COLORADO
Department of Corrections

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OFFENDERS WITH MENTAL ILLNESS IN CENTENNIAL CORRECTIONAL FACILITY

RESIDENTIAL TREATMENT PROGRAM

A Report Submitted to the
Joint Budget Committee
due January 31, 2014, in response to
Department of Corrections FY 2013-14 RFI #1

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January 2014

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Offenders with Mental Illness

This report is submitted in response to the Joint Budget Committee's fiscal year (FY) 2013-14 Request for Information #1 to the Department of Corrections. The request is stated as:

> It is requested that the Department of Corrections submit a report to the House Judiciary Committee and the Senate Judiciary Committee by January 31, 2014, detailing the progress related to the mental health unit at Colorado State Penitentiary.

The current report and data describe the program and its activities through FY 2013.

A program was established at Centennial Correctional Facility (CCF) in 2007 for offenders with mental illness who could be transitioned out of administrative segregation; this small program was created using existing resources. Later, in 2010, the General Assembly funded Colorado Department of Corrections (CDOC) to establish the Specialized Administrative Segregation Program for Offenders with Mental Illness (OMI) at the Colorado State Penitentiary (CSP). In January 2013, the CSP OMI program moved to Centennial Correctional Facility (CCF) as a residential treatment program (RTP). This move was made because an administrative segregation facility is not conducive to conducting therapy. At CCF, offenders could be managed according their individual and changing custody needs, while enabling treatment to be the primary focus rather than security. Also, consolidation of the CCF OMI and CSP OMI programs into the CCF RTP enabled more consistent, uniform care for program participants.

The program's goal is to provide evidence-based treatment services to offenders with mental health issues who would otherwise be administratively segregated in order to improve their ability to function effectively, to decrease their isolation, and to progress to less restrictive facilities. The comprehensive, incentive-based program provides offenders with intensive mental health treatment services including therapeutic and recreational activities, staff interaction, and progressive increases in out-of-cell time. Individualized treatment plans are designed to alleviate psychiatric symptoms and help offenders develop successful self-management skills and prosocial behavior.

Target Population

CDOC uses a coding process to identify and track offenders who have mental health treatment needs. The psychological needs level codes (P codes) range from 1 to 5, with 3-5 indicating moderate to severe needs. An 'M' qualifier on the P code is used to designate those with major mental illness. M qualifiers are designate offenders diagnosed with schizophrenia, bipolar disorder, major depressive disorder, and delusional or psychotic disorders. Priority is given to those with the highest mental health treatment needs (e.g., Axis I major mental illness, risk of self-injury, etc.) among the referral pool of male offenders with a P code of 3-5 in administrative segregation or at risk of transfer to administrative segregation.

Mental health clinicians review offenders with mental illness who meet criteria for RTP placement based on their diagnosis and treatment needs. For offenders referred from other facilities, the mental health clinicians exchange information on the offender's mental health status, treatment plan and compliance, psychiatric stability and medication compliance, and institutional behavior. Offenders with mobility or American Disabilities Act (ADA) issues are referred to the RTP at San Carlos Correctional Facility.

High-need offenders are placed in the program and encouraged to participate in treatment, although they may resist and have a right to refuse treatment. Some offenders may fail to recognize mental health problems, may deny problems because of perceived stigma or vulnerability associated with mental illness, or they may be paranoid and distrustful of treatment providers.

Offenders in the program have been diagnosed with

- an Axis 1 mental disorder (based on the American Psychiatric Association's *Diagnostic*

and Statistical Manual of Mental Disorders, fourth edition, text revision; DSM-IV-TR);

- an Axis II personality disorder (based on the *DSM-IV-TR*) that impairs his ability to function in the general prison population.

Offenders often will meet criteria for both Axis I and Axis II disorders. When symptoms of major mental illness are alleviated due to medication, treatment, or lowered stress, Axis II personality disorder symptoms may become the primary concern. In such instances, treatment services focus on two overlapping groups: Primary Axis I Major Mental Illness and Primary Axis II Personality Disorders (see section on Therapeutic Interventions).

Figure 1 shows program admissions by axis track over time (FY 2013 is split in half according to when the program moved to CCF). Figure 2 shows the primary diagnosis of offenders admitted to the CSP OMI (Aug 2010 – Dec 2012) and CCF RTP (Jan 2013 – Jun 2013). Antisocial personality disorder was the most common primary diagnosis of offenders admitted to the CSP OMI program while bipolar disorders were the most common of those admitted to CCF RTP.

Program Enrollments

As of June 2013, offenders had spent a median of 26 months in administrative segregation prior to program admission. This figure reflects the Department's recent goal to transfer mentally ill offenders who have spent extended periods of time in segregation to the CCF RTP. Originally, the program was designed to help offenders with a major mental illness progress out of an administrative segregation environment to a less restrictive facility. Although, this progression continues today, offenders in less restrictive environments now have the opportunity to engage in intensive treatment opportunities before their behavior escalates to a point where administrative

FIGURE 1
Admissions by Axis Track

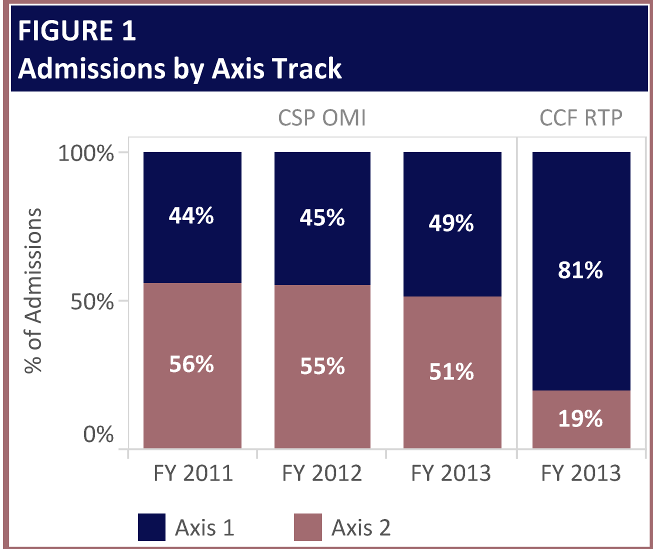
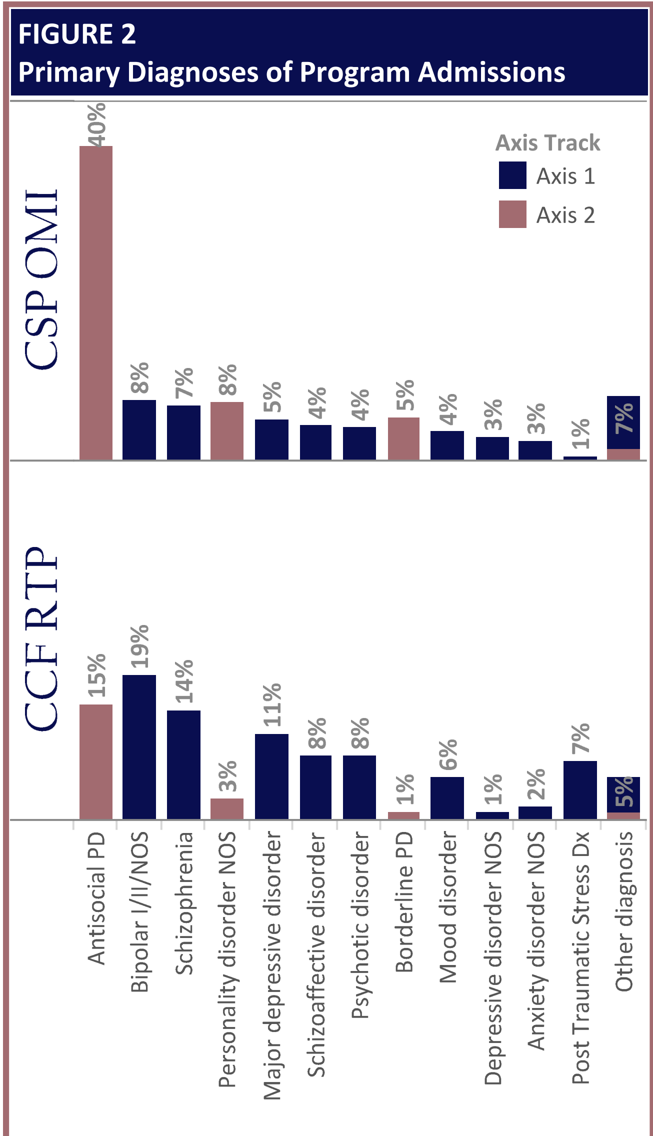


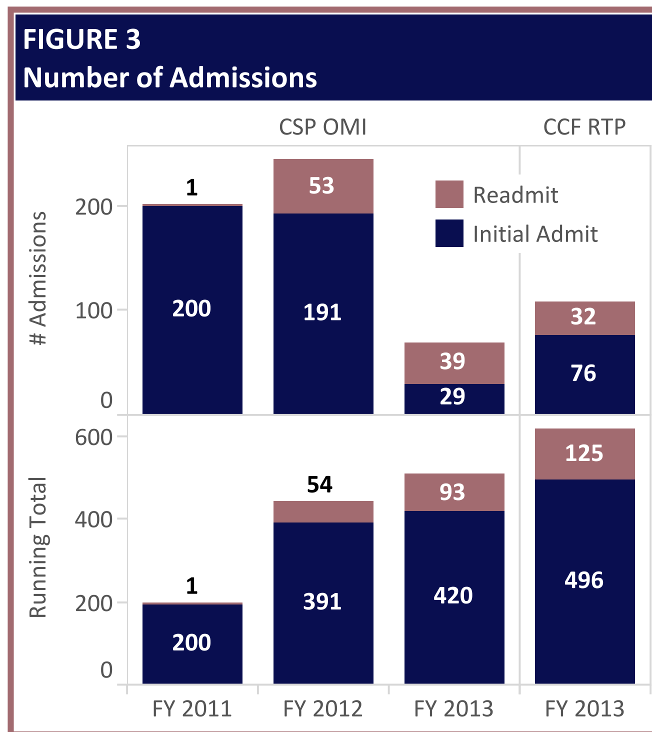
FIGURE 2
Primary Diagnoses of Program Admissions



segregation may result. Since the move to the CCF RTP, some inmates have been diverted to the program without first going to administrative segregation.

Total admissions, including new admissions and readmissions, have climbed steadily since the program began (see Figure 3). Offenders who unsuccessfully terminated may reenroll in the program at a later date. A total of 496 offenders have been admitted to the program since its inception, and another 125 admissions have been due to reenrollments. Previously, offenders who were unsuccessfully terminated from the CSP OMI program were moved to a different unit where they continued to receive standard mental health treatment. Under the CCF RTP, unsuccessfully terminated offenders returned to an administrative segregation facility where they received standard mental health treatment.

FIGURE 3
Number of Admissions



A total of 204 offenders were actively enrolled in the CCF RTP program on June 30, 2013. Figure 4 shows the average daily population of participants in the program across time. Figure 5 shows offenders' length of stay in the program for those enrolled on June 30, 2013, indicating a skewed distribution with half of participants having been in the program for less than 6 months and the other half participating in the program from 6 to 35 months (when the program first opened in CSP).

FIGURE 4
Average Daily Population

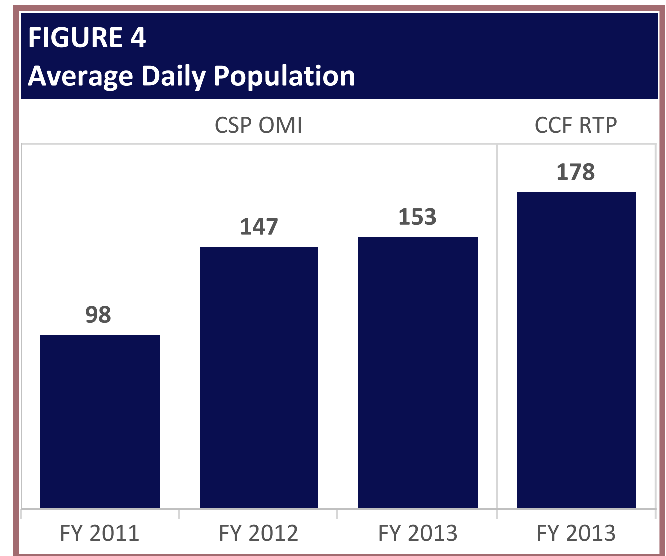
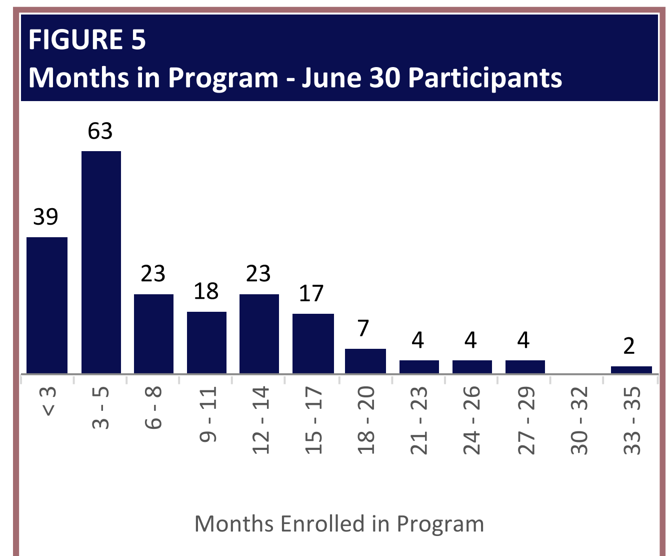


FIGURE 5
Months in Program - June 30 Participants



Program Terminations

Discharges from the program are classified into four types (please note that these categories are intended as broad descriptions of terminations reasons, although termination procedures have varied over time):

1) Successful progressions are defined as offenders who progress to a lower-custody facility or who release directly to the community and made satisfactory progress in treatment;
2) Releases are those who parole or discharge their sentences prior to satisfactory progress in the program;
3) Transfers represent offenders who are moved, primarily due to psychological instability, to San Carlos Correctional Facility RTP, the Colorado Territorial Correctional Facility infirmary, or the Colorado Mental Health Institute at Pueblo.
4) Unsuccessful terminations are offenders who return to regular administrative segregation due to dangerous, violent, or disruptive behavior or noncompliance with the program (but continue to receive mental health treatment, even though they are no longer in the program).

There were fewer program discharges in FY 2013 than in FY 2012, but this decrease was primarily due to a dramatic reduction in unsuccessful terminations (see Figure 6). This data demonstrates a change in the program's philosophy to work with offenders despite their noncompliance or resistance to therapy. This change has become even more pronounced with the program's move to CCF.

Length of stay increased among all discharge types except releases in FY 2013 compared to the previous year (see Figure 7). Under the CCF RTP, offenders spent nearly one year on average in the program prior to successful completion. Those who did unsuccessfully terminate under the new program structure did so after 10 months in the program, another indicator of the program's philosophical change.

FIGURE 6
Program Discharges

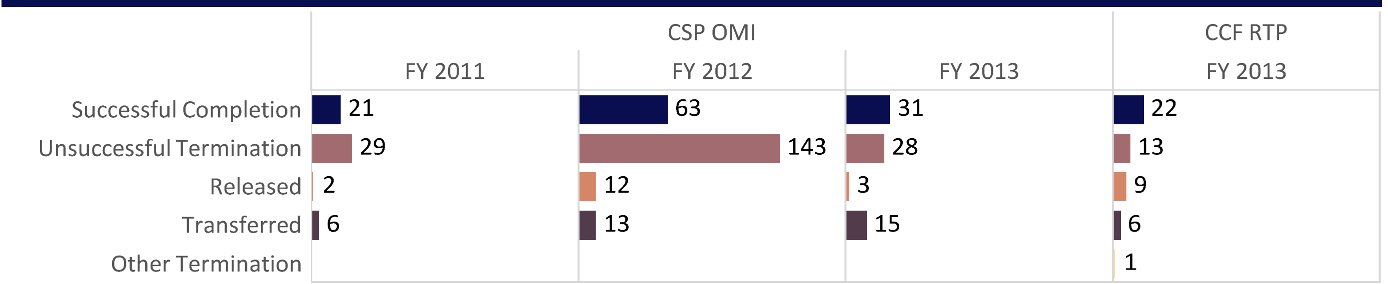
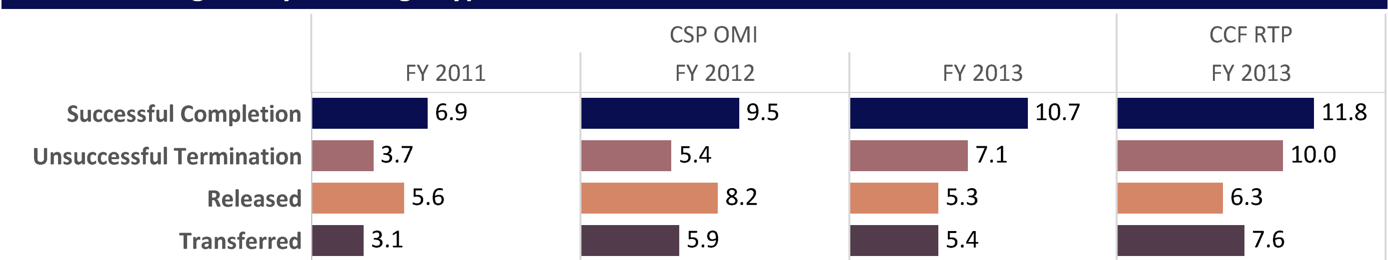


FIGURE 7
Months in Program by Discharge Type and Date



Incentive System

The program utilizes a structured incentive level system that rewards appropriate, cooperative behavior with increasing privileges. Over time, the level system has undergone various changes. Within the CCF RTP, however, the program has consistently employed an 8-level system in which offenders were progressed or regressed on an individual basis, taking into account their diagnosis, seriousness of rule infractions, and motivation to engage in treatment. Within each level, offenders have the opportunity to address personal concerns, criminogenic needs, or irrational belief systems in a therapeutic environment where individual attention is provided.

At Level 1, offenders experience the most restrictions, including the least amount of exercise, phone time, visits, and money for canteen purchases. Offenders generally start at Level 3 upon admission. As offenders progress through the levels, they receive increased opportunities for out-of-cell time and are able to participate in group activities and treatment programs, may access the gymnasium for recreational activities, and may participate in structured social activities. Offenders at the lower levels continue to receive individual treatment outside of their cells until they are stable enough to begin group treatment. Offenders at levels 2 – 4 who demonstrate reasonable self-control may participate in group activities while restrained at treatment tables. At levels 5 and above, offenders participate in group activities without restraints. Table 1 displays the eight levels with associated privileges in effect on June 30, 2013, and Figure 8 shows the program participants at each level.

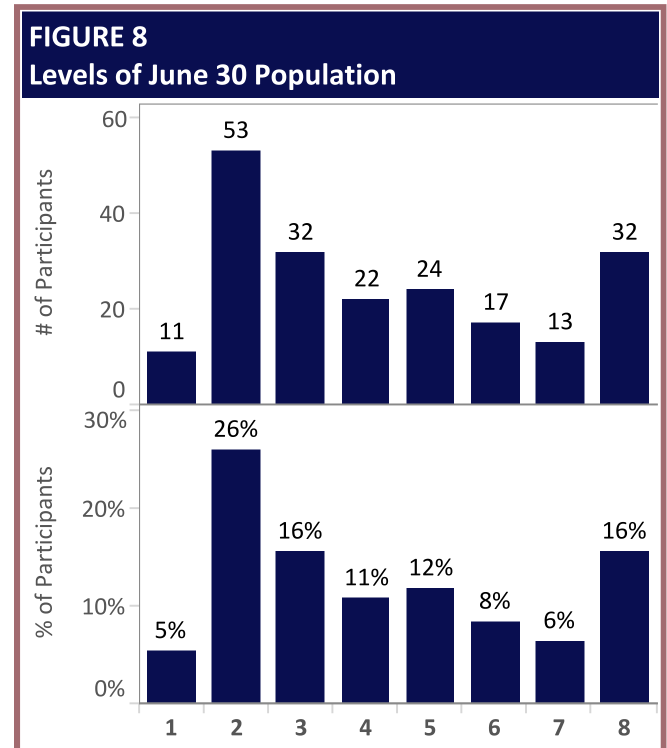


Table 1. Incentive Levels and Privileges, as of June 30, 2013

Privilege	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6	Level 7	Level 8
Yard	1hr/day 5 days/wk	1hr/day 5 days/wk	1hr/day 5 days/wk	1hr/day 5 days/wk	1hr/day 5 days/wk	1hr/day 5 days/wk	1hr/day 5 days/wk	1hr/day 5 days/wk
Shower	15 mins 5 days/wk	15 mins 5 days/wk	15 mins 5 days/wk	During dayhall	During dayhall	During dayhall	During dayhall	During dayhall
Dayhall	None	None	None	4 at a time 1 hr @ 5 days/wk	8 at a time 1 hr @ 5 days/wk	8 at a time 1.5 hr @ 5 days/wk	16 at a time 2 hrs @ 5 days/wk	16 at a time 3 hrs @ 5 days/wk
Phone Sessions	20-min call/mth x1	20-min call/mth x4	20-min call/mth x6	20-min call/mth x6	20-min call/mth x6	20-min call/mth x8	20-min call/mth x8	20-min call/mth unlimited
# Visits/Mth	1	2	4	4	4	6	4	8
Contact Visits	No	No	No	No	No	No	Yes	Yes
Canteen Amt	$10/wk*	$25/wk	$30/wk	$35/wk	$35/wk	$40/wk	$50/wk	$60/wk
TV	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Work	No	No	No	Yes	Yes	Yes	Yes	Yes
# in Grp/Rec Tx	None	Up to 8 restrained	Up to 8 restrained	Up to 8 restrained	Up to 8 unrestrained	Up to 8 unrestrained	Up to 16 unrestrained	Up to 16 unrestrained
Unrestr Moves	No	No	No	No	6 at a time	8 at a time	8 at a time	16 at a time
Group Yard	No	No	No	4 at a time	8 at a time	8 at a time	16 at a time	16 at a time
Gym	No	No	No	No	8 at a time	8 at a time	16 at a time	16 at a time

*Canteen purchases restricted to hygiene and stamps.

Treatment Planning

Each therapist and offender develop a treatment plan as a collaborative team within the first week after the offender enters the therapeutic program. The treatment plan is a structured and individualized living document that guides and evaluates offender treatment. It contains four essential parts that include 1) identification of issues or problems, 2) goals or objectives for treatment, 3) method of achieving these stated goals, and 4) estimated time frames. The purpose of the treatment plan is to hold the offender accountable for his behavior, provide a measure of progress, and guide the course of treatment. Because treatment plans are time sensitive, they are updated on a regular basis to ensure goals have been met, to redefine goals, and to develop new goals.

To manage offender treatment progress, measure overall functioning, and monitor response to treatment, psychological assessments such as the Brief Symptom Inventory (BSI) and the Brief Psychiatric Rating Scale (BPRS) as well as clinical assessments (e.g., mental status examinations and formal psychological testing) are integrated into the treatment plans.

In addition to developing a treatment plan, each offender works in collaboration with line staff and his therapist to identify target behaviors. Target behaviors are those that can effectively assist the offender in achieving successful daily living. Target behaviors enable line staff to provide input about whether the offender is achieving his goals. Target behaviors are discussed by line staff, the offender, and the therapist weekly to determine whether a behavior is increasing or decreasing, depending on the stated goal.

Therapeutic Interventions

Mental health treatment services utilize evidence-based treatments—those that have demonstrated effectiveness in published research—and focus on two overlapping treatment groups:

- **Primary Axis I Major Mental Illness.** Offenders in this group are primarily impacted by symptoms of major mental illness, such as depression, anxiety, and psychosis, and receive treatment services emphasizing illness self-management (medication adherence, cognitive skills, and wellness and recovery planning). The Illness Management and Recovery (IMR) program that is used was developed with support from the Robert Wood Johnson Foundation and the Substance Abuse and Mental Health Services Administration (SAMHSA) as a model for psychosocial treatment of serious mental illnesses (http://www.mentalhealth.samhsa.gov).
- **Primary Axis II Personality Disorders.** Offenders diagnosed with personality disorders participate in cognitive behavioral therapy groups that address offender risk, criminogenic needs, and responsivity. Topics may include anger management, social skills development, positive decision making, and Dialectical Behavior Therapy (DBT) skills. Offender-specific Behavior Management Plans, which specify incentives and consequences, are utilized to address particular behavior problems.

Note that many offenders meet diagnostic criteria in both areas and may move between treatment groups based on current symptom severity and behavior.

Following are descriptions of specific treatment groups offered for mentally ill offenders in the CCF RTP:

Anger Management: The Colorado Extended Anger Management Program is designed to address the offense-specific treatment of assaultiveness. Success depends predominantly on active participation and

the completion of homework assignments related to the offender's thinking and behavior. The intent of the material is to expose participants to the cognitive process and how it applies to anger management.

Anxiety Management: Designed as a nonspecific behavior therapy relevant for treating any condition in which anxiety is a core issue, anxiety management is aimed at free-floating anxieties with no identifiable triggers. Clients are taught to use anxiety responses constructively, as cues for initiating the coping response of relaxation, rather than letting their responses precipitate more anxiety in a vicious cycle.

Assertiveness: *The Assertiveness Learning Activities Workbook* is a tool used to help individuals develop communication skills that support recovery from chemical dependency or codependency. The guide outlines four basic communication styles (passive, aggressive, passive-aggressive, and assertive), gives tips for getting the most out of each group session, and provides exercises with sample answers.

Cognitive-Behavioral Core Curriculum: Founded on a cognitive-behavioral model, the core curriculum describes how people interpret external events and how distorted thinking may lead to poor choices and inappropriate behavior. The intent is to utilize a consistent model in all programs aimed at psychological rehabilitation of offenders, with a standard set of concepts, language, and intervention strategies. Detailed lesson plans have been developed for 7-8 sessions.

Cognitive-Behavioral Therapy: Cognitive therapists examine the thoughts and beliefs connected to our moods, behaviors, physical experiences, and events in our lives. A central idea in cognitive therapy is that our perception of an event or experience can have a powerful effect on our emotional, behavioral, and physiological responses to it.

Dialectical Behavior Therapy (DBT): The first stage of treatment focuses, in order, on decreasing life-threatening behaviors and behaviors that interfere with therapy, the quality of life-threatening behaviors, and increasing skills that will replace ineffective coping behaviors. The goal of Stage I DBT is for the client to move from behavioral dyscontrol to behavioral control. In Stage II, the goal is to help the client move from a state of quiet desperation to one of full emotional experiencing. Stage III focuses on problems in living and aims toward a life of ordinary happiness and unhappiness. Stage IV is specifically for those clients seeking a further goal of spiritual fulfillment or a sense of connectedness to a greater whole. In this stage, the goal of treatment is for the client to move from a sense of incompleteness toward a life that involves an ongoing capacity for experiences of joy and freedom.

Drug and Alcohol: Alcohol and drug counselors work with offenders cell side and in groups, with a particular focus on relapse prevention. Offenders are encouraged to examine the complete picture of their addiction, including family, friends, work, criminal history, and beliefs and values. The program reviews triggers, warning signs, core beliefs, consequences, and personal plans with written homework assignments and discussions.

Foundation Thinking Errors: This curriculum reviews each of the foundation thinking errors in detail, discussing the implications these errors have on the offender's life. The offender will learn how almost all the daily decisions we make are processed through filters consisting of these foundation errors. Assigned homework helps offenders identify how each of these errors applies in their daily lives.

Illness Management and Recovery (IMR): The IMR program guides practitioners in developing illness-management and recovery mental health programs that emphasize personal goal-setting and actionable strategies. Recommendations included in a 10-booklet kit available through SAMHSA are grounded in evidence-based practices.

Mind Over Mood: Mind Over Mood teaches cognitive methods shown to be helpful with mood problems

such as depression, anxiety, anger, panic, jealousy, guilt, and shame. The strategies used can also help offenders solve relationship problems, handle stress better, improve self-esteem, and become less fearful and more confident. Offenders learn to identify thoughts, moods, behaviors, and physical reactions to small situations as well as major life events. There are 12 sections in this curriculum.

Program Rules, Norms, and Policies: At the beginning of a new group, the group leader will use the first few sessions for introductions and discussions of such topics as the purpose of the group, what to expect, fears, ground rules, program rules, comfort levels, and the content of the group. All groups have rules about attendance, cooperation, sensitivity to others, one person talking at a time, keeping shared personal disclosures confidential, positive communication, and no profanity. Program rules also stipulate that offenders must be dressed in all greens, keep hands on the table, remain sitting, refrain from pulling on restraints, and avoid horseplay.

Schema Therapy: Developed to treat personality disorders and Axis I disorders, schema therapy is an integrative approach combining techniques from several different therapies, including cognitive-behavioral therapy, psychoanalytic object relations, attachment theory, and Gestalt therapy. The goal is to help clients meet their core emotional needs by avoiding maladaptive coping styles and modes (mind states) that block feelings and healing unhealthy schemas or life patterns to a achieve a lasting state of well-being.

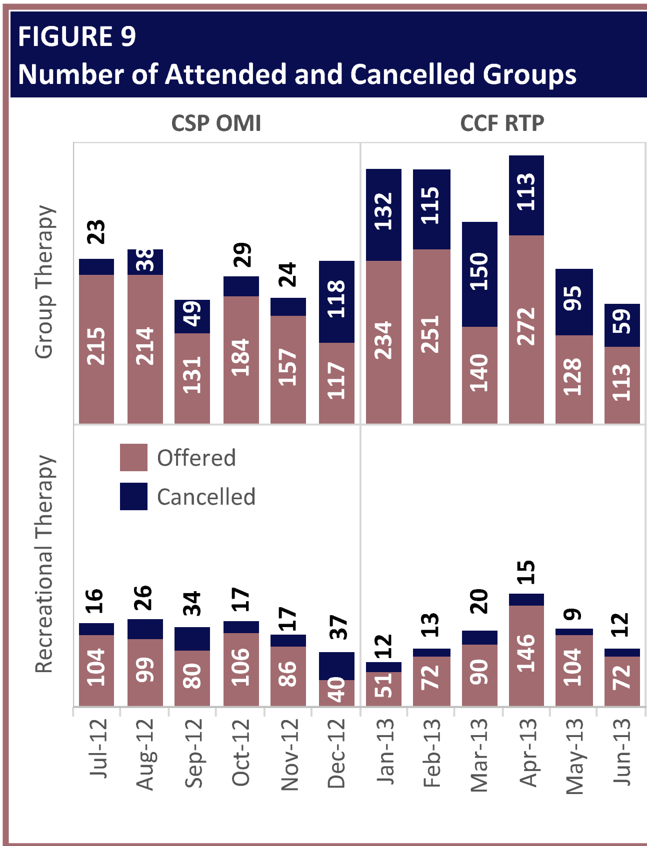
Strategies for Self-Improvement and Change (SSC): SSC is a cognitive-behavioral program designed specifically for substance-abusing offenders, offered in three phases. Groups may also include substance abuse education and relapse prevention.

Wellness Recovery Action Plan (WRAP): The WRAP plan is designed to provide a concrete, written reminder to an individual and his/her support systems regarding signs and symptoms of mental illness, effective approaches to maintaining health and stability, useful interventions, and treatments. Sharing in a group format allows individuals to benefit from the insight and experiences of others, so they can enhance their own WRAP.

Figure 9 shows the number of group and recreational therapy sessions scheduled, broken down by those that were cancelled and those that were offered to inmates. This data only includes group therapy and recreational therapy sessions where a clinician was present; other out-of-cell activities such as showers, gym, and visits are not analyzed in this report. Furthermore, individual therapy sessions are not shown here because they are more easily rescheduled if there is a conflict than are group sessions. Groups were cancelled due to staff shortages (34%), facility or unit lockdowns (33%), preparations for the move to CCF RTP (12%), maintenance or equipment issues (3%), or other reasons such as meals served late (1%); no reason was provided for 17% of cancellations.

Figure 10 shows a breakdown of therapeutic sessions offered to individual inmates each month by whether they attended, refused, or were unavailable. Group and recreational therapy sessions generally have multiple inmates scheduled, so some may refuse while others attend. A “round robin” process is used to fill vacant seats when an inmate refuses or is unavailable to participate, whereby other inmates in the program are asked if they would like to join a group. Every inmate who is scheduled to attend group or volunteers during the round robin process is tracked.

Inmates attending groups comprised the largest category during FY 2013. However, on average, participants refused 27% of group therapy sessions, 28% of recreational therapy sessions, and 9% of individual therapy sessions. In addition, inmates may be unavailable for treatment (e.g., on mental health hold, off grounds), which was the case for 4% of group therapy sessions, 2% of recreational therapy sessions,



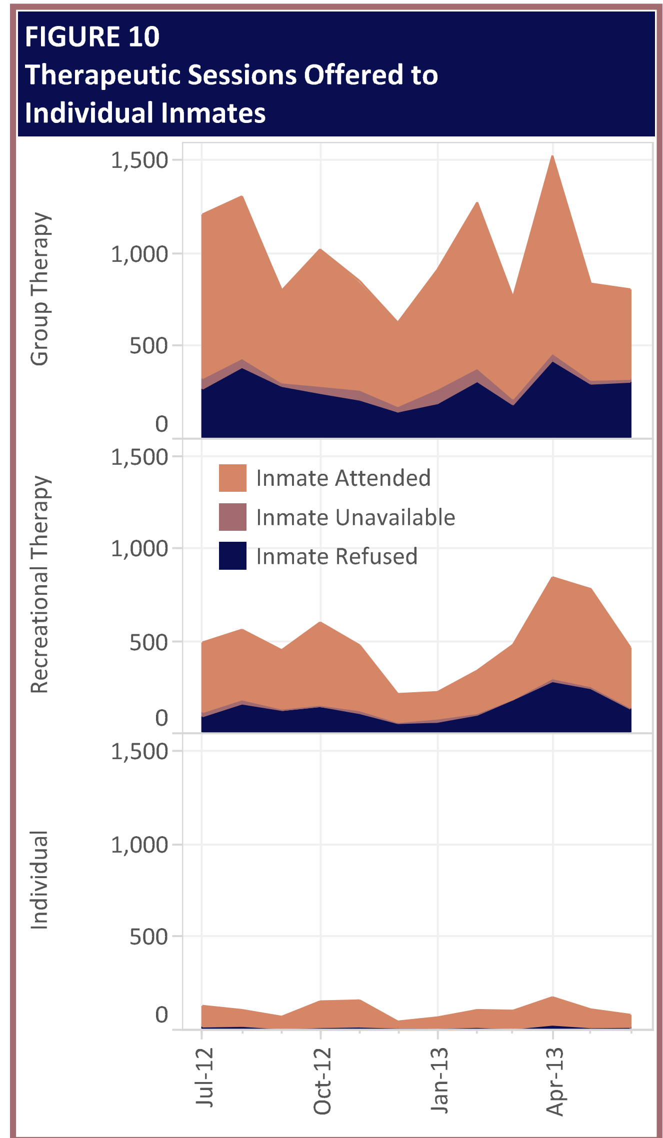


Figure note. This graph shows each time an inmate was offered to attend a therapeutic session. For example, a group offered to three inmates would show as three sessions. If one refused and another inmate volunteered to take his place, a total of four sessions would be shown.

and 1% of individual therapy sessions. On average, group therapy sessions were 78 minutes in duration, recreational therapy 64 minutes, and individual therapy 43 minutes.

New Reforms

In order to provide successful treatment opportunities for offenders with mental illness, RTP program staff continues to evaluate the effectiveness of program curricula. In FY 14, program delivery was restructured. Therapeutic group content is now driven by offender level. This provides clear expectations for participants as they progress through the program levels; furthermore, this ensures all offenders are receiving the same basic treatment based on their progression and current mental health functioning. In addition to standard program treatment, each offender will continue to receive individualized treatment and goal setting based on his specific needs.

In addition to the restructuring of program delivery, program staff continues to work to develop a therapeutic model that is most helpful to those offenders that continue to struggle with the most severe mental illnesses and self-injurious behavior. Currently, alternative forms of therapy (i.e., music and animal assisted) are being evaluated for their therapeutic efficacy. Music therapy and animal assisted therapies may provide participants with additional avenues for outlet and communication as well as increase motivation to engage in treatment and provide emotional support.

The CCF RTP program is working to create several distinct units to address individual treatment needs across a continuum of care. Following are two units new to the program in FY 2014.

Diagnostic Unit. Non-mentally ill offenders from state and private facilities who pose a significant threat to the public, staff, or other offenders due to their disruptive, violent, or dangerous behavior will be placed at Colorado State Penitentiary. For offenders diagnosed with a major mental illness who meet criteria for an administrative segregation review will be housed in a special RTP Diagnostic Unit. This RTP Diagnostic Unit will serve to determine the appropriateness for placement into the Residential Treatment Program or other facility placement. Upon arrival at the RTP Diagnostic Unit, each offender will be assessed to determine appropriateness for the program. This assessment will entail psychiatric provider evaluation, battery of psychological assessments and staff observation. Once all data have been compiled and the evaluation process is complete, recommendations regarding placement will be made. Offenders who do not meet criteria for placement in the Residential Treatment Program will be staffed with Offender Services for appropriate facility assignment.

Self-Injurious Behavioral Unit. To reduce incidence of serious self-harming behaviors within DOC facilities, a self-injurious behavioral unit is being developed to provide specialized assessment and treatment to offenders who engage in serious or repetitive self-injurious behaviors. The goal is to increase stability and decrease costly and damaging repeat episodes. To date, specific cells have been modified to significantly decrease the risk of self-injury, a training curriculum has been developed, staff member has been hired and an animal assisted program plan is currently being developed.