MEDIA RELEASE
DEPARTMENT OF CORRECTIONS
IOWA STATE PENITENTIARY
CLINICAL CARE UNIT

MENTAL HEALTH CONSULTANT REPORT
FEBRUARY 14, 2005

Attached please find the National Institute of Corrections consultant report completed by Dr. Thomas White.

Below is a summary including many of Dr. White's recommendations.

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Based upon the findings and recommendations of Dr. White's consultant report, the Department of Corrections provides the following comments:

- The Department of Corrections sincerely regrets the tragedies and events that have caused the consultant's review of the mental health program of the Iowa State Penitentiary Clinical Care Unit.

- The DOC thanks the National Institute of Corrections and Dr. White for a professional and thorough review of the Clinical Care Unit program.

- The DOC accepts and generally agrees with the findings and recommendations as reported by Dr. White.

- The Department of Corrections is deeply committed to addressing the increasing needs of mentally ill offenders.

- Many of the report recommendations are being implemented including:
  - ✓ Expand process for reviewing self-injury/suicides.
  - ✓ Relocate or reconfigure suicide prevention rooms on A and B Pods.

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- ✓ Place suicidal CCU Offenders in smock/ tear resistant clothing.
- ✓ Develop a clear mission statement that is widely disseminated.
- ✓ Utilize social workers to provide pre-release, education and life skills training.
- ✓ Increase out of cell time to include work, recreation, and hobby craft.
- ✓ Review intake and release process to ensure continuity of care and appropriate placement.
- ✓ Expand recreation, hobby craft and education activity for all offenders.
- ✓ Install security screening over atrium railing and stairway.
- ✓ Establish more therapeutic environment in CCU.
- ✓ Establish one late night per week treatment staff assignment.
- ✓ Increase Mental Health Training for all staff.

➢ The following issues and recommendations are in progress and will be implemented at a future date.
- ✓ Review staff selection criteria for CCU security staff.
- ✓ Establish Mental Health Director to provide overall statewide oversight of DOC Mental Health Programs.
- ✓ Employ Deputy Warden position responsible for the CCU operation.
- ✓ Overall review of DOC mental health and operational policies.
- ✓ Establish on call system of mental health staff for off hour consultation.
- ✓ Move psychologist offices to pods.
- ✓ Establish offender treatment review process.
- ✓ Review DOC suicide Prevention Policy.

➢ The following issues and recommendations require additional resources which have been proposed for legislative consideration.
- ✓ Treatment Services Director
- ✓ Psychiatrist (part time)
- ✓ Psychiatric Nurse
- ✓ Psychologist (Clinical Director)

➢ The following issues and recommendations require additional resources which may be submitted for future consideration:
- ✓ Deputy Warden (1)
- ✓ Security Supervisors (2)
- ✓ Social Workers (2.5)
- ✓ Psychologists (2)
- ✓ Educators (2)

- ✓ Correctional Officers (10)

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February 13, 2005

Mr. Gary Maynard, Director
Iowa Department of Corrections
420 Watson Powell Jr. Way
Des Moines, IA 50309

Re: NIC Technical Assistance Report
NIC Technical Assistance Number: 2005P1042

Dear Director Maynard;

On November 10, 2004, Ms. Laura Sheffert James, Assistant Deputy Director of the Iowa State Department of Correction (DOC), contacted me. We discussed my role in conducting a review of several offender suicides at the Critical Care Unit (CCU), a specialized housing unit located at the Iowa State Penitentiary (ISP). During our initial phone conversation, Ms. Sheffert James asked that I conduct a thorough review of the recent suicides as well as the policies and procedures related to suicide prevention at the CCU. She said that I should feel free to make any recommendations to remedy deficiencies that might be discovered in the current suicide policies or procedures.

Ms. Sheffert James also asked me to examine the policies and procedures pertaining to the management of the mentally ill offenders housed in the CCU. The unit is relatively new, having been in operation for approximately two years. As such, she felt it might be beneficial to review their existing policies to ensure they are meeting the needs of the specialized inmates housed on the unit. On December 8, 2004, I was informed that the National Institute of Corrections (NIC) approved me for a technical assistance grant to fund a portion of this review.

On December 13, 2004, I took part in a conference call with you and several of your executive staff. We discussed a number of general issues concerning the policy and procedures at the CCU as well as those system-wide. The ISP experienced another suicide on December 11, 2004, and you asked me to review that case. I told you I would do the best I could with the limited information that would be available at the time of my visit. You also asked that I use all of the information I obtained during my visit to make recommendations that might enhance existing statewide policies pertaining to mental health services and suicide prevention.

BACKGROUND

On December 16, and 17, 2004, my associate and I conducted a review at the CCU in Fort Madison, Iowa. When we arrived at the facility, we met with Warden Burger and his administrative staff. After discussing my general goals and procedures, I offered a few initial impressions based on my review of the materials I received. Warden Burger stated that he was very eager to hear my findings and told me that his staff would cooperate fully with my review.

Throughout the review, we were accompanied by Dr. Ed O' Brien, DOC Medical Director, and Marilyn Sales, Nurse Administrator, was also available. Both were invaluable in answering numerous questions about statewide mental health operations and their integration with the CCU. Mr. Steve Young, CCU Unit Manager, and several other institution staff were always available to provide information and to coordinate our activities. The information provided by these DOC staff as well as many others who were available during the visit was crucial to my ability to develop a picture of the DOC mental health delivery system in the short time available.

We were provided unfettered access to any staff, inmates, or areas of the institution during the review. We focused as much as possible on matters directly related to suicide prevention, but whenever possible, we also pursued issues pertaining to the wider topic of mental health treatment at the CCU and the statewide delivery of mental health services. In addition to talking to staff who were specifically identified as parties of interest to our inquiries, we had many casual conversations with staff while touring the CCU and the ISP. In all instances, staff were cordial, friendly and helpful. At the conclusion of my review, we again met with the warden and selected executive staff to discuss our findings.

Overview Of Statewide Mental Health Treatment

The Iowa DOC currently houses approximately 8600 offenders in nine institutions. Current national estimates would indicate that approximately 16% of those offenders have some type of mental health treatment needs. General mental health services are offered in all institutions, and specialized treatment services for special needs offenders are offered in three institutions. One of those facilities, the Oakdale medical facility, also provides residential mental health services to mentally ill offenders at the Iowa Medical and Classification Center (IMCC). Currently, the IMCC has 23 beds designated as psychiatric beds. New offenders are seen at IMCC during classification and treated if necessary, or offenders are referred to the IMCC for civil commitment by institution mental health staff. Prior to the construction of the CCU, mentally ill offenders were sent to the special needs units, disbursed throughout the system, or the most difficult to manage offenders were assigned to the ISP Special Housing Unit, Building 220.

With the opening of the CCU, a large number of mentally ill offenders from Building 220 and other locations were transferred to the CCU. Thus, the basic treatment model for

managing most, and clearly the most disturbed, mentally ill offenders was to evaluate them at IMCC and send them to the CCU for extended treatment. Currently, there is another building similar to the design of the CCU being planned for construction at the Oakdale facility, with a portion of those beds designated as psychiatric beds.

In May of 2001, prior to the construction of the CCU, the Iowa DOC, in conjunction with the NIC, contracted the services of Dr. Mary West, Deputy Director of Special Operations, Colorado Department of Corrections. She evaluated their general plan for the 200 bed CCU and for integrating it into the overall mental health delivery system (Attachment I). Her report contained a number of staffing, training, and organizational recommendations for the CCU. To the best of my knowledge, only a few, if any, of those recommendations were implemented prior to the opening of the CCU. Virtually all of Dr. West's recommendations are repeated in this report, and I would strongly suggest that both sets of recommendations be merged where overlap exists.

FINDINGS

The findings and recommendations in this report are based on my review of existing policy, my tour of the CCU and ISP, my conversations with institution staff, and the meetings conducted with various clinicians, correctional, and administrative staff. I also reviewed a large number of institution documents, the latest 2004 Ombudsman's Report, and the May 2001, Technical Assistance Visit report provided by Dr. Mary West. This report represents a "snap shot" of the system at a particular point in time and covers four major areas: 1) an assessment of the current suicide deaths; 2) an overview of management and personnel issues; 3) evaluation of statewide services; and 4) recommendations. The following report provides a detailed account of my review.

CURRENT SUICIDE DEATHS

I will begin with a review of the four suicides at the CCU. The specific details of the suicides are documented in a variety of institution investigations and memos, and therefore, I will not repeat that information in this section. Rather, I will summarize each incident and direct my comments to specific issues of concern. To comply with DOC confidentiality requirements, specific offender names will not be used in this report.

JOHN DOE #1 Mr. Doe #1 was the first suicide to occur at the CCU. He died on January 1, 2003, in Pod A, the locked unit. Offender Doe #1 was a management problem during his entire period of incarceration and continued to be a problem at the CCU. He spent virtually his entire time at the CCU in some form of locked status. In addition to loud singing, acting bizarrely, and being verbally abusive toward staff, he was frequently aggressive, demanding, and belligerent.

Mental Health/Treatment Issues: Mr. John Doe #1's mental health status and the degree of his emotional disturbance were problematic. He was diagnosed with Psychotic Disorder NOS, Questionable Schizophrenia, NOS, Questionable Anxiety Disorder, NOS. His diagnostic situation was never completely resolved during his confinement, but he was generally conceptualized and treated as a management problem, although he was placed on psychiatric medication, which he sporadically refused.

Mr. John Doe #1 threatened suicide on several occasions, and also engaged in self-harm behavior by inserting eating utensils in his rectum. While it is difficult to accurately assess his condition in retrospect, this self-harm behavior seemed more motivated by delusional thinking than attention seeking because his stated motivation for the behavior was to stop his intestines from falling out. He also expressed other questionable somatic complaints about bleeding internally. It does not appear that he ever received or cooperated in a formal mental health evaluation or engaged in any therapy, except medication. As mentioned above, throughout his stay at the CCU his behavior was generally viewed as manipulative or attention seeking and not as the product of significant mental illness. In fact, at the time of his death, he was scheduled to be transferred back to the ISP to general population status.

Security Issues: Mr. Doe #1's suicide raised a number of problems related to the CCU's security procedures and practices. To begin, Mr. Doe #1 told a correctional officer a few minutes prior to his death that he was going to commit suicide. The officer, being relatively inexperienced, passed this along to a more senior officer who said that Mr. Doe #1 frequently threatened suicide and the typical response was to watch him more closely. However, this was not done. He was not removed from the last cell on the range, where he would receive the least amount of observation and the frequency of his observations were not increased. In fact, the unit log indicates that rounds were not even made every 30 minutes, but it was almost one hour from the time of the last entry (when he threatened suicide) until he was discovered hanging in his cell. It also appears that after he was discovered hanging and the ligature was removed, no one initiated CPR and the nurse pronounced him "unrevivable".

JOHN DOE #2 Mr. Doe #2 had a long history of mental illness, suicide attempts, and self-injury, including intentionally gouging his eye. He had been in and out of the Iowa prison system and was well known to mental health treatment staff. At the time of his death he was diagnosed with Schizophrenia, was on SSIP status (suicide precautions) in an observation room on Pod B, and was receiving 15-minute checks.

Security Issues: Mr. John Doe #2's method of death was very unusual and clearly indicated a very extreme desire to die. Mr. Doe #2 died by placing wads of toilet paper along with his underwear down his throat until he eventually suffocated. Unit logs indicate he was observed sleeping every 15 minutes throughout the night until he was discovered at approximately 8:00 a.m., in the morning. Two issues arise from these observations. First,

is the adequacy of the 15-minute observations, particularly for someone with his mental health history who was on suicide watch. Second, he was reported sleeping for at least one and a half-hours after his death. In fact, he was not actually discovered by the officers making rounds, but by the control room officer who was watching him on the closed circuit monitor.

JOHN DOE #3 Mr. Doe #3 also had a long history of mental health diagnosis and treatment prior to his incarceration as well as after being admitted to the DOC and the CCU. He also had a history of prior suicide attempts and a previous diagnosis of Depression, ADHD, and Antisocial Personality Disorder. He was admitted to the CCU on August 12, 2003, for diagnosis clarification and treatment. At various times prior to his death he was diagnosed with Impulse Control Disorder, Dysthymic Disorder, Neurotic Depression, and Borderline Personality. Mr. Doe #3 was also on a very extensive array of medications from antipsychotic to ADHD medications.

While at the CCU he spent a considerable amount of time in some type of locked status for mental health observation, suicide watch, and behavioral infractions. At the time of his death, however, Mr. John Doe #3 was housed on a general population unit. He was discovered dead in his cell at approximately 7:40 a.m. The autopsy report later indicated that he died from the ingestion of a large quantity of his CCU prescribed medication.

Mental Health/Treatment Issues: I was unable to find any indication that Mr. John Doe #3 had received any type of on-going mental health treatment other than medication during his stay at the CCU. There also appeared to be some issue about the severity of his psychiatric condition. Mr. Doe #3 apparently made many statements to other offenders and possibly staff about having the power of resurrection, suggesting the presence of a far more serious psychotic disturbance than his initial or subsequent diagnoses might indicate. It does not appear that his diagnostic status was ever clarified.

Security Issues: The method of Mr. Doe #3's death clearly indicates that he obtained the pills he used for his suicide attempt by "cheeking" or not taking his medication. This was a known problem because he attempted suicide previously by doing the same thing, which resulted in a written order to crush his medication prior to coming to the CCU. Another written order was provided after he arrived at the CCU to "monitor him taking medication and swallowing pills." Security staff were assigned to pill line to ensure that offenders took their medications, but it seems clear that this often did not occur. There are indications that even after Mr. John Doe #3's death, some officers still were not performing medication checks.

Mr. John Doe #3 was discovered dead in his cell at approximately 7:40 a.m., many hours after his death and one and a half-hours after the cells were opened and unit clean up began. He was discovered with a blanket over his head. Again, there are questions about the quality of the 30-minute checks conducted during the early morning hours as well as the accountability of offenders while on the unit.

JOHN DOE #4 Mr. Doe #4, arrived at the CCU on November 25, 2003, and was quickly moved to one of the general population units. While at the CCU, records indicate he received a variety of diagnoses. He was diagnosed with Psychotic Disorder, NOS, Dysthymic Disorder, and Schizophrenia.

Mental Health/Treatment Issues: There are a number of computer generated records of psychological encounters which say very little other than that he was doing fine and could be transferred to another institution. The remainder of the information pertaining to his case is still in the hands of the DCI and was unavailable for my review.

Security Issues: From staff and offender interviews I was able to obtain a general idea about the circumstances surrounding Mr. John Doe #4's death. His body was found on November 1, 2004, at approximately 9:30 a.m., on Pod E, one of the general population units. Mr. John Doe #4 was discovered with a plastic garbage bag over his head, the bag was secured around his neck, he had a rag in his mouth, and his hands were tied behind his back with a slipknot. The physician at the scene estimated the death occurred approximately 6-8 hours prior to being discovered. The death occurred on Halloween, which may or may not have been significant.

As with the previous suicides, there are questions about the quality of 30-minute rounds made during the evening, since he was apparently counted as being alive for as many as eight security checks after his death. There are other issues about offender accountability raised in this case, since he did not report for pill line, did not report to his work detail, and was not discovered for three and a half-hours after the cells were opened for unit clean up. Apparently none of the staff had direct responsibility for determining why he was not at pill line, at work, or was not seen on the unit for more than three hours after the offenders were released from their cells.

SUMMARY OF SUICIDE DEATH REVIEW

Since each of these offenders died using different methods, on different units, at different times, and under the supervision of different staff members, there does not appear to be a direct connection between the deaths. Also, except for the statements Mr. John Doe #1 made to the officer prior to his death, there does not appear to be any evidence that staff were directly aware of information that could have prevented the deaths. In fact, both inmates and staff seemed very surprised by the deaths of each individual, with the exception of Mr. John Doe #2, who most people felt was very mentally ill and highly suicidal. However, there does appear to be a number of systemic issues that are relevant to these cases.

Mental Health/Treatment Issues: About one-third of all CCU offenders have a diagnosis of Psychotic Disorder, NOS, including two of the suicides (John Doe #1 and John Doe #4). According to the DSM-IV- TR, the NOS modifier (Not Otherwise Specified) should be used

in those cases where symptoms are hard to clarify, insufficiently observed, or do not meet specific criteria described in the other diagnostic categories. While the modifier is used in complicated cases, in my judgement the number of NOS modifiers at the CCU seems somewhat high for a mentally ill population with this history and level of daily observation. Diagnostic accuracy is important because uncertainty makes it more difficult to deliver appropriate treatment or evaluate the effectiveness of treatment that is provided.

Also, about 20% of offenders are diagnosed with conditions such as Antisocial, Borderline, or Personality Disorder, either alone or in conjunction with other diagnoses. Offenders in these diagnostic categories are sometimes found in psychiatric treatment facilities, but they are frequently very disruptive and often are not amenable to treatment. Many treatment staff commented on the fairly large number of inappropriate offenders that have been sent to the CCU and the difficulty they have had getting these offenders transferred to other facilities. The reason for raising these somewhat technical issues is to highlight potential problems in the CCU's application of the traditional psychiatric diagnostic and treatment process. These findings also raise questions about the accuracy of diagnosis for all offenders statewide as well as acceptance, transfer and referral process for offenders at the CCU.

It seems clear that there is virtually no professional therapy being offered to CCU offenders, despite the existence of individual treatment plans. Except for brief crisis intervention, unit rounds, and contacts during emergencies, this seemed to be the case for the suicides that were reviewed as well. It also appears that mental health staff are often not responsive to requests to see offenders, and that this sometimes leads to minor problems escalating into crisis situations. The need for greater professional contact with offenders at all levels was a recurrent theme that surfaced throughout the staff reviews.

In the absence of psychotherapy contacts, the only treatment that was received by these offenders was medication, if they would take it. In almost every case, each offender was receiving several medications and the ability of one psychiatrist, who serves the entire CCU and many other DOC populations, to adequately manage and monitor this level of medication is questionable.

Security Issues: There was one thread that ran through each of the suicide cases. That thread was the adequacy of security procedures, particularly the rounds, checks, and documentation performed by the security staff. In most cases, the suicides were not detected for several hours after the offender died. In the case of Mr. John Doe #1, rounds were not made for almost one hour, suicide threats were not reported, he was not provided additional observation or another cell assignment, and no CPR was performed after he was discovered.

Correctional standards and practices suggest that while making rounds, officers are typically instructed to shine a light into each cell, check for skin, and observe for signs of life. Rounds should be made at irregular intervals using different routines, officers should

be vigilant for lack of movement, and for obstructions that prevent adequate observations such as blankets over heads. It does not appear that these standard procedures for conducting security rounds could have been followed in the cases reviewed. Similarly, the level of offender accountability on the units and at the work site appears to have broken down in two of the general population suicides. It is impossible to determine the extent to which the adequacy of these security practices was a factor in each of the deaths, but it clearly indicates the need for better training, supervision, and oversight of correctional procedures at the CCU.

The fact that Mr. John Doe #3 was able to "cheek" a sufficient number of pills from his prescribed medication to use for his suicide attempt clearly indicates that pill line procedures were not performed adequately. Memos in the file from offender interviews indicated some offenders knew that Mr. John Doe #3 had a quantity of pills in his possession for some time. Consequently, in addition to the pill line checks, this information raises additional questions about the quantity and quality of unit shakedowns performed on the general population units.

Training Issues

Correctional staff, based on their frequent interactions with offenders, are often the first to identify signs of potential suicide, mental illness, or behavior abnormalities. Therefore, accepted correctional standards suggest that all correctional officers, program staff and management staff who regularly work with offenders should be trained annually in identification and management of suicidal and mentally ill offenders. Similarly, standards recommend that staff be trained to administer Cardiopulmonary Resuscitation (CPR) and instructed to perform CPR in any emergency such as suicide involving strangulation. Finally, standards recommend staff should be instructed to continue CPR until the inmate is pronounced dead by a physician.

OVERVIEW OF MANAGEMENT AND PERSONNEL ISSUES

My associate and I were able to interview a wide, cross section of CCU staff numbering approximately 35-40 employees. We spoke with all but one of the treatment staff, most recreation specialists, administrative support staff, a union representative, correctional supervisors, and correctional officers from the day and evening shifts. I also interviewed several offenders from the general population unit. During these interviews staff were candid and appeared honest in their appraisals. There was a surprising degree of agreement between most groups even though they were interviewed separately. A large portion of the material cited below flowed from these interviews and was verified, as much as possible, by our observations or other independent interview comments.

Mission of the CCU

Staff at the facility do not appear share a common vision about the purpose of the CCU or its long-term mission. There seems to be two competing and contradictory visions that are in perpetual conflict. If not resolved, this conflict may make it impossible for either vision to be ultimately realized.

Simply put, the differences seem to depend on whether you see the offenders as mentally ill people who are in prison, or prisoners who happen to be mentally ill. Those who see the facility as an institution for treating the mentally ill express the former vision. They seek to provide a supportive therapeutic environment within the prison that will foster treatment and eventually allow offenders to return to general population. The competing vision, held primarily by correctional officers, is that the facility is first and foremost a prison and offenders should be held accountable for their actions, regardless of their mental illness. In fact, many feel that treating CCU offenders differently from inmates at the ISP is counterproductive and will not help them when they are released. In my judgement, it is imperative that every effort be made to ensure the treatment vision prevails or it is likely the program will continue to experience further incidents.

Culture and Philosophy

The competing visions of the facility's mission appear to stem from the fact that the CCU was located adjacent to the ISP and has drawn it's staffing complement from the ISP. As is the case in most penitentiary settings, inmate management stresses high levels of personal accountability, responsibility, and strict adherence to rules. There are also high levels of behavioral control, which relies heavily on restricted movements, locked status housing, and frequent counts and regulations.

Many of the ISP staff who work in the CCU have brought the ISP management model with them. This results in CCU offenders being managed as if they are ISP inmates and being held to the same policies and standards of behavior. In fact, this level of control is inappropriate for many CCU offenders from both a treatment and classification standpoint. As Attachment II indicates, a relatively small number of CCU offenders are Maximum Custody and many were in open population before coming to the CCU. Nevertheless, CCU offenders are locked in their cells for significant periods of time each day, have very restricted movement when out of their cells, and are expected to maintain the same levels of personal accountability as their ISP counterparts. Unfortunately, this highly rule based and consequences oriented approach, which may be reasonable for penitentiary inmates, is typically too inflexible for working with mentally ill and special needs offenders.

The emphasis on personal accountability results in some CCU offenders receiving many disciplinary reports for behavioral infractions. As a result, a number of CCU offenders serve long periods of Disciplinary Segregation time, and sometimes are managed as if they did not have significant mental health issues that contributed to their infractions. Long periods of lockdown seem to have little direct therapeutic value for the low functioning

offenders who often continue reoffending while in lockdown and accumulate longer periods of disciplinary segregation. Also, CCU policy provides as many as six separate, but overlapping, categories under which CCU offenders can be placed in some form of locked status. Not only does research show that extended periods of isolation is detrimental to the long-term stability of mentally ill offenders, but it can also make it more difficult to establish a meaningful treatment relationship once the offender is released from locked status.

In general, long periods of segregation should be rare for mentally ill offenders, unless warranted to control psychotic patients, and even in those cases, treatment personnel should initiate and closely monitor the placement. As a general rule, locked status should be used only to the point where the offender gains sufficient ability to manage their mental illness appropriately. Also, locked status should be authorized and closely supervised by treatment staff to ensure that even legitimate disciplinary segregation does not become detrimental to the offender's mental condition.

Day and Evening Shift Selection

The penitentiary culture already appears deeply rooted in the policies and practices of the CCU, but they may be difficult to change due to the staffing procedures used to fill security positions. According to the American Federation of City and Municipal Employees (AFSCME) contract, each post is filled based on bids for the position and the bidding is based strictly on seniority. It is widely known and acknowledged by all staff that this leads to many officers bidding for posts based on days off and day shift work rather than a desire to work with the unique CCU population.

Bidding for shifts appears to have created a very unexpected and far more complicated staffing structure than might be initially predicted. Since senior officers fill most of the day shift posts, that shift generally has more mature, experienced officers. Many of these senior officers do a very good job with the CCU offenders and some even bid the posts because they like the work. This leaves the less desirable evening and night shifts to be filled by less experienced officers. Many of these officers do not want to be there, but have so little seniority that they can not bid any other positions. It is typically these less experienced officers who tend to be more rigid, more rule oriented and less able to exert authority in a flexible, individualized manner. Thus, the unintended consequence of the shift bidding procedure has created distinctly different environments in the CCU between the day and evening shifts. One that is flexible and more individualized during the day shift, which facilitates treatment objectives and the other that is less flexible and more controlling during the evening shift, which hinders treatment goals.

To further complicate these issues, ISP officers receive no initial training before coming to the CCU so they have little idea about the basic treatment philosophy of the unit or what is expected of them. It is easy to see how these attitudes and procedures lead to significant inconsistencies between shifts, particularly when there are no treatment staff available after 4:00 p.m., on weekdays or on weekends (to be discussed in subsequent sections). Such

radical swings in expectations and rule enforcement between the day and evening shifts are highly detrimental to the CCU offenders who need consistent and predictable structure on a regular and daily basis.

Security Staffing

After reviewing the security staffing pattern, it is my view that the treatment mission of the CCU is also hampered by an insufficient number of correctional officers, particularly on the evening and night shifts. For example, on the evening shift after officers are assigned to each housing unit, there is one lieutenant and one activities officer to run the entire facility. To further exacerbate this problem, there are no treatment staff that work after 4:00 p.m. or on weekends, no mental health staff have a regular on-call schedule, and security staff have few treatment activities to fill the evening hours. This leaves the correctional supervisor with little or no margin for error to cope with unanticipated situations or provide offenders with off-unit activities. It also places correctional supervisors in the unfair position of making critical, spur of the moment decisions about the management of the mentally ill offenders with little or no input from mental health professionals.

Of additional concern is the fact that the CCU's basic complement is so small that vacation relief officers must be drawn from a pool of ISP officers. Thus, on any given shift up to 20-25% of the complement are ISP officers who are unfamiliar with the CCU goals and policies, are there only for one day and gone, and often have no desire to be there at all. The large number of unfamiliar and often disinterested officers on each shift only compounds the management and consistency issues that already compromise the treatment objectives.

Mental Health and Treatment Staffing

The psychiatrist at the CCU is responsible for medication management for all CCU patients as well as assisting with the other eight DOC institutions. This level of patient care responsibility places the psychiatrist in a very vulnerable position for making mistakes and errors simply due to volume. Apparently there are several psychiatric vacancies throughout the DOC and every effort should be made to fill these vacancies to alleviate the current workload on the one CCU psychiatrist.

Currently there are three unlicensed psychologists (licensure is not required for DOC employment) to provide all of the mental health assessments and treatment for CCU offenders. This number is insufficient to provide professional treatment services and it seems clear there is no psychotherapeutic treatment being provided to the CCU offenders other than crisis intervention and administrative reviews. In my judgement, for a facility such as the CCU, which has become the DOC's defacto mental health facility (to be discussed in more detail in subsequent sections), this level of staffing is inadequate to meet the treatment needs of the offender population. Because psychotherapy is not available, the only treatment being provided to the low functioning inmates is medication,

which, as mentioned above, is being monitored by only one psychiatrist who is clearly overtaxed.

There are two Bachelors level social workers assigned to community placement activities, but neither is licensed to provide treatment services. There are no other social workers, no psychiatric nurses, no specialized paraprofessionals, or other professionals to provide any therapy programs. Consequently, CCU offenders not only do not receive individual and group therapy, but they do not receive sex offender treatment, drug and alcohol treatment, intensive life skill programs, or any other therapy activities normally associated with the treatment of the mentally ill. While counselors do offer some psychoeducational programs, this is not their primary job focus and they are unable to offer these groups at a level that can reach a large number of inmates.

Similarly, education, literacy, and many hobby craft and recreational programs are not sufficiently staffed to provide the level of services that are needed with this population. In summary, it appears the staffing patterns for the mental health and treatment disciplines are insufficient to provide the level of service required for this population. This issue will be addressed more completely in the Management, Oversight, and Leadership sections of this report.

Treatment Environment

While the need for increased treatment services is critical, they will have a minimal impact on CCU activities without substantial changes in policy. Almost to a person, interviews indicated that CCU offenders in the general population units are locked in their cells too many hours each day. Unit schedules indicate that no CCU offender is out of his cell more than 5 or 6 hours a day and almost all of that time is on their living unit. It has only been recently that offenders have been allowed to eat in ISP dining room, and even then, they are marched over together, eat, and immediately return to the unit. Before this time, offenders were not taken off their units for months at a time.

At this point, going to the dining room is the only off-unit, outside activity available to offenders, except going to the small, walled, concrete exercise yard when recreational staff is available, which is rare due to staffing. CCU offenders also have very limited recreation, hobby craft, or educational activities. Without relatively easy access to the offenders, treatment programs will be very difficult to initiate and maintain, even if staffing levels are increased. However, of greater significance is the fact that the highly restrictive living conditions are detrimental to creating the type of treatment environment that is desirable for mental health patients, and may actually inhibit the development of appropriate social skill building.

Physical Plant and Architectural Issues

Immediately upon entering the facility it is apparent that the architectural design does not lend itself to mental health treatment, and in some cases, may be detrimental. For example, when entering the general population units, one finds himself atop a two-story high atrium. The entrance is large, expansive, and totally open, making it very easy for a depressed, suicidal offender to simply jump over the small railing and fall two stories to the concrete floor below.

The living areas are concrete, stark, sterile, and almost totally devoid of color or texture. The common areas are relatively small for the number of offenders, unless most are locked in their cells, the television viewing area is inadequate, and the acoustics make it loud and difficult to hear. There is one office and one group room on each pod, but these are small and the acoustics are undesirable. Unfortunately, similar problems exist in the off-unit group rooms used for psychoeducation classes, hobby craft, and education. These rooms are still not fully completed, with ceiling tiles not installed, broken chairs, and inadequate acoustics.

Perhaps the most noticeable feature of the individual units is their very low level of ambient light. In addition, all cells have small, slit windows that are frosted allowing very little sunlight into the individual cells and even less light to filter into the units. This creates a very gloomy, depressed feeling even when the sun is shining.

Given that offenders very rarely leave the unit and almost never have outside activities, living in this environment for long periods of time can, in and of itself, exacerbate rather than facilitate treatment goals. After touring the entire facility and examining the adequacy of the space for mental health treatment, it appears the CCU has many design deficiencies for use as a mental health treatment facility.

Management, Oversight, and Leadership of Treatment Services

Generally speaking, the CCU appears to be a person driven rather than a policy driven unit. As the people change, so do the procedures, expectations, and direction of the unit. Since the unit opened, there has been a succession of directors who have all instituted various changes that often conflicted. There is limited follow-up on any direction that is given and attempts to provide direction rarely lead to any meaningful changes. Most people we interviewed seemed very willing, if not eager, to have someone who could provide some clear structure and leadership.

Clearly, there is no meaningful oversight of clinical activities. All of the mental health staff do exactly as they please with regard to treatment, interventions, and decision making. No one actually supervises their day-to-day activities and it is impossible to know what they

are doing or the quality of their work, unless something happens to highlight their performance. It seems clear that leadership is needed in both operational and clinical aspects of the program. The level of supervision that is needed in each area argues strongly for two co-equal managers to jointly coordinate both aspects of the program. Attachment III provides a proposed staffing and supervision plan consistent with the two-manager model.

Consistent with contemporary treatment practices, it may be beneficial to provide offenders with a stratified level of treatment and independence. Using a fairly traditional psychiatric model, there could be locked, semi-open, and open units with offenders progressing through the various levels based on the ability to manage their behavior and mental illness. Services at each level could be structured around a multidisciplinary team approach. In this scheme, a clinical director (ideally a licensed Ph.D. psychologist) would have direct supervision over all mental health treatment staff. Additional psychologists would be hired to ensure that each pod had had its own psychologist who would be housed on the unit.

Two additional Masters level social workers (clinical social workers) would be hired and allocated to provide half-time services to each general population (open) unit. Counselors and unit officers would be similarly assigned to each team. Additional recreation, hobby, and vocational staff may also be needed. The psychologist on each pod would be responsible for treatment oversight and direct supervision of the team members' clinical activities. They, in turn, would be supervised by the clinical director who would answer to a deputy warden with overall responsibility for the CCU. The operational director would have similar duties to the existing unit manager with direct supervision of security personnel, clerical personnel, and treatment support staff (recreation, education, vocational services, etc).

EVALUATION OF STATEWIDE MENTAL HEALTH SERVICES

From my inquiries and observations, it does not appear that the DOC currently has sufficient in-patient bed capacity to adequately respond to and treat psychotic inmates. Given the national figures that approximately 16% of offenders are mentally ill, even if a small percentage of those offenders required in-patient treatment at any given time, the 23 psychiatric beds at the IMCC are not sufficient. However, even those limited beds are not actually available for treatment because they are used almost exclusively for unsentenced forensic cases. As a result, seriously mentally ill offenders are managed at the institution level by overtaxed clinicians in less than adequate treatment conditions. Only when they become psychotic and unmanageable are they then considered for transfer to the IMCC for civil commitment. This seems to be the exact circumstances surrounding the most recent suicide of Mr. John Doe #5 at the ISP on December 11, 2004.

However, once the IMCC does accept an acute case for transfer, the limited bed space forces them to seek civil commitment and transfer the offender back to the institutions for maintenance. In some cases this probably works with few complications, but my experience indicates these inmates still require a good deal of follow up and maintenance from institution personnel. Civilly committed patients who refuse treatment once they reach an institution are not returned to an in-patient facility, but rather, are required to take medication, by force if necessary, at the institution. They remain in these non-medical facilities subject to predatory inmates and followed by treatment providers who may or may not have experience treating psychotic patients. These providers may also have very limited time to devote to treatment activities for these high maintenance offenders. In any case, the staff will receive little, if any, day-to-day clinical supervision by experienced mental health professionals. Under these circumstances it seems inevitable that offenders will receive unpredictable and inconsistent levels of treatment.

The most practical treatment options available for most mentally ill offenders would seem to be placement in one of the special needs programs or at the CCU, which was built for that purpose. In fact, many of the offenders now at the CCU say they were in special needs units prior to being transferred. However, each these facilities, including the CCU, make it clear in their policies that they are "NOT psychiatric treatment or hospital settings." On its face, this statement seems inconsistent with the stated mission of the CCU where all of the offenders have serious psychiatric diagnoses. In fact, the CCU currently has 23 civilly committed cases (slightly more than half of the DOC's civilly committed offenders), which by definition represent the most seriously mentally ill offenders in the DOC.

While this general treatment model as well as the civil commitment alternative placement mechanism is permitted by Iowa statute, in my experience it is a unique and unconventional way to manage severely mentally ill offenders, particularly civilly committed patients who are being treated involuntarily. While this decentralized treatment model eliminates the necessity for having a comprehensive psychiatric in-patient treatment facility; it seems to be an inefficient and inconsistent treatment practice that offers very little continuity of care for offenders with severe mental illness.

From an administrative perspective, there appears to be no functional, systemwide oversight mechanism to ensure quality control, policy compliance, or clinical supervision. Presently there is no position, such as a director of mental health, which is responsible for overall program management. In my judgement, assigning a few individuals, who may not be mental health professionals, to provide remote supervision for all of the treatment staff throughout the state is simply inadequate to meet oversight requirements in such a decentralized system. In the absence of adequate supervision, institution mental health staff function in a relatively autonomous manner, which may have serious consequences if the staff are inexperienced. Also, since there is no regular, independent audit function, there is no mechanism to ensure program consistency or continuity of care for offenders housed in the various institutions.

CONCLUSIONS

Based on my admittedly limited view of the overall mental health delivery system in the DOC, it is my judgement that urgent and decisive steps must be taken immediately to correct a large number of critical deficiencies in the delivery of services. To begin, the IMCC does not have sufficient in-patient capacity, and therefore, relies on a highly decentralized, institution based system for treating its most seriously mentally ill offenders. This treatment model provides limited oversight, minimal supervision, and poor continuity of care for offenders receiving institution-based treatment. By design and by default, the CCU has become the primary facility for housing the vast majority of seriously mentally ill offenders, even though its policies claim not to be a psychiatric or hospital program.

However, as the above review indicates, it is my judgement that the CCU is currently incapable of providing the level and quality of mental health treatment that should be provided to severely mentally ill offenders. Perhaps, more important than the clinical and treatment difficulties, is the need to address and resolve the cultural and architectural problems that have plagued the CCU since its inception. In my opinion, the DOC and the CCU staff must confront these problems head-on and find common ground among all of the stakeholders to overcome these impediments, if the program is to survive as a viable treatment program.

In fairness, it should be pointed out that the current living and treatment conditions at the CCU are far superior to what existed prior to its construction. The warden has instituted positive changes, and the CCU staff have tried to develop a credible program in the face of management instability, staffing reductions, anti-treatment sentiments, and physical plant limitations. However, despite these early accomplishments, the CCU and the DOC is now faced with the need to move on from its initial efforts to develop a more comprehensive treatment program that is adequate to meet the needs of their offenders.

On a statewide level, the oversight mechanisms needed to adequately manage such a highly decentralized system are currently not in place. Every effort should be made to address these deficiencies at the earliest possible date. Some of the deficiencies cited in this review may be corrected easily by reallocating existing resources, restructuring work assignments, and phasing in some staffing recommendations. However, even under the most creative management strategies, developing a more comprehensive and integrated mental health delivery system will be difficult, requiring substantial additional resources, a realistic long range plan, and a strong commitment at all levels of government. It is my considered opinion that without these commitments it is likely that problems in the delivery of mental health services will continue, if not increase, as the mentally ill prison population in the DOC grows over time.

RECOMMENDATIONS

Based upon the above review, the following recommendations are submitted for your consideration.

Suicide Review Recommendations

1) Rewrite the current DOC Suicide Prevention Policy: Separate suicide procedures from self-injury and mental health observation procedures. Identify specific staff responsibility for implementation and oversight of the Suicide Prevention Program (Suggested policy outline available if requested).

2) Ensure the warden initiates a specific, systematic process for reviewing completed suicides after each death. This should include a psychological autopsy or reconstruction. Responsibility for follow-up on recommendations or deficiencies should be assigned to specific management authorities at the Deputy Warden level.

3) Require annual, on-going training for all staff at the CCU to ensure policy awareness and responsibility. This training should include the requirement to notify mental health staff if offenders make suicide threats or gestures. Training should also include CPR training and the requirement for first responders to initiate and continue CPR until the offender is pronounced dead by a physician.

4) Relocate or reconfigure existing CCU suicide watch rooms to afford offenders more privacy (rooms are now totally visible and adjacent to elevators).

5) Ensure that all suicide watch and mental health observation status offenders are clothed in suicide smocks and receive tear resistance blankets. Offenders should never be housed in either status without clothing.

6) Mental Health staff should authorize the use of restraints for all suicidal and mental health observation offenders.

7) Consider training for all clinical staff statewide in suicide assessment and suicide risk management. If rewritten, training on the new policy procedures should also be included.

8) Consider developing a standard suicide assessment protocol to be used for all suicide evaluations that would be part of the ICON system.

9) Consider developing required, standardized in-service training for all clinical staff on mental health assessment and DSM-IV-TR diagnosis.

Management and Personnel Recommendations

Mission Statement

10) Upper level DOC management, the warden, and senior institution staff should articulate a clear and unequivocal mission statement for the CCU. This should be disseminated widely, and frequently to all CCU and ISP staff by as many methods as possible, including memos, staff recalls, visits to the facility, and meetings with various institution and community groups.

Culture, Philosophy, and Security Staffing

11) The DOC should develop specific selection criteria for CCU security staffing. This may be accomplished in several ways: 1) by designating the CCU an independent work site and rehiring staff; 2) by utilizing existing Iowa State special job descriptions such as a psychiatric security specialist or residential treatment worker; 3) develop an in-house specialty training program combining DOC personnel and professional academic training (i.e., a college course in abnormal psychology, diagnosis, psychiatric nursing, etc.). This could be accomplished in a number of phases or combinations. The method is not as important as the end result — to ensure that trained, qualified, and appropriately motivated correctional officers are working at least key security posts at the CCU. In my judgement, implementation of this recommendation seems critical to successful operation of the CCU.

12) Ensure that the warden's decision to remove dogs from the CCU is continued.

13) Correctional officers working in the CCU should receive performance evaluations with input from treatment staff.

14) Develop and implement a daily "call-out" system to account for all offenders who are not on their units or work details. This allows staff to know where offenders are if they are not at an assigned location. This ensures total accountability for all offenders at all times.

15) The correctional complement at the CCU should be increased. If nothing else, the complement should be increased by the number necessary to ensure the presence of security supervisors on two shifts seven days a week and for sufficient officers to provide vacation relief officers to guarantee continuity of performance for 16 hours per day, seven days per week.

16) The warden and correctional supervisors must ensure policy compliance and take corrective actions when violations are reported. Failure to do so should be investigated and appropriate remedies taken.

17) Develop a brief orientation program for all officers to ensure they are aware of CCU policies and procedures. Over time, ensure that all security staff working in the CCU have completed this orientation before assuming their posts.

Mental Health Staffing

18) Establish contract positions, if necessary, to reduce the demands on the current CCU psychiatric position.

19) Establish two additional psychology treatment providers to ensure that each pod has one permanent psychologist and one counselor. This would result in a total of five psychology positions.

20) Establish two licensed social work positions (apparently licensure is required for performing clinical work).

21) Assess the feasibility of utilizing existing social work positions for providing pre-release, psychoeducational, or life skills training.

22) Establish a CCU Clinical Director who is a mental health professional to provide clinical supervision and oversight to all treatment staff. This should be a Ph.D. Psychologist who is licensed and if possible, experienced in in-patient treatment.

23) Institute a multidisciplinary team concept to enhance treatment supervision and communications (see attachment III).

24) Consider augmenting existing personnel with contract service providers from local hospitals, community mental health clinics, colleges, or through shared services with other DOC facilities in the immediate area.

25) Consider establishing a psychiatric nursing position. Also, consider establishing two permanent nursing positions for the CCU, possibly from the existing ISP complement.

26) Encourage all treatment staff to obtain licensure in their respective disciplines. Seek to hire the most qualified and experienced mental health professionals available, particularly for supervisory positions.

27) Establish a Director of Mental Health Position at the Central Office level (or remotely located) to provide statewide oversight of all mental health programs. This position would develop policy, coordinate services, provide on-site quality control audits at each institution, and generally serve as a mental health resource to wardens and administrators. This position would function best if a licensed Ph.D. psychologist or Ph.D. social worker with psychiatric experience filled it.

Treatment Environment

28) The warden should immediately appoint a workgroup composed of CCU treatment staff to develop policies and procedures that permit far greater out of cell time for CCU offenders.

29) All existing ISP policies and procedures should be evaluated to determine their applicability for the CCU offender population and rewritten, if necessary.

30) Review the transfer and acceptance process for the CCU to determine if it is the most efficient and expeditious way to ensure adequate continuity of care and appropriate placement for offenders.

31) Review the appropriateness of each offender for placement in the CCU. Ensure that any offender who is not appropriate for placement is transferred.

32) Develop policy to ensure that mental health treatment providers order or authorize the placement of CCU offenders in locked status. They must also be responsible for follow-up.

33) Develop procedures to permit daily outside activities by CCU general population offenders. This should include the opportunity to continue going to lunch at the ISP, to use ISP facilities for yard activities, the gym, recreation activities, and to smoke during their outside yard time.

34) Evaluate the possibility of utilizing the unit recreation areas on a limited basis without direct recreation staff supervision.

35) Increase out of cell time, expand recreation, education, and hobby craft activities. If necessary, evaluate the adequacy of current staffing in these areas.

Physical Plant

36) Security screening should be placed over the atrium entrance and stairway. <u>This should be done immediately.</u>

37) Develop a more "people friendly" environment, particularly on the general population units. This might include painting the units, increasing the lighting, and increasing access to natural light. It may be therapeutic to allow the offenders to do as much of the work as they can to establish some degree of pride and ownership in the end product.

38) Complete the construction of the common group rooms, expand the hobby craft area, and consider carpeting all of the group rooms, including the rooms on the general population units.

39) Given the physical limitations of the CCU design for its stated purpose, DOC managers should develop a joint central office/institution workgroup to assess the strengths

and weakness of the current architectural design before it is constructed at the Oakdale facility.

Management, Oversight, and Leadership

40) Rewrite the current DOC Mental Health Services: Identify specific staff responsibility for implementation and oversight of the policy components (Suggested policy outline available if requested).

41) Establish a Deputy Warden position over the CCU to provide direct oversight of policy, operations and procedures.

42) Establish a co-equal leadership structure at the CCU, with a Director of Operations and a Director of Clinical Services (see attachment III) who answer directly to the Deputy Warden.

43) Establish a permanent CCU workgroup chaired by the deputy warden to review existing policy, evaluate the need for policy consolidation or new policy, and develop a more policy driven process for managing the CCU. This workgroup should also develop oversight procedures with identified personnel responsible for follow-up and compliance.

44) Establish a rotating on-call system for mental health providers to be available for emergency consultation and guidance after 4:00 p.m. and on weekends and holidays.

45) Establish a work schedule that requires one late night per week (until 9:00 p.m. lockdown) for all treatment staff (i.e., counselors, recreation, and mental health when fully staffed). This will permit quick access to treatment staff, increase total staffing in the evening, and permit some evening programming.

46) Consider developing an external CCU referral system that is not committee based. Assign one individual (perhaps Chief of Mental Health) to accept referrals for the CCU. This would expedite the referral process, remove it from institutional influences, and better define admission criteria.

47) As quickly as possible, develop some form of clinical oversight for treatment providers, to evaluate responsiveness and adequacy of documentation, until a treatment director can be hired.

48) Establish and implement an offender treatment review process such as a unit team meeting (at least weekly) for A and B pods and for each general population unit.

49) Move psychology staff to office space on the units. With increased staffing, each unit will have one primary service provider located on the unit who is easily accessible to the offenders.

50) Develop a multidisciplinary workgroup to assess the feasibility of making relevant parts of the ICON system available to treatment, security, and medical staff with a legitimate need for the information.

In conclusion, I appreciated working with the staff from the Iowa Department of Corrections. I found them to be helpful, professional, and extremely interested in enhancing the delivery of mental health treatment. If I can be of any further assistance, please contact me at your convenience.

Sincerely;

Thomas W. White, Ph.D.

cc: National Institute of Corrections
Prison Division
320 First Street, N.W.
Washington, D.C. 20534

Attn: Cameron Coblentz,
Technical Assistance Administrative Assistant

ATTACHMENT I

STATE OF COLORADO

COLORADO DEPARTMENT OF CORRECTIONS
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May 2, 2001

Copies
Larry Brimeyer Deputy Di
Lowell Brandt, Asst. Di
Warden Rusty Rogerson
Warden John Mathes

Walter Kip Kautzky, Director
Iowa Department of Corrections
523 East 12th Street
Des Moines, IA 50319-0001

Dear Kip:

Thank you for the opportunity to meet with you and the staff of the Iowa Department of Corrections. It was a pleasure to work with such knowledgeable and committed professionals.

Attached is my final report with recommendations. If I can offer assistance in the future, please contact me. I am also available by telephone and e-mail.

Yours Truly,

Mary

Mary E. West, EdD
Deputy Director of Special Operations
Colorado Department of Corrections

TECHNICAL ASSISTANCE #2001P1039
PRISONS DIVISION
IOWA DEPARTMENT OF CORRECTIONS

PLANNING

To assist the Iowa Department of Corrections in treating the mentally ill offenders, Director W.L. Kautzky requested technical assistance from the Prisons Division of the National Institute of Corrections. In seeking out a consultant, the Department specifically required a combination of clinical and correctional management experience to develop their blueprint for progress. Under the current plan, the Department will open a 200-bed Special Needs Unit in August 2002. The Legislature approved a companion 170-bed facility at the Iowa Medical and Classification Center.

MENTAL HEALTH SERVICES

Currently, the Iowa Department of Corrections provides residential mental health services to mentally ill offenders at the Iowa Medical and Classification Center in Oakdale. A 23-bed forensic hospital at this facility serves as an evaluation center for pre-trial and convicted offenders to determine competency. Individuals found not to be competent typically receive a civil commitment as well as a sentence. The IDOC receives permission via this commitment to treat the mentally ill offender without his/her inmates consent. The Oakdale facility also has a unit which houses and treats mentally ill and developmentally disabled offenders. This facility also serves as the reception center for 5000 inmates coming to the system each year.

The capacity is as follows:

1) 434 reception inmates including 34 female inmates
2) 30 special needs beds
3) 23 psychiatric beds
4) 349 general population

Total Capacity: 836

The Iowa State Penitentiary at Fort Madison houses the most aggressive and behaviorally disruptive offenders in Cellblock 220. Mentally ill offenders are also mainstreamed into general population facilities whenever possible.

IOWA MEDICAL AND CLASSIFICATION CENTER MEETING

On Sunday April 8, 2001 I traveled from Denver to Coralville, Iowa where I met with Director Kautzky and discussed operational practices in the department as they relate to the mentally ill offenders. We also discussed my agenda for the next three days and set the schedule. Director Kautzky and I agreed that I would initiate the process of developing a comprehensive mental health treatment delivery system for IDOC.

On Monday April 9, 2001 I met with Director Kautzky, Warden Russell Rogerson, Assistant Deputy Director Dan Craig, Marilyn Sales, Director of Nursing, and Assistant Director Lowell Brandt, and John Spence of the Offender Services Division located within the Oakdale facility. We discussed the challenges focused on the correctional system at the Iowa State Penitentiary as the delivery of mental health services change. We reviewed the role of the Oakdale facility in the treatment of mentally ill offenders as well as the role of the Iowa State Penitentiary (ISP). A new 200-bed unit is being constructed at the ISP for special needs offenders. The department wide mental health delivery system should initially include the Oakdale and ISP facilities. In the future the system should identify protected environments or step down units in other facilities and should also formally include a coordinated mental health delivery system for women offenders. For the remainder of Monday discussions continued on the role of the administrative law judge when hearing misconduct reports regarding mentally ill offenders and on staff training.

TRAINING

All newly hired staff receive 160 hours of basic training. There is some annual in-service training for CPR and firearms however it appears to be minimal and inconsistent. The Oakdale facility does not even have a training officer. Mental health and medical staff are afforded the opportunity to go to outside training to maintain their continuing education requirements.

On Tuesday morning Warden Rogerson, Marilyn Sales, Dan Craig and I traveled to Ft. Madison to the Iowa State Penitentiary. Warden John Mathes was appointed in January 2001 and is clearly already gaining the respect and confidence of staff. He has facilitated the development of a mission statement with staff and spends a generous amount of time meeting individually with staff at their posts to discuss his vision for the facility.

Capacity at ISP is currently used as follows:

597 maximum-security cells including 48 cells for behavioral disorders

* Plexi-glass is attached to the bars to avoid assaults on staff

202 medium security cells

102 minimum beds (Farm 1)

147	minimum beds (Farm 3)
17	hospital beds

Total Capacity: 1065

In the 48-bed behavioral unit (Cellblock 220) offenders are allowed outside yard or inside exercise time for one hour 5x's/week. Showers are offered 3x's/week. The only other time that an offender is allowed out of his cell is for counseling sessions. To gain a clearer understanding of the types of offenders, housed in Cellblock 220, I interviewed Inmate Chris Myers and Inmate Albert Weber. Both of these inmates have severe behavior problems and cannot be placed at the Medical and Classification Center in Oakdale because the physical construction of this facility does not permit 23-hour lock down if needed. This issue will be rectified with the opening of the new 200-bed special needs facility at Ft. Madison.

On Tuesday afternoon a meeting was held with Warden Rogerson, Warden Mathes, Deputy Wardens Helling and Sperfslage, Director of Nursing, Marilyn Sales and several staff who have expressed an interest in planning for and working in the new unit. I also met with John Kemper and Jan Corderman, President of the American Federation of State City and Municipal Employees (AFSME). AFSCME expressed concerns about hiring a different employee class i.e. Psychiatric Security Specialist vs. Correctional Officer to the Special Needs Unit. Also discussed was the bidding process and whether correctional officers can bid for shift, days off, and a single post or bid for shift and days off. The former is current practice at the ISP. On the other hand, the latter would allow staff to change a post if they were uncomfortable with an assignment or wanted to receive cross training in another area of the unit.

On Wednesday morning I met with Warden Mathes to discuss management strategies for moving toward change in the Iowa State Penitentiary. We worked on the table of organization, the program delivery system for the Special Needs Unit and discussed strategies for attracting quality staff for this unit.

Dan Craig, Lowell Brandt and I drove to the Mt. Pleasant Correctional Facility and toured the women's special needs unit. Finally, I met with Deputy Director Larry Brimeyer in Cedar Rapids to discuss my findings.

The following are my recommendations to Director Kautzkty:

RECOMMENDATIONS REGARDING THE MENTAL HEALTH SYSTEM

1) Iowa's research identifies 20% of new prison admissions are mentally ill, mentally retarded, or behaviorally inadequate. This phenomenon requires facilities designed to treat as well as control behavior.

2) The 200-bed Special Needs Unit at Fort Madison and the 170-bed addition at Oakdale are essential to a mental health delivery system.

3) The growing prison population and the related demand for mental health services suggests that general medical and mental health services require separate leadership. Previously the medical director managed both general medical and mental health.

4) Hire a psychiatrist as the Mental Health Director. This position should be responsible for setting statewide standards of care, quality assurance, staff training, and staff supervision.

5) The Department of Corrections is currently contracting with the University of Iowa Department of Psychiatry to implement these changes.

6) The Mental Health Director should review and abridge, if possible, the formulary in order to effect cost control measures.

7) The Mental Health Director should develop "clinical pathways" for prescribing costly psychotropic medications.

8) The Mental Health Director should review the tele-psychiatry process and how it should be most appropriately utilized. Onsite services are critical at Oakdale and ISP and the Iowa Correctional Institution for Women. The special needs offenders at these facilities require a treatment team approach.

9) The University of Iowa Psychiatric consultant should coordinate hiring of contract psychiatrists for facilities with the Mental Health Director.

10) The Mental Health Director should structure clinical supervision for all psychologists or identify licensed psychologists who can do onsite supervision.

11) Require/encourage psychologists to be licensed by the State.

12) Mental health staff need to be trained to serve as consultants and team members with correctional staff when managing inmate behavioral problems. All staff seem to be aware of who is classically mentally ill and who has behavior or character disorders. However, this distinction does not serve the facility if treatment plans are not being developed for this type of offender. Mental health professionals are equipped to develop management plans and should assist the correctional staff with interventions.

13) Initiate a quality assurance program that evaluates the effectiveness of interventions when correctional staff and mental health staff plan together.

RECOMMENDATIONS REGARDING TRAINING

Due to longstanding budget restrictions, training in the Iowa correctional system is front loaded. When new staff are hired, they complete a 160-hour Pre-Service Training program. In-service training is limited to life safety training (CPR) and emergency preparedness training.

1) On going training for all staff working in facilities is a critical need for the Iowa Department of Corrections. All staff must be trained to policies and procedures of the department on an annual basis. Correctional staff need ongoing training in use of force, key and lock control, classification, communication skills with offenders, and signs and symptoms of mental illness to name only a few.

2) To build an effective treatment team, both contract and non-contract staff must be trained to the same standards of care. It is unreasonable to expect supervisors, medical, mental health and line staff to work together as a team serving the greater needs of the department and the state if the day to day expectations and change in requirements are not crystal clear to everyone in the organization.

3) Correctional staff should be trained on signs and symptoms of mental illness and on how the mentally ill offender's behavior cannot be managed in the same way that the anti-social offender's behavior is managed. Working with special needs offenders requires a sophisticated understanding of mental illness and techniques of managing this population. Without this knowledge a correctional officer becomes frustrated with the offenders leaving both staff and inmates hostile to one another.

4) Administrative Law Judges need extensive training in order to determine mitigating factors attached to the misconduct of mentally ill offenders. Segregation sanctions may exacerbate continued acting out by the mentally ill offender thus keeping the cycle of behavior and segregation going on indefinitely.

5) The minimum training requirements should be modeled after Ohio. The training areas include:

   a.) Concept of treatment team in delivering patient care
   b.) The role of the correctional officer in a treatment unit

c.) Major mental illness
d.) Personality disorders
e.) Behavioral disorders
f.) Dual Diagnosis
g.) Developmental disabilities
h.) Psychotropic medications
i.) Appropriate use of behavior modification with mentally ill offenders
k.) Cognitive behavior programming for special needs inmates
l.) Case law regarding the conditions of confinement for mentally ill offenders
m.) Use of Force in a treatment setting
n.) Confidentiality

RECOMMENDATIONS REGARDING STAFFING

1) The individual that is selected for the manager of the special needs unit at ISP will be critical to ensuring that this program succeeds. Therefore I would recommend that the IDOC conduct an open competitive search.

2) The Director's position should have basic qualifications that include education and experience in mental health delivery systems as well as experience in operating an agency or division. This may require that the position is higher than a traditional unit manager.

3) The requirements and expectations of line staff should be clearly articulated and communicated to staff prior to the bidding process.

4) From a strategic point of view the department should play the change in class (psychiatric security specialist) as a card that they are willing to give up for AFSCME. In return the IDOC should structure movement line staff within the unit as is necessary for the employees and the program.

RECOMMENDATIONS REGARDING THE DIVISION OF OFFENDER SERVICES

1) The executive staff should look at a revision of the responsibilities of the Division of Offender Services. Intra state transfers are necessary to the functioning of any department of corrections. The office of

offender services is well positioned to make transfer decisions for the overall good of the department. When placed under the authority of wardens this process can quickly become divisive because every warden must consider the needs of his own facility as a priority. He has the added burden of explaining to staff why he agreed to accept an inmate that has just assaulted staff. It is strongly recommended that all transfers be managed centrally by the Assistant Director of Offender Services and his staff.

2) The Division of Offender Services should manage transfers of special needs offenders with input from the Director of Mental Health, the Director of Nursing or their designee.

MISCELLANEOUS RECOMMENDATIONS

1) Warden Rogerson, Warden Mathes, and Ms. Sales should meet to outline the plan for coordinating the treatment of the mentally offenders in the two facilities.

2) Each warden should appoint a person from the correctional line staff, a correctional supervisor, a mental health staff person and a medical staff person at a minimum to form a cross functional team. These teams should meet regularly alternating facilities in order to put recommended structure to this statewide program for special needs offenders

In conclusion it was a pleasure to work with the Iowa Department of Corrections. The staff that I worked with were genuine professionals and clearly interested in improving the mental health care delivery system.

ATTACHMENT II

A few members of the steering committee have been asked to develop a proposal for increasing the amount of time the unrestricted population of the Clinical Care Unit is out of their cells. The goal of this proposal is to continue to abide by the mission statement of the Clinical Care Unit of "protecting the public, staff, and offenders by confining offenders in a safe, secure, and humane environment consistent with their custody needs, while also challenging offenders to be responsible". In providing the offenders of the CCU the opportunity to come out of their cells on their own, we would be providing a more positive setting and holding the offender more responsible for his behaviors and choices.

Offenders are currently leaving the units for pill lines, chow lines, exercise, and sick call appointments. This discussion is limited to the unit itself. One area that has been discussed is a mandatory exercise that could take place in the morning time. This was an intervention, in the past, that appeared to work well and the majority of the CCU population participated willingly. Mandatory exercise would consist of an offender doing anything physical such as, but not limited to: walking in the day room, playing basketball in the rec area, doing push-ups, sit-ups, or pull-ups, jumping jacks, toe touches, stretching exercises. After offenders return to the unit from breakfast and are counted, the idea would be to begin this 30 minute exercise time. The exercise would be implemented only Monday-Friday and would also exclude any state holiday. Staff on the unit would then document those who did not participate and that information could be used for the regular monthly review process. Again, the goal is getting the CCU population to become more active, as it would be beneficial to the mental health of the offenders.

Currently, there is restricted cell time for GPR and GPU offenders, in the CCU. A majority of the offenders, in the larger pods of CCU, were actually in a GP setting at other institutions. A large majority of the offenders in CCU score in the medium and minimum custody range. According to statistics off of ICON and 137 offenders, the percentages of offenders who score in what custody are below:

Maximum: 31%- 16 of these are "overrides" from Clarinda/Anamosa

Medium: 57%

Minimum: 10%

In order to make the exercise program all the more effective, the idea of having the GPU population remain without a restricted time of when they have to be in their cells was discussed. The idea of allowing the GPU inmates to come out of their cells at 630, and remain out the entire day, was also discussed. The idea here is that the exercise program will be more effective if the population is encouraged to remain out of their cells, with the obvious exceptions of count and restricted movement. Other than the two exceptions just listed, the GPU population would be able to remain out of their cells. Operations would be to run a cell line at 5 minutes before the hour until 5 minutes after the hour. This time would allow the inmates the opportunity to enter and exit their cells and retrieve whatever they needed. Exceptions would need to be made when returning to the unit (after breakfast, for example) when the return time may be after the allotted cell line.

There may be benefits and consequences to both ideas presented. Here are some possible benefits that could result:

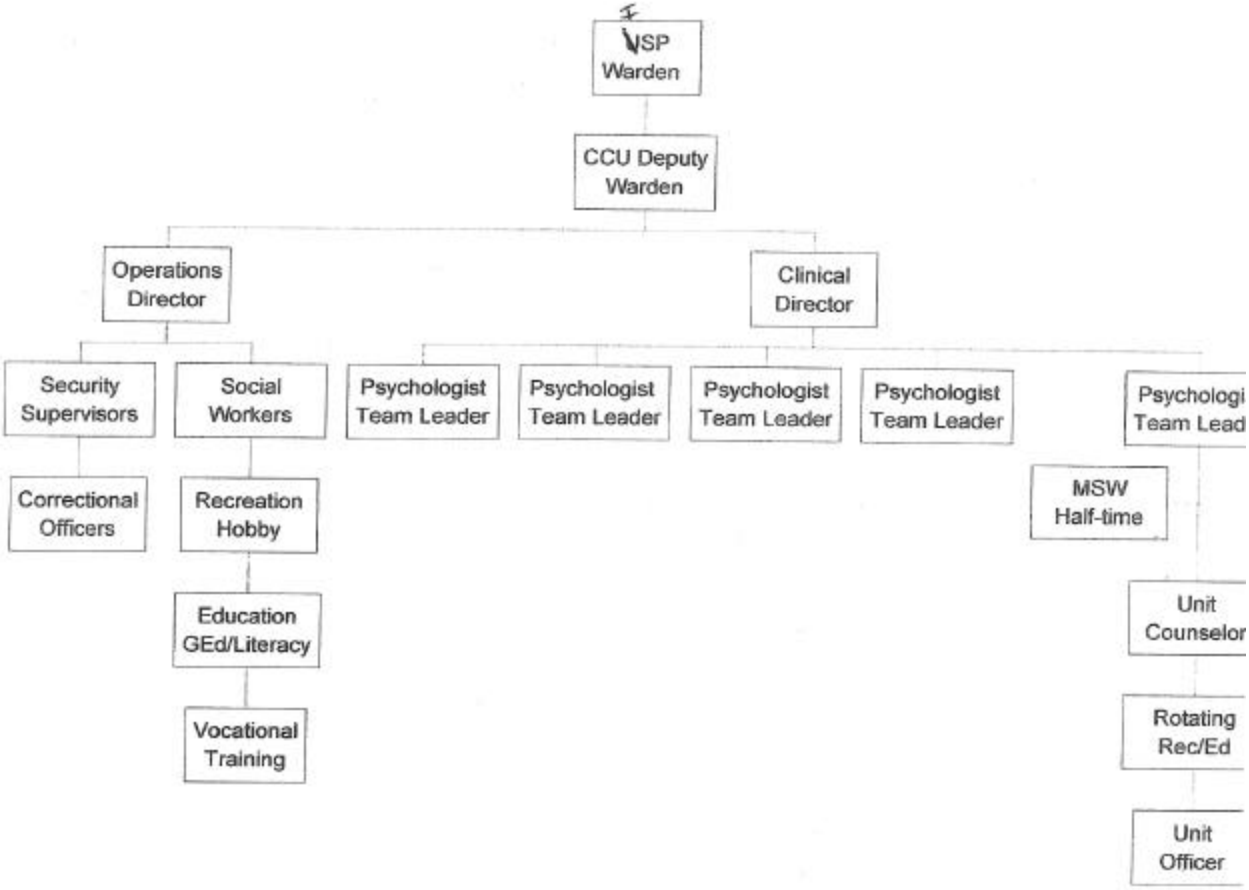
1. Gives the offender the responsibility to come out of his cell, as opposed to sleeping the entire day. One of the goals of CCU is to encourage the offender to be more responsible.
2. Promotes positive mental health treatment. Offenders with mental health issues would benefit from being able to come out of their cells more often.
3. Give the security staff more opportunities to monitor behavior on the units. By implementing this, security staff would also have the opportunity to provide more input on an offender, due to increased supervision.
4. This will provide more information for staff when it comes to recommending transfers to other institutions. We have found ourselves in some difficult situations, in the past, when we transferred offenders who had spent a majority of their time in a GP status, however they were locked up a majority of the time.

With that said, the steering committee would like to hear from unit staff on any concerns that may be brought about by allowing the GPR population to be the only population that would have a designated restricted cell time. Attached to this memo is a sheet of paper that will allow you to voice any concerns to the steering committee on this issue. Do not feel obligated to sign your name as the purpose is not to put staff on the spot, rather to continue to improve the atmosphere of the Clinical Care Unit and to continue following the mission statement. All positive and negative feedback is welcomed. Please return the feedback portion of this to Brad Hoenig or place it in his mailbox. The concerns will then be discussed at the next steering committee meeting. Your cooperation is greatly appreciated.

ATTACHMENT III

Proposed Organizational Chart for Clinical Care Unit

Multi-disciplinary Team Approach



ATTACHMENT IV

01.00.00. POLICY OF THE DEPARTMENT

The Iowa Department of Corrections (IDOC) recognizes that the prevention of resident suicide is a critical issue in all DOC facilities. While suicides cannot be totally eliminated, the department is responsible for monitoring the health and welfare of individual residents and for ensuring that procedures are pursued to help preserve life. It is the department's policy to manage potentially suicidal residents in a safe, humane, and healthful environment based on ethical, moral and legal considerations. The purpose of this policy is to set forth a comprehensive set of guidelines for the management of potentially suicidal residents in all DOC institutions.

Each DOC warden or facility head shall ensure that a suicide prevention program is implemented as directed herein. In addition, since suicide is a leading cause of death in correctional facilities, wardens shall regularly discuss the issue of suicide at department head meetings, staff recalls, correctional supervisor meetings, etc., to heighten staff awareness about the need to detect and report any changes in resident behavior that might suggest suicidal intent.

02.00.00. TABLE OF CONTENTS

05.50.01. Application of Cardiopulmonary Resuscitation
05.50.02. Intervention Procedures
05.60.00. TRANSFER OF RESIDENTS TO OTHER INSTITUTIONS
05.60.01. Emergency Transfer and Notification
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05.90.00. ADMINISTRATIVE REVIEW
05.90.01. Review Procedures
05.90.02. Review Focus
05.91.00. PROGRAM REVIEW
05.91.01. Quality Control Procedures

03.00.00. REFERENCES

Iowa code, sections **(Specific Codes inserted here)**.
Iowa Department of Correction administrative policy **(Specific Policy Here)-** Use of Force.
Standards for Adult Correctional Institutions, third edition, standards: 3-4195M, 3-4248, 3-4244, 3-4364, 3-4343M, 3-4344M, 3-4367, 3-4355, 3-4292, 3-4386, 3-4384.
Standards for Health Services in Prisons, American Medical Association, standards: 112, 140, 142, 144, 150, 159.

04.00.00 DEFINITIONS

Facility Health Authority: The on-site Health Authority or senior health staff assigned.

Medical Authority: Iowa Department of Correction Health Services Chief.

Medical Director: A physician (M.D.) either employed by the Iowa Department of Corrections or the physician in charge if medical services are privatized.

Regional Health Manager: The individual assigned as the primary manager who is administratively responsible for the delivery of medical services if health services are privatized.

Qualified Health Professional: Physician, physician assistant, nurse practitioner, nurse, dentist or others who by virtue of their education, credentials and experience are permitted by law within the scope of their professional practice to evaluate and care for patients.

Qualified Mental Health Professional: One who has specialized training and skills in the nature and treatment of mental illness. Mental health professionals shall include

psychologists, psychiatrists, social workers, and clinicians whom by virtue of their education, credentials and experience are permitted by law to evaluate and care for patients.

(Other relevant definitions inserted here)

05.00.00. PROCEDURE

05.00.01. Purpose and Scope: Each Iowa correctional facility will implement a suicide prevention program which conforms to the procedures outlined in this directive. Each facility will develop specific written procedures consistent with the intent of this directive to conform to the specific characteristics of individual facilities. Any significant deviation from the procedures outlined in this policy must be authorized by the Central Office **(specific authorizing authority inserted here)** prior to implementation.

05.10.00. SUICIDE PROGRAM COORDINATOR

05.10.01: Designation of Suicide Program Coordinator: Each warden or facility head shall designate, in writing, a full-time qualified mental health professional to serve as Program Coordinator for an institution Suicide Prevention Program. The Program Coordinator shall be responsible .....

(1) Delegation of Authority. The Program Coordinator may delegate program responsibility to another qualified mental health professional .....

(2) Coverage. The Program Coordinator, in conjunction with institution executive staff, shall ensure that adequate coverage is available.....

(3) Special Housing Units. Due to the high risk nature of locked units for suicide attempts and completed suicides, the Program Coordinator or designee shall make weekly rounds of Special Housing Units (SHU), ...and provide quarterly training (see Section 05.10.02.) to all staff at each shift change. It is important that staff be instructed to make frequent rounds in the SHUs .....

(4) Supervision of Suicidal Residents. Any resident identified as suicidal will receive appropriate preventive supervision .....

05.10.02. Training: ..... all correctional officers, program staff and management staff with responsibility for suicide prevention and intervention will be trained annually in identification and management of the suicide prone resident. Supplemental specialty training for medical staff, correctional supervisors and reception staff/admissions unit staff will be conducted .....(see Attachment B). Additional supplemental specialty training shall also be provided each quarter to staff who work with residents in Special Housing Units at all institutions (see Attachment C).

The Program Coordinator in conjunction with the warden or facility head will be responsible for ensuring that all staff receive annual training..... Suicide prevention training shall include:

- identifying suicidal indicators and risk factors;
- .....
- .....
- .....
- .....

05.10.03. Identification: All new residents and parole/probation violators admitted to each DOC institution shall be reviewed by a clinician for suicidal potential. The receiving officer shall complete the Mental Health Screening Form (Attachment A: *Workgroup Product*) upon admission..... Whenever there is ANY question about a resident's suicide potential, staff shall refer the resident immediately on an emergency basis to the Program Coordinator or designee for further evaluation.

For all non-emergency cases, mental health reviews of Attachment A shall be conducted by one of the department's clinicians on all new residents. This review will be completed within one working day ..... This report will be sent to the appropriate staff and records.

05.10.04: Referral: During regular working hours staff shall immediately advise the Program Coordinator of any resident who exhibits.....

In emergency situations or during non-routine working hours, the resident will be placed on formal suicide ..... However, any staff member who has reason to believe a resident may be suicidal or is uncertain as to the degree of suicide risk, may place a resident on suicide watch pending evaluation by the Program Coordinator or designee.

The Program Coordinator or designee should evaluate the resident at his/her earliest opportunity. However, at a minimum, they should consult with institution staff ..... the watch may not be terminated, under any circumstance, without a face to face evaluation being performed by the Program Coordinator or designee.

05.10.03. Assessment/Intervention:

Because suicidal threats of deliberate self-injurious behavior does not necessarily reflect suicidal intent, the Program Coordinator may ..... will clearly document the rationale for the intervention in the resident's medical/mental health file.

(1) **Non-Suicidal Residents.** If the Program Coordinator determines that the resident does not appear imminently suicidal, he/she shall .....

(2) Suicidal Residents. If the Program Coordinator determines the individual has imminent potential for suicide, the resident will be placed on suicide watch .....
a. Visits. The Program Coordinator or designee shall ordinarily interview or monitor each resident on suicide watch at least daily and record clinical notes following each visit. Unit staff shall also have frequent contact with the resident.

b. Chronological Log. During each suicide watch a chronological log will be maintained by the individual assigned to perform the suicide watch..... the log at 15-minute intervals

c. Termination of Watch. Only the Program Coordinator will have the authority to remove a resident from suicide watch. Termination of the watch will .....

05.20.00. HOUSING SUICIDAL RESIDENTS

05.20.01. Levels of Supervision: The necessary level of supervision afforded to a suicidal resident differs depending upon their degree of immediate suicide risk.....

05.20.02. Formal Suicide Watch: For residents who are deemed to be at imminent risk for suicide, Formal Suicide Watch procedures will be implemented .....

Normally residents on formal suicide watch will be clothed in a suicide smock and given tear resistant bedding. However, the Program Coordinator ..... The resident may or may not be admitted as an in-patient, depending upon consultation between the Program Coordinator and the Medical Officer.

05.20.03. Suicide Watch Room: Residents on Formal Suicide Watch will be placed in the institution's designated suicide prevention room

As referenced above, the suicide watch cell shall ordinarily be located in the infirmary or .....

05.20.04. Requirements for Formal Suicide Watch: Individuals assigned to perform a suicide watch will have verbal communication with, and CONSTANT one-on-one observation of, the suicidal resident at all times.....

(1) Supervison of Resident on Formal Suicide Watch. The suicide watch may be conducted either by institution staff or, when authorized by the warden, trained resident "companions" chosen by the Program Coordinator (see Paragraph 05.30.00.)..... behavior.

(2) Training for Suicide Watch. Staff or residents assigned to a suicide watch must have received training .....

(3) Chronological Logs. A chronological record of the resident's activities will be maintained on each resident on formal suicide watch. These logs shall be maintained .....

05.20.05. Close Observation: The purpose of Close Observation Status shall be to more carefully monitor the behavior and actions of a resident who is not imminently suicidal but who possesses suicide risk factors.....

05.20.06. Requirements for Close Observation: Close Observation Status shall provide as many opportunities as possible to .....

(1) Resident Supervision in Close Observation: Staff assigned to close observation of a resident should .....

(2) Daily Behavioral Log: A Daily Behavior Log will be developed on each resident assigned to Close Observation Status.....

(3) Health and well-being checks will be noted after each observation in the resident's Daily Behavior Log. Other activities shall also be recorded .....

(3) Disruptive Residents: If a Close Observation resident becomes seriously insubordinate, disruptive and/or violent, the Program Coordinator will .....

(4) Use of Resident Companions: The warden or facility head may authorize the use of resident companions to assist in monitoring Close Observation residents (see Paragraph 05.30.00.). Those residents trained to act as companions for Formal Suicide Watch may also be used .....

05.30.00. RESIDENT COMPANION PROGRAM

05.30.01. Resident Companions: Any institution, at the warden's discretion, may utilize residents as companions to help monitor suicidal residents. If the warden authorizes a companion program, the Program Coordinator will be responsible .....

(1) Selection. Companions shall be selected based upon.....

(2) Training. Each companion shall receive at least four hours of training before assuming a suicide watch and ..... Each training session shall review policy requirements and instruct the residents on their duties and responsibilities during a suicide watch, including:

- the location of suicide watch are:

- .....
- .....
- .....

Attachment E, is a suggested course outline for resident companion training.

(3) Meetings with Program Coordinator. companions shall meet at least quarterly with the Program Coordinator or designee to.....

(4) Records. The Program Coordinator shall maintain a file containing:
- an agreement of understanding and expectations signed by each resident companion;
- .....
- .....

(5) Supervision of Companions During a Suicide Watch. .....provided by staff in the immediate area and shall consist of at least 30-minute checks.,

(6) Removal of Companions from Program. The Program Coordinator or designee may remove any companion from the program at his/her discretion.

05.40.00. IDENTIFYING POTENTIALLY SUICIDAL BEHAVIOR

05.40.01. Suicide Risk Factors: Staff who work directly with residents shall consistently monitor residents under their supervision for any of the following risk factors or behaviors:

1. sleeping difficulties or irregular sleeping hours;
2. .....;
3. .....;
4. .....;

Staff who observe any of the above risk factors or behaviors shall immediately report the behavior(s) verbally and/or in writing to the Program Coordinator

05.50.00. EMERGENCY RESPONSE TO SUICIDE ATTEMPTS

05.50.01. Application of Cardiopulmonary Resuscitation: .....Program Coordinator shall ensure that all staff receive annual training in CPR and basic first aid. It also emphasizes the need for a prompt, effective application of CPR to any emergency involving strangulation..... responding staff should always initiate and continue appropriate life-saving measures (CPR) until they are relieved by arriving medical personnel. Only a physician or other

appointed medical personnel is qualified to pronounce death or stop providing emergency services once they have been initiated.

05.50.02. Intervention Procedures: When a resident is found hanging, the staff member who discovers the resident should .....

05.60.00. TRANSFER OF RESIDENTS TO OTHER INSTITUTIONS

05.60.01. Emergency Transfer and Notification: The Program Coordinator will be responsible for making emergency referrals of suicidal residents to the appropriate DOC facility.....

05.60.03. **Routine Transfer and Tracking:** Mental Health Staff at each DOC institution will have access to appropriate sections of the ICON system to .....

05.70.00. CRITICAL INCIDENT STRESS DEBRIEFING

05.70.01. Staff Assistance Procedures: When staff are exposed to traumatic events such as suicide, they should have an opportunity to receive appropriate assistance, if desired. Critical Incident Stress Debriefing (CISD) .....

Debriefing sessions should be offered to all staff as soon as reasonably possible after the situation .....

05.80.00. AUTOPSIES

05.80.01. Procedures: In all deaths resulting from suicide, the coroner will arrange for a medical autopsy. The treatment services manager will arrange for a psychological autopsy (see Attachment F) to be completed by the Program Coordinator .....Copies of this psychological autopsy will be provided to the facility head and to the administrative review committee (see 05.90.00).

05.90.00. ADMINISTRATIVE REVIEW

05.90.01. Review Procedures: Within 24 hours of each incident, the warden or facility head will ensure that a multidisciplinary Administrative Review Committee is established to review all of the formal reports .....

05.90.02. Review Focus: The primary focus of the administrative review is to determine exactly what happened during the incident and .....

This administrative review is intended to supplement mortality reviews that are typically conducted by medical staff .....

05.91.00. PROGRAM REVIEW

05.91.01. Quality Control Procedures: A continuing analysis of the program's operation is crucial to its long term effectiveness. Each Program Coordinator shall maintain a Suicide Prevention Program file that tabulates information about each suicide .....

Director, Department of Corrections **Date**

ATTACHMENTS

Attachment A

EXAMPLES OF SCREENING QUESTIONNAIRE

Attachment B

SUICIDE PREVENTION TRAINING OUTLINE FOR MEDICAL STAFF, CORRECTIONAL SUPERVISORS, AND RECEPTION/ADMISSIONS STAFF

Attachment C

SUICIDE PREVENTION TRAINING OUTLINE FOR SPECIAL HOUSING UNIT STAFF

Attachment D

GUIDELINE FOR SUICIDE RISK ASSESSMENT

Attachment E

SUICIDE PREVENTION TRAINING OUTLINE FOR RESIDENT COMPANIONS

ATTACHMENT V

MENTALLY ILL INMATES,

1. POLICY OF THE DEPARTMENT

The Iowa Department of Corrections (IDOC) recognizes its obligation to identify, treat, and manage inmates with serious/major mental illness. The department is responsible for monitoring the mental health and welfare of individual inmates and for ensuring that procedures are pursued to provide a reasonable and acceptable level of care. It is the department's policy to manage mentally ill inmates in a safe, humane, and healthful environment based on ethical, moral and legal considerations. The purpose of this policy is to set forth a comprehensive set of guidelines for the management of mentally ill offenders in all DOC institutions.

Each DOC warden or facility head shall ensure that a mental health management program is implemented as directed herein. In addition, wardens shall regularly discuss the issue at department head meetings, staff recalls, correctional supervisor meetings, etc., to heighten staff awareness about the need to detect and report any changes in resident behavior that might suggest mental illness.

2. PURPOSE AND SCOPE.

To provide policy, procedures, standards, and guidelines for managing mentally ill inmates in all IDOC correctional institutions. As the inmate population has grown in recent years, so also has the number of mentally ill inmates in custody. The vast majority of mentally ill inmates are maintained in regular institutions. Although the number of mentally ill inmates in any one institution may be small, the high visibility of this special population, their potential for disruption, and their concentration in higher security institutions dictates that they be closely monitored.

Traditionally, regular institutions have provided services to these inmates, emphasizing, whenever possible, institutional management/ treatment rather than referral for hospitalization. Successful long-term management of these cases requires a comprehensive program of institution-based care that includes accurate and early identification procedures, effective treatment programs, and, in cases of acute psychological disturbance, timely referral to a specialty institution.

3. PROGRAM OBJECTIVES.

The expected results of this program are:

a. The need for hospitalization of mentally ill inmates will be reduced
b. All inmates arriving at an institution will be screened ……..
c. For each inmate identified as needing treatment services,……
d. Necessary management/treatment information will be entereed……..
e. Any transfer will be coordinated by a qualified mental health professional …….

4. STANDARDS REFERENCED

a. American Correctional Association Foundation/Core Standards for Adult Correctional Institutions: C-4221, C-4148.
b. American Correctional Association 3rd Edition Standards for Adult Correctional Institutions: 3-4292, 3-4369.
c. American Correctional Association Foundation/Core Standards for Adult Local Detention Facilities: C2-5187, C2-5182.
d. American Correctional Association 3rd Edition Standards for Adult Local Detention Facilities: 3-ALDF4B-03, 4E-28, 4E-37.
e. American Correctional Association 2nd Edition Standards for Administration of Correctional Agencies: 2-CO-4B-04.
f. American Psychological Association (APA) Ethical Principles of Psychologists and Code of Conduct (1992).
g. APA General Guidelines for Providers of Psychological Services (1987).
h. APA Specialty Guidelines for Providers of Psychological Services (1987).

5. DEFINITIONS.

For the purposes of this Program Statement, mental illness is defined as any emotional or mental condition which substantially impairs the inmate's ability to function within the institutional setting. Using criteria presented in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV-TR), substantial impairment is defined as the presence or history of a major Axis I disorder and/or a severe Axis II disorder, along with either a history of or a current Axis V (Global Assessment of Functioning Scale) of 40 or below.

Facility Health Authority: The on-site Health Authority or senior health staff assigned.

Medical Authority: Iowa Department of Correction Health Services Chief.

Medical Director: A physician (M.D.) either employed by the Iowa Department of Corrections or the physician in charge if medical services are privatized.

Qualified Health Professional: Physician, physician assistant, nurse practitioner, nurse, dentist or others who by virtue of their education, credentials and experience are permitted by law within the scope of their professional practice to evaluate and care for patients.

Qualified Mental Health Professional: One who has specialized training and skills in the nature and treatment of mental illness. Mental health professionals shall include psychologists, psychiatrists, social workers, and clinicians whom by virtue of their education, credentials and experience are permitted by law to evaluate and care for patients.

Clinical Care Unit (CCU) The CCU is a small, self-contained unit housing special needs offenders who are mentally ill, developmentally disabled, or who have frequent problems adjusting in open population in regular institutions.

6. RESPONSIBILITIES.

To ensure consistent treatment throughout the system, each institution shall develop a comprehensive approach for managing mentally ill inmates which.....

a. Each Warden is responsible for the adequate management of mentally ill inmates in his/her institution and shall designate a full-time Qualified Mental Health Professional Program Coordinator.....

b. The Program Coordinator shall manage the treatment of mentally ill inmates and ensure that all provisions of this Program Statement are implemented.

c. Responsibility for aspects of the mentally ill inmate's management and/or treatment may be provided by either the psychiatrist or the Program Coordinator, but .....
In institutions which utilize a contract psychiatrist, the Program Coordinator is responsible for maintaining ongoing consultation and follow up as specified in Section 12 of this Program Statement.

7. PROGRAM COMPONENTS.

The standard program for managing mentally ill inmates at each institution shall address a minimum of six concerns:

a. Assessment and Treatment Planning.
b. Treatment Compliance.
c. Special Housing and Management.
d. Crisis Intervention and Emergency Transfer.
e. Consultation and Follow-up.
f. Communication Regarding Transfer.

8. ASSESSMENT AND TREATMENT PLANNING.

The Coordinator shall ensure that assessment and treatment planning procedures exist to identify all inmates entering the institution with either a recent history or current symptoms .....

a. Initial Intake Screening. All inmates arriving at the institution will be screened by medical personal before being released to the general population.....

b. Scope of Follow up Assessment and Treatment Planning. The Program Coordinator shall review the referred inmate's history of mental illness/suicide and assess the inmate's current mental status, ...

Based on this assessment process, the Program Coordinator shall:.....
a. .....

For an inmate with more extensive treatment needs, the Program Coordinator shall:

9. TREATMENT COMPLIANCE.

The Program Coordinator shall monitor mentally ill inmates to assess treatment compliance. Any inmate placed in a special housing assignment for mental health reasons.....

The Program Coordinator shall monitor ongoing treatment needs for mentally ill inmates. This may include.....

10. SPECIAL HOUSING AND MANAGEMENT.

To assist with the adjustment of mentally ill inmates, it may occasionally be necessary to modify a mentally ill inmate's housing, work, or program assignment. This may include .....

The Program Coordinator shall serve as the institution's contact person regarding all questions about the mentally ill inmate's

To facilitate coordination of treatment activities, the Program Coordinator or his/her designee shall have the authority to:
a. .....
b. .....

11. CRISIS INTERVENTION AND EMERGENCY TRANSFER.

The Program Coordinator shall be responsible for the emergency treatment and referral of mentally ill inmates to an appropriate treatment facility.....

12. CONSULTATION AND FOLLOW-UP.

The Program Coordinator shall ensure that adequate consultation and follow-up occur with all staff, contract personnel, and/or volunteers involved in the treatment and/or management of mentally ill inmates.....

The Program Coordinator shall establish regular (i.e., at least quarterly, but preferably monthly) case consultation meetings with

12. COMMUNICATION REGARDING TRANSFER OF MENTALLY ILL INMATES.

When the Program Coordinator determines that a mentally ill inmate should be referred to an in-patient, intensive treatment program.....