Colorado State Penitentiary/Centennial Correctional Facility
Offenders with Mental Illness
Specialized Administrative Segregation Program
Update February 2011

Mission: The mission of the CSP/CCF OMI program is to provide evidence based mental health services to administratively segregated offenders with mental illness to improve their ability to function effectively and progress to less restrictive facilities.

Population Served: The Colorado State Penitentiary Offenders with Mental Illness (CSP OMI) program will house and provide more intensive treatment to offenders who are classified as administrative segregation and who have been identified as having mental illnesses. Offenders who have medical problems or require ADA accommodations will be included in the program.

An offender is classified as administrative segregation due to his or her violent, dangerous or disruptive behavior which precludes management at a less restrictive custody level. Offenders are not classified as administrative segregation based on a mental illness. However, offenders with mental illnesses may be dangerous or disruptive and be classified as administrative segregation because of the risk they pose to security of the facilities.

The Colorado Department of Corrections has a system that includes a coding process to identify and track those offenders who have mental health treatment needs. All offenders are rated on psychological needs level by trained clinicians upon intake into CDOC and periodically during their incarceration as warranted. The psychological needs level has a 5-point rating, where higher values indicate the need for more intensive services and a qualifier code that indicates whether the offender has a serious and persistent mental disorder. Most offenders rated 3 through 5 have an Axis I diagnosis, although certain Axis II diagnoses may infrequently warrant this rating (e.g., borderline, schizotypal). Disorders that typically qualify as serious and pervasive are mood disorders including depressive disorders, major depressive disorders, dysthymic, and bipolar disorders; psychotic disorders including schizophrenic, paranoid, delusional, and schizophreniform disorders; dissociative identity disorder; and posttraumatic stress disorder.

Most of the offenders considered for this program meet criteria for a serious Axis I mental disorder diagnosis, per the American Psychiatric Association's Diagnostic and Statistical Manual IV-R. These diagnoses include those disorders which are targeted for state funded mental health services through the community mental health system. That is, these are the diagnoses which are most likely to cause significant impairment in the offender's ability to function effectively due to interfering symptoms.

Many incarcerated offenders also meet criteria for personality disorder diagnoses. These disorders are defined as ingrained personality traits and patterns of behavior that are dysfunctional, but are not considered to be major mental illnesses. Frequent examples in DOC include antisocial personality disorder, narcissistic personality disorder, and

borderline personality disorder. Many of the offenders targeted by this program meet criteria for both serious mental illness diagnoses, and personality disorders. That is, they have symptoms of both a major mental illness and personality disorders. When symptoms of major mental illness are alleviated due to medication and treatment, the personality disorder symptoms may become magnified. This treatment program will offer services designed to treat both types of disorders.

Legislative Report Requirements:

1. ***Basic purpose of the OMI beds at CSP in terms of the role those beds serve relative to the offenders' mental health status:***

The purpose of the CSP OMI program is to provide more intensive mental health treatment services to offenders with mental illnesses who are classified as administrative segregation. Offenders in the program will benefit from increased interaction with staff and from monitoring to ensure their psychological well-being. Mental health services are first targeted to alleviate symptoms and help offenders develop successful self-management skills. Services will be offered to assist offenders in successfully transitioning to less restrictive facilities. For offenders who cannot be safely transitioned to lower custody facilities, ongoing services will be directed toward maintaining safety and psychiatric stability, and improvement of quality of life in an administrative segregation setting. However, evaluation of their ability to transition will be ongoing.

2. ***Criteria the DOC will use to place offenders in the beds:***

Offenders will be referred to these units by mental health staff. The referral pool will be comprised of male offenders who have a P code of P3-P5 and who are classified as administrative segregation. Priority will be given to those with the highest mental health treatment needs (e.g., Axis I major mental illness, those who present a risk of self-injury, those demonstrating an inability to adapt to or progress in administrative segregation).

Many offenders with mental health treatment needs resist treatment. They may fail to recognize mental health problems, may deny problems because of perceived stigma or vulnerability associated with mental illness, or they may be paranoid and distrust treatment providers. These offenders may not understand the positive effects of medications or dislike the side effects and often become non-compliant with medications. These factors contribute to the difficulty in treating mental illness. This is not planned as a voluntary placement. Rather, high needs offenders will be placed and managed on the special units and encouraged to participate in treatment.

Program selection:

- Mental health supervisors will identify administrative segregation offenders who have the highest clinical needs based on an assessment of diagnoses, current symptoms, acuity, and risk of injury to self or others.
- Mental health supervisor recommendations will be staffed with a multidisciplinary CSP facility team (e.g., case manager III, custody and control

staff, intelligence staff, clinical services staff) The final selection will be based on clinical need and approved by this team.

Update – The process outlined in this section is being utilized for identification of offenders to be placed in the program. The multi-disciplinary team continues to staff the offenders to determine the progress through the program.

3. Services that will be provided to the offenders:

Physical plant. The CSP OMI program will total 192 beds in specific pods in designated living units. Utilization of these units allows for access to two areas for one-to-one treatment sessions, and a group treatment area outside the living units. In addition, each living unit will have tables installed which will allow for psycho education programs and activity therapies. CCF will have 144 beds assigned in a similar method.

Update - The total beds available at the CSP facility has been changed from 192 to 202. The physical plant design allow for the increase of 10 beds because of the cell house design. This allows for 13 complete living unit to be designated for the OMI program.

Mental Health Treatment Services. The CSP/CCF OMI program will be differentiated from other administrative segregation programs by the enhanced mental health services that assigned offenders will receive. All assigned offenders will be assessed and will have an individual treatment plan prepared by mental health clinicians. Program participant assessment will include standardized testing for all offenders (e.g., the Brief Symptom Inventory) as well as the current assessments used in the DOC to determine symptom severity and acuity. Test results will be used for treatment planning and as a repeated measure to assess progress over time. Additional psychological testing may be utilized as needed to clarify treatment needs. Offenders will also participate in ongoing assessments and treatment plan updates as required by DOC mental health standards.

Mental health treatment services for the CSP OMI units will utilize evidence based treatments. This means that treatment programs and components have demonstrated effectiveness in published research. Treatment services will focus on three overlapping treatment groups. These are serious mental illness (primary Axis I, major mental illness), cognitive behavioral treatment (primary Axis II personality disorders), and self-injury treatment groups. These are not distinct groups and many offenders meet diagnostic criteria for both Axis I and Axis II disorders. Many offenders who are persistently self-injurious have particular personality disorders and may have Axis I disorders as well. Offenders may move between treatment areas based on current symptom severity and behavior. The physical structure of CSP allows for 12 separate living units to be utilized for this program. Specific units will be designated to address specific problem areas.

Serious Mental Illness. As described above, this group includes offenders who are primarily impacted by symptoms of major mental illness, including depression, anxiety, and psychosis. Treatment services will emphasize an illness self-management model (Corrigan, McCracken & McNeilly, 2005; Mueser & MacKain,

2005). Specific topics will include education about mental illnesses, medication adherence, cognitive skills, and wellness and recovery planning. The Illness Management and Recovery (IMR) program was developed with support from the Robert Wood Johnson Foundation and the Substance Abuse and Mental Health Services Administration (SAMHSA) as a model for psychosocial treatment of serious mental illnesses.

Cognitive Behavioral Treatment Units. These units will be dedicated to treatment services that more directly address personality disorder and behavioral problems. This program will utilize group program focused on cognitive skills, and will include programs to address criminogenic needs (Bonta, 1997; Bonta & Andrews, 2007; French & Gendreau 2006). Topics will include anger management, social skills development, and positive decision making. dialectical behavior therapy (Linehan, 1993) is an evidence based treatment approach designed for certain personality disorders and will be utilized.

Self-Injury Units. These units will be specifically identified for treatment and management of offenders who present a risk of self-injury. A structured evaluation (White, 1999) will be completed for all offenders who are referred for this program. This evaluation provides a thorough review of risk factors and guides treatment/management planning. Dialectical behavior therapy is often the treatment of choice for persistently self-injurious offenders. Other treatment topics will include cognitive skills development related to anxiety management and coping skills.

Update - After consultation with two leading mental health experts in the management of Offenders with Mental illness, we have redefined the groups changing from three to two. The self injury offenders have diagnosis that fit into the two groups either Serious Mental Illness or Cognitive Behavioral Treatment and the behaviors can be managed within the those groups. The treatment modalities are similar and both groups focus on symptom reduction including self injury behaviors.

Safety/Mileau. This program will establish a safe and positive therapeutic milieu for participants and increase the offender sense of safety. Whether the offender with mental illness is aggressive and dangerous, or lack skills to cope with other offenders, clinical and correctional staff will observe, document behavior, reinforce positive behavior and assist with management of conflicts or difficulties.

Update – To date, there have been no incidents resulting in injury for offenders or staff.

Medication Management. Psychiatric services are currently available, and medication management education will be offered with related issues being addressed in multiple group programs.

Incentive Levels System. All units in the CSP OMI Program will utilize a structured incentive levels system that rewards appropriate, cooperative behavior with increasing

privileges. In general, offenders must demonstrate appropriate, cooperative behavior at each level for a specified time period in order to be considered for progression to the next level. Offenders who display disruptive or dangerous behavior may be regressed to a more restrictive level and re-start their progression through levels. Decisions regarding level changes are made by a multidisciplinary team including both mental health and correctional staff.

Although operated in an administrative segregation facility, offenders in this program will have access to programs and services not available to other offenders in administrative segregation. Specifically, offenders will be able to participate in group treatment programs and structured social activities such as accessing the gymnasium for recreational program. Offenders who present a risk to others will be restricted to participation in groups in therapy booths. These booths are individual enclosures with wire mesh on the front and sides that allow for sight and sound interaction. Booths will be arranged for group programming on some of the units. Offenders who demonstrate reasonable self-control may participate in group activities at treatment tables. These offenders are restrained to a secured table, but have unimpeded sight and sound access to other group participants. At the least restrictive levels of the incentive system, offenders may participate in group activities without security restraints.

Update – Treatment delivery is done primarily in group settings. Individual needs of offenders are addressed in individual counseling sessions however the groups have been very effective. Our consultants have found that to be true in other programs across the nation.

Program participants are assessed and work with their primary therapist to develop an individualized treatment plan. Based on each individual's needs and treatment plan, offenders participate in a variety of group therapy programs. The program options include anger management, depression management, anxiety management, The Price of Freedom is Living Free, social skills training, substance abuse, Cognitive Behavioral Therapy for Psychotic Symptoms, Social Anxiety in Schizophrenia, stress management, Controlling Anger and Learning to Manage It, bipolar management, Dialectic Behavioral Therapy, journaling and core groups in Strategies for Self-Improvement and Change, Wellness Recovery Action Plan and Illness Management and Recovery. Recreational therapy programs also meet the special needs of the offenders in this program.

4. ***The classification levels that will be used and an explanation of the characteristics of those levels:***

There are five security levels – minimum, minimum-restrictive, medium, close and administrative segregation – to which offenders are assigned. CDOC uses a standardized, objective classification instrument that was developed specifically for the management of Colorado's offender population (Austin, Alexander, Anuskiewicz, & Chin, 1995). The classification instrument is used to assign offenders to minimum through close security levels. However, administrative segregation is a long-term segregation placement for

offenders who display violent, dangerous, and disruptive behaviors. Placement is determined through an administrative action that is separate and distinct from both the usual classification system and the disciplinary system. Although disciplinary infractions may affect classification at all levels, the disciplinary process is a punitive response to a finding of guilt for an institutional rule violation and may result in punitive segregation, which can extend up to 60 days. Therefore, punitive segregation is of short duration used for punishment and administrative segregation is of long duration used for management purposes. The administrative action to classify an offender to administrative segregation begins with a hearing, frequently following either a serious violation or a series of less serious infractions.

The CSP OMI program will house offenders who are classified as administrative segregation. The management of these offenders will be different from other administrative segregation offenders. There will be three different levels of management for offenders involved in the program. The levels will be administrative segregation (Ad Seg) high, intermediate and low. Ad Seg Low is the least restrictive; Ad Seg High is the most restrictive.

Offenders are expected to enter this program at level that they currently hold in their administrative segregation placement. Most offenders will enter at the Ad Seg Intermediate level. Offenders at this level will be able to participate in treatment groups of up to 8 offenders. Groups may be conducted with offenders in therapeutic modules. These modules allow offenders to communicate with the therapist and other offenders while preventing violent physical contact.

The Ad Seg Low level is subdivided into four phases providing the most options based on individual progress and treatment goals. As offenders progress through the phases, therapeutic groups will be conducted with larger numbers. Therapeutic groups may include structured passive recreation or socialization activities as well as more traditional group therapy programs. Recreational activities will be conducted in the gymnasium with groups of two offenders and may progress to groups of four by the last phase. The phases will prepare the offenders for movement to CCF.

Ad Seg High level will be utilized when offenders are engaging in disruptive behaviors and are not participating appropriately in the program. This level is designed to allow offenders to be housed within a more restrictive environment for their safety and the safety of others. Offenders may engage in one to one contact with a therapist, but may not be allowed to participate in group activities. The goal of this level is to modify violent or threatening behavior, without losing the treatment contacts. This level will be for short periods of time and will require a weekly review to ascertain if the offender is ready for progression back to intermediate.

Update - The program has found that the levels are a very fluid process and the multi-disciplinary team is critical to the evaluation of the progress for the offenders. The change in levels is based on behavior and participation in the program. The majority of the groups have been conducted utilizing the treatment tables in the living units.

5. ***Whether and, if so, how offenders will transition from CSP to the general population*:**

Offenders who are able to benefit from treatment and demonstrate appropriate skills and self-control will progress to general population in lower custody facilities. These offenders may move from administrative segregation in a step-wise progression to a close custody placement at the Centennial Correctional Facility (CCF) OMI Units. The CCF program continues to provide a structured incentive program for mentally ill offenders with mental health groups and supports on designated housing units. After completion of the CCF OMI program, offenders will continue the transition to other general population facilities.

When an offender has successfully progressed through the CSP OMI program, he will be transitioned to the CCF OMI units. Individual treatment goals will be established based on the offender's behaviors and whether the offender is able to apply concepts learned in treatment. Progress will be assessed by the multidisciplinary team on a monthly basis.

These offenders are re-classified as close custody when they move into the program. Specialized services support their adjustment to this custody level, with ongoing mental health treatment groups and close monitoring of interactions with staff and other offenders. There are phases in the program to allow for increased privileges based on the individual's treatment response and progress. Low level phases include the ability to go to the gymnasium in groups up to eight in structured and open gym use. The offenders may be approved for increased visiting privileges in Phase 3. Treatment groups will include up to eight unrestrained participants.

In addition, two mental health clinical positions are planned to serve as transition specialists. These clinicians will provide an in-reach transition service to assist offenders as they move to new facilities. The in-reach model involves transition specialists meeting with offenders before they move to the new facility to assist them with anticipated issues or concerns and ensure continuity of care. The transition specialist will assist in the offenders' integration and adjustment after they transfer to the new facility. For offender transitioning to parole or community, the transition specialists will work with community parole officers and re-entry staff to assist with transition plans and continuity of care with community mental health agencies.

Update – All offenders who will participate in the CSP program have been identified and prioritized for the program. The current caseload involved in the program is 138 offenders. They are receiving programs as described previously in this document. As staff are hired, new groups will be added to the program. There are some offenders in the program that will be moving to CCF but currently remain at CSP. CCF has 96 offenders participating the program. The remaining 48 beds at CCF will be implemented when the remaining staff are hired. Offenders from CCF have transitioned to a general population setting in another facility.

6. ***A description of the conditions of confinement, such as the amount of time offenders will be out of their cells, the amount of time in solitary confinement, the availability of recreational, visitation, educational, therapeutic and other programming opportunities and condition for participating in those opportunities:***

This program will provide an immediate increase in structured activities both in and out of the cell for OMIs. These are in addition to the existing program components at CSP/CCF. CSP/CCF provides quality programming providing for meaningful activities such as adult basic education, GED, library services that augment the treatment modalities in the OMI program to all offenders. The following are examples of the additional treatment modalities included in the program.

- Individual counseling sessions
- Group counseling sessions
- Recreation therapy sessions
- Cell assignments such as journaling

As the offender progresses in treatment, they will have opportunities for an increase in out of cell time for group interaction.

- Increase in out of cell time includes socialization in small groups within the living units.
- Passive recreation activities within the living units.
- Small group instruction for education or cognitive learning groups in the living units or other locations within the facility.
- Recreation activities in the gymnasium

The CSP and CCF facilities are accredited by the American Correctional Association. Our procedures and policies are guided by these nationally recognized standards. In keeping with these standards **all** offenders will be afforded the following:

- Monitoring by staff at least every 30 minutes. Correctional staff move from cell to cell interacting with offenders during these rounds.
- Reading materials selected by the offenders are provided by the librarian on a regularly basis.
- Access to programs and services include, but are not limited to, academic education, cognitive education, religious guidance, canteen, library, mental health counseling, medical services, case management, recreation, and visitation.

The conditions of confinement at CSP and CCF are not an attempt to place offenders in solitary confinement. Solitary confinement has been defined as a punishment that is aimed at denying offenders the ability to communicate and or have contact with other persons. Program participants will be seen frequently by clinical, custody, and program staff. They are encouraged to communicate with staff in writing or verbally. The therapeutic interventions are designed to increase the amount of contact between offenders to prepare them for successful progression to general population facilities.

Update – When offenders begin the program and begin working in groups, the treatment tables in the housing units are utilized. Each group begins with four

offenders at the treatment tables for sessions one and one half hours in length. The groups occur two times per week in the beginning and progress to more session weekly as offenders are able to sit closer together at the treatment tables. Assuring the safety of the offenders is critical to successful implementation of the program. As the staff evaluates the group for safety and offenders are more comfortable in the group setting, the size of the group is increased. To date, there have been no incidents resulting in injury for offenders or staff.

When an offender begins the program the out of cell time increases during the first week. As the offender progresses in the program, the out of cell time increases with group activities, recreation therapy and additional time for hygiene activities. The time out of the cell ranges between eight and twelve hours weekly. As the offender progresses through the program, the goal will be to reach approximately 18 to 20 hours out of cell time weekly.

As often occurs with new programs, there have been several offenders refusing to participate in the program. Those offenders remaining in the living unit and are offered participation in the program frequently. They are contacted by mental health staff and encouraged to begin participation.

Staff Recruitment. The DOC has initiated staff recruitment efforts for the CSP/CCF OMI unit positions. These efforts have ranged from placing newspaper advertising, advertising on mental health professional organization websites, and placing recruitment posters in college career centers. The DOC is also developing recruitment postcards that will be mailed to mental health professionals listed in the DORA licensure database.

Update - Staff recruitment and hiring has been in large part accomplished. We currently have three remaining vacancies. The staff have either completed the required training and are on duty or currently in training.

Staff Training. In addition to the existing basic and ongoing training received by all staff with the Colorado Department of Corrections, CSP and CCF staff will have an increase in training on managing OMIs. The training will provide information regarding the specific program components and assist the staff in participating in the multi-disciplinary team approach of the program.

Update - Specialized training has been provided to staff at CSP/CCF. This includes programs on Mental Health First Aid and Motivational Interviewing. Ongoing training needs will continue to be assessed.

Program Evaluation Plan. All offenders will be evaluated upon entrance into the program. Participants will be asked to complete standardized testing, to include the Brief Symptom Inventory (BSI) and other testing as required. The BSI may be used as a repeated measure of progress on a quarterly or biannual basis. Program participants will also be assessed for symptom severity on the Brief Psychiatric Rating Scale and for acuity on the Resource Consumption Scale, which are repeated at least every six months.

Research will assess the offenders who are placed in the CSP/CCF OMI program and the services provided within the therapeutic environment as specified above. Participants in the OMI program will be profiled in order to better understand their demographic features, criminal history, and co-occurring treatment needs areas (e.g., substance abuse, sex offender) as compared to the general offender population. The assessment scales described above will be analyzed to describe the psychological features of the program participants as well as to determine changes in psychological functioning over time. The researchers will also examine the lengths of stay and recidivism rates of offenders who leave the program. Finally, the researchers will evaluate the services provided, to include tracking offenders' participation in educational programs, mental health services, and recreation as well as other programmatic features (e.g., increased out of cell time) that distinguish the OMI program from traditional administrative segregation placements.

Update – The program has been developed to enable solid research tracking with measurable benchmarks. The database will be multi-functional management tool for program staff as well as research staff. Planning and Analysis office is developing a research plan to conduct process evaluation to report on the activities of the program and outcome evaluation to determine whether there is improvement in psychological well-being over time.

References

American Psychiatric Association (2000), *Diagnostic and statistical manual of mental disorders* (4th edition text revision) Washington, DC

Austin,J.,Alexander,J., Anuskiewicz, S., & Chin,L. (1995). *Evaluation of the Colorado Objective Prison Classification System*. San Francisco: National Council on Crime and Delinquuency.

Bonta, J. (1997). *Offender rehabilitation: From research to practice*. Canada: Solicitor General Canada

Bonta, J. & Andrews, D. (2007). *Risk-need-responsivity model for offender assessment and rehabilitation*. (Cat. No.: PS3-1/2007-6; ISBN No.: 978-0-662-05049-0) Public Safety Canada.

Corrigan, P., McCracken, S. & McNeilly, C. (2005). *Evidence-Based Practices for People with Serious Mental Illness and Substance Abuse Disorders*. In C. E. Stout Y R.A. Hayes (Eds.), *The Evidence-Based Practice: Methods, Models, and Tools for Mental Health Professionals* (153-176) Hoboken, N.J.: John Wiley & Sons, Inc. 153-176.

French, S. & Gendreau, P. (2006). Reducing prison misconducts: What works! *Criminal Justice and Behavior, 33*(2), 185-218.

Linehan, M. (1993). *Cognitive behavioral treatment of borderline personality disorder*. New York: The Guilford Press.

Mueser, K.T., & MacKain, S. (2005, October). *Illness management and recovery for people in contact with the criminal justice system*. Paper presented at the SAMHSA Evidence-Based Practice for Justice Involved Individuals: Illness Self-Management Expert Panel Meeting, Bethesda, MD.

White, T. (1999). *How to identify suicidal people: A systematic approach to risk assessment*. Philadelphia, PA: The Charles Press Publishers.