



CORRECTIONAL MEDICAL AUTHORITY

CLOSE MANAGEMENT MONITORING SURVEY

of

LOWELL CORRECTIONAL INSTITUTION

in

Lowell, Florida

on

May 27-29, 2003

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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 are 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.

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 includes a stipulation that the authority monitors 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	5
Close Management Team Decision 2	9
Close Management Team Decision 3	20
Total Close Management Population	34

Program Description

Close management inmates at Lowell Correctional Institution (LOWCI) were housed on one wing of one dorm in the Annex portion of the institution. 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. The required exercise times had not yet been fully implemented, however the agreement does not require full compliance until July 1, 2003. In progressive stages based on their individual classifications, inmates were permitted to make monitored telephone calls, receive canteen privileges, dayroom access, access to social television programs during dayroom periods, and non-contact visits.

According to documentation provided by the institution at the time of the survey, clinical staff dedicated to the program included one psychological specialist only. There was a vacant position for a senior psychologist at the time of the survey, however it was reported that the position was not being advertised and no projected hire date had been set. Psychiatric services were provided by one psychiatrist whose duties also included the provision of psychiatric care for inmates in the general population at the Main Unit and the Annex. The inmate population receiving psychiatric services in these combined units was in excess of 900 inmates at the time of the survey. Three psychiatrists were employed with the aid of Locum Tenens.

OVERVIEW

Survey Summary

The survey consisted of 16 individual inmate record reviews. These included 10 close management mental health and classification record reviews, six self-injury/suicide prevention record reviews, and six psychotropic medication practices record reviews. A comprehensive review was also completed of close management systems including policies, procedures, and practices. A tour was conducted of the close management housing wing including the dayroom and recreation yard. A sample of inmate daily record of segregation forms (DC6-229) was reviewed for mental health rounds, dayroom access including justification for the suspension of privileges, telephone privileges, canteen privileges, and exercise obtained. Finally, formal interviews were conducted with two clinical staff, the classification supervisor, three correctional officers, and six inmates. The inmates interviewed represented various levels of close management and were all 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

- The quality of mental health treatment rendered was good. In the majority of cases reviewed, inmates were seen at a greater frequency than required.
- Houses of Healing and Cage Your Rage group modules were provided for inmates in all close management levels.
- All inmates interviewed expressed positive comments about the quality of mental health services received.
- Mental health documentation was completed in a timely manner. The quality of the documentation permitted reviewers to follow the course of care easily.

Survey Results

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

CLOSE MANAGEMENT SYSTEMS	
Finding(s)	Suggested Corrective Action(s)
<p>CM-1: Security staff interviews indicated a need for further training regarding mental health issues relevant to a close management population. No security staff interviewed had seen the three-hour close management training video, which is required viewing within the first 60 days of employment (see discussion below).</p>	<p>Provide staff training.</p> <p>Only staff members who have received the appropriate training should be assigned to the close management post.</p>
<p>CM-2: Mental health treatment groups were not provided at the prescribed frequency due to cancellations (see discussion below).</p>	<p>Develop a system to remove barriers that disrupt the provision of services.</p> <p>Create a standardized schedule of close management program services to guide staff.</p>
<p>CM-3: Provision of the following services was not consistently documented:</p> <ul style="list-style-type: none"> • Weekly mental health rounds; • Telephone calls; • Exercise; • Dayroom access. 	<p>Provide inservice training to relevant staff on the documentation of required services on the DC6-229, <i>Daily Record of Segregation</i>.</p> <p>Monitor a minimum of five DC6-229s (for different inmates) per month to ensure compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.</p>
<p>CM-4: Confidentiality was not maintained during the provision of psychiatric services.</p>	<p>Ensure that all mental health services are provided only in an environment that allows for privacy.</p>

Discussion:

CM-1: Three security officers (one sergeant and two correctional officers) were interviewed. None had viewed the required training video. Furthermore, one of the correctional officers was a trainee who was uncertified and had yet to attend the academy. The high acuity of this specialized population suggested that only certified officers with appropriate training should be assigned this post.

CM-2: A review of available documentation indicated that treatment groups were frequently cancelled (50% in one month of review) due to disruptions such as use-of-force and arrival of new close management inmates. In most cases, it was documented that rescheduling of the group was often attempted but not always successful. A tentative unit schedule was available for surveyor’s review, however it was not utilized in the housing wing to ensure services.

CM-4: Although a room was designated for psychiatric interviews, psychiatric staff were observed conducting interviews at a table in the center of the housing unit within sight and sound of other inmates.

Additional Discussion Items:

Outdoor exercise was provided one day per week over the span of a four-hour time period. However, included in this time period was the transportation of inmates to and from the recreation area. As a result, the majority of inmates did not enjoy the full time period allotted. No exercise equipment was available in the recreation area but had been ordered. Indoor aerobics classes were offered some evenings to those inmates eligible for participation. Beginning July 1, 2003, the agreement requires that six hours of exercise be provided each week.

Many inmates interviewed reported that security staff inconsistently called mental health staff in the event that an inmate declared a psychological emergency. A review of available documentation could neither confirm nor refute these reports.

Records Reviewed:	CLOSE MANAGEMENT RECORD REVIEWS
10	
Finding(s)	Suggested Corrective Action(s)
CM-5: Special Housing Health Appraisals (DC4-769) were not consistently present in the records reviewed.	<p>Provide training to nursing staff regarding the requirement for completion of a DC4-769 for all inmates entering confined housing units.</p> <p>Monitor all newly arriving CM records each month for compliance. Continue monitoring until closure is affirmed through the CMA CAP assessment.</p>
CM-6: Documentation of Institutional Classification Team (ICT) reviews at required intervals was not consistently present in the records reviewed.	<p>Ensure that ICT reviews occur at specified intervals (once per week for the first 60 days in CM and every 30 days thereafter).</p> <p>Provide inservice training to relevant staff on the need to document reviews (DC6-229).</p> <p>Monitor a minimum of five classification records per month for compliance. Continue monitoring until closure is affirmed by the CMA CAP assessment.</p>

Records Reviewed:	PSYCHOTROPIC MEDICATION PRACTICES
6	

Finding(s)	Suggested Corrective Action(s)
CM-7: Medication consent forms were not consistently present in the records reviewed.	<p>Provide inservice training to relevant staff on the need to complete medication consents.</p> <p>Monitor a minimum of five records for compliance. Continue monitoring until closure is affirmed by the CMA CAP assessment.</p>
CM-8: An annual physical health appraisal was not consistently present for those inmates receiving psychotropic medications.	<p>Provide inservice training to responsible staff members regarding the requirement for an annual health appraisal.</p> <p>Monitor a minimum of five records for compliance. Continue monitoring until closure is affirmed by the CMA CAP assessment.</p>

Records Reviewed:	SELF-INJURY/SUICIDE PREVENTION
23-hr	1
SOS	5
Other	0

Finding(s)	Suggested Corrective Action(s)
CM-9: The physician did not consistently cosign verbal orders.	<p>Provide inservice training to responsible staff.</p> <p>Monitor a minimum of five records for compliance. Continue monitoring until closure is affirmed by the CMA CAP assessment.</p>
CM-10: Post-discharge follow-up sessions were not consistently provided at the required frequency.	<p>Provide inservice training to responsible staff.</p> <p>Monitor a minimum of five records for compliance. Continue monitoring until closure is affirmed by the CMA CAP assessment.</p>

Additional Discussion Item: One case reviewed by the survey team followed the care of an inmate through her placement into SOS status, referral to inpatient care, and subsequent return to close management at LOWCI. Upon her return to LOWCI, documentation of care that was conducted at LOWCI was missing from her medical record. Attempts to locate this documentation during the survey resulted in a packet of information being found at Broward Correctional Institution. Maintenance of the medical record is a critical component of care. The Office of Health Services should promptly address this intrasystem issue.

CONCLUSION

The development and implementation of the close management program for females, first at Dade Correctional Institution and then at LOWCI, was a complicated task requiring modification in mental health, security, and program approaches to the management of inmates with behavioral problems. Previously a very restricted disciplinary program, the close management program resulting from the *Osterback* agreement not only attempts to provide a safe, controlled environment for the most dangerous inmates, but it also attempts to provide comprehensive mental health treatment to those in need of such care.

The mental health care provided to the close management inmates at LOWCI was appropriate in the eyes of the survey team as well as the staff and inmates interviewed. Staff are encouraged to maintain this high level of services. Programmatic aspects of the settlement agreement are not yet provided or documented at the required frequencies. Creation of a standardized, operational unit schedule would be a beneficial step in ensuring that all activities are occurring as intended. Furthermore, recruiting a psychologist to fill the current vacancy is crucial to fulfilling the mission of not only the close management program but also the provision of all outpatient mental health services at Lowell Correctional Institution and its Annex. Currently, only one psychologist is employed to function as clinical and administrative supervisor for both the close management program and the mental health program in the Main Unit and Annex. Filling the vacant position would allow a more manageable distribution of workload as well as provide an additional clinician for direct services to close management inmates.