



CORRECTIONAL MEDICAL AUTHORITY
CLOSE MANAGEMENT MONITORING SURVEY

of

FLORIDA STATE PRISON

in

Raiford, Florida

on

January 11 – 14, 2005

&

February 15 – 18, 2005 (See Addendum)

CMA Team Leaders:

Murdina Campbell, MSW

Team Members:

Peter McGrath, MD

Karen Milo, PhD

Sandra Bauman, PhD, ARNP

Victoria Lund, PhD, ARNP

Jane Holmes-Cain, LCSW

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 (CM) 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. In early December 2004, a 116-bed transitional care unit (TCU) was opened at Union Correctional Institution (UNICI) to house close management inmates requiring inpatient mental health services (referred to as “V” dorm).

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 for the January 11-14, 2005 survey.

Close Management Level	Current Census
Close Management Team Decision 1	553
Close Management Team Decision 2	259
Close Management Team Decision 3	259

Program Description

Inmates at Florida State Prison (FSP) were housed on twelve wings of the institution. The close management (CM) population has increased since the survey conducted in 2002, at which time only seven wings housed CM inmates. In 2002, approximately 200 psychological grade 3 (S3) inmates were housed at the institution. On January 03, 2005, 835 S3 inmates were housed at the institution, over 700 of whom were on CM status. Florida State Prison houses the majority of the highest mental health acuity CM inmates who are S3s.

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. Notably, staff interviews and record review data indicated that significant numbers of inmates refused mental health services at FSP.

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. Documentation of privileges afforded CM inmates was inconsistent in two areas: weekly mental health rounds and dayroom privileges were inconsistently documented in H wing (housing CM3 inmates) and F wing (housing CM2 inmates). See the discussion in the findings section of the report.

According to documentation provided by the institution at the time of the survey, clinical positions dedicated to the program included five psychiatrists, thirty psychologists and psychological specialists including a mental health director, three registered nurses, four licensed practical nurses, and one certified medical technician (CMT). There were three psychological specialist vacancies at the time of the survey. One psychiatrist, one senior psychologist, and two psychological specialists were contracted Mental Health Management (MHM) personnel. These four staff met statutory licensure requirements for contracted personnel.

Critical Marketing Pay Additive

The department has worked with the Department of Management Services to implement a salary additive for nursing staff at select institutions, including FSP. The selected institutions use about 60% of agency nursing staff. Salary additives increase nursing salaries to approximately \$24/hr. for staff RNs (\$31.50 including benefits). For OPS nursing staff, the hourly rate is approximately \$31/hr. or the combination of the salary and benefits package of a regular employee. This compares to the approximately \$41/hr. paid to the agency for providing a nurse (\$22-\$28/hr to the nurse). The

department costs are less than paying an agency to provide a nurse¹. Administrative staff reported increased stability in the institution's nursing services since the salary additive was implemented. This is positive for the delivery of mental health services to a complex population.

¹ In May-July 2004, 72 nurses were recruited as a result of the department's nursing recruiting program. However, during the same period, 84 nurses left the department for other health care or agency positions. It is hoped the critical marketing pay additive program will offset that rate of departure. This information was reported in the authority's Budget and Personnel Committee meeting draft minutes dated October 21, 2004.

OVERVIEW

Survey Summary

The survey conducted January 11-14, 2005, was the authority's third routine survey of the close management program at FSP. In preparation for the survey, the authority requested documentation of mental health services during the six months prior to the survey. Subsequent review of the FSP inpatient referral log revealed a 109 percent increase in the number of S3 CM inmates referred and transferred to UNICI for inpatient care since October 2004. Consequently, the authority visited "V" dorm (the recently opened UNICI inpatient mental health unit) on February 15-18, 2005. The authority's purpose was to assess the outpatient treatment records of care received at FSP prior to last fall's transfers to UNICI of some of the most acutely mentally ill FSP CM inmates. This survey forms a complete assessment of the FSP CM program when combined with the findings of the January 11-14, 2005, survey of FSP. Please refer to the addendum for a detailed report of the February 15-18, 2005 survey (there are no findings requiring formal corrective action as the survey was a retrospective assessment of the FSP CM program and the department had identified and addressed the problems noted).

The January 11-14, 2005, survey consisted of 46 individual inmate record reviews. These included 20 close management mental health and classification record reviews, 10 self-injury/suicide prevention, 8 psychotropic medication practices, and 8 use-of-force record reviews. There were no inmates housed at the institution who had psychiatric restraints applied in the last six months. A comprehensive review was also completed of close management systems including policies, procedures, and practices. A tour was completed of six of the 12 CM 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 (a total of 25 inmates were reviewed on six CM housing wings). Formal interviews were conducted with 14 clinical staff, the classification supervisor, 10 correctional officers, and nine 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 S3 inmates.

Refer to the addendum for an overview of the February 15-18, 2005 survey, including sampling methodology.

Exit Conference and Final Report

At the conclusion of the January 11-14, 2005 and February 15-18, 2005 surveys, 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 – January 11-14, 2005

Strengths

- The department undertook a clinical case review process October 19 through December 06, 2004, during which approximately 900 close management, psychiatric grade three inmates housed at Florida State Prison were evaluated to determine current mental health needs. As a result, those close management inmates requiring inpatient mental health services were transferred to inpatient facilities at Union Correctional Institution.
- In response to the inpatient treatment needs identified among the close management population, the department established a 116-bed transitional care unit at Union Correctional Institution.
- At the time of the survey, Florida State Prison had not had a use of psychiatric restraints for six months.
- A specialized intake team had been developed to review all new admissions to Florida State Prison.
- The institution reported excellent communication between mental health staff at Florida State Prison and Union Correctional Institution regarding clinical and patient care issues.
- Improved working relationships were reported between departments within Florida State Prison.
- The department introduced a critical marketing pay additive program to address the retention of nursing staff. Staff interview data indicated that this program was adding to the stability and reliability of the nursing program at Florida State Prison.

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: Documentation of inmate privileges on the Daily Record of Segregation (DC6-229) was inconsistent in the following areas: weekly mental health rounds and dayroom privileges (in three of six housing wings reviewed). (See discussion below).	Review documentation requirements with the relevant staff. Monitor a monthly sample of DC6-229s to ensure compliance until closure is affirmed through the CMA CAP assessment.
CM-2: Records reviewed indicated written requests for mental health services were not consistently received in the mental health department in a timely manner (see discussion below).	Review the process for submitting written requests to the mental health department. Determine barriers to timely receipt in mental health. Address necessary corrective action. Monitor a minimum of ten records selected from the request log each month for compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.

CM-1 Discussion:

A random sample of 30 total inmates from six of the 12 CM wings was reviewed for documentation of privileges. Documentation reviewed included the DC6-229's and the contact cards. Results of the review including the inmates' names, DC #s and housing location (wing) were provided to the institution at the

time of the survey. Weekly mental health rounds and dayroom privileges were inconsistently documented in H wing (CM3) and F wing (CM2). Dayroom privileges were also inconsistently documented on I wing (CM3). Notably, documentation was consistently compliant on the CM1 wings reviewed (D and E). None of the inmates interviewed indicated there was a problem accessing privileges in the CM program.

Documentation of exercise and telephone privileges was compliant for the 30 inmates reviewed.

CM-2 Discussion:

Four of the 20 CM records reviewed documented five requests that took between six and 19 days from the date the request was written until it was received in the mental health department (the inmates' DC #s and names were provided to the institution at the time of the survey). None of the inmates interviewed during the current survey stated their requests had not been answered. Staff interview data indicated that some inmates may retain their requests in their cells for some time prior to submitting the request. This was not confirmed or refuted during the survey.

During the last survey several inmates reported they had submitted written requests for mental health services but did not receive replies. At that time, a review of available documentation could neither confirm nor refute these complaints.

Additional Discussion Item:

During the first CM survey of FSP, caseloads of individual psychological specialists were in the 20's. By last year, caseloads had risen dramatically with the increase in the CM inmate population requiring mental health services. At this time, most specialists had caseloads in the 70's. During the current survey 14 of the 27 psychological specialists continued to have assigned caseloads in the 60's. Clinical caseloads may benefit from a workload distribution analysis. The high acuity level and increased service requirements of this population continue to necessitate the maintenance of lower caseloads.

Additional Discussion Item:

The Offender Based Information System (OBIS) was not consistently utilized. During the past six months admissions to the infirmary isolation rooms (IMRs) were not consistently entered into OBIS.

Records Reviewed:	CLOSE MANAGEMENT RECORD REVIEWS	
20		
Finding(s)	Suggested Corrective Action(s)	
CM-3: In four cases (20%) problems in the inmates' adjustment or behavior, including mental health status deterioration were not consistently identified and responded to in a clinically appropriate manner. Two cases (10%) were of considerable concern (see discussion below).	<p>Ensure adequate documentation of mental status by psychology and psychiatry and that the Behavioral Risk Assessment (BRA) process and treatment/service planning are adequate in response.</p> <p>Monitor a minimum of ten records per month to ensure compliance until closure is affirmed through the CMA CAP assessment.</p>	
CM-4: In three cases (15%) information on the BRA was not consistently accurate and did not consistently address recent critical events (see discussion below).	<p>Ensure BRA information is accurate and that recent critical events are addressed.</p> <p>Monitor a minimum of ten records per month to ensure compliance until closure is affirmed through the CMA CAP assessment.</p>	

CM-3 Discussion:

Two cases (10%) were of significant concern: One inmate had considerable mental health needs identified on the BRA; however, treatment was not implemented for eight months. In the other case, treatment interventions did not adequately address the presenting mental health symptoms; nor were existing treatment recommendations implemented in a timely manner. Extensive notes were provided to the institution regarding these two cases at the time of the survey.

Of the remaining two cases, one inmate had requested services due to his complaint of severe depression but was not seen for 19 days (from the date of the request). The other inmate had not been taking psychotropic medication for three months, reported command hallucinations but was not referred to psychiatry. The inmates' DC #s and names were provided to the institution at the time of the survey.

CM-4 Discussion:

In one case the BRA omitted the Axis I diagnosis and did not address an episode of intentional self-injury. In another case the S1 inmate was represented as having no history of mental illness; however, he complained of depression, voiced possible delusions and had a documented lengthy history of depression including treatment with psychotropic medication. In the remaining case, the BRA did not reflect the Axis I diagnosis or current symptoms despite the inmate reporting command hallucinations and being off psychotropic medication for three months (this inmate was also noted in CM -3 above). The inmates' DC #s and names were provided to the institution at the time of the survey.

Additional Discussion Item:

While there were no findings in the ten records reviewed for psychotropic medication practices, three CM record reviews and two suicide and self-injury prevention record reviews indicated inconsistencies in the administration and/or documentation of psychotropic medication. For example, in one chart the psychiatrist noted the inmate was not receiving his medication daily as required and the medication administration record (MAR) noted the medication was "not available" on four days. In another case, the inmate missed ten days of medication when the medication order expired; a new order was not written until the inmate complained and was scheduled for an appointment with the psychiatrist, but not for one week. In three other cases either the MAR was not consistently initialed by the administering nurse or inmate refusals documented; a dose of medication was missed without an explanation; or the MAR indicated that the medications may have been administered incorrectly. The names and DC #s of these cases were passed on to the institution at the time of the survey.

Also, medication times on the MARs were specified as "AM" and "PM" instead of specific times, as is required by standard nursing practice. This was further complicated by a lack of written procedures to govern the process. Prior to the actual administration of medications, the MARs were signed by the nurses indicating administration has occurred. Finally, medication error rates were lower than expected for the size of the inmate population. However, none of these findings is unique to FSP. Such lapses may be expected given the number of S3 inmates housed at FSP and the past reliance on agency nurses who may not have been consistently familiar with medication practices at the institution. The critical marketing pay additive discussed above may help address this problem by encouraging the retention of nursing staff.

Records Reviewed:		SELF-INJURY/SUICIDE PREVENTION	
10			
Finding(s)		Suggested Corrective Action(s)	
CM-5: Documentation of suicide observation status (SOS) orders and notes was inconsistent: <ul style="list-style-type: none"> a. In nine cases, the physician's order did not specify 15-minute observations b. In two cases, the physician's order lacked the physician's signature c. In four cases, physician signature stamps were missing 		Review documentation requirements with the physicians. Monitor a minimum of ten records per month to ensure compliance until closure is affirmed through the CMA CAP assessment.	

CM-5 Discussion:

While the physicians' orders did not specify 15-minute observations of inmates on SOS, other documentation indicated that the inmates were observed at least every 15 minutes.

The use of a "template" in some of the psychiatric notes, while a reasonable tool to ensure all components of SOS notes are addressed, also may result in a lack of individualization unless modified for each patient (examples were given to the institution at the time of the survey). Two records reviewed reflected inconsistency in the inmates' diagnoses within daily notes, without clinical rationale or clarification.

Records Reviewed:		USE-OF-FORCE	
8			
Finding(s)		Suggested Corrective Action(s)	
CM-6: In three of eight use-of-force cases reviewed, inmates on the mental health caseload were not referred as required to mental health upon completion of the post-use-of-force physical examination.		Review requirements with the medical staff. Monitor a minimum of ten cases each month for compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.	

CONCLUSION

Since the inception of the close management program at FSP approximately three years ago, both dramatic improvements and serious problems have been noted (and addressed). Please refer to the addendum of this report for a discussion of the close management program during the six to nine months prior to October 2004. Notably, the survey report of outpatient care provided prior to October 2004 indicated serious findings in 48% of the sample. By contrast, significant concerns were identified with only 10% of the survey sample in the January 11-14, 2005 survey. The department should be commended for the progress made to date.

Prior to October 2004, the department identified serious problems with the management of FSP close management inmates requiring inpatient mental health services, and initiated corrective action. Positive achievements of the close management program include the performance of a clinical case review of approximately 900 S3 inmates at FSP during October 19 through December 06, 2004, and the opening of a 116-bed inpatient unit for close management inmates at UNICI in early December 2004.

Corrective action is encouraged to include a periodic clinical case review component of the significant S3 close management population housed at FSP, in addition to the routine CM program monitoring performed by the department. It is recognized that managing FSP is one of the most difficult and dangerous jobs in the correctional system and requires constant vigilance to maintain program standards.

ADDENDUM

CLOSE MANAGEMENT MONITORING SURVEY

FEBRUARY 15-18, 2005

Background

In preparation for the January 11-14, 2005, CM survey of FSP, the department provided the authority with documentation of mental health services at the institution in the prior six months. Included in this documentation was a copy of the inpatient referral log. This log indicated referral and transfer dates for mostly psychiatric grade 3 (S3) CM inmates requiring inpatient mental health services, i.e., crisis stabilization unit (CSU) or transitional care unit (TCU) placement. The *Osterback* agreement specifies that CM inmates requiring inpatient mental health care are to be removed from the CM program which focuses on outpatient care (S1, S2 and S3) and placed in an appropriate inpatient treatment setting within the department (S4, S5 and S6).

Review of the FSP inpatient referral log revealed a 109 percent increase in the number of S3 CM inmates referred and transferred to UNICI for inpatient care since October 2004.² These inmates were transferred subsequent to a clinical case review of approximately 900 S3 inmates instituted by the department at FSP between October 19 and December 06, 2004. Mental health staff from department institutions other than FSP performed the clinical review. Initially, the inmates were referred to two treatment facilities at UNICI³. Most of these inmates were eventually transferred to “V” dorm, a 116-bed TCU opened at UNICI in early December 2004.⁴

The CMA visited “V” dorm at UNICI on February 15-18, 2005. The authority’s purpose was to assess the outpatient treatment records of care received at FSP prior to last fall’s transfers to inpatient care at UNICI of some of the most acutely mentally ill FSP CM inmates. This survey forms a complete assessment of the FSP CM program combined with the findings of the January 11-14, 2005, CM survey of FSP reported above.

A report of the February 15-18, 2005, survey is detailed below.

² Prior to October 2004, an average of 11 inmates per month was referred (total of 43). Between October 01, 2004, and December 31, 2004, an average of 30 inmates per month was referred (total of 90).

³ One was the 27-bed CSU known as “T” dorm. The other was the 54-bed TCU known as “S” dorm.

⁴ The purpose of “V” dorm is to treat the most severely mentally ill CM inmates who require inpatient mental health services.

Methodology

A total of 64 records were reviewed. Thirty-seven CM outpatient record reviews were completed on the services provided at FSP prior to the inmates' transfer to inpatient care at UNICI. Ten psychotropic medication practices records were reviewed. In addition, seventeen inpatient records were reviewed for continuity of care. The sample was chosen from entries on the FSP inpatient referral log dated October 01, 2004, through December 31, 2004 (this coincided with the clinical case review conducted by the department on FSP inmates). The criteria for selection included: current residence in the UNICI inpatient program (mostly "V" dorm); CM status at FSP prior to transfer to UNICI; S3 status at FSP; and, residence at FSP for at least three months prior to transfer (most inmates selected for review were housed at FSP much longer than three months prior to transfer to inpatient care).

Findings

- While currently receiving inpatient mental health services, 18 (49%) of the 37 inmates reviewed clearly were not provided these services in a timely manner. Many of the FSP inmates reviewed were displaying symptoms warranting inpatient care for at least six months prior to their transfer to UNICI.
- In an additional six cases, the mental health notes at FSP were significantly inconsistent regarding mental status and symptoms. The degree and severity of mental health problems at FSP was difficult to determine from these records.
- Twenty-two examples were noted during the CM record reviews where documentation indicated inmates consistently refused mental health services at FSP, including medications or group and/or individual treatment. Of note is that 16 of those same inmates accepted some form of mental health services in the inpatient units at UNICI.
- In two of the 18 cases, the records indicated the inmates had not received their psychotropic medications continuously at FSP. In one of the 18 cases the record documented the inmate's psychotic behavior and inability for care for himself; he had lost 40 lbs in weight prior to his eventual transfer to UNICI. Another inmate (one of 18) had demonstrated significant symptoms at FSP one month prior to his transfer to UNICI (i.e., paranoia, delusions and bizarre behaviors, including pulling out his toenail). Another inmate (one of 18) had received multiple uses-of-force at FSP prior to his transfer to UNICI; a memo in the record from the correctional officer colonel subsequently disapproved the use of force with this inmate. In two FSP records (one of 18 and one of 37) the clinical documentation was unprofessional or judgmental.

There were no notable trends regarding inpatient care at UNICI. The inpatient program at UNICI was not reviewed in depth at this time except to determine continuity of care in individual cases.

A list of inmate names, DC #s and notes regarding individual cases was provided to the institution at the time of the survey.

Conclusion

While findings indicate 49%⁵ of the inmates reviewed were not transferred to inpatient care in a timely manner given the documented mental health symptoms, there are no findings requiring formal corrective action. The department identified the problem prior to October of 2004 and commenced corrective action by initiating a clinical case review process at FSP and subsequently transferring a significant number of CM inmates to the inpatient setting. Also, the opening of an added transitional care unit (“V” dorm) is an initiative recognizing the need for additional inpatient beds for CM inmates. The department needs to determine how many inpatient beds are required for the acutely mentally ill CM population.

It is anticipated that in the inpatient setting at UNICI, CM inmates with significant mental health histories including multiple diagnoses and medications can be appropriately evaluated. Diagnoses can be clarified and psychotropic medications reviewed and adjusted as necessary. The chronically mentally ill CM inmates requiring ongoing inpatient care can be appropriately removed from the CM program. Those whose mental illness can be managed in an outpatient setting may also be appropriately identified and returned to the CM program. This should result in more effective management of the CM program as well as addressing the needs of acutely mentally ill CM inmates.

Given FSP’s history and the concentration of S3 CM inmates at the institution, the authority recommends the department continue periodic review of the mental health status of CM inmates at FSP in addition to any routine monitoring of the CM program performed by the department. Notably, the January 11-14, 2005, CM survey of FSP indicated progress had been made in addressing the problems identified in the management of FSP CM inmates; two (10%) of 20 CM records reviewed demonstrated considerable concerns regarding the clinical management of the inmates. Clearly the trend of correction is significant when compared to problems identified in 49% of the February 2005 survey sample.

⁵ The survey team identified two of the 37 cases where it was not clear why the inmates required transfer to the inpatient setting. However, given the significant numbers of inmates who required earlier transfer, this was clearly the problem that needed to be addressed. It may be beneficial to discuss referral criteria with clinical staff and provide training as necessary to ensure consistent standards in accessing inpatient care when indicated. It is recognized that clinical decision making takes place in a complex environment including significant mental health symptoms and treatment histories of S3 CM inmates and that individual inmates with similar symptoms may vary in their level of functioning and in the environments that best meet their needs. The department is to be commended for re-evaluating the FSP inmates’ mental health needs.