regionally accredited educational institution or (2) were the basis for psychology licensure by the state in which they practice.

5.02 Statements by Others

(a) Psychologists who engage others to create or place public statements that promote their professional practice, products, or activities retain professional responsibility for such statements.

(b) Psychologists do not compensate employees of press, radio, television, or other communication media in return for publicity in a news item. (See also Standard 1.01, Misuse of Psychologists' Work.)

(c) A paid advertisement relating to psychologists' activities must be identified or clearly recognizable as such.

5.03 Descriptions of Workshops and Non-Degree-Granting Educational Programs

To the degree to which they exercise control, psychologists responsible for announcements, catalogs, brochures, or advertisements describing workshops, seminars, or other non-degree-granting educational programs ensure that they accurately describe the audience for which the program is intended, the educational objectives, the presenters, and the fees involved.

5.04 Media Presentations

When psychologists provide public advice or comment via print, internet, or other electronic transmission, they take precautions to ensure that statements (1) are based on their professional knowledge, training, or experience in accord with appropriate psychological literature and practice; (2) are otherwise consistent with this Ethics Code; and (3) do not indicate that a professional relationship has been established with the recipient. (See also Standard 2.04, Bases for Scientific and Professional Judgments.)

5.05 Testimonials

Psychologists do not solicit testimonials from current therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence.

5.06 In-Person Solicitation

Psychologists do not engage, directly or through agents, in uninvited in-person solicitation of business from actual or potential therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence. However, this prohibition does not preclude (1) attempting to implement appropriate collateral contacts for the purpose of benefiting an already engaged therapy client/patient or (2) providing disaster or community outreach services.

6. RECORD KEEPING AND FEES

6.01 Documentation of Professional and Scientific Work and Maintenance of Records

Psychologists create, and to the extent the records are under their control, maintain, disseminate, store, retain, and dispose of records and data relating to their professional and scientific work in order to (1) facilitate provision of services later by them or by other professionals, (2) allow for replication of research design and analyses, (3) meet institutional requirements, (4) ensure accuracy of billing and payments, and (5) ensure compliance with law. (See also Standard 4.01, Maintaining Confidentiality.)

6.02 Maintenance, Dissemination, and Disposal of Confidential Records of Professional and Scientific Work

(a) Psychologists maintain confidentiality in creating, storing, accessing, transferring, and disposing of records under their control, whether these are written, automated, or in any other medium. (See also Standards 4.01, Maintaining Confidentiality, and 6.01, Documentation of Professional and Scientific Work and Maintenance of Records.)

(b) If confidential information concerning recipients of psychological services is entered into databases or systems of records available to persons whose access has not been consented to by the recipient, psychologists use coding or other techniques to avoid the inclusion of personal identifiers.

(c) Psychologists make plans in advance to facilitate the appropriate transfer and to protect the confidentiality of records and data in the event of psychologists' withdrawal from positions or practice. (See also Standards 3.12, Interruption of Psychological Services, and 10.09, Interruption of Therapy.)

6.03 Withholding Records for Nonpayment

Psychologists may not withhold records under their control that are requested and needed for a client's/patient's emergency treatment solely because payment has not been received.

6.04 Fees and Financial Arrangements

(a) As early as is feasible in a professional or scientific relationship, psychologists and recipients of psychological services reach an agreement specifying compensation and billing arrangements.

(b) Psychologists' fee practices are consistent with law.

(c) Psychologists do not misrepresent their fees.

(d) If limitations to services can be anticipated because of limitations in financing, this is discussed with the recipient of services as early as is feasible. (See also Standards 10.09, Interruption of Therapy, and 10.10, Terminating Therapy.)

(e) If the recipient of services does not pay for services as agreed, and if psychologists intend to use collection agencies or legal measures to collect the fees, psychologists first inform the person that such measures will be taken and provide that person an opportunity to make prompt payment. (See also Standards 4.05, Disclosures; 6.03, Withholding Records for Nonpayment; and 10.01, Informed Consent to Therapy.)

6.05 Barter With Clients/Patients

Barter is the acceptance of goods, services, or other nonmonetary remuneration from clients/patients in return for psychological services. Psychologists may barter only if (1) it is not clinically contraindicated, and (2) the resulting arrangement is not exploitative. (See also Standards 3.05, Multiple Relationships, and 6.04, Fees and Financial Arrangements.)

6.06 Accuracy in Reports to Payors and Funding Sources

In their reports to payors for services or sources of research funding, psychologists take reasonable steps to ensure the accurate reporting of the nature of the service provided or research conducted, the fees, charges, or payments, and where applicable, the identity of the provider, the findings, and the diagnosis. (See also Standards 4.01, Maintaining Confidentiality; 4.04, Minimizing Intrusions on Privacy; and 4.05, Disclosures.)

6.07 Referrals and Fees

When psychologists pay, receive payment from, or divide fees with another professional, other than in an employer-employee relationship, the payment to each is based on the services provided (clinical, consultative, administrative, or other) and is not based on the referral itself. (See also Standard 3.09, Cooperation With Other Professionals.)

7. EDUCATION AND TRAINING

7.01 Design of Education and Training Programs

Psychologists responsible for education and training programs take reasonable steps to ensure that the programs are designed to provide the appropriate knowledge and proper experiences, and to meet the requirements for licensure, certification, or other goals for which claims are made by the program. (See also Standard 5.03, Descriptions of Workshops and Non-Degree-Granting Educational Programs.)

7.02 Descriptions of Education and Training Programs

Psychologists responsible for education and training programs take reasonable steps to ensure that there is a current and accurate description of the program content (including participation in required course- or program-related counseling, psychotherapy, experiential groups, consulting projects, or community service), training goals and objectives, stipends and benefits, and requirements that must be met for satisfactory completion of the program. This information must be made readily available to all interested parties.

7.03 Accuracy in Teaching

(a) Psychologists take reasonable steps to ensure that course syllabi are accurate regarding the subject matter to be covered, bases for evaluating progress, and the nature of course experiences. This standard does not preclude an instructor from modifying course content or requirements when the instructor considers it pedagogically necessary or desirable, so long as students are made aware of these modifications in a manner that enables them to fulfill course requirements. (See also Standard 5.01, Avoidance of False or Deceptive Statements.)

(b) When engaged in teaching or training, psychologists present psychological information accurately. (See also Standard 2.03, Maintaining Competence.)

7.04 Student Disclosure of Personal Information

Psychologists do not require students or supervisees to disclose personal information in course- or program-related activities, either orally or in writing, regarding sexual history, history of abuse and neglect, psychological treatment, and relationships with parents, peers, and spouses or significant others except if (1) the program or training facility has clearly identified this requirement in its admissions and program materials or (2) the information is necessary to evaluate or obtain assistance for students whose personal problems could reasonably be judged to be preventing them from performing their training- or professionally related activities in a competent manner or posing a threat to the students or others.

7.05 Mandatory Individual or Group Therapy

(a) When individual or group therapy is a program or course requirement, psychologists responsible for that program allow students in undergraduate and graduate programs the option of selecting such therapy from practitioners unaffiliated with the program. (See also Standard 7.02, Descriptions of Education and Training Programs.)

(b) Faculty who are or are likely to be responsible for evaluating students' academic performance do not themselves provide that therapy. (See also Standard 3.05, Multiple Relationships.)

7.06 Assessing Student and Supervisee Performance

(a) In academic and supervisory relationships, psychologists establish a timely and specific process for providing feedback to students and supervisees. Information regarding the process is provided to the student at the beginning of supervision.

(b) Psychologists evaluate students and supervisees on the basis of their actual performance on relevant and established program requirements.

7.07 Sexual Relationships With Students and Supervisees

Psychologists do not engage in sexual relationships with students or supervisees who are in their department, agency, or training center or over whom psychologists have or are likely to have evaluative authority. (See also Standard 3.05, Multiple Relationships.)

8. RESEARCH AND PUBLICATION

8.01 Institutional Approval

When institutional approval is required, psychologists provide accurate information about their research proposals and obtain approval prior to conducting the research. They conduct the research in accordance with the approved research protocol.

8.02 Informed Consent to Research

(a) When obtaining informed consent as required in Standard 3.10, Informed Consent, psychologists inform participants about (1) the purpose of the research, expected duration, and procedures; (2) their right to decline to participate and to withdraw from the research once participation has begun; (3) the foreseeable consequences of declining or withdrawing; (4) reasonably foreseeable factors that may be expected to influence their willingness to participate such as potential risks, discomfort, or adverse effects; (5) any prospective research benefits; (6) limits of confidentiality; (7) incentives for participation; and (8) whom to contact for questions about the research and research participants' rights. They provide opportunity for the prospective participants to ask questions and receive answers. (See also Standards 8.03, Informed Consent for Recording Voices and Images in Research; 8.05, Dispensing With Informed Consent for Research; and 8.07, Deception in Research.)

(b) Psychologists conducting intervention research involving the use of experimental treatments clarify to participants at the outset of the research (1) the experimental nature of the treatment; (2) the services that will or will not be available to the control group(s) if appropriate; (3) the means by which assignment to treatment and control groups will be made; (4) available treatment alternatives if an individual does not wish to participate in the research or wishes to withdraw once a study has begun; and (5) compensation for or monetary costs of participating including, if appropriate, whether reimbursement from the participant or a third-party payor will be sought. (See also Standard 8.02a, Informed Consent to Research.)

8.03 Informed Consent for Recording Voices and Images in Research

Psychologists obtain informed consent from research participants prior to recording their voices or images for data collection unless (1) the research consists solely of naturalistic observations in public places, and it is not anticipated that the recording will be used in a manner that could cause personal identification or harm, or (2) the research design includes deception, and consent for the use of the recording is obtained during debriefing. (See also Standard 8.07, Deception in Research.)

8.04 Client/Patient, Student, and Subordinate Research Participants

(a) When psychologists conduct research with clients/patients, students, or subordinates as participants, psychologists take steps to protect the prospective participants from adverse consequences of declining or withdrawing from participation.

(b) When research participation is a course requirement or an opportunity for extra credit, the prospective participant is given the choice of equitable alternative activities.

8.05 Dispensing With Informed Consent for Research

Psychologists may dispense with informed consent only (1) where research would not reasonably be assumed to create distress or harm and involves (a) the study of normal educational practices, curricula, or classroom management methods conducted in educational settings; (b) only anonymous questionnaires, naturalistic observations, or archival research for which disclosure of responses would not place participants at risk of criminal or civil liability or damage their financial standing, employability, or reputation, and confidentiality is protected; or (c) the study of factors related to job or organization effectiveness conducted in organizational settings for which there is no risk to participants' employability, and confidentiality is protected or (2) where otherwise permitted by law or federal or institutional regulations.

8.06 Offering Inducements for Research Participation

(a) Psychologists make reasonable efforts to avoid offering excessive or inappropriate financial or other inducements for research participation when such inducements are likely to coerce participation.

(b) When offering professional services as an inducement for research participation, psychologists clarify the nature of the services, as well as the risks, obligations, and limitations. (See also Standard 6.05, Barter With Clients/Patients.)

8.07 Deception in Research

(a) Psychologists do not conduct a study involving deception unless they have determined that the use of deceptive techniques is justified by the study's significant prospective scientific, educational, or applied value and that effective nondeceptive alternative procedures are not feasible.

(b) Psychologists do not deceive prospective participants about research that is reasonably expected to cause physical pain or severe emotional distress.

(c) Psychologists explain any deception that is an integral feature of the design and conduct of an experiment to participants as early as is feasible, preferably at the conclusion of their participation, but no later than at the conclusion of the data collection, and permit participants to withdraw their data. (See also Standard 8.08, Debriefing.)

8.08 Debriefing

(a) Psychologists provide a prompt opportunity for participants to obtain appropriate information about the nature, results, and conclusions of the research, and they take reasonable steps to correct any misconceptions that participants may have of which the psychologists are aware.

(b) If scientific or humane values justify delaying or withholding this information, psychologists take reasonable measures to reduce the risk of harm.

(c) When psychologists become aware that research procedures have harmed a participant, they take reasonable steps to minimize the harm.

8.09 Humane Care and Use of Animals in Research

- (a) Psychologists acquire, care for, use, and dispose of animals in compliance with current federal, state, and local laws and regulations, and with professional standards.
- (b) Psychologists trained in research methods and experienced in the care of laboratory animals supervise all procedures involving animals and are responsible for ensuring appropriate consideration of their comfort, health, and humane treatment.
- (c) Psychologists ensure that all individuals under their supervision who are using animals have received instruction in research methods and in the care, maintenance, and handling of the species being used, to the extent appropriate to their role. (See also Standard 2.05, Delegation of Work to Others.)
- (d) Psychologists make reasonable efforts to minimize the discomfort, infection, illness, and pain of animal subjects.
- (e) Psychologists use a procedure subjecting animals to pain, stress, or deprivation only when an alternative procedure is unavailable and the goal is justified by its prospective scientific, educational, or applied value.
- (f) Psychologists perform surgical procedures under appropriate anesthesia and follow techniques to avoid infection and minimize pain during and after surgery.
- (g) When it is appropriate that an animal's life be terminated, psychologists proceed rapidly, with an effort to minimize pain and in accordance with accepted procedures.

8.10 Reporting Research Results

- (a) Psychologists do not fabricate data. (See also Standard 5.01a, Avoidance of False or Deceptive Statements.)
- (b) If psychologists discover significant errors in their published data, they take reasonable steps to correct such errors in a correction, retraction, erratum, or other appropriate publication means.

8.11 Plagiarism

Psychologists do not present portions of another's work or data as their own, even if the other work or data source is cited occasionally.

8.12 Publication Credit

- (a) Psychologists take responsibility and credit, including authorship credit, only for work they have actually performed or to which they have substantially contributed. (See also Standard 8.12b, Publication Credit.)
- (b) Principal authorship and other publication credits accurately reflect the relative scientific or professional contributions of the individuals involved, regardless of their relative status. Mere possession of an institutional position, such as department chair, does not justify authorship credit. Minor contributions to the research or to the writing for publications are acknowledged appropriately, such as in footnotes or in an introductory statement.
- (c) Except under exceptional circumstances, a student is listed as principal author on any multiple-authored article that is substantially based on the student's doctoral dissertation. Faculty advisors discuss publication credit with students as early as feasible and throughout the research and publication process as appropriate. (See also Standard 8.12b, Publication Credit.)

8.13 Duplicate Publication of Data

Psychologists do not publish, as original data, data that have been previously published. This does not preclude republishing data when they are accompanied by proper acknowledgment.

8.14 Sharing Research Data for Verification

- (a) After research results are published, psychologists do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release. This does not preclude psychologists from requiring that such individuals or groups be responsible for costs associated with the provision of such information.
- (b) Psychologists who request data from other psychologists to verify the substantive claims through reanalysis may use shared data only for the declared purpose. Requesting psychologists obtain prior written agreement for all other uses of the data.

8.15 Reviewers

Psychologists who review material submitted for presentation, publication, grant, or research proposal review respect the confidentiality of and the proprietary rights in such information of those who submitted it.

9. ASSESSMENT

9.01 Bases for Assessments

- (a) Psychologists base the opinions contained in their recommendations, reports, and diagnostic or evaluative statements, including forensic testimony, on information and techniques sufficient to substantiate their findings. (See also Standard 2.04, Bases for Scientific and Professional Judgments.)
- (b) Except as noted in 9.01c, psychologists provide opinions of the psychological characteristics of individuals only after they have conducted an examination of the individuals adequate to support their statements or conclusions. When, despite reasonable efforts, such an examination is not practical, psychologists document the efforts they made and the result of those efforts, clarify the probable impact of their limited information on the reliability and validity of their opinions, and appropriately limit the nature and extent of their conclusions or recommendations. (See also Standards 2.01, Boundaries of Competence, and 9.06, Interpreting Assessment Results.)
- (c) When psychologists conduct a record review or provide consultation or supervision and an individual examination is not warranted or necessary for the opinion, psychologists explain this and the sources of information on which they based their conclusions and recommendations.

9.02 Use of Assessments

- (a) Psychologists administer, adapt, score, interpret, or use assessment techniques, interviews, tests, or instruments in a manner and for purposes that are appropriate in light of the research on or evidence of the usefulness and proper application of the techniques.

(b) Psychologists use assessment instruments whose validity and reliability have been established for use with members of the population tested. When such validity or reliability has not been established, psychologists describe the strengths and limitations of test results and interpretation.

(c) Psychologists use assessment methods that are appropriate to an individual's language preference and competence, unless the use of an alternative language is relevant to the assessment issues.

9.03 Informed Consent in Assessments

(a) Psychologists obtain informed consent for assessments, evaluations, or diagnostic services, as described in Standard 3.10, Informed Consent, except when (1) testing is mandated by law or governmental regulations; (2) informed consent is implied because testing is conducted as a routine educational, institutional, or organizational activity (e.g., when participants voluntarily agree to assessment when applying for a job); or (3) one purpose of the testing is to evaluate decisional capacity. Informed consent includes an explanation of the nature and purpose of the assessment, fees, involvement of third parties, and limits of confidentiality and sufficient opportunity for the client/patient to ask questions and receive answers.

(b) Psychologists inform persons with questionable capacity to consent or for whom testing is mandated by law or governmental regulations about the nature and purpose of the proposed assessment services, using language that is reasonably understandable to the person being assessed.

(c) Psychologists using the services of an interpreter obtain informed consent from the client/patient to use that interpreter, ensure that confidentiality of test results and test security are maintained, and include in their recommendations, reports, and diagnostic or evaluative statements, including forensic testimony, discussion of any limitations on the data obtained. (See also Standards 2.05, Delegation of Work to Others; 4.01, Maintaining Confidentiality; 9.01, Bases for Assessments; 9.06, Interpreting Assessment Results; and 9.07, Assessment by Unqualified Persons.)

9.04 Release of Test Data

(a) The term *test data* refers to raw and scaled scores, client/patient responses to test questions or stimuli, and psychologists' notes and recordings concerning client/patient statements and behavior during an examination. Those portions of test materials that include client/patient responses are included in the definition of *test data*. Pursuant to a client/patient release, psychologists provide test data to the client/patient or other persons identified in the release. Psychologists may refrain from releasing test data to protect a client/patient or others from substantial harm or misuse or misrepresentation of the data or the test, recognizing that in many instances release of confidential information under these circumstances is regulated by law. (See also Standard 9.11, Maintaining Test Security.)

(b) In the absence of a client/patient release, psychologists provide test data only as required by law or court order.

9.05 Test Construction

Psychologists who develop tests and other assessment techniques use appropriate psychometric procedures and current scientific or professional knowledge for test design, standardization, validation, reduction or elimination of bias, and recommendations for use.

9.06 Interpreting Assessment Results

When interpreting assessment results, including automated interpretations, psychologists take into account the purpose of the assessment as well as the various test factors, test-taking abilities, and other characteristics of the person being assessed, such as situational, personal, linguistic, and cultural differences, that might affect psychologists' judgments or reduce the accuracy of their interpretations. They indicate any significant limitations of their interpretations. (See also Standards 2.01b and c, Boundaries of Competence, and 3.01, Unfair Discrimination.)

9.07 Assessment by Unqualified Persons

Psychologists do not promote the use of psychological assessment techniques by unqualified persons, except when such use is conducted for training purposes with appropriate supervision. (See also Standard 2.05, Delegation of Work to Others.)

9.08 Obsolete Tests and Outdated Test Results

(a) Psychologists do not base their assessment or intervention decisions or recommendations on data or test results that are outdated for the current purpose.

(b) Psychologists do not base such decisions or recommendations on tests and measures that are obsolete and not useful for the current purpose.

9.09 Test Scoring and Interpretation Services

(a) Psychologists who offer assessment or scoring services to other professionals accurately describe the purpose, norms, validity, reliability, and applications of the procedures and any special qualifications applicable to their use.

(b) Psychologists select scoring and interpretation services (including automated services) on the basis of evidence of the validity of the program and procedures as well as on other appropriate considerations. (See also Standard 2.01b and c, Boundaries of Competence.)

(c) Psychologists retain responsibility for the appropriate application, interpretation, and use of assessment instruments, whether they score and interpret such tests themselves or use automated or other services.

9.10 Explaining Assessment Results

Regardless of whether the scoring and interpretation are done by psychologists, by employees or assistants, or by automated or other outside services, psychologists take reasonable steps to ensure that explanations of results are given to the individual or designated representative unless the nature of the relationship precludes provision of an explanation of results (such as in some organizational consulting, preemployment or security screenings, and forensic evaluations), and this fact has been clearly explained to the person being assessed in advance.

9.11. Maintaining Test Security

The term *test materials* refers to manuals, instruments, protocols, and test questions or stimuli and does not include *test data* as defined in Standard 9.04, Release of Test Data. Psychologists make reasonable efforts to maintain the integrity and security of test materials

and other assessment techniques consistent with law and contractual obligations, and in a manner that permits adherence to this Ethics Code.

10. THERAPY

10.01 Informed Consent to Therapy

(a) When obtaining informed consent to therapy as required in Standard 3.10, Informed Consent, psychologists inform clients/patients as early as is feasible in the therapeutic relationship about the nature and anticipated course of therapy, fees, involvement of third parties, and limits of confidentiality and provide sufficient opportunity for the client/patient to ask questions and receive answers. (See also Standards 4.02, Discussing the Limits of Confidentiality, and 6.04, Fees and Financial Arrangements.)

(b) When obtaining informed consent for treatment for which generally recognized techniques and procedures have not been established, psychologists inform their clients/patients of the developing nature of the treatment, the potential risks involved, alternative treatments that may be available, and the voluntary nature of their participation. (See also Standards 2.01e, Boundaries of Competence, and 3.10, Informed Consent.)

(c) When the therapist is a trainee and the legal responsibility for the treatment provided resides with the supervisor, the client/patient, as part of the informed consent procedure, is informed that the therapist is in training and is being supervised and is given the name of the supervisor.

10.02 Therapy Involving Couples or Families

(a) When psychologists agree to provide services to several persons who have a relationship (such as spouses, significant others, or parents and children), they take reasonable steps to clarify at the outset (1) which of the individuals are clients/patients and (2) the relationship the psychologist will have with each person. This clarification includes the psychologist's role and the probable uses of the services provided or the information obtained. (See also Standard 4.02, Discussing the Limits of Confidentiality.)

(b) If it becomes apparent that psychologists may be called on to perform potentially conflicting roles (such as family therapist and then witness for one party in divorce proceedings), psychologists take reasonable steps to clarify and modify, or withdraw from, roles appropriately. (See also Standard 3.05c, Multiple Relationships.)

10.03 Group Therapy

When psychologists provide services to several persons in a group setting, they describe at the outset the roles and responsibilities of all parties and the limits of confidentiality.

10.04 Providing Therapy to Those Served by Others

In deciding whether to offer or provide services to those already receiving mental health services elsewhere, psychologists carefully consider the treatment issues and the potential client's/patient's welfare. Psychologists discuss these issues with the client/patient or another legally authorized person on behalf of the client/patient in order to minimize the risk of confusion and conflict, consult with the other service providers when appropriate, and proceed with caution and sensitivity to the therapeutic issues.

10.05 Sexual Intimacies With Current Therapy Clients/Patients

Psychologists do not engage in sexual intimacies with current therapy clients/patients.

10.06 Sexual Intimacies With Relatives or Significant Others of Current Therapy Clients/Patients

Psychologists do not engage in sexual intimacies with individuals they know to be close relatives, guardians, or significant others of current clients/patients. Psychologists do not terminate therapy to circumvent this standard.

10.07 Therapy With Former Sexual Partners

Psychologists do not accept as therapy clients/patients persons with whom they have engaged in sexual intimacies.

10.08 Sexual Intimacies With Former Therapy Clients/Patients

(a) Psychologists do not engage in sexual intimacies with former clients/patients for at least two years after cessation or termination of therapy.

(b) Psychologists do not engage in sexual intimacies with former clients/patients even after a two-year interval except in the most unusual circumstances. Psychologists who engage in such activity after the two years following cessation or termination of therapy and of having no sexual contact with the former client/patient bear the burden of demonstrating that there has been no exploitation, in light of all relevant factors, including (1) the amount of time that has passed since therapy terminated; (2) the nature, duration, and intensity of the therapy; (3) the circumstances of termination; (4) the client's/patient's personal history; (5) the client's/patient's current mental status; (6) the likelihood of adverse impact on the client/patient; and (7) any statements or actions made by the therapist during the course of therapy suggesting or inviting the possibility of a posttermination sexual or romantic relationship with the client/patient. (See also Standard 3.05, Multiple Relationships.)

10.09 Interruption of Therapy

When entering into employment or contractual relationships, psychologists make reasonable efforts to provide for orderly and appropriate resolution of responsibility for client/patient care in the event that the employment or contractual relationship ends, with paramount consideration given to the welfare of the client/patient. (See also Standard 3.12, Interruption of Psychological Services.)

10.10 Terminating Therapy

(a) Psychologists terminate therapy when it becomes reasonably clear that the client/patient no longer needs the service, is not likely to benefit, or is being harmed by continued service.

(b) Psychologists may terminate therapy when threatened or otherwise endangered by the client/patient or another person with whom the client/patient has a relationship.

(c) Except where precluded by the actions of clients/patients or third-party payors, prior to termination psychologists provide pretermination counseling and suggest alternative service providers as appropriate.

History and Effective Date Footnote

This version of the APA Ethics Code was adopted by the American Psychological Association's Council of Representatives during its meeting, August 21, 2002, and is effective beginning June 1, 2003. Inquiries concerning the substance or interpretation of the APA Ethics Code should be addressed to the Director, Office of Ethics, American Psychological Association, 750 First Street, NE, Washington, DC 20002-4242. The Ethics Code and information regarding the Code can be found on the APA web site, <http://www.apa.org/ethics>. The standards in this Ethics Code will be used to adjudicate complaints brought concerning alleged conduct occurring on or after the effective date. Complaints regarding conduct occurring prior to the effective date will be adjudicated on the basis of the version of the Ethics Code that was in effect at the time the conduct occurred.

The APA has previously published its Ethics Code as follows:

American Psychological Association. (1953). Ethical standards of psychologists. Washington, DC: Author.

American Psychological Association. (1959). Ethical standards of psychologists. *American Psychologist*, 14, 279-282.

American Psychological Association. (1963). Ethical standards of psychologists. *American Psychologist*, 18, 56-60.

American Psychological Association. (1968). Ethical standards of psychologists. *American Psychologist*, 23, 357-361.

American Psychological Association. (1977, March). Ethical standards of psychologists. *APA Monitor*, 22-23.

American Psychological Association. (1979). Ethical standards of psychologists. Washington, DC: Author.

American Psychological Association. (1981). Ethical principles of psychologists. *American Psychologist*, 36, 633-638.

American Psychological Association. (1990). Ethical principles of psychologists (Amended June 2, 1989). *American Psychologist*, 45, 390-395.

American Psychological Association. (1992). Ethical principles of psychologists and code of conduct. *American Psychologist*, 47, 1597-1611.

Request copies of the APA's Ethical Principles of Psychologists and Code of Conduct from the APA Order Department, 750 First Street, NE, Washington, DC 20002-4242, or phone (202) 336-5510.

Ethics Code 2002.doc 10/8/02

Appendix E

General Guidelines for Providers of Psychological Services, Specialty Guidelines for Forensic Psychologists, & American Academy of Clinical Neuropsychology (AACN) Practice Guidelines for Neuropsychological Assessment and Consultation

Please consult these at www.apa.org/about/division/cpmprofessional.html#20,
<http://www.ap-ls.org/links/currentforensicguidelines.pdf>,
http://www.theaacn.org/position_papers/AACNPractice_Guidelines.pdf

Appendix F

Master Audit Database (MAD) audit forms

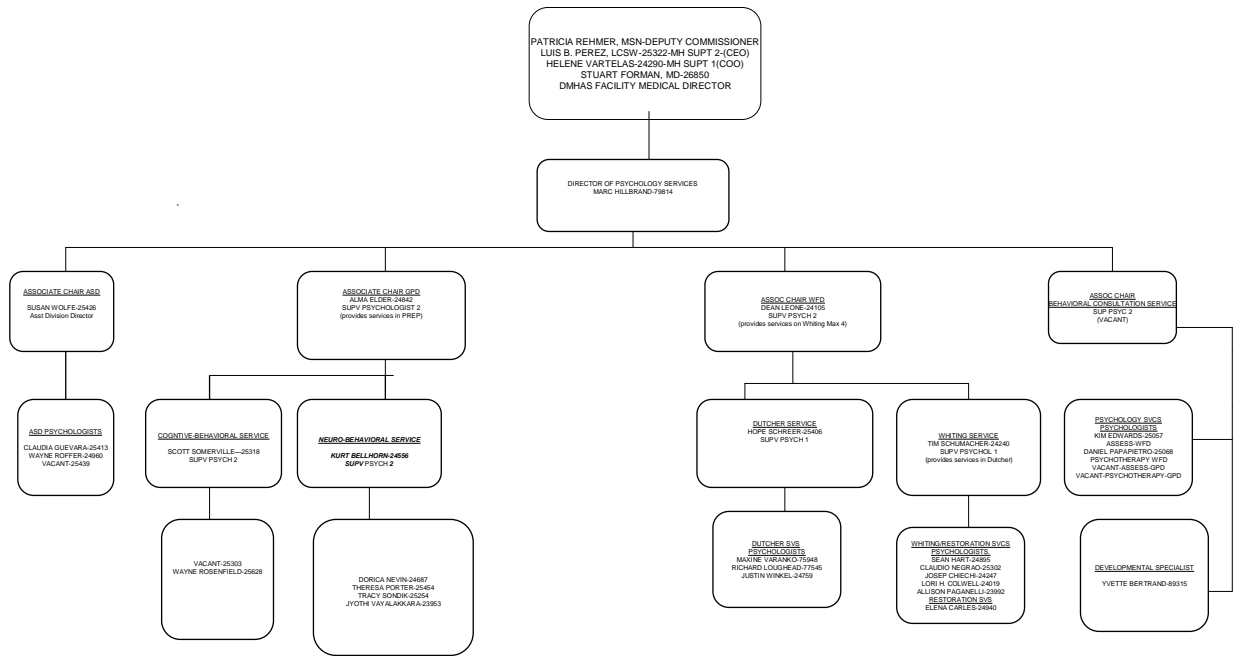
The Master Audit Database (MAD) audit forms can be found at T:DOJ/Finalized monitoring tools:

- Group Psychotherapy Monitoring Tool
- PBSP Monitoring Tool
- Psychology Monitoring Tool
- Psychotherapy Monitoring Tool
- Suicide Risk Assessment Monitoring Tool

Appendix G

Organizational Chart (also available at T:Manuals/Psychology/TO)

CONNECTICUT VALLEY HOSPITAL
PSYCHOLOGY SERVICES
07.28.08



Appendix H

CVH-348 Request for Psychological Evaluation

CONNECTICUT VALLEY HOSPITAL REQUEST FOR PSYCHOLOGICAL EVALUATION

☐ General Psychiatry Division
☐ Addiction Services Division
☐ Whiting Forensic Division

Name _____

MPI#	Date of Birth
------	---------------

Print or Addressograph Imprint

Attending Psychiatrist _____ Unit _____

Referral Question to be Addressed: _____

Current Diagnosis and Medication: _____

History Relevant to Referral Question: _____

Referring Psychiatrist/Physician Signature

Date of Referral

DISTRIBUTION:

ORIGINAL - Psychology

COPY – Medical Record

Appendix H

CVH-638 Initial Integrated Psychological Evaluation

Rev. 4/11

**INTEGRATED INITIAL
PSYCHOLOGICAL EVALUATION**

MPI# _____ *Print or*

Addressograph Imprint

Division: ☐ General Psychiatry ☐ Whiting Forensic Division ☐ Addiction Services Division

Admission Date _____ Date of Birth _____ Date of Evaluation: _____

Reason for Referral: Gathering baseline data for assessment and treatment planning purposes?

☐ Yes ☐ No ☐ Other: _____

Sources of information: _____

Review of Relevant History (including: reason(s) for admission, risk factors [e.g., suicidality, aggression, trauma, substance abuse], and presenting symptoms; specify if there has been a recent significant clinical change, a failure to respond to treatment, or if the individual engages in behavior(s) that poses a significant barrier to treatment or therapeutic programming):

Validity of Historical Data: Were there factual inconsistencies in the historical data?

☐ Yes ☐ No

If yes, what is the plan to resolve these? _____

Behavioral Observations (including: physical appearance, sensorimotor behavior, cognitive processes, cooperation, and interpersonal behavior): _____

Initial Assessment (including any psychological testing, if relevant or clinically indicated):

Cognitive: _____

Patient Name: _____ MPI#: _____

Affective: _____

Behavioral: _____

Interests, activities, life skills and functional strengths and weaknesses: _____

Formulation (*initial case conceptualization, including goals, strengths, and barriers*): _____

Recommended strategy for engagement (*learning style, approach strategy, motivational strategy, rapport-building strategy*): _____

Recommended level of Rehab groups (*check one*):

☐ Supported ☐ Assisted ☐ Independent ☐ Advanced

Plan (*specific recommendations for further assessment and treatment including plan to address unresolved clinical or diagnostic question*): _____

Completed by:

Signature: _____

Print Name: _____

Date completed: _____

Date presented to treatment team: _____