



CORRECTIONAL MEDICAL AUTHORITY
CLOSE MANAGEMENT MONITORING SURVEY

of

FLORIDA STATE PRISON

in

Raiford, Florida

on

December 9-12, 2003

CMA Team Leaders:

Deborah McNamara, LCSW

Team Members:

Sara Tirumalasetty, MD

Karen Milo, PhD

Larry Goble, LCSW

Carmen Paroby, LCSW

Kaye Harris, RN

Deborah Ray Kings, RN, C-NA

SURVEY PURPOSE

In December 2001, the department entered into an agreement in a lawsuit entitled *Osterback v. Moore*. This lawsuit involved mentally ill inmates housed in a restricted setting called close management. Plaintiffs argued the placement of an inmate with a mental illness in a restricted housing unit exacerbated the symptoms of the mental illness. This claim was centered around the contention that placement in a close management unit, in which the majority of the inmates are housed in single-cells for 24 hours per day, is a form of sensory deprivation.

As a result of the agreement, the department committed to significant changes in the close management program. Prior to the lawsuit, close management units were located throughout the state in institutions that also housed general population inmates. The *Osterback* agreement required consolidation of all close management inmates into four facilities that house only close management inmates. The four specified institutions were Florida State Prison (FSP), Santa Rosa Correctional Institution (SARCI), Charlotte Correctional Institution (CHACI) and, for females, Dade Correctional Institution (DADCI). Subsequently, the department designated Lowell Correctional Institution (LOWCI) as the facility for close management females and added an additional institution for male inmates, Union Correctional Institution.

A primary focus of the agreement included increased mental health assessment and treatment. Prior to placement in close management housing, mental health staff complete an assessment, recommending the level of programming needed for adequate adjustment. Then, a Behavioral Risk Assessment is completed. This document identifies areas, such as risk for suicidal behavior and violence, where programming and treatment should be focused.

Once the assessment is completed, the agreement calls for increased mental health treatment for those close management inmates in need of services. The 2001 General Appropriations Act provided additional mental health staffing to FSP and SARCI for this purpose. Increased group treatment as well as an expanded treatment team including security, classification, and program staff are significant changes enacted by the agreement.

In addition to mental health treatment, increased contact with program staff, to include education and religious services, increased phone calls and visitation, and increased outdoor recreation time are enhancements to the close management program.

The *Osterback* agreement also included a stipulation that the authority monitor the provisions of the agreement. In response to this requirement, the authority developed a monitoring instrument based on the *Osterback* agreement, Chapter 33-601.800, F.A.C., and Office of Health Services (OHS) policies and procedures. The authority provided the instrument to department staff and the plaintiffs' attorneys for review and comment.

DEMOGRAPHICS

The institution provided the following information in the Pre-survey Questionnaire.

Close Management Level	Current Census
Close Management Team Decision 1	648
Close Management Team Decision 2	192
Close Management Team Decision 3	212

Program Description

Inmates at Florida State Prison (FSP) were housed on twelve wings of the institution. The close management population has increased since the survey conducted in 2002, at which time only seven wings housed close management inmates. Policies, procedures and practice related to close management promoted progressive assignments of inmates to the least restrictive level necessary. The full range of outpatient mental health services was available including group and individual treatment, case management, psychiatric consultation, psychotropic medications and referral to inpatient care. Close management inmates were permitted reading materials and the right to purchase a portable radio with headphones. Educational and literacy courses were available. In progressive stages based on their individual classifications, inmates were permitted to make monitored telephone calls, receive canteen privileges, access the dayroom, watch social television programs during dayroom periods, and participate in non-contact visits.

According to documentation provided by the institution at the time of the survey, clinical staff dedicated to the program included five psychiatrists, one psychiatric ARNP, thirty psychologists and psychological specialists, five registered nurses and one licensed practical nurse.

OVERVIEW

Survey Summary

The survey consisted of 59 individual inmate record reviews. These included 27 close management mental health and classification record reviews, and 7 self-injury/suicide prevention, 10 psychotropic medication practices, 5 psychiatric restraint, and 10 Use of Force record reviews. A comprehensive review was also completed of close management systems including policies, procedures, and practices. A tour was completed of the close management housing wings including the dayrooms, recreation yards, and staff offices. A sample of inmate contact cards and the daily record of segregation (DC6-229) forms were reviewed for mental health rounds, dayroom access including justification for the suspension of privileges, telephone privileges, canteen privileges, and exercise obtained. Formal interviews were conducted with ten clinical staff, the classification supervisor, six correctional officers, and ten inmates. Staff from a variety of disciplines were interviewed. They performed a variety of duties, were assigned to different wings, represented different ranks (correctional officers), and were state employees as well as Mental Health Management appointees. The inmates interviewed represented all levels of close management and were mainly psychological grade three (S3) inmates.

Exit Conference and Final Report

At the conclusion of the survey, an exit conference was held with institutional personnel to discuss preliminary survey results. The findings and final conclusions presented in the report are a result of further analysis of the information collected during the survey. The suggested corrective actions(s) included in this report should not be construed as the only action required to demonstrate correction, but should be viewed as a guide for developing a corrective action plan. Where recommended corrective actions suggest in-service training, a copy of the curriculum and attendance roster should be included in the corrective action plan files. Additionally, evidence of appropriate monthly monitoring should be included in the files for each finding. Monitoring by a clinician peer must be documented by a monthly compilation of the following:

- 1) The criteria/finding being reviewed;
- 2) The inmate names and DC numbers corresponding to the charts (medical records) reviewed;
- 3) An indication of whether or not the criteria/finding was met for each chart reviewed;
- 4) The percentage of charts reviewed each month that complied with the criteria;
- 5) Back-up documentation consisting of copies of the relevant sections reviewed from the sampled charts.

FINDINGS

Strengths

- Comprehensive, proactive mental health staff meetings were held on a regular basis.
- Standardized group therapy modules were developed and were appropriate for the population served.
- An Inmate Data Tracking Access system was developed to track and plan required therapeutic activities. This system was accessible by all staff and permitted supervisors to monitor the activities of their case managers.
- A graduation ceremony was held for inmates graduating the Rethinking Personal Choices program, signifying their readiness to return to the general population.
- Response time to psychiatric referrals was typically within 24 hours in the cases reviewed.
- An evening pill line was offered for Hour-of-Sleep medications.

Survey Results

The following areas of review resulted in findings requiring attention or corrective action.

CLOSE MANAGEMENT SYSTEMS	
Finding(s)	Suggested Corrective Action(s)
CM-1: The number of inmates enrolled in the therapy groups was too high in some cases (i.e.: 18 or 19).	In those cases where the number of group participants is high, consider a division into smaller groups.

CM-1 Discussion:

A review of the therapy rosters and observation of group practices suggested that the number of participants in some groups exceeded the number traditionally included in a therapy group, as well as exceeding the number that could comfortably fit into the room.

Additional Discussion Item:

Since the last survey, caseloads of individual psychological specialists have risen dramatically with the increase in the inmate population. At the time of this survey, most specialists had caseloads in the 70's compared to caseloads in the 20's one year prior. The high acuity level and increased service requirements of this population necessitate the maintenance of low caseloads.

Additional Discussion Item:

During the month prior to the survey, several of the inmate telephones were broken, thereby disrupting access to the phone privileges included in the Settlement Agreement. During the course of the survey, all telephones were repaired and institutional staff instituted a process to ensure that problems are reported and resolved in a timely manner.

Additional Discussion Item:

Several inmates reported that they had submitted written requests for mental health services but did not receive replies. A review of available documentation could neither confirm nor refute these complaints.

Records Reviewed: CLOSE MANAGEMENT	
24 RECORD REVIEWS	
Finding(s)	Suggested Corrective Action(s)
CM-2: Items identified on the Behavioral Risk Assessment as scoring two or above were not reflected on the ISP in six cases reviewed.	<p>Ensure that all problems identified using the Behavioral Risk Assessment have adequate service planning.</p> <p>Monitor a minimum of five records per month to ensure compliance until closure is affirmed through the CMA CAP assessment.</p>
CM-3: Documentation of clinical encounters did not consistently identify treatment provided.	<p>Provide inservice training on the documentation of intervention and plan when rendering individual or group therapy.</p> <p>Monitor a minimum of five records per month to ensure compliance until closure is affirmed through the CMA CAP assessment.</p>

Records Reviewed: SELF-INJURY/SUICIDE	
7 PREVENTION	
Finding(s)	Suggested Corrective Action(s)
CM-4: Post-discharge follow-up sessions were not consistently conducted at the required frequency following SOS admissions.	<p>Provide inservice training on the requirement for follow-up at 3, 10, and 30 days after discharge.</p> <p>Monitor a minimum of five records per month to ensure compliance until closure is affirmed through the CMA CAP assessment.</p>

Records Reviewed: PSYCHIATRIC RESTRAINT	
5	
Finding(s)	Suggested Corrective Action(s)
CM-5: In two cases reviewed, insufficient documentation was present to justify the use of psychiatric restraints.	<p>Provide inservice training on the requirement to document precipitating behavioral signs and the attempt of less restrictive means of behavioral control prior to the application of the restraints.</p> <p>Monitor all cases of psychiatric restraint each month to ensure compliance until closure is affirmed through the CMA CAP assessment.</p>
CM-6: Psychiatric restraints were not consistently removed after 30 minutes of calm behavior.	<p>Provide inservice training on the need to begin removal of restraints after 30 minutes of calm behavior.</p> <p>Monitor all cases of psychiatric restraint each month to ensure compliance until closure is affirmed through the CMA CAP assessment.</p>

Records Reviewed:	
10	USE-OF-FORCE
Finding(s)	Suggested Corrective Action(s)
CM-7: Chemical agents were administered to an asthmatic inmate.	<p>Provide inservice training to staff regarding the contraindication of chemical agents with asthmatic inmates.</p> <p>Monitor a minimum of five chemical agent use-of-force incidents, or all if fewer, each month to ensure no chemical agents were administered to inmates with asthma or other contraindicated conditions.</p>

CM-7 Discussion:

Following the conclusion of the survey, CMA staff researched the use of chemical agents with asthmatics and confirmed the dangerousness of the practice. This concern was discussed with Central Office staff, who immediately instituted corrective action, not only at FSP, but also throughout the state.

Additional Discussion Item:

A system for conducting referrals to mental health following a use-of-force was in place at FSP. However, recent changes to Administrative Rule require that this be done using form DC4-529, *Staff Referral/Request*. Staff should adopt the new requirement.

Additional Discussion Item:

Interview data indicated some concern regarding the use of chemical agents. Of particular concern was the frequency of complaint that chemical agents were used in response to inmates declaring psychological emergencies. A review of available documentation could neither confirm nor refute these claims. Additionally, seven healthcare staff reported the use of chemical agents as a method of disciplinary action.

A review of the use of force log indicated that multiple administrations of chemical agents were not uncommon when force was used. Policy dictates that the chemical agent OC be administered initially. If the situation does not resolve, OC may be administered a second time. If the second administration fails, the staff may administer a more pungent chemical agent, CS. Of the ten cases reviewed, three cases involved two administrations. Five progressed to three administrations. In the two remaining cases, chemical agents were administered four times before the situation resolved.

The following areas of review resulted in no significant negative record review problems.

- Psychotropic Medication Practices

CONCLUSION

Since the inception of the close management program at FSP approximately two years ago, dramatic improvements have been noted. Staff should be commended on their efforts. Corrective action following this survey should focus on the documentation of service provision, particularly specific treatment rendered. Additional education regarding the use of psychiatric restraints also seems warranted.