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, 2017, IN RESPONSE TO**

**DEPARTMENT OF CORRECTIONS FY 2015-16 RFI #1**

PREPARED BY

*OFFICE OF PLANNING AND ANALYSIS*

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# 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, 2017, 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 2016.

**2007** Using existing resources, a program was established at Centennial Correctional Facility (CCF) to accommodate offenders with mental health needs that were transitioned out of administrative segregation.

**2010** Funded by the General Assembly, the Colorado Department of Corrections (CDOC) established the Specialized Administrative Segregation Program for Offenders with Mental Illness (OMI) at the Colorado State Penitentiary (CSP).

**2013** The CSP OMI program moved to CCF as a residential treatment program (CCF RTP). This change was an effort to reduce the number of offenders with mental health needs in administrative segregation since the environment was not conducive to mental health treatment.

Treatment is the primary focus at CCF and offenders are managed based on their individual custody needs. Moreover, consolidation of the CCF OMI and CSP OMI programs into the CCF RTP enable more consistent care for program participants.

**2014** Senate Bill (SB) 14-064 prohibits DOC from placing offenders diagnosed with a serious mental health disorder in administrative segregation or restrictive housing-maximum security status (RH-Max). In response to this SB and due to internal policy changes, offenders with serious mental health disorders are no longer placed in RH-Max.

The RTP program delivers best practice and evidence-based treatment services to offenders with mental health needs who could otherwise be placed in RH-Max or the general inmate population. Such treatment improves their ability to function effectively, decrease isolation, and transition into less restrictive facilities. The comprehensive program provides offenders with intensive mental health services including therapeutic exercises, recreational activities, staff interaction, and out-of-cell opportunities. Individualized treatment plans are designed to alleviate psychiatric symptoms, help offenders develop strong self-management skills, and enhance pro-social behavior.

## TARGET POPULATION

Mental health treatment needs are tracked by a coding identification process utilized by the CDOC. The psychological needs level codes (P codes) range from 1 - 5, with 3 - 5 indicating moderate to severe needs. An 'M' qualifier in conjunction with the P code is used to designate offenders as having a serious mental illness (SMI). Offenders with a P4 and P5 are also classified as having a significant functional impairment. Placement priority 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 who, due to their behavior, are at risk for placement into RH-Max.

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, various psychological assessments, and staff observations to recommend appropriate treatment interventions. Clinically 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. Clinically referred offenders with mobility issues that qualify under the American Disabilities Act (ADA) are sent 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 an appropriate housing assignment. The evaluating psychologist recommends treatment methods that may be effective with the individual offender. Such treatment can enhance the continuity of care between the diagnostic unit and the receiving general population facility.

Some offenders placed in the RTP may lack awareness, struggle to recognize mental health problems, deny problems because of perceived vulnerability associated with mental health needs, or experience paranoia and distrust of treatment providers. Program participants often meet criteria for both serious mental illness and significant personality disorders that affect activities of daily living. When treatment alleviates symptoms of serious mental health disorders, personality disorder symptoms may become the primary concern; therefore, treatment services focus on two overlapping needs (see section on Therapeutic Interventions).

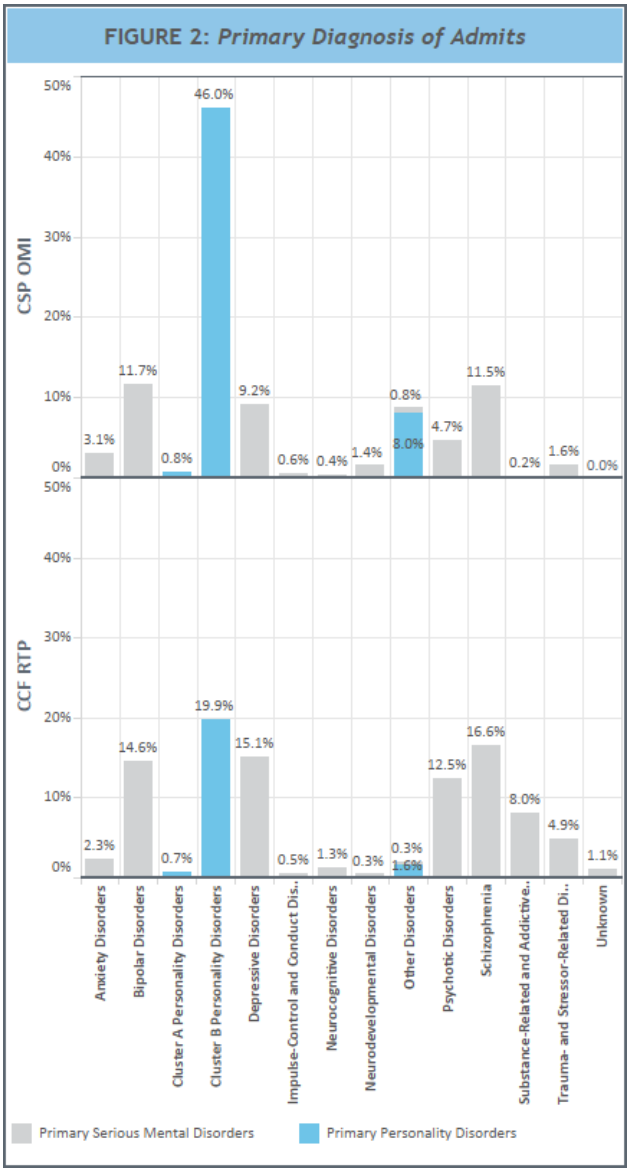




**Figure 1** shows program admissions by mental health disorder over time (FY 2013 is split in half according to when the program moved to CCF).

**Figure 2** shows the primary diagnosis of offenders admitted to the CSP OMI (August 2010 – December 2012) and CCF RTP (January 2013 – June 2016). Antisocial personality disorder was the most common primary diagnosis of offenders admitted to CSP OMI program. Major mental illness (e.g., psychotic disorders, schizophrenia, bipolar, and major depressive disorders) was the most common diagnosis for offenders admitted to CCF RTP.

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

The RTP Diagnostic Unit conducts diagnostic clarification, assessments for treatment needs and makes recommendations for appropriate facility and/or program assignments. Historically, CDOC focused on transitioning offenders with serious mental illness from administrative segregation environments into an RTP. Since administrative segregation reform in June 2014, CDOC has successfully kept mentally ill offenders from administrative segregation environments with the inception of the RTP Diagnostic Unit.

In FY 2016 there were 52 re-admissions, an increase from previous years (see **Figure 3**). New admissions increased to 163 offenders. Since inception, 902 offenders have been admitted to the program for the first time, along with 233 re-enrollments, for a total of 1,135 admissions.

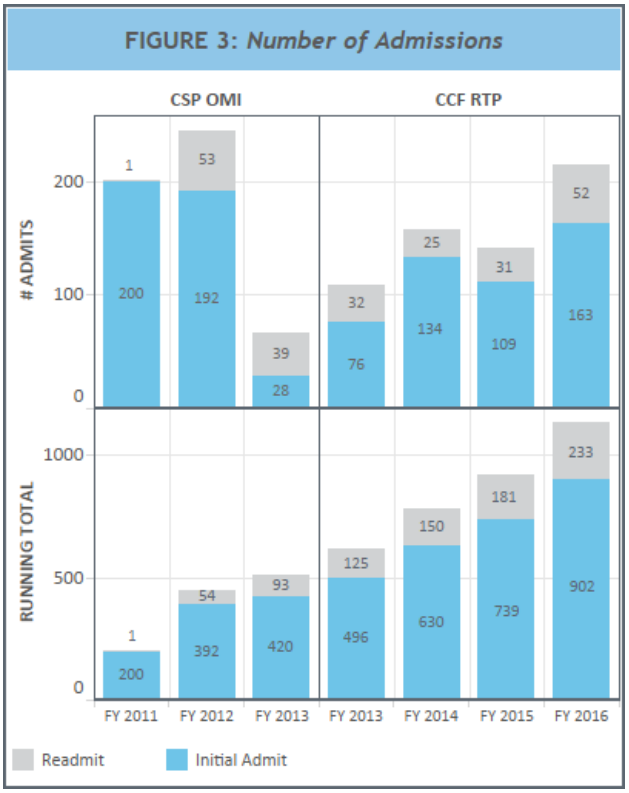
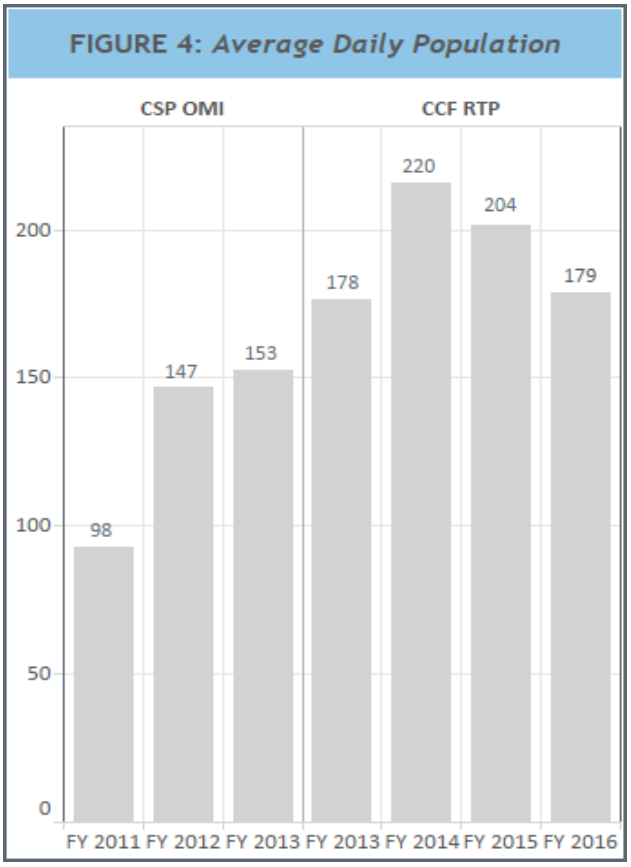
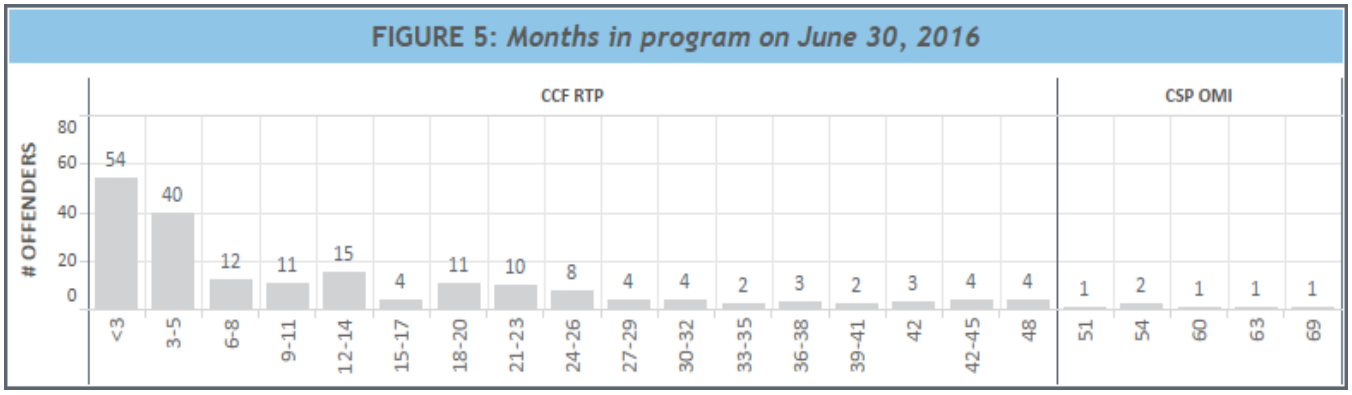


**Figure 4** shows the average daily population of participants in the CSP OMI program and CCF RTP over the past seven fiscal years. The average daily population continued its downward trend, begun in FY 2015, down to 179 in FY 2016.

**Figure 5** shows the distribution of lengths of stay in the program for those enrolled on June 30, 2016. As can be expected, the figure demonstrates a positive skew with the majority (69%) of participants in the program for less than 18 months. Approximately a fifth (19%) of participants have been in the program between 18 months and 3 years, with the remainder in the program for three or more years.



## PROGRAM DISCHARGES

Discharges from the program fall into five categories (these categories are broad descriptions of termination reasons):

***Completions*:** Offenders who made satisfactory progress during treatment and transferred to a lower-custody facility, or were released to a Community Corrections facility

***Terminations*:** Offenders that no longer meet the criteria for participation in the CCF RTP; who are not benefiting from placement in the program; and who, through dangerous or 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. Other terminations include offenders who are deceased.

***Releases*:** Offenders who paroled or discharged prior to completion of the program.

***Transfers*:** Offenders transferred to San Carlos Correctional Facility RTP, the Colorado Territorial Correctional Facility infirmary, or the Colorado Mental Health Institute at Pueblo.

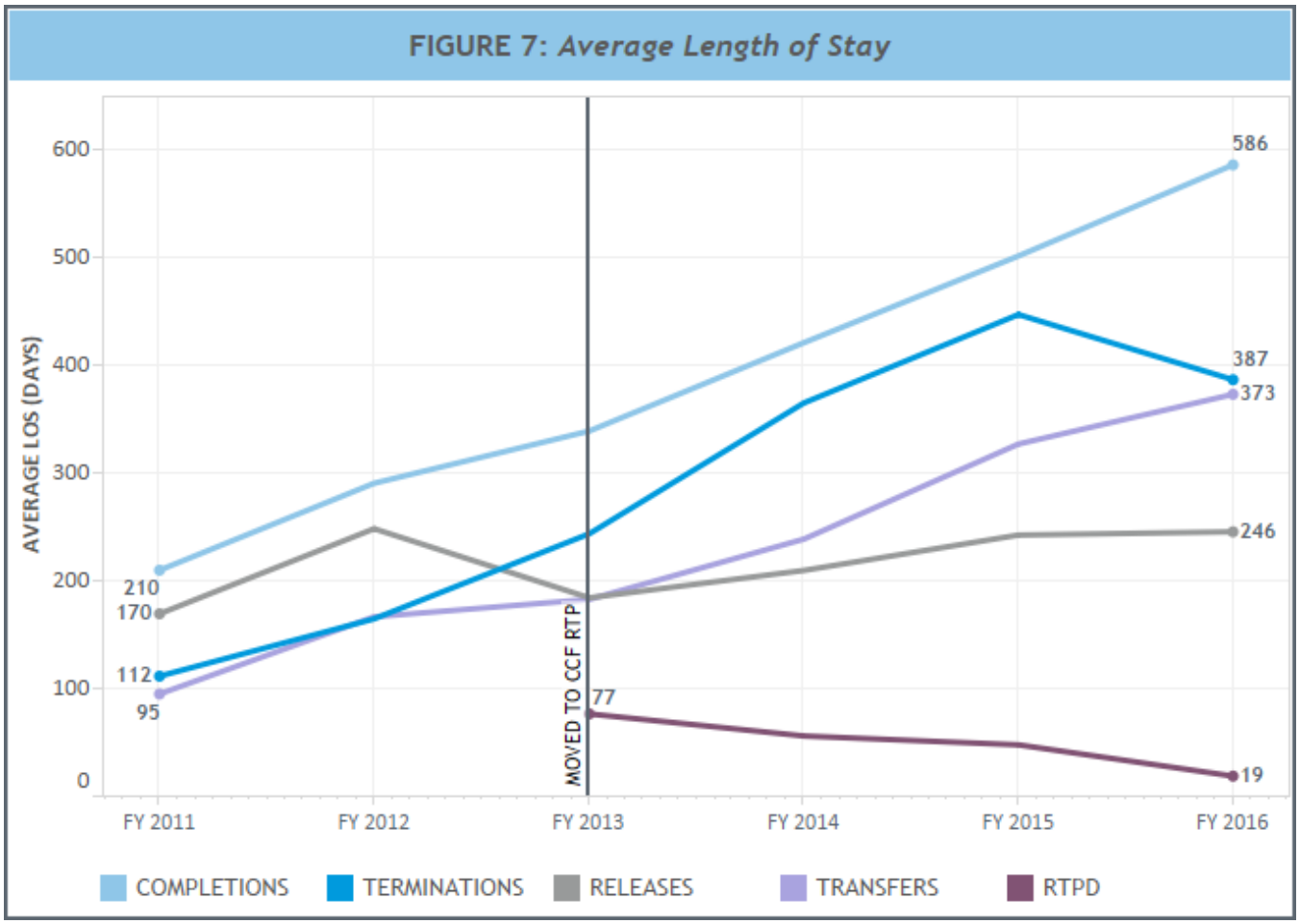
**RTPD:** Offenders who left from the RTP diagnostic unit not recommended for RTP level programs.

As **Figure 6** demonstrates, successful completions increased between FY 2015 and FY 2016 from 67 to 87, while terminations decreased to a record low of just a single offender. Over the same period the number of offenders released from CCF RTP decreased slightly while the number transferred increased by more than a half.

FIGURE 6: *Program Discharges*

| | CSP OMI | | | CCF RTP | | | |
|---|---|---|---|---|---|---|---|
| | FY 2011 | FY 2012 | FY 2013 | FY 2013 | FY 2014 | FY 2015 | FY 2016 |
| COMPLETIONS | 21 | 63 | 31 | 22 | 75 | 67 | 87 |
| TERMINATIONS | 29 | 143 | 28 | 14 | 21 | 15 | 11 |
| RELEASES | 2 | 12 | 3 | 9 | 35 | 37 | 29 |
| TRANSFERS | 6 | 14 | 15 | 6 | 25 | 22 | 36 |
| RTPD | | | | 2 | 1 | 4 | 28 |

**Figure 7** charts the average months in the program by type. There was an increase in the average length of stay for all discharge types apart from terminations in FY16.



## INCENTIVE SYSTEM

The program utilizes a structured incentive level system that rewards appropriate and cooperative behavior with increased privileges. Prior to FY 2016 through the on-going evaluation and adjustment in the delivery of therapeutic programming, CCF RTP integrated a customized curriculum and adjusted the incentives to align with the other programs across the country. CCF RTP utilizes a five-level system which tracks an individual offender's course of treatment. Factors considered includes diagnosis, the seriousness of rule infractions, and the individual's motivation to engage in treatment. Within each level, offenders have the opportunity to address their individual treatment issues, criminogenic needs, and/or irrational belief systems in a therapeutic environment.

The program focuses, at first, on treatment planning and introduces treatment processes. As offenders progress through the levels, they are offered opportunities for additional supplemental treatment groups to enhance coping skills. Recreational activities and participation in structured social activities occur on the milieu of the living unit and off unit programs area. Offenders also have access to outdoor exercise periods and gymnasium.

Offenders at all levels receive individual treatment outside of their cells along with group treatment. At the lower levels, offenders participate in group activities while restrained at treatment tables, enabling offenders to learn safe coping strategies in a group setting. At higher levels offenders participate in group activities without restraints.

**Figure 8** shows the program participants at each level as of June 30, 2016. It is a fairly even distribution for levels 2, 3, and 5 with the highest (28%) proportion of participants at level 3.

FIGURE 8. *Population Levels as of June 30, 2016*

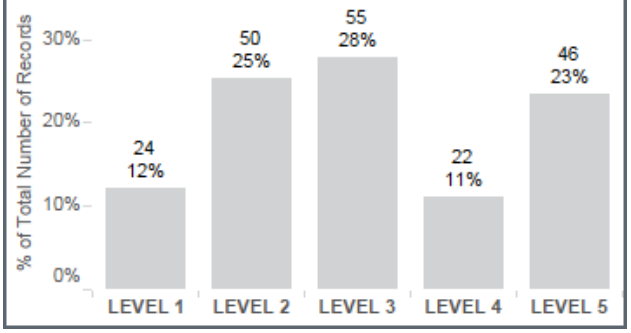


**Table 1** displays the five levels with associated privileges that were in effect on June 30, 2016. As stated in CDOC Administrative Regulation 650-04, Residential Treatment Programs for Offenders with Mental Illness and Intellectual and Developmental Needs, "residential treatment programs will offer 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."

**TABLE 1:** ***Incentive levels and privileges in effect on June 30, 2016***

| Privilege | Level 1 | Level 2 | Level 3 | Level 4 | Level 5 |
|---|---|---|---|---|---|
| Yard | 5 days/wk<br>1hr/day | 5 days/wk<br>1hr/day | 5 days/wk<br>1hr/day | 5 days/wk<br>1hr/day | 5 days/wk<br>1hr/day |
| Shower | 5 days/wk<br>15 mins | During dayhall | During dayhall | During dayhall | During dayhall |
| Dayhall | 8 at a time<br>2 hr @ 2 days/wk | 8 at a time<br>1.5 hr @ 5 days/wk | 8 at a time<br>2 hr @ 7 days/wk | 16 at a time<br>2 hr @ 7 days/wk | 16 at a time<br>open @ 7 days/wk |
| Phone Sessions | 20-min call/mth<br>x6 | 20-min call/mth<br>x6 | 20-min call/mth<br>x6 | 20-min call/mth<br>x8 | Unlimited<br>calls |
| # Visits Per Month | 4 | 4 | 4 | 6 | 8 |
| Contact Visits | No | No | Yes | Yes | Yes |
| Canteen Amount | $30/mth | $35/mth | $40/mth | $50/mth | $60/mth |
| TV | No | Yes | Yes | Yes | Yes |
| Work | No | No | No | No | Yes |
| # in Grp/Rec Therapy | Up to 8<br>restrained | Up to 8<br>restrained | Up to 8<br>unrestrained | Up to 16<br>unrestrained | Up to 16<br>unrestrained |
| Unrstrctd Moves | No | No | No | 4 at a time | 8 at a time |
| Group Yard | No | No | 8 at a time | 16 at a time | 16 at a time |
| Gym | No | No | 8 at a time | 16 at a time | 16 at a time |

# TREATMENT PLANNING

Treatment needs are identified by the clinical team and offender during the first week of RTP. Treatment plans are structured and individualized living documents that guide and evaluate 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
4) Estimated time frames for goal completion.

Treatment plans are designed to guide the course of treatment, and provide a measure of progress. Since 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.

To manage offender treatment progress, measure overall function, and monitor response to treatment, a psychological assessment (the Brief Psychiatric Rating Scale [BPRS]) clinical assessments (e.g., mental status examinations and formal psychological testing) as well as psychiatric services are integrated into the treatment plans.

Behavioral management plans are implemented through a multi-disciplinary team process for offenders who require additional support and structure. 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 illness or engaging in high risk behavior choices. The implementation of a behavior management plan is time limited that involves specific interventions. Consistent monitoring by housing and clinical teams may reduce distress experienced by the individual so he can continue to engage in meaningful treatment.

# THERAPEUTIC INTERVENTIONS

Mental health treatment services utilize best practices and evidence-based treatments—those 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 personality disorders. These disorders are defined as:

**Primary Serious Mental Health Disorder** – associated with symptoms of major mental health disorder (e.g., depression, anxiety, and psychosis). Also, related to receiving treatment services emphasizing illness self-management (medication adherence, cognitive skills, and wellness and recovery planning).

**Primary Personality Disorders** – associated with ingrained and maladaptive patterns of behavior (e.g., failure to conform to social norms, impulsivity, aggressiveness, irresponsibility and lack of remorse). Also, related to treatment services addressing offender risk, criminogenic needs and coping strategies through Cognitive Behavioral Therapy (CBT). CBT examines thoughts and beliefs about events that occur in an individual's life and how these thoughts and beliefs connect to that individual's emotions, physical experiences, choices, and behaviors.

## GROUPS

Comprehensive curriculum based treatment groups are delivered according to the 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 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.

**Level 1 -** The group leader will use the first few sessions to orient members to the group format. Topics such as the purpose of the group, expectations, fears, ground rules, program rules, and the content of the group are discussed. New Freedom core curriculum, as well as New Freedom anger management curriculum is introduced.

**Level 2 -** Offenders are provided New Freedom Main Skills that include Illness Management and Recovery (IMR), and distress tolerance.

**Level 3** – Starts with Systems Training for Emotional Predictability and Problem Solving. Offenders are presented with New Freedom curriculum that informs about cognitive distortions, early warning signs and how to cope with stress.

**Level 4** - Offenders are tasked with identifying their personal boundary issues and interpersonal struggles by creating a wellness plan to decrease the intensity of relapse.

**Level 5** – Offenders are able to apply the skills attained and explore higher levels of coping skills through Dialectical Behavior Therapy (DBT). 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 Wellness Recovery Action Plan (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 offender population or the community. Level 5 also provides opportunity for offenders to gain additional skills and practice pro-social skills by being assigned to a work duty.

## SUPPLEMENTAL GROUPS

**Drug and Alcohol** - Alcohol and drug counselors work with offenders at their cell and in groups, focusing on relapse prevention. The offenders are encouraged to look at all aspects of how their addiction impacts their lives, such as 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.

**Re-Entry -** The CCF reentry program is a six-week course designed to provide basic skills and resources for reentry into the community. The class provides resources for housing, employment, community mental health providers, and local resources (i.e. Social Security offices, housing authorities, food pantries, clothing pantries, soup kitchens, shelters, etc.). During the course, the offenders learn how to create a budget, write a resume, and fill out employment and housing applications. Medication compliance is also discussed. Offenders are given the opportunity to ask questions and discuss concerns about returning to the community.

## ADDITIONAL INTERVENTIONS

**Staffing interventions** - Interventions are facilitated for offenders with negative behaviors or lack of progress in treatment. The offender's treatment plan, progress, participation, and behaviors are reviewed. Treatment goals maybe reformulated, interventions developed and expectations for progress are discussed and implemented. The primary clinician monitors the offender's progress through the treatment plan

**Psychiatric consults** - Clinicians provide relevant information to the psychiatric provider regarding the history and current symptom presentation. The psychiatric provider reviews this information, conducts research and may meet with or observe the offender's behavior to determine a course of treatment which may include medication adjustments, modify treatment plan, and/or a recommendation for change in facility placement.

**De-escalation rooms** De-escalation rooms (designated therapeutic rooms) allows offenders to practice self-calming skills to manage behavior and emotions in a safe and soothing environment. Sessions are self-initiated and terminated by the offender, allowing multiple options for an offender to utilize in self-regulation.

De-escalation rooms are now available for offenders with tranquil wall colors and murals while they practice relaxation skills. Offenders have the options to select multiple therapeutic interventions, such as, puzzles, use of chalk, coping skills sheets, reading materials, and tactile materials. An individual is able to select music or nature sounds to enhance their regulation of emotions.

**Human-Animal Interaction -** Human-Animal Interaction 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 and during individual sessions for those offenders whom the treatment team believes could benefit from becoming more engaged in the process (e.g., those who engage in self-injurious behavior or those with serious mental illness that are hesitant to engage in group and individual sessions).

**Figure 9** shows the number of scheduled group and recreational therapy sessions. Sessions are delineated into two groups: canceled 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.

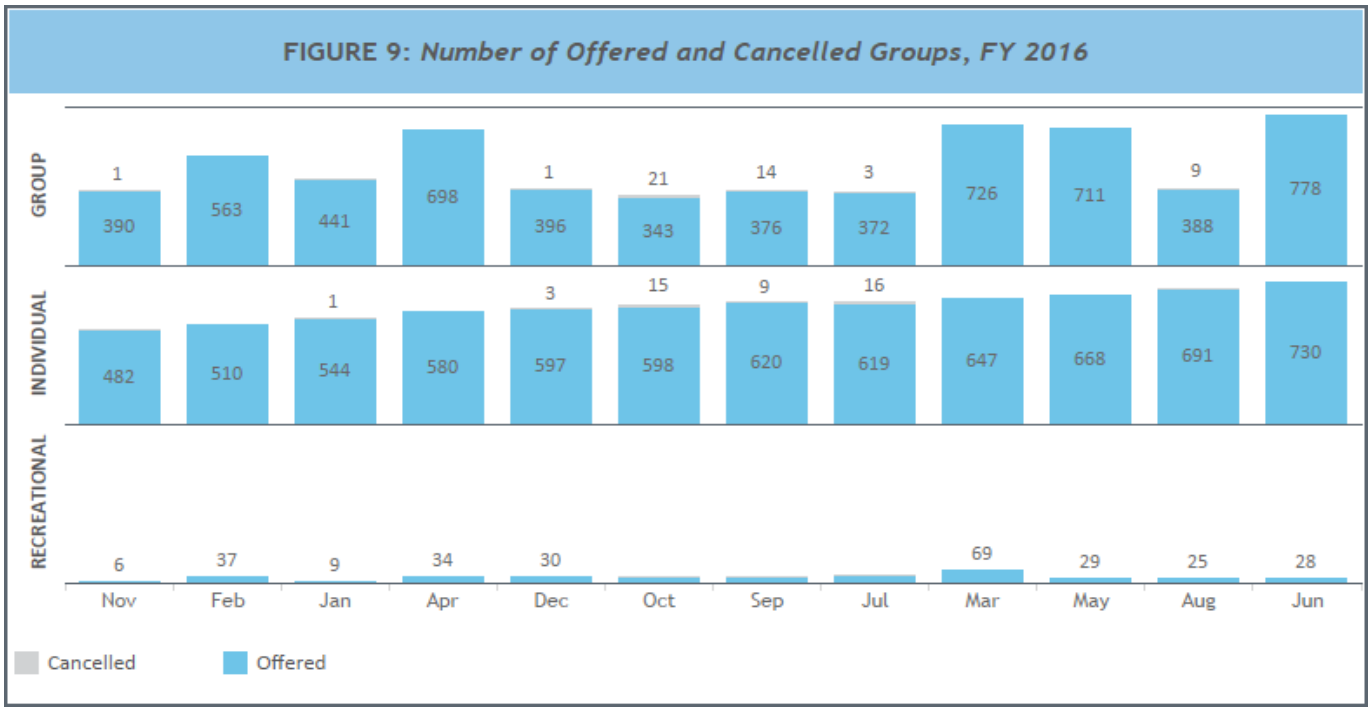


**Figure 10** shows a breakdown of therapeutic sessions offered to individual offenders each month. They are delineated into three groups: attended, refused, or unavailable. Group and recreational therapy sessions had multiple offenders scheduled. If indicated, a "round robin" process is used to fill vacant seats when an offender refuses or is unavailable to participate. This allows other offenders in the program to join a group. "Round robin" participants and volunteers are tracked. There may be instances, as determined by the treatment team, where groups will be closed. During FY 2016, group therapy was the most widely offered and attended form of therapy in the program.

FIGURE 10: *Therapeutic Sessions Offered, FY 2016*

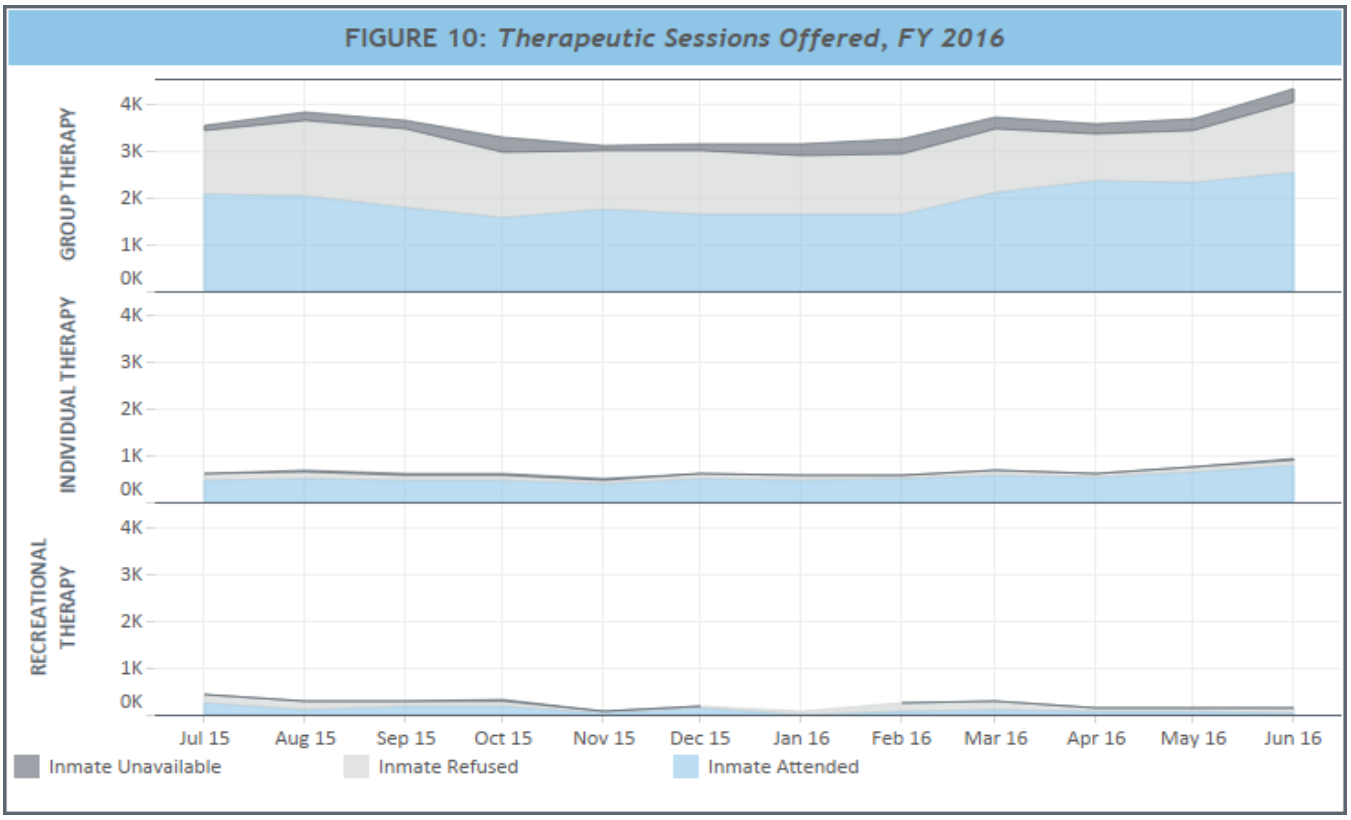



Figure note. This graph shows each time an offender was offered to attend a therapeutic session. For example, a group offered to three offenders would show as three sessions. If one refused and another offender volunteered to take his place, a total of four sessions would be shown.

# NEW REFORMS

To provide successful treatment opportunities for offenders with serious mental health needs, RTP program staff evaluate the effectiveness of treatment interventions that include the curriculum. The RTPs contracted with the Phoenix Company to develop a custom curriculum. Such curriculum addresses the stages of contemplation in regards to treatment adherence, engagement, reducing major symptoms, (e.g. those directly impacting behavior), coping skill practice, symptom monitoring, and situational confidence when facing high-risk situations. Additional reforms include:

**Modification to self-Injurious behavior treatment**:
Moving forward with the treatment for this high risk and challenging client population; groups have been designed to address the needs of offenders in RTP levels 3-5. The goal continues to increase stability while decreasing costly and repetitive damaging episodes of self-injurious behavior.

**Enhanced music activities:**
A proposal has been submitted, reviewed and approved to provide additional music equipment based on the safety of offenders and the success of programming. Since offenders have embraced the opportunity and cooperated with precautions the management team has approved instruments that were previously restricted.

**Level 5 treatment enhancement:**
Offenders are considered for this group when primary clinicians identify their clients as able to tolerate potentially triggering events (i.e. another offender sharing part of their story in group), can exercise the coping skills they have been taught, are able to turn in homework on time, and are a safe person for other offenders to interact with.

Therapeutic interventions are targeted toward offenders who identify having symptoms related to past trauma (i.e. "I have nightmares, flashbacks, and panic attacks that I cannot control"). The goals include improving depression levels, increasing insight into behaviors and life events, improving life direction, and increasing feelings of self-safety by decreasing occurrence of distressing symptoms.

**Increase of non-therapeutic time out of cell:**
By collaborating with security and housing, increasing the amount of time out of cell, non-therapeutic, pro-social activities promote the application of skills learned in group setting and individual sessions. It is the hope of CCF RTP that out of cell non-therapeutic hours will far exceed the minimum of 10 hours. This provides the opportunity to sustain recovery and improve overall wellbeing.

**Token Economy:**
In an effort to decrease refusals by offenders and encourage positive behaviors and growth through the use of incentives rather than solely gaining compliance through punishment or regression, the CCF RTP is developing a token economy program to be piloted in the next fiscal year. Research indicates that positive feedback generally improves performance and increases motivation to continue to do well. Incentives serve as tangible forms of positive feedback and have been found to be useful not only in effecting behavioral change but also in increasing cooperation. This is especially true when the incentives affect a larger group as a whole and not only an individual.

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