State of Iowa Department of Corrections

Policy and Procedures

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1. PURPOSE

To provide guidelines regarding mental health housing operations in Iowa Department of Corrections (IDOC) institutions.

2. POLICY

It is the policy of the IDOC to provide specialized housing where such housing is necessary in order to meet patient mental health treatment needs. Designation of these specialized housing areas is the responsibility of the IDOC Health Administrator. Mental health services provided shall be in accordance with IDOC Health Services policies. Where practicable, conditions within the housing area, and the privileges afforded to patients housed there, shall be consistent with the custody level and security needs of the individual patient.

Some of the provisions of this policy may not, at this time, be fully implemented in all settings due to physical plant or staffing issues. The IDOC Health Administrator shall work collaboratively with the Warden and institutional staff to ensure compliance wherever possible.

Patients in mental health housing shall have individualized treatment plans, developed by the Treatment Team, to govern the management of the patient including activities of daily living. Keeping in mind safety and security, the goal is to optimize opportunities for persons in mental health housing to reach maximum

functioning using innovative, creative therapeutic approaches that meet the treatment needs of the populations in each level of mental health care.

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3. DEFINITIONS - As used in this document:

A. Acute Level of Care – A level of care for those patients with acute distress and/or impairment in functioning, who are actively psychotic and/or seriously depressed and who are unable to participate adequately in assessment and ability to care for self, or those presenting acute/chronic danger to self or others. The goal of this level of care is to manage medications, stabilize the illness process within six to eight weeks and to ensure that treatment planning is developed to move patients through the continuum of care.

B. Care Review Committee - Institutional-based Committee that reviews cases that are not achieving anticipated health outcomes, require transfer to another facility when necessary level of health care is not available in-house, require adaptations to traditional treatment services, or require customized treatment interventions/services. Care Review Committee membership is a cross-

representation of staff, which may include Nurse Supervisor and licensed nurses, Health Services Administrator, Physician (includes PA, NP), Psychiatrist, Social Workers, Psychologists, Unit Managers, Correctional Counselors, Program Staff, Activity Staff, Security Supervisors, involved security line staff and/or Associate Warden.

C. Chronic Persistent Mental Illness (CPMI) – Patients who display chronic persistent psychiatric symptoms, aggressive behavior and may not respond rapidly to psychotropic medications. The management focus centers on safety, use of incentives, self-recognition of behavioral triggers and self-control of responses, and medication managements.

D. Intellectual and Developmental Delays (IDD) - A subset of outpatient level of care for those with full scale IQ of 70 and below and/or whose adaptive functioning requires additional assistance in daily activities and programming.

E. Intensive Outpatient Level of Care (IOP) – A level of care for those patients who need a mental health setting with a higher level of monitoring and available programming than outpatient level of care is able to provide. This level of care may be short term (up to six weeks to maximize stabilization) or long-term (up to 12 months or longer including a permanent housing assignment). These are general population living units that provide protective housing for vulnerable patients who have chronic persistent mental illnesses (CPMI) and/or intellectual and developmental delays (IDD).

F. Medical Care Provider - Qualified health care professionals who by virtue of their education, credentials and experience are permitted by law to prescribe medications. These include physicians, physician assistants and nurse practitioners.

G. Mental Health Care Professionals – Qualified health care professionals who by virtue of their education, credentials and experience are permitted to care for the mental health needs of patients. These include psychiatrists, psychologists, nurses, and social workers.

H. Mental Health Observation (MHO) - A special observation status **(HSP-711)** for those with mental status/behavioral changes that warrant closer observation than their current living situation allows.

I. Safety Rooms – Used solely as a temporary therapeutic intervention or a controlled timeout. Safety rooms are not to be used as a bed assignment.

J. Serious Mental Illness - A serious and persistent disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality or

cope with the ordinary demands of life within the prison environment which is manifested by substantial suffering or disability. Serious mental illness requires a documented mental health diagnosis, prognosis and treatment as appropriate by mental health staff. This would include the broad categories of: Schizophrenia and other psychotic disorders, bipolar disorders, depressive disorders, dementia and other organic brain disorders.

K. Sub-Acute Level of Care – A level of care for those patients who require further stabilization from acute level of care, or as a result of deterioration in functioning and/or mental status. This level of care is generally from 6 weeks to 6 months; however, some specialized populations such as CPMI may be housed in special subacute units for much longer periods of time.

L. Suicide and Self-Injury Protection (SSIP) - An observation status **(HSP-710)** for those patients who have shown intent to self-harm or who may present a risk of direct harm to others.

M. Treatment Plan - A series of written statements that specify the particular course of treatment and the roles of clinical and nonclinical personnel in carrying it out. A treatment plan is individualized, based on assessment of the individual patient's needs and includes statements of the short- and long-term measurable goals and the methods by which the goals will be pursued. When clinically indicated, the treatment plan provides patients with access to a range of supportive, therapeutic and rehabilitative services such as individual or group counseling and/or self-help groups that the treatment team deems appropriate. The treatment plan shall also incorporate plans for release from mental health housing and reentry planning.

N. Treatment Team - Team of interdisciplinary staff that includes at minimum, health services staff, mental health care professionals (including psychiatric nurse and psychologist), social workers, security - supervisor/unit manager and line staff, activity specialists and correctional counselor. The team is responsible for the mental health level of care treatment needs and the operational requirements of patients in mental health housing.

4. PROCEDURES

A. Treatment Team and Treatment Planning

1. Patients in mental health housing shall be managed in a manner reflecting the understanding that the amount of control a patient with mental illness is able to exercise over his/her behavior varies widely by patient and by circumstances. Patients shall be managed

consistent with their level of cognition and ability to control their own behavior.

2. All patients in mental health housing shall be managed in accordance with their treatment plan developed by the Treatment Team. An individualized treatment plan shall be developed by the Treatment Team for each patient assigned to mental health housing.

3. Institutions shall establish the positions that comprise the Treatment Team, consistent with a multi-disciplinary, team-oriented approach.

4. Institutions shall develop the mechanism by which staff can readily assess patients' individual treatment plan directives.

5. When Living Unit Officers have access to information regarding patients mental health needs, their observations aid in mental health assessment and they are better equipped to encourage treatment compliance de-escalate potential crisis situations, and alert clinical staff when additional intervention is necessary.

B. Suicide/Self Injury Prevention (SSIP)

1. All institutions within the IDOC will utilize IDOC Policy **HSP-710**, *Suicide and Self Injury Prevention (SSIP)* and relevant forms to monitor those patients demonstrating self-injurious and/or assaultive behavior. Facility orientation records will reflect that appropriate staff has received training in this policy and procedure. **Appropriate action is to be taken when any staff member has reason to believe that a patient may intentionally injure himself/herself.**

2. All staff shall observe patient behaviors and if the potential for self-injury is identified, ensure that psychology is notified immediately. In the absence of psychology, nursing staff shall be notified. Staff will ensure the Shift Supervisor is notified immediately following notification to Psychology or nursing. Psychology or nursing staff will evaluate the patient for SSIP placement. Reporting staff will document via the unit logs.

3. Any time staff observe an incarcerated individual/patient whose behavior indicates potential for self-injury, or makes statements threatening self-injury the patient will remain under constant staff observation until assessed by psychology or nursing staff and follow on status is identified.

4. On duty Shift Supervisor is responsible for ensuring that notifications to psychology or nursing staff have been completed.

5. All new staff will attend "Managing Mentally Ill Offenders" during their Core Training, which covers SSIP, MHO policy and procedure, warning signs, behavior signs, interventions, etc. The training is to be provided during new employee orientation. In addition, all staff responsible for patient supervision will receive training annually.

C. Housing Assignment

1. Patients shall be admitted to mental health housing – acute care, sub-acute care and intensive outpatient - when their mental health status/condition cannot be effectively managed within their assigned living unit.

2. Planned admissions shall be made by the Care Review Committee. If admission is made on the basis of transfer from another institution, the Deputy Director of Institution Operations/Designee shall approve and arrange for the transfer.

3. When staff notice that a patient's behavior is deteriorating and/or there is a display of odd or inappropriate behaviors or self-reported need that requires professional mental health intervention, they shall contact Mental Health staff. If Mental Health staff are not readily available, the request shall be forwarded to nursing staff for evaluation and determination if placement in mental health housing is indicated.

4. Unplanned admission (including emergency placements) into acute care or sub-acute care mental health housing must be authorized by Mental Health Care Professional staff or the Medical Care Provider.

5. Placement into intensive outpatient or a change in the level of care within mental health housing in an institution shall be made by the Treatment Team.

6. When an institution is unable to meet, or when another institution is better equipped to meet a patient's mental health care needs, the Treatment Team shall forward the case to the Mental Health Bed Utilization Review Committee (MHBURC). A Care Review Committee member shall consult with the proposed receiving facility's mental health services administrator or Care Review Care Review Committee

to evaluate the suitability and efficacy of the proposed transfer prior to initiating an intra-system transfer. Such transfers shall be in compliance with **HSP-502** *Intra-System Transfers*, and *Identified Mental Health Levels of Care,* **HSP-740** and shall be coordinated through the Deputy Director of Institution Operations/Designee.

7. The initial specific living unit and bed assignment for any person in mental health housing shall be made by the Treatment Team consistent with **IO-HO-01** *Unit Management*. In the absence of the Treatment Team the Unit Manager/Shift Supervisor with input of Mental Health or Licensed Nursing Staff shall assign the specific living unit and/or bed assignment.

8. The following factors shall be considered in making bed assignments in mental health housing:

    a. Proximity to the nursing/officer station

    b. Medical and/or mental health care need

    c. Security level

    d. Keep separate

    e. Access to activities/programs

    f. Sexual violent propensity score

    g. Ability to be easily observed by staff

9. Institutional procedures shall outline procedures for changing room/cells within the same living unit assignment.

10. The Treatment Team shall determine whether a patient is released from mental health housing, considering available information regarding the mental health status of the patient, including the recommendation of the Mental Health Provider. Institutional procedures shall define the process if there is a disagreement.

11. When the patient is to be moved to another facility, the transfer will be coordinated through the Deputy Director of Institution Operations/Designee.

D. Mental Health Housing Orientation

1. All patients shall be oriented to mental health housing and living units within 72 hours of assignment. In the event that the patient cannot be oriented within 72 hours due to his/her mental health condition, the reasons orientation is not completed shall be documented in the mental health care record and added as a goal on the patient's treatment plan.

2. Orientation may include written and/or posted materials and shall include the opportunity for patients to seek clarification and receive answers to their questions. Institutional procedures shall identify who develops materials and procedures for delivery of orientation.

3. Orientation topics shall include, at a minimum:

    a. Mental health housing schedule

    b. Mental health housing rules/regulations

    c. Mental health housing activities

    d. Patient accountability

    e. Patient expectations – conduct rules, property, dress, etc.

    f. Access to programs and services

    g. Avenues for resolving conflict and grievances

    h. Location of clocks, calendars, and schedules

4. Specific individual accommodations that may be required depending on the need will be determined by the Treatment Team.

E. Operations – Security

1. Security operations shall be consistent with general population unless specified herein.

2. Institutions shall establish procedures governing the types and frequency of area searches within the unit, and documentation of such. K-9 teams will not be used for searches or transports of

patients in mental health housing; any exceptions must be approved by Associate Warden of Security.

3. Consistent with IDOC Policy **IO-SC-18** *Searches*, institutions shall establish procedures governing personal searches to include:

    a. Entry/exit to/from the living unit

    b. Entry/exit to/from the housing unit

    c. Type of searches

    d. Random searches (and frequency)

    e. Documentation of searches

4. Modifications to procedures governing strip or pat searches shall be outlined in the treatment plan.

5. Institutions shall establish procedures to prevent unauthorized access to mental health housing and living units.

6. Institutional procedures shall outline exceptions to security measures directly affecting mental health housing operations for any security topics, including:

    a. Mental Health Housing Control Center, if applicable

    b. Patient counts

    c. Security inspections

    d. Searches

    e. Key control

    f. Tool control

7. In lieu of including these institutional procedures within this policy, institutions may elect to provide the required information in a separate policy. At a minimum, the corresponding policy and procedure shall be identified.

8. Institutional procedures shall outline property items (and quantities) that a patient may retain while assigned to mental health housing. Modifications to property retained by a patient in mental health housing shall be outlined in the patient's treatment plan.

9. Institutional procedures and individual treatment plans shall outline individual patient access to the dayroom. Consideration may include staff ability to see into the rooms, cognitive ability and custody level of the patient, and shall be accomplished in the least restrictive manner.

F. Operations - Out of Cell Time

1. Opportunities for out-of-cell time shall be maximized to promote a patient's optimal functioning, stabilization, and mental health. Considerations will include the institution's custody designation, patients' classification status, level incentive program assignment, and physical plant restrictions or opportunities.

2. Minimum requirements for daily out-of-cell time are outlined below. Exceptions may be granted due to therapeutic restrictions as outlined in the treatment plan or disruptive behavior reported to the Unit Manager and documented in the electronic unit log.

    a. Acute - minimum of two hours

    b. Sub-acute – minimum of four hours

    c. Specialized CPMI sub-acute - maximized to the individual's capacity/ability.

    d. Intensive outpatient – consistent with general population.

3. Treatment plans may reduce Out of Cell time due to individual capacity/ability.

4. Progressive amounts of out-of-cell time shall be part of the treatment plan.

5. Out-of-cell time shall include both formal opportunities such as programs, work assignments and yard, as well as mental health housing and living unit activities such as dayroom time, access to exercise yards, and access to unit services.

6. Institutional procedures shall implement out-of-cell time; procedures shall also address quiet hours, lights out, etc. through institutional schedules that reflect the unique physical plant, program opportunities, and other local factors.

7. In collaboration with the Warden, the IDOC Health Services Administrator and the Deputy Director of Institution Operations may require that institutional operations be adjusted to maximize opportunities for Out of Cell time for patients housed in mental health housing.

G. Operations – Movement

1. The type of movement may be based partially on patients' needs for assistance or cognitive functioning as outlined in the treatment plan.

2. Institutions shall establish procedures governing movement within and out of mental health housing units. The movement procedures shall address any documentation accounting for movement that is required. Procedures will address the following types of movement at a minimum:

    a. Escorted - Acute patients will be escorted when off the living unit.

    b. Directed

    c. Observed

    d. Restricted Movement

3. Officers shall reference patient treatment plans and be sensitive to the patient's cognitive ability to comprehend directives when conducting movement. The treatment plan shall take precedence over institutional procedures.

4. Use of restraints during movement shall be governed by institutional procedure.

H. Operations – Managing Patient Behavior

1. Staff working mental health housing shall make a prompt referral for mental health intervention when there are clear changes in an

individual's self-care, the onset of bizarre or disorganized behavior, or a surge in irritability.

2. To the extent feasible, Associate Warden of Security and Unit Managers shall ensure officers are assigned to a mental health living unit for a sufficiently long period of time to maximize the consistency of operations.

3. In order to promote and encourage prosocial patient behavior, active supervision of patients requires staff to:

    a. Be a prosocial role model,

    b. Clearly communicate expectations for patients,

    c. Have positive and appropriate interactions with patients,

    d. Resolve patient concerns at the lowest level possible,

    e. Be approachable and responsive to patients and their needs,

    f. Manage conflict using de-escalation techniques,

    g. Be responsive to patients' mental health care needs,

    h. Encourage the use of coping skills,

    i. Follow the treatment plan, and be cognizant of medication compliance/non-compliance,

    j. Use a variety of strategies in responding to behaviors, and

    k. Actively communicate as part of the unit team.

4. Living Unit Officers shall conduct formal rounds of assigned living units at least once every 30 minutes on an irregular basis. During rounds, staff will communicate with patients, observe patients' mental health state, look for damage and contraband, inspect to identify safety and security issues, resolve minor issues, report any changes in condition/behavior, etc. Formal rounds shall be documented in the Post Logbook.

5. Staff shall manage patient behavior using a variety of strategies that routinely initiate interaction with patients and provide continual visual observation of the living unit. Staff shall:

    a. Monitor all patients and areas,

    b. Respond to patient requests in a timely and fair manner,

    c. Report changes in a patient's mental health,

    d. Investigate any activities or changes in patient behavior appearing out of the ordinary,

    e. Recognize potential problems between patients and move swiftly to resolve them,

    f. Enforce living unit and facility rules consistently,

    g. Provide feedback that encourages self-assessment and self-correction, and assists in developing personal responsibility by advancing patient self-sufficiency,

    h. Communicate with patients in a respectful and courteous manner, and

    i. Use behavior modification principles and alternative sanctions whenever possible

6. Living Unit Staff shall be watchful for patients who are not actively participating in mental health housing activities or are not productively engaged and, when appropriate, staff shall work with the patient and unit team members include appropriate individualized activities in that patient's treatment plan.

7. Institutions shall establish procedures that outline the extent of authority Living Unit staff have regarding modifying of privileges, imposing sanctions (rule violations), developing and administering incentives, addressing negative or noncompliant behavior, etc.

8. Staff shall remain on post in the assigned living unit(s) until properly relieved or directed otherwise by proper authority.

9. Unit Officers shall monitor mentors in accordance with **HSP-781** *Mental Health Mentoring Program*, and observers in accordance with

HSP-712 *Patient Observers*, both in terms of their behavior and their interaction with patients in mental health housing.

10. Institutions shall develop procedures consistent with **HSP-712** and **HSP-781**. Staff shall be observant and cognizant of Observers and/or Mentors, patient worker work assignment responsibilities and monitor for behavior and whereabouts that do not support the patient's work assignment responsibilities. Institutional procedures shall outline responses when Mentors, Observers or patient workers are found out of place or not fulfilling their work responsibilities.

11. The Warden or designee, Deputy Warden, Nurse Supervisor, Psychologist/Supervising Mental Health Professional and designated department heads shall visit each mental health living unit at least weekly to promote informal contact with staff and patients and to informally observe living and working conditions. Such visits shall be noted in the appropriate Post Logbook.

12. Use of medical restraints shall be only to provide for the patient safety consistent with **HSP 720** *Health Care Restraints*. A mental health professional or licensed nurse in consultation with mental health professional or provider shall determine the use of and maximum timeframes for the application of medical restraints.

13. Patients may initiate placement in a designated room as a self-regulated intervention for a voluntary unlocked time-out.

14. Non-voluntarily placement into designated shall be per **HSP-721** *Use of Safety Rooms*. Use of these designated rooms shall be used for the least amount of time needed, with no more than four hours. Institutional procedures shall outline this process for placement.

I. Operations – Leisure Activities

1. Institutions shall incorporate a wide range of leisure time activities within the housing and living units to keep patients productively engaged, to reduce idleness, to build socialization skills, and to create opportunities for self-awareness, character building and team building. The degree to which activities are offered shall be guided by the institution's level incentive program, physical plant, staffing levels, patients' custody status, commensurate with the abilities of the population, etc.

2. Leisure time opportunities shall be afforded in a variety of settings within the unit, which may include:

    a. Group and individual leisure activities,

    b. Organized events,

    c. Nonscheduled activities,

    d. Peer-led activities/events

3. Leisure activities may include, but are not limited to:

    a. Television

    b. Telephone

    c. Games – board, card

    d. Computer

    e. Exercise yard

    f. Publications

    g. Late night

    h. Books (on-unit, or central library)

    i. Self-help groups

    j. Arts and crafts

    k. Hobbycraft (may require a permit)

    l. Special events/activities

    m. Personal fitness

    n. Community service activities

    o. Electronic/Media devices

    p. Musical instruments

4. The Unit Manager shall designate a staff member who shall coordinate with the treatment teams to provide for modification of the activities to meet the needs of the mental health population. The types of leisure time activities offered shall be informed by patient and staff surveys, the results of completed assessments, etc. and be reflective of patients' needs and preferences. The leisure time activity program shall be evaluated on a periodic basis as determined by the institution but at least annually. The Unit Manager/Treatment Team Leader provides for the implementation of activities in mental health housing and as identified in the Treatment Plans.

5. A range of leisure activities shall be available when access to the living unit's common area is allowed.

6. Leisure activities shall be available and scheduled at various times during the day/week to accommodate various patient schedules.

J. Operations - Programs and Services

1. When feasible, programs and services are delivered at the unit level. This will allow institutions to be more responsive to the needs of specific populations, will increase the frequency and quality of interaction between staff and patients, will create opportunities for unit staff to build rapport and will support program decisions being made by those who are most familiar with the patient.

2. Patients in mental health housing shall be afforded programs and services similar to those provided in general population consistent with custody/classification and the patient's treatment plan.

3. Institutional procedures shall determine how patients in mental health housing access the following programs and services:

    a. Meals*

    b. Mail – institution schedule

    c. Laundry – institution schedule

    d. Health care – housing unit schedule

    e. Personal hygiene – living unit schedule

f. Self-help groups – housing unit schedule

g. Commissary – institution schedule

h. Religious programs – living unit schedule

i. Social services – housing unit schedule

j. Education – housing unit schedule

k. Counseling – housing unit schedule

l. Visits – institution schedule

m. Work assignments (on-unit)

n. Library (on-unit)

o. Laundry (on-unit)

*Meal procedures shall address whether attendance at centralized dining (if applicable) is mandatory or voluntary. If mandatory, procedures shall address what happens when a patient refuses to go to dining. If voluntary, procedures shall address whether non-participating patients shall remain in their assigned living unit or other designated location. In addition, meal procedures shall address the provision of meals for those temporarily unable to attend centralized dining due to psychiatric symptoms and/or behavior or other authorized reason.

4. In lieu of including these institutional procedures within the policy, Institutions may elect to provide the required information in a separate procedure. At a minimum, the corresponding policy and procedure shall be identified.

K. Operations – Housekeeping

1. Mental Health housing and living units shall maintain a clean and healthy environment in order to mitigate safety hazards and prevent infection and illness, while enhancing patient life skills.

2. Institutional procedures shall outline a housekeeping plan for mental health housing and living units consistent with **IS-SH-02**, *Sanitation Procedures*. Institutions may elect to provide the required

information in a separate policy and/or within this policy. At a minimum, the corresponding policy and procedure shall be identified.

3. Housekeeping plans shall require, at a minimum:

    a. Daily cleaning and routine sanitizing of occupied cells/rooms

    b. Daily cleaning and sanitizing of dayrooms and common areas

    c. Routine cleaning and sanitizing of unoccupied cells/rooms

    d. Routine cleaning and sanitizing of unoccupied areas

    e. Distribution, handling and storage of cleaning supplies/material

    f. Handling and disposal of hazardous materials

    g. Sanitation inspections on a daily, weekly, monthly and annual basis

    h. Documentation – shall be consistent with the institution housekeeping plan.

4. Institutional procedures shall outline the use of work force and protocol patient workers to assist with room/cell and living unit housekeeping.

L. Mental Health Housing Documentation

1. Mental Health housing staff shall be required to document a full range of activities and tasks, including but not limited to:

    a. Living unit and cell assignments

    b. Entry/exit of staff, volunteers, visitors

    c. Safety and security rounds begin and end times

    d. Deviation from scheduled unit activities

    e. Critical and unusual incidents

    f. Area searches

g. Personal searches

h. Headcounts

i. Shift activity updates/briefings

j. Shift changes

2. Institutions shall establish procedures that outline the information to be recorded, the form of the documentation, and the staff post/position responsible for the documentation.

3. Designated supervisors shall review required documentation on a routine, regular basis to determine whether the required information is being properly documented, whether formal rounds are being performed in accordance with established procedure, if there are gaps in scheduled activities/services, trends in unit activity, etc. The designated supervisor shall take the necessary steps to resolve any identified discrepancies or deficiencies in documentation.