State of Iowa Department of Corrections
Policy and Procedures

Policy Number: HSP-713
Applicability: DOC
Policy Code: Public Access
Iowa Code Reference: N/A
Chapter 6: Health Services
Sub Chapter: Mental Health
Related DOC Policies: IO-HO-11, HSP-710, HSP-711, HSP-720, HSP-753
Administrative Code Reference: N/A
Subject: Crisis Intervention
ACA Standards: 5-ACI-6A-28, 5-ACI-6A-08, 5-ACI-5E-09, 5-ACI-6A-07
Responsibility: Dr. Jerome Greenfield
Effective Date: November 2020
Authority:

1. PURPOSE

To ensure potential patient crises are recognized at the earliest possible point in time and that the least restrictive intervention necessary is used to de-escalate the crises and assist the patient to regain self-control.

2. POLICY

Collaborative crisis intervention strategies must be utilized in an effort to intervene and assist the patient before more restrictive interventions are employed.

3. DEFINITIONS

A. Crisis – a situation experienced by the patient as stressful, short-term and overwhelming that results in a disruption of his/her ability to cope and/or problem solve.

B. Crisis Intervention – focused, short-term strategies to assist the patient to return to their pre-crisis level of functioning.

C. Crisis Plan – Patient identified interventions that would be helpful during periods of crisis, including activities that will most likely help them to resolve the crisis. The Crisis Plan is part of the Mental Health Care Plan.

D. Crisis Triggers – Patient identified symptoms, stressors, perceptions that trigger emotional responses such as anxiety, fear and anger that results in crisis.

E. De-escalation – strategies that reduce the emotional response and intensity of the crisis. Techniques include assessing the situation, calming the patient, assessing the patient's need and available resources and facilitating a positive outcome. De-escalation is a fluid process.

F. PRN Psychiatric Medication – An "as needed" psychiatric medication that is meant to target behavioral symptoms when escalating or in crisis, not for the purposes of chemical restraint. Use of PRN medication might calm agitation, help the patient to concentrate and be more accessible to interpersonal intervention. Administration of PRN medication must be preceded by an appropriate clinical assessment.

G. Psychotropic Medication – A drug that exerts an effect on thought, mood, and behavior. Psychotropic medications are used to treat various disorders as well as mental illness.

H. Safety Room - A safe space where a patient who is anxious, agitated, or losing control can be allowed time to regain control. This space is not to be used for restraint. Safety rooms within the IDOC are located at the Iowa Correctional Institution for Women and the Iowa State Penitentiary only.

I. Time Out/Quiet Time – A suggested de-escalating strategy by either a patient or staff that will reduce and/or resolve a crisis situation. This may occur in the patient's cell, a small dayroom or other designated space, or a safety room.

J. Mental Health Care Plan – A series of written statements that specify the particular course of therapy and the roles of medical and nonmedical personnel in carrying it out. A Mental Health Care Plan is individualized, based on assessment of the individual patient's needs, and includes a statement of the short and long-term goals and the methods by which they can be obtained and measured. When clinically indicated, the treatment plan provides patients with access to a range of supportive and rehabilitative services, such as individual or group therapy and/or self-help groups that the treatment team deems appropriate.

K. See IDOC Policy **AD-GA-16** for additional Definitions.

4. PROCEDURES

A. Use De-escalation Strategies: De-escalation Strategies work best when employed at the earliest opportunity when staff first observes a change in a patient's behavior or demeanor. Initial attempts should be to engage the patient in conversation consistent with **HSP-713 Attachment A**, *Crisis Intervention Communication Strategies*.

1. Assess Safety

    a. Assess the need to remove the patient from stimuli into a quiet area and implement interventions consistent with their treatment plan.

    b. Assess whether or not de-escalation is working.

    c. Suggest voluntary use of Safety Room or obtain order for short-term involuntary use of Safety Room for those facilities that have a Safety Room. The maximum duration of the order for a Safety Room is 4 hours.

    d. At any point during crisis intervention, it may become necessary for the safety of the patients and staff to use more directive interventions including the use of *Mental Health Observation*, **HSP-711** and *Suicide and Self-Injury Prevention*, **HSP-710**.

2. Engage the Patient to Assist in Self-Management of Symptoms

    a. Offer comfort/calming measures identified in the patient's treatment plan, i.e. music, etc.

    b. Ask the patient about what might help to calm him/her.

    c. Keep requests clear and simple; offer a choice if possible.

    d. Empower and encourage the patient in every step they take toward calming themselves.

    e. Try to establish the reason for distress.

    f. Refer to Mental Health Provider to assess for underlying medical and/or mental health issues that may be causing the crisis.

3. Provide Structure

a. Set limits in ways that maximize the patient's sense of self-control and involvement; let the patient suggest alternatives and choices if possible.

b. If the patient does not suggest alternatives, offer alternatives that you know have previously worked to calm the patient as outlined in his/her treatment plan.

4. Assist with Symptom Management

a. Voluntary Quiet Time either in own room or designated room.

b. Structured routine.

c. Nurse shall assess and when appropriate, offer PRN medication.

B. Mental Health Care Plan Review

1. When the situation is no longer threatening, review the crisis with the patient to strengthen his/her ability to think about what happened. Include reviewing what precipitated the crisis, identifying crisis triggers, and what worked to decrease his/her stress level.

2. Give supportive feedback to the patient for taking an active role in regaining self-control and resolving his/her crisis.

C. Notifications and Documentation

1. Security staff is to notify mental health professionals about crisis situations, any significant behaviors and/or concerns. Officers shall document the incident in the e-log.

2. Any non-medical or non-mental health professionals, i.e., counselors, activity staff, etc. are to document the incident and notify mental health professionals about the incident.

3. A nurse encounter documenting the incident will be entered into Medical ICON. This will include the behavior involved, crisis strategies employed and response to these strategies.

   If PRN medication is administered, it will be documented in the Electronic MAR. Documentation should include the response to the PRN medication.

4. A psychology encounter is to be documented in Medical ICON describing the incident, all crisis strategies employed and the patient's response, and any recommendations for treatment plan changes. Members of the treatment team will be notified about the incident and any immediate changes made to the Mental Health Care Plan.

5. If more restrictive interventions are employed, documentation consistent with **HSP-710**, **HSP-711**, and **HSP-720** *Medical Restraints*.