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, 2015, IN RESPONSE TO

DEPARTMENT OF CORRECTIONS FY 2014-15 RFI #1

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Offenders with Mental Health Needs

This report is submitted in response to the Joint Budget Committee's fiscal year (FY) 2014-15 Request for Information #1 to the Department of Corrections. The request is stated as:

> The Department is requested to submit a report to the House Judiciary Committee, the Senate Judiciary Committee, and the Joint Budget Committee by January 31, 2015, detailing the progress related to the mental health unit at Centennial Correctional Facility.

The current report and data describe the Centennial Correctional Facility (CCF) Residential Treatment Program (RTP) and its activities through FY 2014.

A program was established at Centennial Correctional Facility (CCF) in 2007 for offenders with mental health needs who could be transitioned out of administrative segregation; this small program was created using existing resources. 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 CCF as a residential treatment program, known as the CCF RTP. This transition occurred in response to SB 11-176 and from on-going efforts to reduce the number of offenders with mental health needs in administrative segregation recognizing that this type of environment is not conducive to mental health treatment. Moreover, 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 needs who would otherwise be placed in restrictive housing maximum security status, formerly administrative segregation, 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 opportunities. 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 in conjunction with the P code is used to designate inmates with serious mental disorders. Placement into the CCF RTP is given to those with the highest mental health treatment needs among the referral pool of male offenders with a P code of 3-5 and/or offenders with impaired functionality whose behavior is such that they would otherwise be at risk for placement into restrictive housing maximum security status.

Clinicians in the CCF RTP diagnostic unit will evaluate offenders for serious mental health needs and/or impaired functionality to determine whether or not they meet criteria for placement into the RTP. A thorough assessment utilizing a psychiatric provider evaluation, a psychological assessment, and staff observation are compiled in order to recommend the best plan of treatment or referral for treatment for each offender referred to the RTP

diagnostic unit. Mental health clinicians review offenders with mental health disorders 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. After the evaluation, clinicians determine whether placement into the RTP or other facility placement is most appropriate. Offenders who do not meet criteria for placement in the RTP are staffed with offender services for appropriate facility assignment. The evaluating psychologist includes treatment approaches that may be effective with the individual offender to increase and enhance the continuity of care between the diagnostic unit and the receiving general population facility.

The remaining offenders are then 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 health needs, or they may be paranoid and distrustful of treatment providers.

Offenders in the program have been diagnosed with primary serious mental disorder and primary personality disorder. Offenders will often meet criteria for both mental and personality disorders. When symptoms of serious mental health disorders are alleviated due to medication, treatment, or lowered stress, personality disorder symptoms may become the primary concern. In such instances, treatment services focus on two overlapping groups: Primary Serious Mental Disorders and Primary Personality Disorders (see section on Therapeutic Interventions).

Figure 1 shows program admissions by mental disorder 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 2014). Antisocial personality disorder was the most common primary diagnosis of offenders admitted to the CSP OMI program while bipolar disorders are the most common diagnosis for offenders admitted to CCF RTP indicating a change in program philosophy and prioritization of placement.

Figure 1. Admissions by mental disorder.

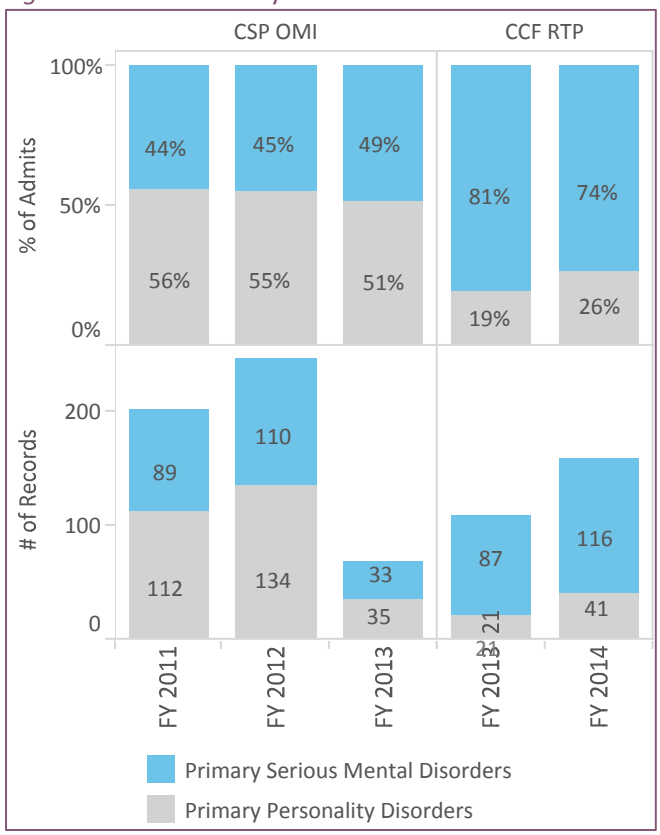
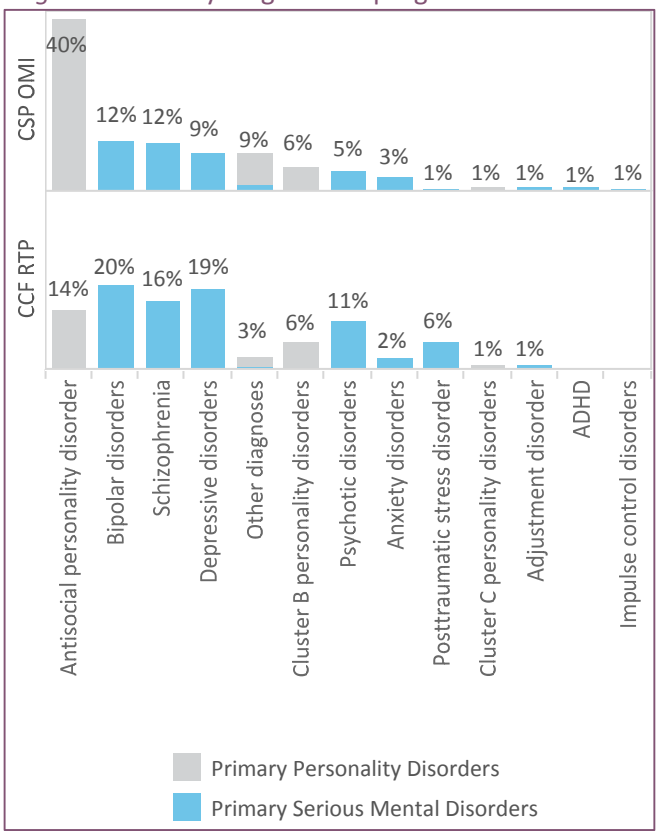


Figure 2. Primary diagnosis of program admits.



Program Enrollments

Originally, the program was designed to help offenders with symptoms of mental health disorders progress out of an administrative segregation environment to a less restrictive environment. Offenders now have the opportunity to engage in intensive treatment before their behavior escalates to the point where restrictive housing maximum security status, formerly administrative segregation, would be necessary. In FY 2014, offenders spent an average of 11 months in administrative segregation prior to program admission. As a comparison, in FY 2013, program participants spent an average of 27 months in administrative segregation prior to placement. The decrease in time spent in administrative segregation prior to admission reflects the Department's goal of transferring offenders with symptoms of mental health disorders and impaired functionality who are displaying dangerous behavior to the CCF RTP rather than to administrative segregation. At the end of FY 2014, as a result of internal policy changes and in response to SB 11-176 and SB 14-064, which prohibits DOC from placing inmates diagnosed with a serious mental health disorder in administrative segregation or maximum security status, offenders with serious mental health disorders were no longer being placed in the maximum security status environment. As fewer admissions enter the CCF RTP from the restrictive housing environment, the Department expects this number to trend toward zero, over time.

Total admissions, including new admissions and readmissions, have climbed steadily since the program began (see Figure 3). For several reasons, some offenders who were terminated from the program were later reenrolled at a later date. A total of 628 offenders have been admitted to the program since its inception, and another 150 admissions have been due to reenrollments. 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 the last day of the reporting period, June 30, 2014. Half of the participants have been in the program for fewer than 12 months and the other half participating in the program from 12 to 45 months (when the program first opened at CSP).

Figure 3. Number of admissions.

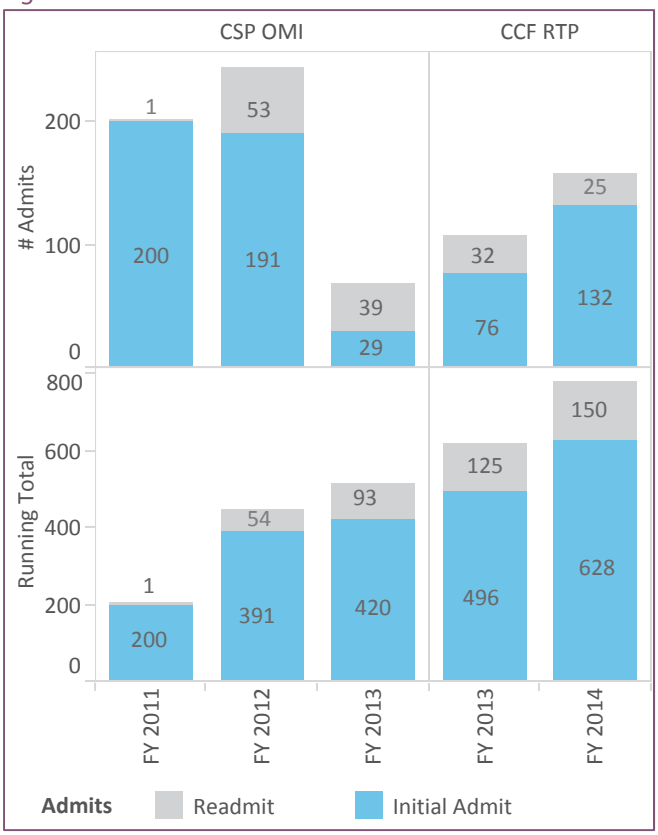


Figure 4. Average daily population.

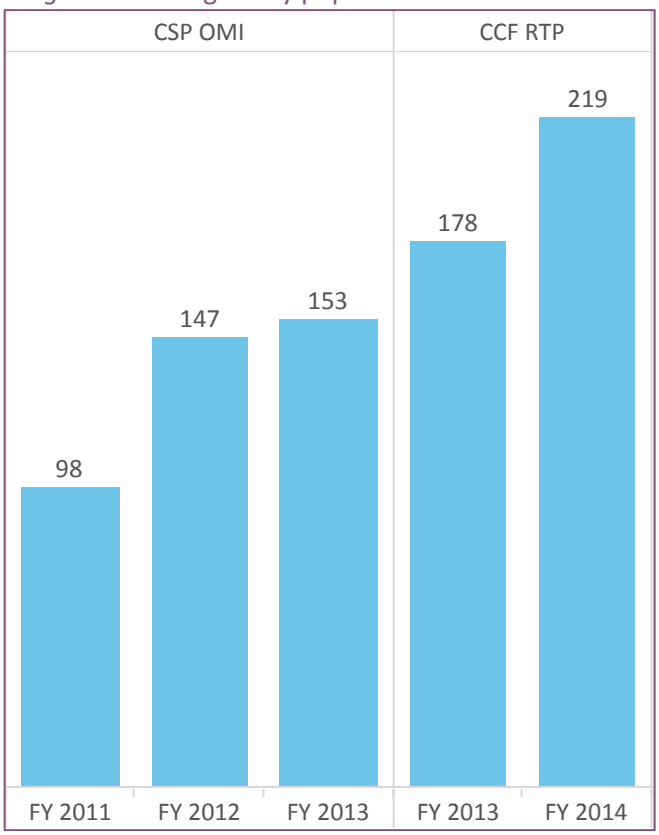
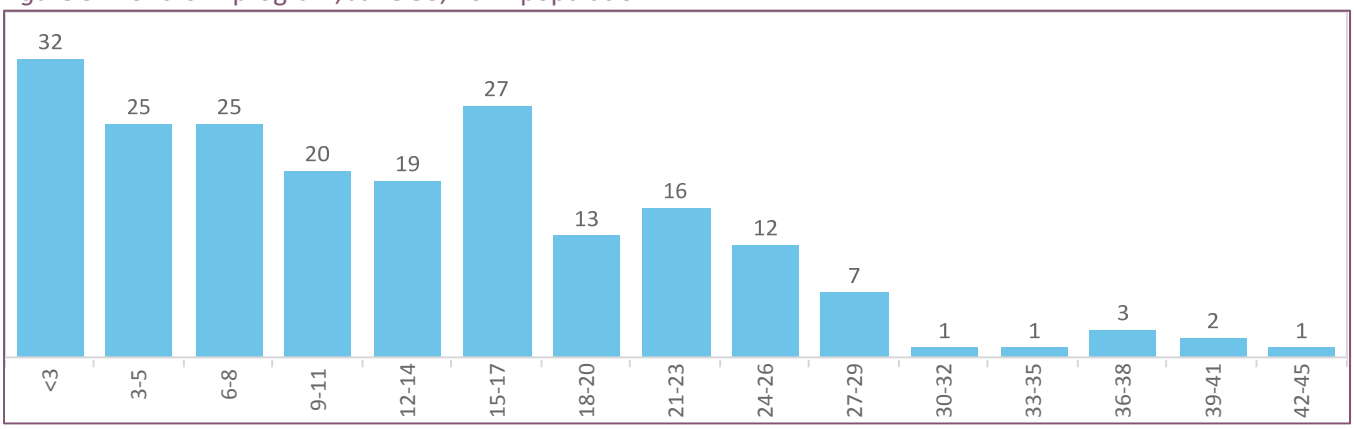


*Figure 5.*Months in program, June 30, 2014 population.



Program Terminations

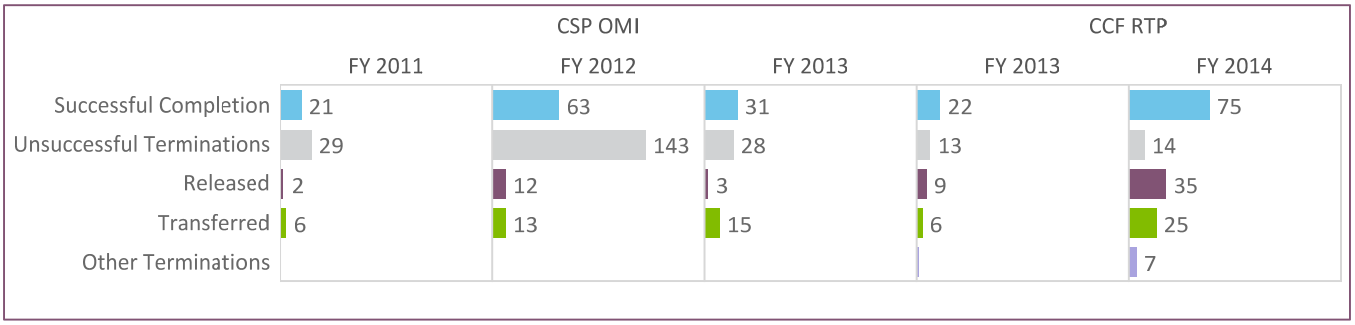
Discharges from the program are classified into four types (please note that these categories are intended as broad descriptions of terminations reasons, although termination procedures have varied over time):

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 successful completion of 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) Historically, unsuccessful terminations were offenders who were returned to regular administrative segregation due to dangerous, violent, or disruptive behavior or noncompliance with the program (but continued to receive mental health treatment, even though they were no longer in the program). As a result of policy changes and in response to SB 14-064, as of June 2014, unsuccessful terminations are inmates who no longer meet the criteria for admission into the CCF RTP; who are not benefiting from placement in the program; and who, through their dangerous and disruptive behavior, are a danger to other offenders participating in the program. These offenders are placed into close custody management control units or close custody transitional units where they receive programming appropriate for their needs.

There were fewer program discharges in FY 2013 and FY 2014 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.

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. Until recently, under the CCF RTP, unsuccessfully terminated offenders returned to an administrative segregation facility where they received standard mental health treatment.

Figure 6. Program discharges.



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. Figure 7 shows the program participants at each level, and Table 1, on the following page, displays the eight levels with associated privileges as of June 30, 2014. According to CDOC Administrative Regulation 650-04 section IV.A.3, "residential treatment programs will offer offenders at all levels a minimum of ten out-of-cell therapeutic contact hours per week, and a minimum of ten out-of-cell non- therapeutic contact hours per week."

Figure 7. Levels of June 30, 2014 population.

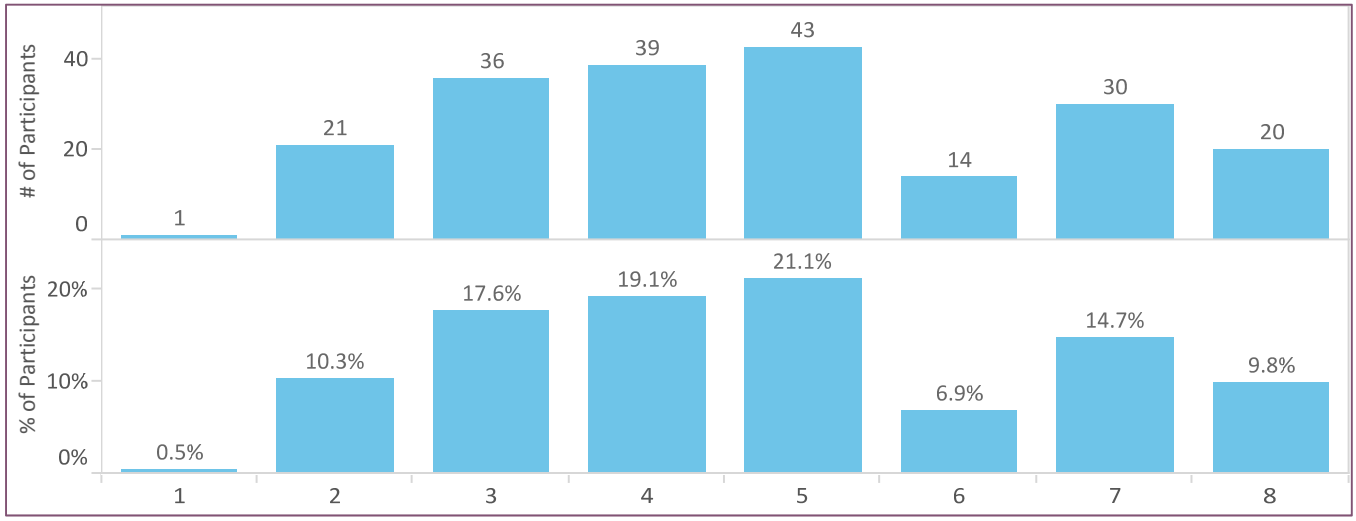


Table 1. Incentive levels and privileges, as of June 30, 2014.

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	8 at a time 2 hr @ 2 days/wk	8 at a time 2 hr @ 2 days/wk	8 at a time 2 hr @ 2 days/wk	8 at a time 1 hr @ 5 days/wk	8 at a time 1.5 hr @ 7 days/wk	8 at a time 2 hr @ days/wk	16 at a time unlimited @ 7 days/wk	16 at a time unlimited @ 7 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	4	6	8
Contact Visits	No	No	No	No	Yes	Yes	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	Up to 8 restrained	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	8 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 develops 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, a psychological assessment (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.

Additionally, behavioral treatment plans can be developed and implemented through a multi-disciplinary team process where clinical staff work with security and housing teams to structure the programing for an individual offender who may be struggling with managing symptoms of mental health needs or high risk behavior choices. The implementation of a behavior treatment plan is time limited with specific interventions and monitoring during a period in hopes of reducing distress experienced by the individual so he can continue to engage in meaningful treatment.

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 Major Mental Health Disorder.** Offenders in this group are primarily impacted by symptoms of major mental health disorder, 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 health disorders (http://www.mentalhealth.samhsa.gov).
- **Primary 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 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 serious mental 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 health needs, 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 8 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.

Figure 8. Number of offered and cancelled groups for FY 2014.

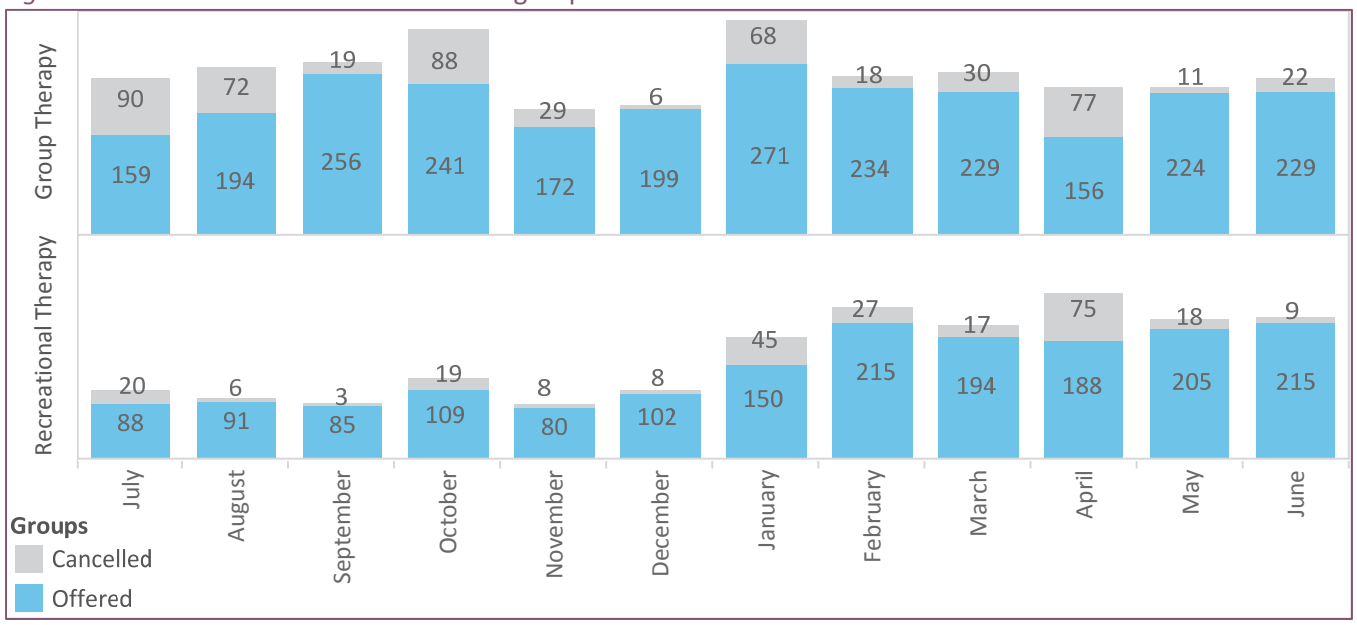


Figure 9 shows a breakdown of therapeutic sessions offered to individual inmates each month by whether they attended, refused, or were unavailable. Group and recreational therapy sessions generally have multiple inmates scheduled, some may refuse while others attend. A "round robin" process is used to 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.

Figure 9. Therapeutic sessions offered to individual inmates in FY 2014.

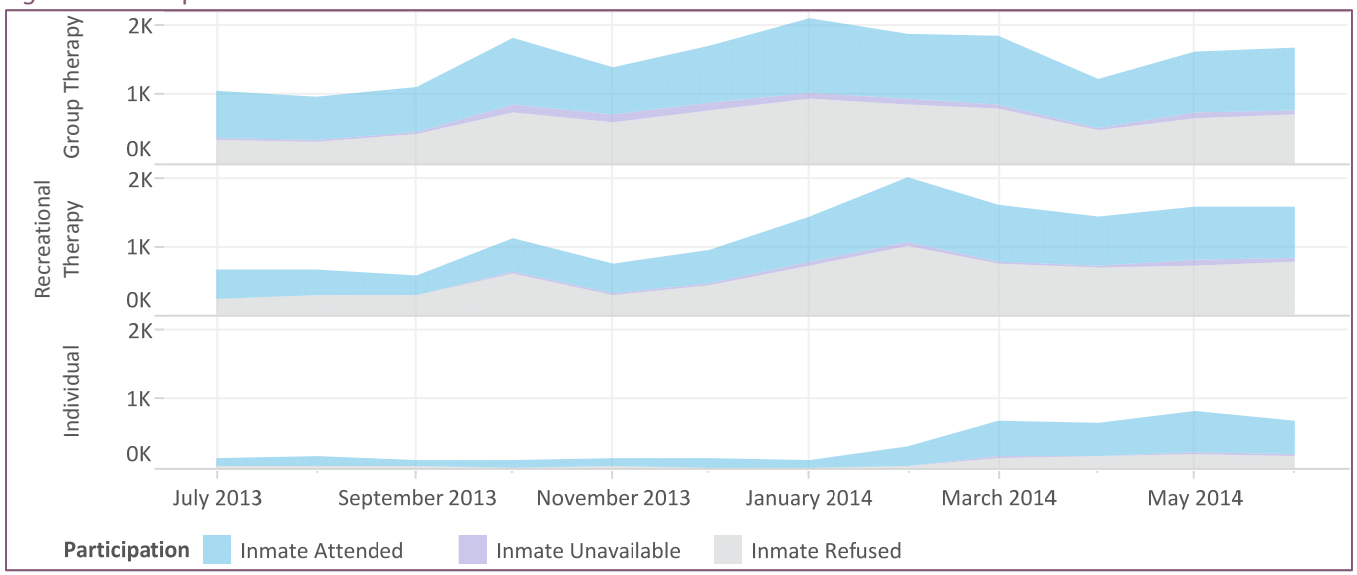


Figure note. This graph shows each time an inmate was offered to attend a therapeutic session. For example, a group offered to three inmates would show as three sessions. If one refused and another inmate volunteered to take his place, a total of four sessions would be shown.

Inmates attending groups comprised the largest category during FY 2014. However, on average, participants refused 41% of group therapy sessions, 47% of recreational therapy sessions, and 20% 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, 3% of recreational therapy sessions, and 2% of individual therapy sessions.

New Reforms

In order to provide successful treatment opportunities for offenders with mental health needs, 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.

Self-Injurious Behavior. Therapeutic interventions have been targeted toward offenders who engage in serious or repetitive self-injurious behaviors. The goal is to increase stability and decrease costly and damaging repeat episodes of self-injurious behavior. To date, all CCF RTP cells have been modified to significantly decrease the risk of self-injury and a training curriculum has been developed for staff. In addition, animal-assisted therapy utilizing dogs from the Colorado Correctional Industries Prison-Trained K9 Companion Program provides opportunities for offenders to engage with rescued dogs. During offenders' interactions with the dogs, they are encouraged to identify emotional shifts experienced, thereby increasing their self-awareness. Introduction of concepts of dialectical behavior therapy specifically emotional regulation, distress tolerance, mindfulness, and interpersonal effectiveness skills during this process provides alternative coping strategies in hopes of replacing the self-injurious behavior choices.