

**CORRECTIVE ACTION PLAN ASSESSMENT**

of

Florida State Prison  
Close Management Program

held on

May 9, 2003

for the

Close Management Monitoring Survey  
Conducted November 19-22, 2002

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## CAP Assessment of Florida State Prison Close Management Program

### **Overview**

On November 22, 2002, the Correctional Medical Authority (CMA) concluded a close management monitoring survey of Florida State Prison (FSP). The survey report, detailing the findings of the survey team, was distributed on December 17, 2002. The CMA received the final corrective action plan (CAP) from the Department of Correction's Office of Health Services (OHS) on March 3, 2003. On May 9, 2003, CMA staff conducted a corrective action plan assessment, results of which are reported herein.

### **Summary**

#### **CM-1: CORRECTED**

*CM-1: There was not an identified leadership structure at the institutional level to ensure the CM program was implemented most effectively.*

Since the time of the survey, two significant changes were enacted regarding the leadership structure of the Close Management (CM) program. First, the department established a senior psychologist position to function as the clinical coordinator of the program. Next, the department created an Assistant Director of Mental Health position with the sole responsibility of governing the mental health program at Florida State Prison and Union Correctional Institution.

Through the creation of these two positions, the department has met the CMA's recommendation outlined in finding CM-1. However, it should be noted that despite a leadership structure having been established, serious deficiencies in the implementation of the program components remain. It is recommended that the department examine the administration of the program to determine why the newly established leadership structure has been ineffective.

#### **CM-2: CORRECTED**

*CM-2: There was not a comprehensive policy available to institutional staff addressing components of the close management program.*

A lengthy instructional document was developed to outline the implementation of the CM program at FSP. DC Procedure 601.402 *Close Management* was the foundation for this document.

It is recommended that similar documents be developed for each institution designated to house CM inmates.

**CM-3: CORRECTED**

*CM-3: Clinical and security staff indicated a need for further training regarding mental health issues relevant to a close management population. The majority of staff interviewed had not seen the three-hour close management training video, which is required viewing within the first 60 days of employment.*

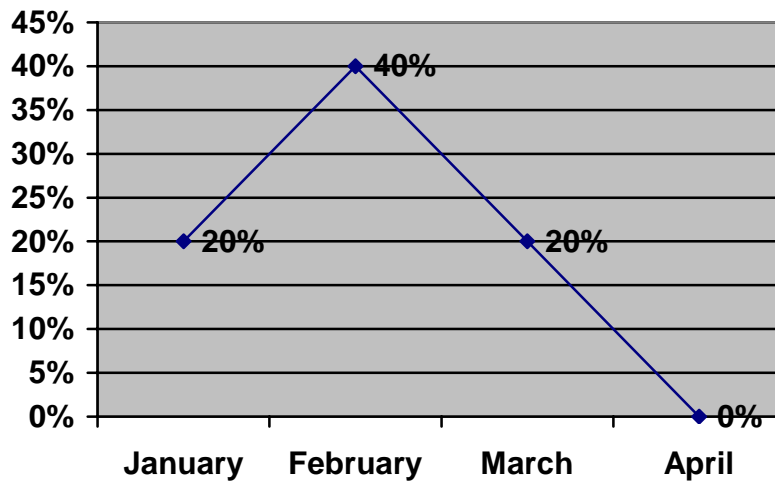
Documentation was provided in the CAP file indicating that training had been provided to employees from all departments with direct inmate contact.

**CM-4: NOT CORRECTED**

*CM-4: There was not an adequate system in place for the Multidisciplinary Team (MDST) to conduct Behavioral Risk Assessments (BRAs) in a timely manner.*

Documentation of a plan for conducting BRAs, dated one day prior to the CAP assessment, was present in the CAP file.

Institutional monitoring failed to demonstrate that BRAs are being completed within the required time frames. Compliance rates were as follows:



Recommended Corrective Action: Institutional staff should implement the plan for conducting BRAs that was developed one day prior to the CAP assessment. A minimum of five records per month should be selected for review. Monitoring should continue until closure is affirmed through the CMA CAP assessment.

**CM-5: CORRECTED**

*CM-5: There was not a system in place to adequately track Individualized Service Plan (ISP) implementation and review dates.*

A database has been established using Microsoft Access to track the ISP process.

**CM-6: CORRECTED**

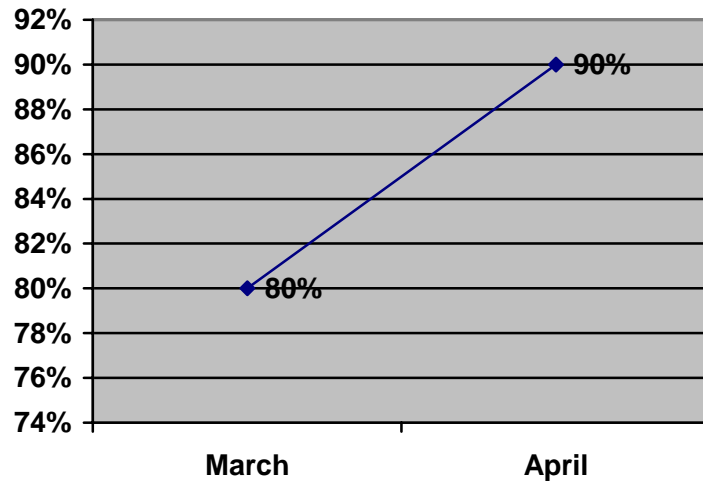
*CM-6: There were no written descriptions for the treatment groups to ensure consistency at the institutional level and replication to other CM facilities.*

Two therapeutic groups are being offered at FSP. The first is a sex offender treatment group, for which a description was provided in the CAP file. The second group, entitled *Corrective Thinking* is based on a program developed by Stanton Samenow, PhD. Documentation was provided in the CAP file indicating that program materials are available to group facilitators in each of the housing wings.

**CM-7: NOT CORRECTED**

*CM-7: There was confusion regarding the documentation of program privileges.*

An instructional memorandum was issued to institutional staff outlining documentation requirements of program privileges. Institutional monitoring indicated that the compliance rate was improving, however, monitoring had not been conducted for a sufficient period of time to indicate that corrective action had been fully implemented.

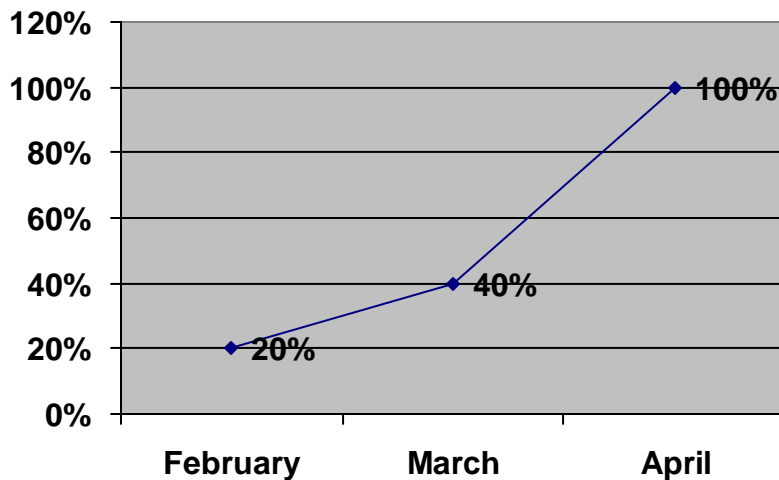


Recommended Corrective Action: Continue monitoring a minimum of five records per month to ensure compliance until closure is affirmed through the CMA CAP assessment.

**CM-8: NOT CORRECTED**

*CM-8: Close Management Referral Assessments (DC6-128) were not consistently present in the records reviewed.*

A review of records conducted during the CAP assessment and discussion with institutional staff suggested that the Close Management Referral Assessments are being completed as required, however the forms are not being filed in the records and sent along with the inmate to FSP. This is evidenced by documentation from the State Classification Office that the form had been reviewed prior to sending the inmate to close management. However, the form was not located in either the medical record or the classification master file. Institutional monitoring produced the following results:



Recommended Corrective Action: Develop a system to ensure that the Close Management Referral Assessment is present in the record upon the inmate’s arrival. If it is determined that no assessment form is present, the sending institution should be contacted to ascertain the location of the form. Document monitoring of a minimum of five records of newly arriving inmates each month to ensure compliance until closure is affirmed through the CMA CAP assessment.

**CM-9: CORRECTED**

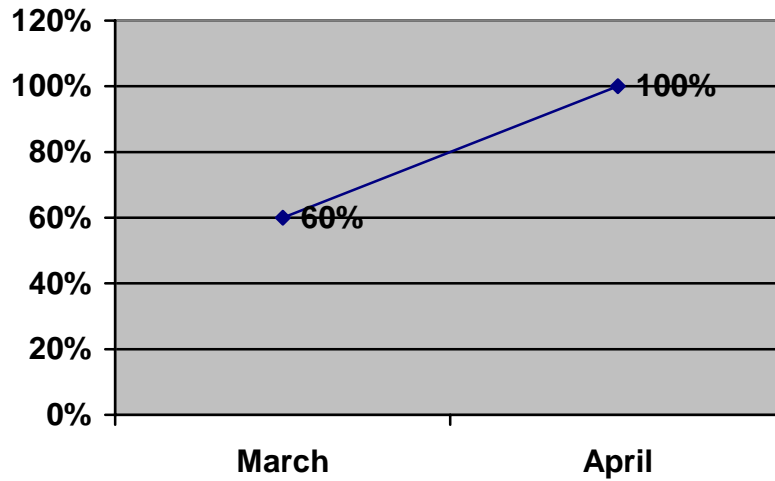
*CM-9: Documentation of Institutional Classification Team (ICT) review at required intervals was not consistently present in the records reviewed.*

A review of classification master files conducting during the CAP assessments indicated that ICT reviews are occurring as required.

**CM-10: NOT CORRECTED**

*CM-10: Documentation of State Classification Team (SCO) reviews at required intervals was not consistently present in the records reviewed.*

Institutional monitoring indicated that the compliance rate was improving, however, monitoring had not been conducted for a sufficient period of time to indicate that corrective action had been fully implemented.

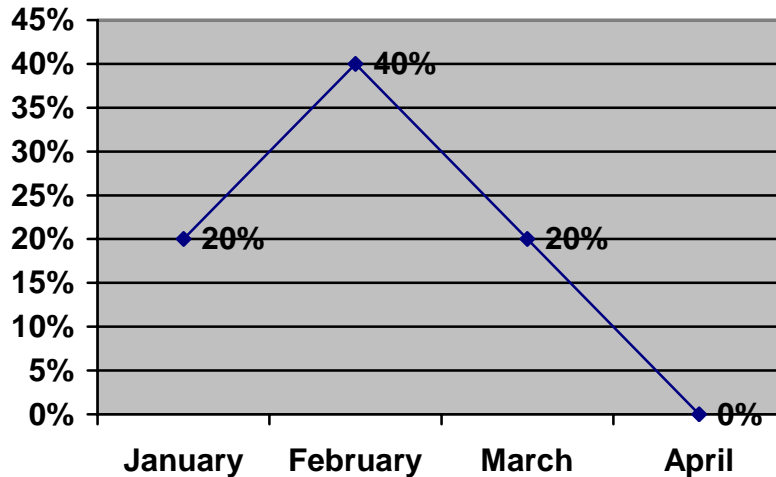


Recommended Corrective Action: Continue monitoring a minimum of five records per month to ensure compliance until closure is affirmed through the CMA CAP assessment.

**CM-11: NOT CORRECTED**

*CM-11: BRAs were not consistently completed within the required time frames.*

Institutional monitoring failed to demonstrate acceptable compliance rates of the completion of BRAs within required time frames. Monitoring results were as follows:



**CM-12: NOT CORRECTED**

*CM-12: In several records reviewed, the BRA did not document critical events in the inmate's history.*

Although institutional monitoring was conducted related to this finding, two of the three months identified no applicable records. By policy, BRAs are to be completed each time an ISP is reviewed. Documentation that ISP reviews occurred during these months, indicates that there would be applicable records available for review.

Recommended Corrective Action: Select a minimum of five records per month of scheduled for completion of the BRA. Ensure that all critical events in the inmate's history are reflected in the results of the BRA. Continue monitoring until closure is affirmed through the CMA CAP assessment.

**CM-13: CORRECTED**

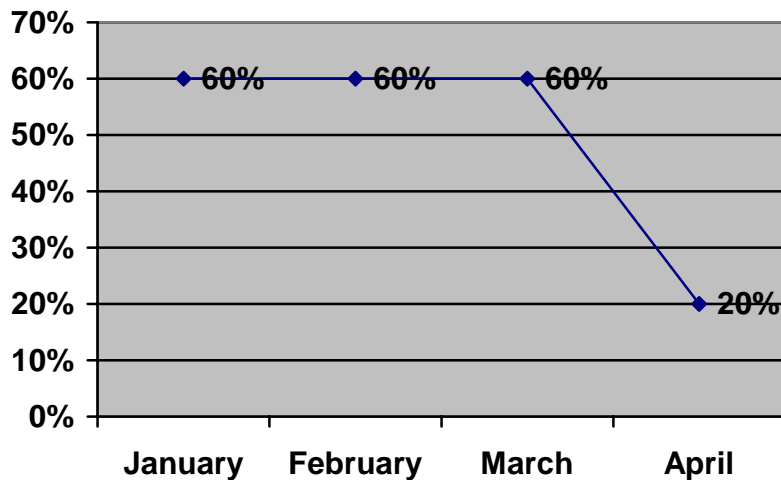
*CM-13: Documentation that the results of the BRA were considered in Institutional Classification Team (ICT) and State Classification Office (SCO) reviews was not consistently present in the records reviewed.*

A sample of records reviewed during the CAP assessment and institutional monitoring indicated that corrective action had been successfully implemented.

**CM-14: NOT CORRECTED**

*CM-14: ISP reviews were not consistently conducted at required intervals.*

Although monitoring was completed for the deficiencies regarding ISP documentation outlined in CM-15, no monitoring was conducted regarding the timing of ISP reviews. However, monitoring was conducted regarding this issue in the corrective action plan assessment for the Physical and Mental Health survey conducted June 4-7, 2002 (finding MH-5). The results of that monitoring were as follows:



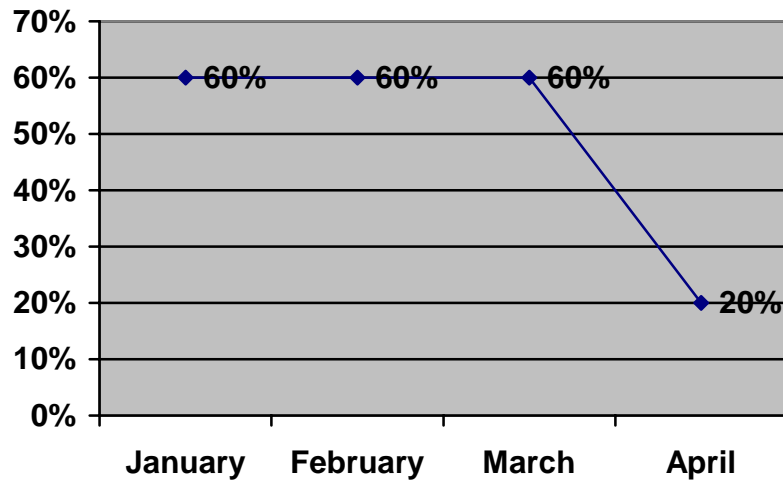
Recommended Corrective Action: Using the newly developed Access database described in CM-5, ensure that ISP reviews are conducted within the required time frames. Continue monitoring a minimum of five records per month for compliance until closure is affirmed through the CMA CAP assessment.

**CM-15: NOT CORRECTED**

*CM-15: ISP documentation was problematic:*

- *Problems identified on the BRA (with a score of 2 or higher) were not always reflected on the ISP;*
- *Interventions listed were not always appropriate to the identified problem;*
- *Goals and problem descriptions were not always clear.*

Enclosed in the CAP file was evidence of extensive training administered to clinical staff regarding the development of ISPs. Despite this training, institutional monitoring failed to demonstrate that corrective action was successful:



Recommended Corrective Action: Address identified deficiencies in ISP documentation individually with practitioners during weekly clinical supervision times. Continue to monitor a minimum of five records per month for compliance until closure is affirmed through the CMA CAP assessment.