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, 2016, IN RESPONSE TO

DEPARTMENT OF CORRECTIONS FY 2015-16 RFI #1

PREPARED BY

OFFICE OF PLANNING AND ANALYSIS

TABLE OF CONTENTS

INTRODUCTION

This report is submitted in response to the Joint Budget Committee's fiscal year (FY) 2015-16 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, 2016, 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 2015.

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 to their individual and changing custody needs, while enabling treatment to be the primary focus. Also, consolidation of the CCF OMI and CSP OMI programs into the CCF RTP enabled more consistent, uniform care for program participants. 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 offenders diagnosed with a serious mental health disorder in Administrative Segregation or Restrictive Housing-Maximum Security status (RH-Max), offenders with serious mental health disorders were no longer being placed in the RH-Max environment. This trend continued into FY 15 with no offenders with serious mental illness being placed in RH-Max.

The program's goal is to provide evidence-based treatment services to offenders with mental health needs who would otherwise be placed in RH-Max in order to improve their ability to function effectively, to decrease 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 pro-social behavior.

TARGET POPULATION

CDOC uses a coding process to identify and track offenders who have mental health treatment needs. Placement into the CCF RTP is given to those with the highest mental health treatment needs among the referral pool of male offenders.

Clinicians in the CCF RTP diagnostic unit evaluate offenders for serious mental health needs and/or impaired functionality. The assessment process utilizes a psychiatric provider evaluation, a battery of psychological assessments, and staff observations to recommend appropriate treatment interventions. Referred offenders are staffed weekly during the residential treatment program conference call to exchange information on the offender's mental health status, treatment plan compliance, psychiatric stability, medication compliance, and institutional behavior. Referred offenders whom have mobility issues that qualify under the American Disabilities Act (ADA) are referred to the RTP at San Carlos Correctional Facility (SCCF). Upon completion of the diagnostic evaluation, offenders who are recommended for residential treatment are assigned a treatment level. Offenders who do not meet criteria for placement in RTP are staffed with offender services and facility mental health supervisors for appropriate housing 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.

Some offenders placed in the RTP may lack awareness and struggle to recognize mental health problems, may deny problems because of perceived stigma or vulnerability associated with mental health needs, or may be paranoid and distrustful of treatment providers.

Offenders in the program will often meet criteria for both serious mental illness and significant personality disorders that affect activities of daily living. When symptoms of serious mental health disorders are alleviated due to treatment, personality disorder symptoms may become the primary concern; therefore treatment services focus on two overlapping needs (see section on Therapeutic Interventions).

Figure 1 shows program admissions by mental health 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 (August 2010 – December 2012) and CCF RTP (January 2013 – June 2015). Antisocial personality disorder was the most common primary diagnosis of offenders admitted to CSP OMI program while major mental illness (e.g., psychotic disorders, schizophrenia, bipolar, and major depressive disorders) is the most common diagnosis for offenders admitted to CCF RTP.

Figure 1: Admissions by mental disorder

Figure 2: Primary diagnosis of admits

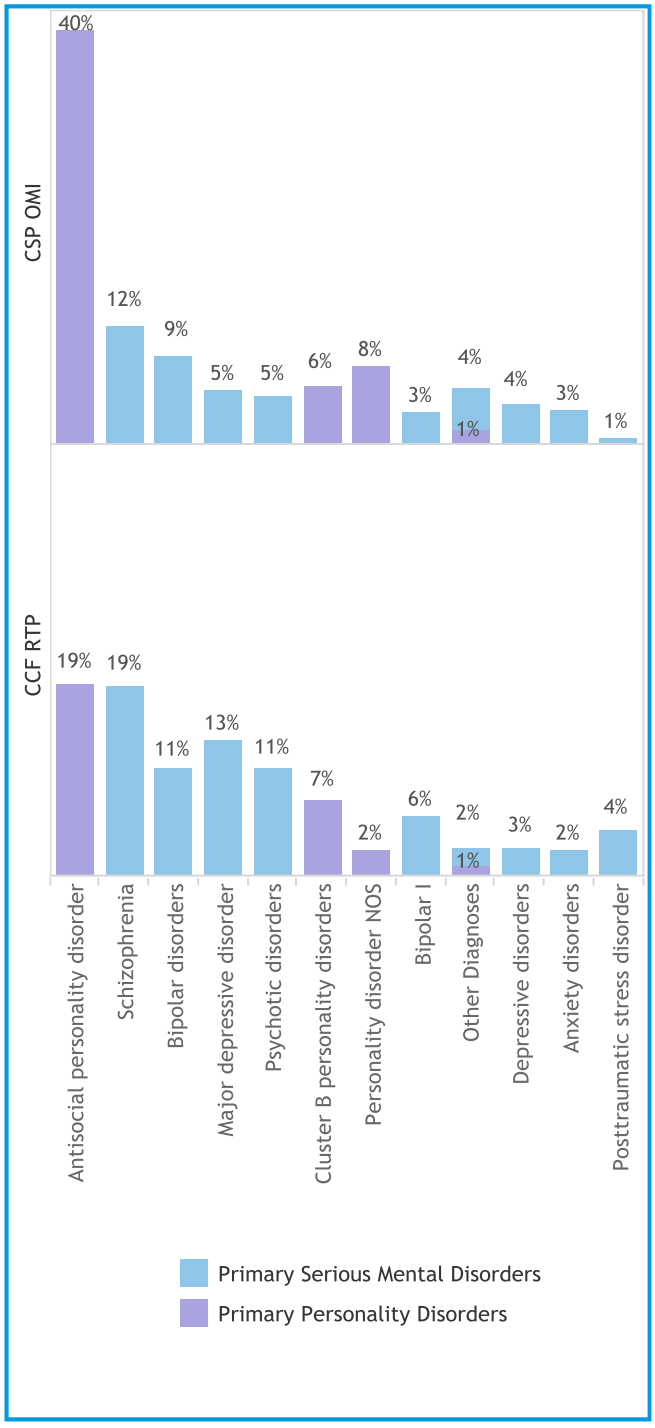


Figure Note: "Other Diagnoses" include less than 1% of the population including ADHD, impulse control adjustment disorders, cluster C personality disorders, and cognitive disorders.

PROGRAM ENROLLMENTS

Historically, the focus of CDOC was transitioning offenders with serious mental illness from administrative segregation environments into an RTP. Since reforms for administrative segregation took place June 2014, CDOC has been successful at keeping mentally ill offenders from administrative segregation environments with the inception of the RTP Diagnostic Unit. During FY 2015 no offenders with serious mental illness were placed in RH Max. The RTP Diagnostic Unit conducts diagnostic clarification, assessments for treatment needs and makes recommendations for appropriate facility and or program assignments.

RTP continues to have offenders who have previously served time in administrative segregation prior to the reforms. Time spent in administrative segregation/RH Max prior to RTP admission has decreased in past years. Offenders enrolled in RTP during FY 2015 spent an average of 25 days in administrative segregation/RH Max over the course of their entire incarceration; in comparison to FY 2014 offenders who spent an average of 11 months prior to admission to RTP. With the increased awareness of the potential effects of RH Max, clinical staff conducts assessments in order to respond to emerging treatment needs that can occur.

For FY 2015, re-admissions climbed compared to last fiscal year (see **Figure 3**). However, new admissions declined marginally decreasing the total admissions for the fiscal year. This change is influenced by several factors including improvements to the vetting process to ensure offenders with the highest mental health treatment needs are being accepted into the program. Additionally, continued support from staff ensured the offenders received increased individualized focus and time needed to work on their treatment goals. Some offenders who were terminated from the program were re-enrolled at a later date. A total of 739 offenders have been admitted to the program since its inception, while another 181 admissions have been due to re-enrollments. **Figure 4** shows the average daily population of participants in the program. **Figure 5** shows offender's length of stay in the program for those enrolled on June 30, 2015. Under half (49%) of the individuals participated in the program for less than 12 months, whereas the remaining (51%) participated in the program for 12 - 45 months.

Figure 3: Number of admissions.

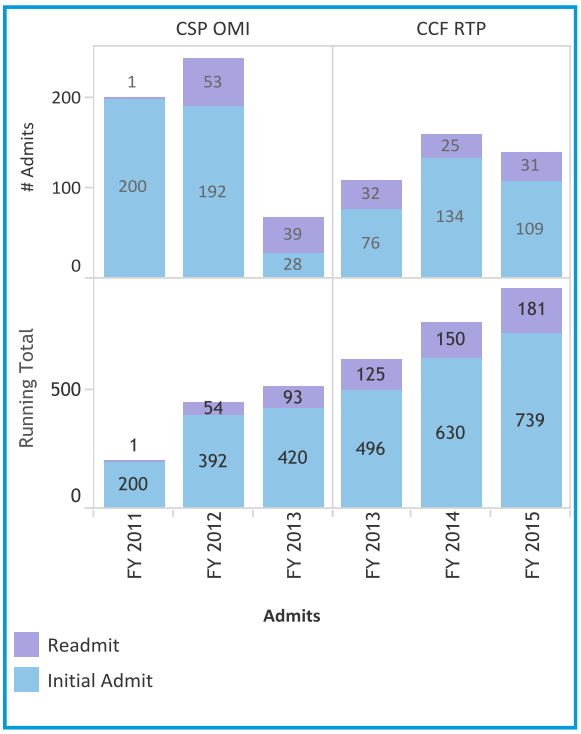


Figure 4: Average daily population

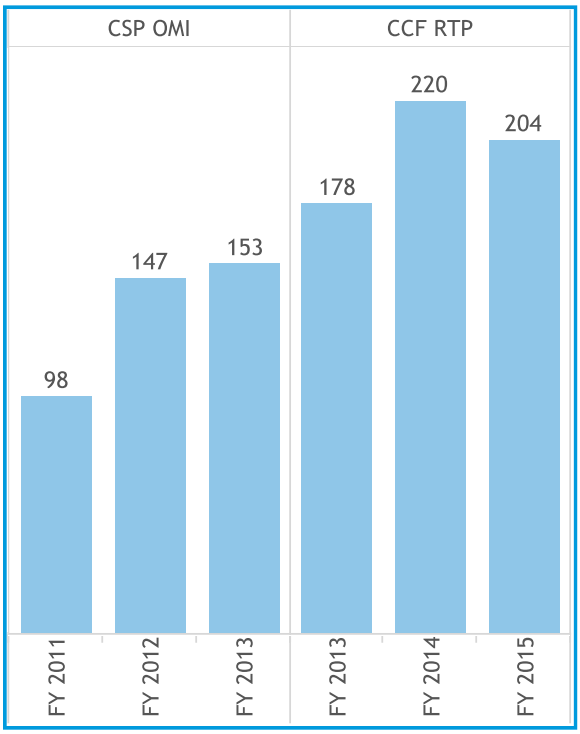
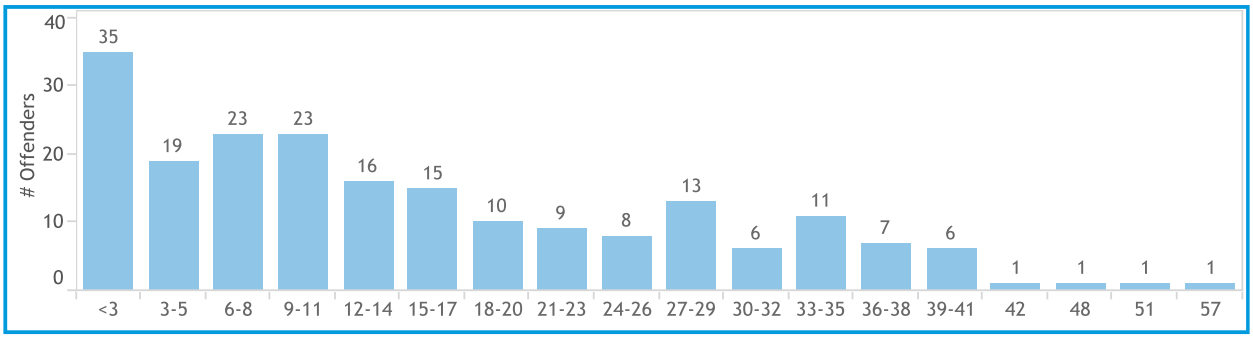


Figure 5: Months in program on June 30, 2015



PROGRAM DISCHARGES

Discharges from the program fall into five categories (please note that these categories are intended as broad descriptions of termination reasons):

1. Successful Completions: Offenders who made satisfactory progress in treatment and were transferred to a lower-custody facility or were released to a Community Corrections facility
2. Released: Offenders who paroled or discharged prior to successful completion of the program.
3. Transferred: Offenders who are moved to San Carlos Correctional Facility RTP, the Colorado Territorial Correctional Facility infirmary, or the Colorado Mental Health Institute at Pueblo.
4. Unsuccessful Terminations: Offenders that no longer meet the criteria for admission into CCF RTP; who are not benefiting from placement in the program; and who, through dangerous and disruptive behavior, are a danger to other offenders participating in the program. These offenders are placed into Close Custody Management Control Units (MCUs) or Close Custody Transitional Units (CCTUs) where they receive programming appropriate for their needs.
5. Other Terminations: Offenders who are deceased, or were transferred to MCU or CCTU.

As **Figure 6** demonstrates, the discharges from FY 2015 have remained relatively consistent with that of FY 2014. In accordance with the program's philosophy, staff members are encouraged to work with offenders despite their noncompliance or resistance to therapy. **Figure 7** denotes the average length of stay for those that were unsuccessfully discharged from the program.

Figure 6: Program discharges

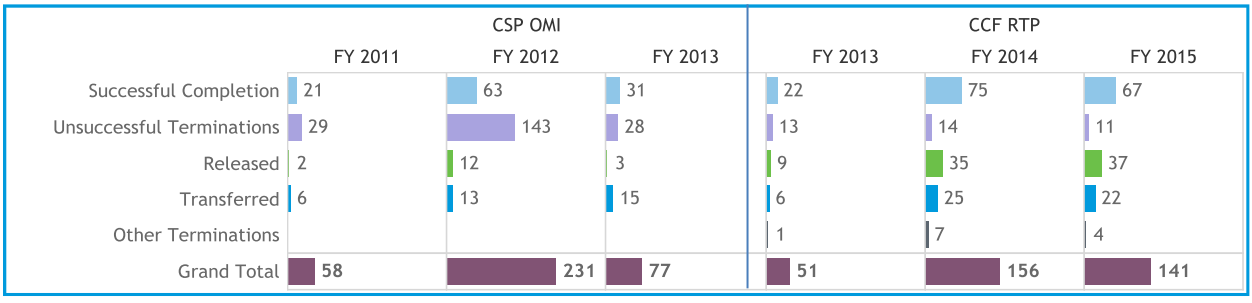
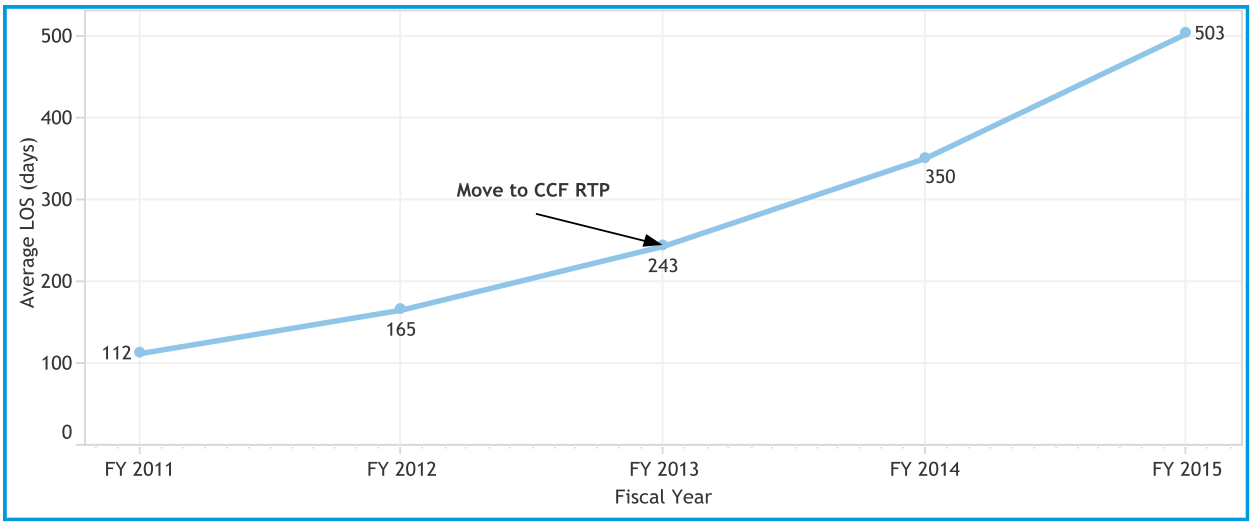


Figure 7: Average Length of Stay for Unsuccessful Discharges



INCENTIVE SYSTEM

The program utilizes a structured incentive level system that rewards appropriate, co-operative behavior with increased privileges. CCF RTP employs an eight-level system in which offenders are progressed or regressed on an individual basis, taking into account his 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.

Level 1 provides focus on treatment planning and an introduction to treatment processes. As offenders progress through the levels, they are offered opportunities for additional supplemental treatment groups to further enhance coping skills. Recreational activities, and participation in structured social activities occur on the milieu of the living unit. Offenders also have access to outdoor exercise periods.

Offenders receive individual treatment outside of their cells along with group treatment. Offenders at the lower levels participate in group activities while restrained at treatment tables; this helps offenders to learn safe coping strategies in a group setting. At levels 5 and above, offenders participate in group activities without restraints. **Figure 8** shows the program participants at each level. **Table 1** displays the eight levels with associated privileges in effect on June 30, 2015. As stated in CDOC Administrative Regulation 650-04, Residential Treatment Programs, "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 hours per week."

Figure 8. Population levels as of June 30, 2015
Figure note. Counts include both number of offenders and percentage of total RTP population

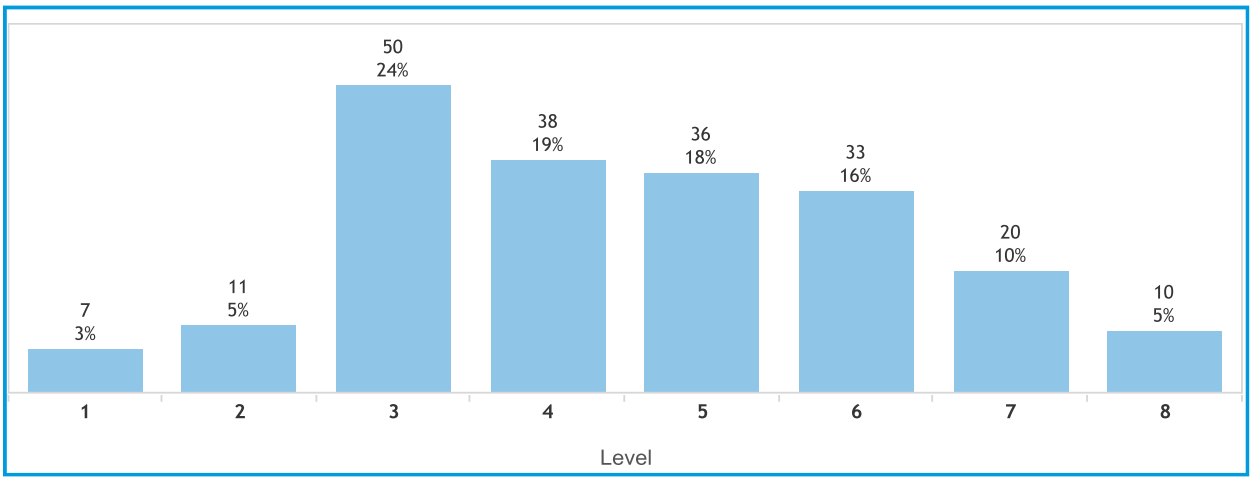


Table 1: Incentive levels and privileges in effect on June 30, 2015

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 @ 7 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 Per Month	1	2	4	4	4	4	6	8
Contact Visits	No	No	No	No	Yes	Yes	Yes	Yes
Canteen Amount	$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 Therapy	Up to 8 restrained	Up to 8 restrained	Up to 8 restrained	Up to 8 restrained	Up to 8 un-restrained	Up to 8 un-restrained	Up to 16 un-restrained	Up to 16 un-restrained
Unrstrctd 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

During the first week of participation in RTP, treatment needs are identified by the clinical team and offender. The treatment plan is a structured and individualized living document that guides and evaluates offender treatment. It contains four essential parts; 1) identification of issues or problems, 2) goals or objectives for treatment, 3) method of achieving the stated goals, and 4) estimated time frames for goal completion. The purposes of the treatment plan are 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 reviewed on a regular basis to ensure goals have been met, to redefine goals if necessary, and to develop new goals.

In order to manage offender treatment progress, measure overall function, 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.

Behavioral treatment plans can also be developed and implemented through a multi-disciplinary team process where clinical staff work with security and housing teams to structure the programming 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 sensitive with specific interventions and monitoring in place with the goal of reducing distress experienced by the individual so he can continue to engage in meaningful treatment.

THERAPEUTIC INTERVENTIONS

Mental health treatment services utilize treatments that have demonstrated effectiveness in published research and best practices to focus on overlapping treatment needs since many offenders meet the diagnostic criteria of both serious mental health disorders and significant functional impairment. These disorders are defined as:

- **Serious Mental Illness:** The current diagnosis of any of the following DSM diagnoses denoting the presence of a major mental disorder: schizophrenia, schizoaffective disorder, delusional disorder, schizophreniform disorder, brief psychotic disorder, substance-induced psychotic disorder (excluding intoxication and withdrawal), unspecified schizophrenia spectrum and other psychotic disorder (previously psychotic disorder not otherwise specified), major depressive disorders, and bipolar disorders. Offenders, regardless of diagnosis, indicating a high level of mental health needs based upon high symptom severity and/or high resource demands, which demonstrate significant functional impairment within the correctional environment.
- **Significant Functional Impairment:** The demonstration of difficulty functioning within the confines of the correctional environment as evidenced by engaging in deliberate self-harming behaviors, such as cutting, self-mutilation, ingestion or insertion of a foreign body, head banging, drug overdose, hanging, biting, or jumping from heights with intent to cause self-harm; demonstrating difficulty maintaining activities of daily living such as eating, maintaining personal hygiene, or participating in recreation; and/or a pervasive pattern of dysfunctional, bizarre, or disruptive social interaction as a consequence of an underlying mental disorder.

GROUPS

Comprehensive curriculum based treatment groups are delivered according to program level. This ensures all offenders are receiving the same information to expand their coping skills and increase stability. In addition to standard program treatment, each offender receives individualized treatment and sets goals based on his specific mental health diagnosis and needs.

The following is a description of the treatment groups offered for mentally ill offenders in the CCF RTP. The concepts and adaptive coping strategies offered at each level are progressive, each concept and skill being a building block for the next.

- **Orientation groups:** The group leader will use the first few sessions to orient members to the group format. Introductions and discussions of topics such 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, verbal interruptions,

confidentiality, positive communication, and use of profanity. Program rules also stipulate that offenders must be dressed in complete offender attire, keep hands visible at all times, remain seated, refrain from pulling on restraints, and refrain from horseplay.

- **Level 1 and 2 groups:** These levels focus on stabilization, accountability and willingness to change utilizing the concept of Foundation Thinking Errors. During group the offender reviews each of the Foundation Thinking Errors in detail, discussing the implications these errors have on his life. The offender learns how daily decisions he makes are processed through filters consisting of these foundation errors. Assigned homework helps him identify how each of these errors applies in his daily life.
- **Level 3 groups:** This level focuses on building awareness through the use of the Illness Management and Recovery (IMR) curriculum and Samenow's Commitment to Change curriculum. The IMR curriculum emphasizes personal goal-setting and self-management strategies for persistent symptoms. Samenow's Commitment to Change curriculum utilizes inter-active videos and correlating worksheets and reading assignments to help the offender to first discover errors in thinking in other people, along with the consequences they create. The offender then builds his awareness of his own thinking and begins the process of accepting responsibility of his choices and choosing to live responsibly.
- **Level 4 groups:** This level utilizes the **S**ystems **T**raining for **E**motional **P**redictability and **P**roblem **S**olving (STEPPS) Curriculum. STEPPS focuses on building awareness of symptoms and negative cognitive filters and the relationship between these filters and their subsequent patterns of thoughts, feelings and behaviors. The curriculum then moves to developing emotional management skills to build confidence in the offender's ability to manage his symptoms. Finally the offender will learn behavior management skills (e.g., healthy eating, sleeping, exercise, leisure, physical health, abuse avoidance and relationship behaviors).
- **Level 5 groups:** This level utilizes the STAIRWAYS Curriculum and is the next step focusing on continued skills development and symptom management. The offender will participate in sections focusing on **S**etting goals, **T**rying new things, **A**nger management, **I**mpulsivity control, **R**elationship management, **W**riting a script, **A**ssertiveness training, **Y**our choices, and **S**taying on track.
- **Level 6 groups:** This level utilizes the Wellness Recovery Action Plan (WRAP). The WRAP plan is designed to provide a concrete, written reminder to the offender and his 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. Opportunities to practice parts of the WRAP are offered in group

through role plays.

- **Level 7 groups:** This level serves as a review of concepts discussed throughout the program. The Schema Therapy curriculum's goal is to help an offender meet his core emotional needs by avoiding maladaptive coping styles and modes (mind states) that block feelings and healing unhealthy schemas or life patterns to achieve a lasting state of well-being.
- **Level 8 groups:** This level serves as a time for offenders with the diagnosis of a serious mental illness to receive continued support and opportunity to practice their WRAP and make revisions as needed. This level is utilized to support offenders with symptoms requiring additional provisions and practice to facilitate their transition to a general population facility or to the community.

SUPPLEMENTAL GROUPS FOR LEVELS 5 - 8

- **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 and recidivism prevention.
- **Drug and Alcohol:** Alcohol and drug counselors work with an offender cell side and in groups, with a particular focus on relapse prevention. The offenders are encouraged to look at all aspects of how his addiction impacts his life including his core beliefs, attitudes and values. The program reviews triggers, warning signs, core beliefs, consequences, and personal plans with discussions and written homework assignments.
- **Music assisted therapy group**: This group offers the offender opportunities to listen to and review lyrics in order to discuss and work through difficult emotions and life situations. Playing an instrument provides the offender the opportunity to communicate his emotions in an alternative way. Additionally, writing lyrics and melodies, reduces stress and improves overall well-being through creative and appropriate expression. The ultimate goal of the group is to transfer these abilities to other areas of the offender's life.

ADDITIONAL INTERVENTIONS

- **Behavioral Treatment Plans (BTP):** Offender-specific BTP specify incentives and consequences and can be utilized to address particular behavior problems.
- **Staffing interventions**: Multi-disciplinary staffings conducted with the offender to address negative behaviors or lack of progress in treatment. The offender's progress, participation and behaviors are reviewed and expectations for progress are discussed and implemented. The primary clinician monitors the offender's progress in meeting the outlined expectations.
- **Psychiatric consults**: Clinicians consult with the psychiatric provider in cases where the cause of the offender's symptom presentation or the course of action to address certain symptoms is not clear. The clinician conducts a

thorough file review and provides relevant information to the psychiatric provider regarding the file review and current symptom presentation. The psychiatric provider reviews this information, conducts his/her own research and may meet with or observe the offender's behavior. The psychiatric provider and primary clinician then consult and determine a course of treatment which may include medication adjustments, change in a treatment plan, and/or a recommendation for change in facility placement.

- **Cool-down Period/De-escalation rooms**: De-escalation rooms are designated therapeutic rooms for an offender to practice self-calming skills to manage his behavior and emotional state in a safe and calm environment. This was initially implemented as cool-down periods in intake in December 2014. The de-escalation rooms are now available for offenders outside of intake, offering soothing wall colors and furniture for use while practicing relaxation skills. Each room has a sound box with a variety of soothing sounds for utilization. These periods are self-initiated and terminated by the offender, allowing multiple options for the offender to utilize in self-regulation.
- Animal-assisted therapy: Animal-assisted therapy utilizes dogs from the Colorado Correctional Industries Prison-Trained K9 Companion Program and provides opportunities for offenders to engage with rescue dogs. During an offender's' interaction with a dog, he is encouraged to identify emotional shifts he experiences, thereby increasing his self-awareness and improving his self-care and self-esteem. This occurs in groups as well as in the individual sessions for those offenders whom the treatment team believes could benefit from becoming more engaged in the treatment process (e.g., those who engage in self-injurious behavior or those who due to their serious mental illness have been hesitant to engage in group and individual sessions).

Figure 9 shows the number of group and recreational therapy sessions scheduled. They are delineated into two groups: cancelled and offered. 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. Individual therapy sessions are not shown here.

Figure 9: Number of offered and cancelled groups for FY 2015

Figure 10 shows a breakdown of therapeutic sessions offered to individual offenders each month. They are delineated into three groups: attended, refused, or unavailable. Group and recreational therapy sessions have multiple offenders scheduled. If indicated a "round robin" process is used to fill vacant seats when an offender refuses or is unavailable to participate. This allows other offenders in the program to join a group. Every offender who is scheduled to attend group or volunteers during the "round robin" process is tracked. There may be instances, as determined by the treatment team, where this process cannot be used due to group continuity, emotional safety and cohesion.

Figure 10: Therapeutic sessions offered in FY 2015

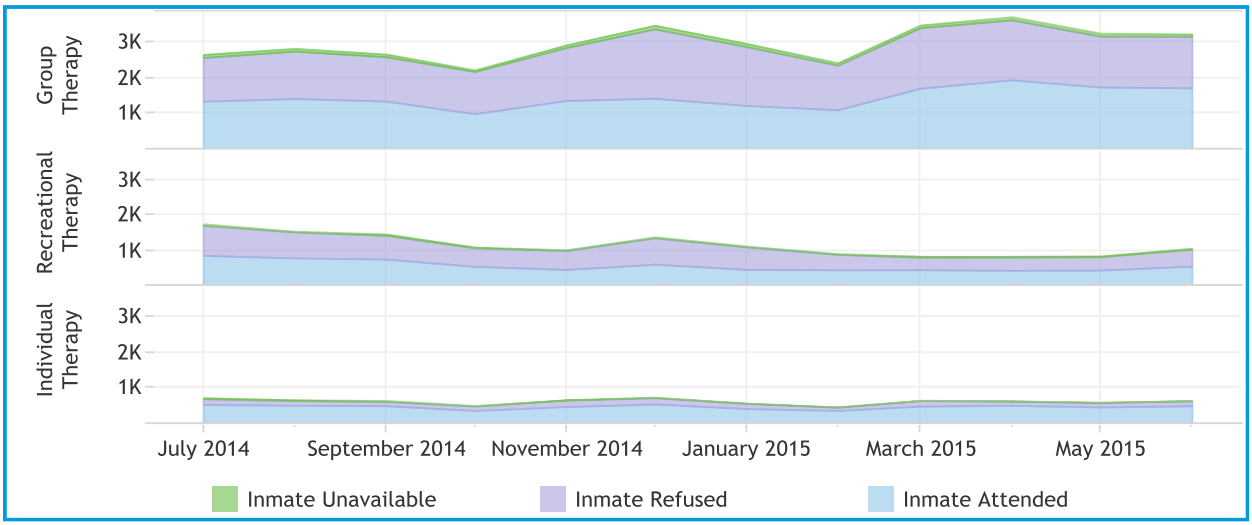


Figure note. This graph shows each time an offender was offered to attend a therapeutic session. For example, a group offered to three offenders would show as three sessions. If one refused and another offender volunteered to take his place, a total of four sessions would be shown.

Offenders attending group therapy comprised the largest category during FY 2014 at a 54% attendance rate. During FY 2015, offenders refusing group therapy comprised the largest category. In FY 2015, participants refused 49% of group therapy sessions, 50% of recreational therapy sessions, and 23% of individual therapy sessions. In addition, offenders may be unavailable for treatment (e.g., on mental health hold, off grounds), which was the case for 3% of group therapy sessions, 2% of recreational therapy sessions, and 2% of individual therapy sessions. The overall attendance rate across the three types of therapy was 51%.

NEW REFORMS

In order to provide successful treatment opportunities for offenders with serious mental health needs, RTP program staff continues to evaluate the effectiveness of the treatment interventions being provided to include the curricula. In FY 2015 AR 650-04 was revised. The RTP's contracted with the Phoenix Company to develop a custom curriculum called New Freedom. This curriculum focuses on addressing the stages of contemplation in regards to treatment adherence and engagement, reducing major symptoms, (especially those directly impacting behavior), coping skill review and practice, symptom awareness and monitoring, and situational confidence in facing high-risk situations. Additionally, plans were completed for the program to move from an eight level program to a five level program July 1, 2015, in line with similar level programs across the country. Additional reforms to the RTPs include:

- 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 repetitive damaging episodes of self-injurious behavior. 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. To date, all CCF RTP cells have been modified to significantly decrease the risk of self-injury and a training curriculum has been developed and implemented. Specific programming has been developed and proposed to offer specialized self-injurious behavior treatment groups. Participants are selected based on a thorough file review and their amenability to this treatment intervention. It is projected that beginning at level 3, offenders would be considered for these groups, after demonstrating an ability to follow group norms as well as increased stability and willingness to engage in treatment.

- De-escalation Rooms: In FY 2015, the CCF RTP began looking for ways to further increase the effectiveness of the de-escalations rooms. The implementation of a chalk board for offender use in each room is projected to be implemented. Developments of additional tools for the de-escalation rooms are being explored.

Additional areas of focus include: Addressing more comprehensive treatment interventions for medication abuse, the revision and meaningful implementation of AR 700-29, Mental Health Interventions (Mental Health Watches), and comprehensive discharge planning for offenders in the CCF RTP.

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