

OFFENDERS WITH MENTAL ILLNESS

A REPORT SUBMITTED TO THE HOUSE AND SENATE JUDICIARY COMMITTEES

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Offenders with Mental Illness

In 2010, the Colorado Department of Corrections (CDOC) established the Specialized Administrative Segregation Program for Offenders with Mental Illness (OMI) at the Colorado State Penitentiary (CSP) and the Centennial Correctional Facility (CCF). The current report and data describe the program and its activities through fiscal year (FY) 2012.

The program's goal is to provide evidence-based treatment services to administratively segregated offenders who have mental illnesses in order to improve their ability to function effectively, to decrease their isolation, and to progress them to less restrictive facilities. The comprehensive, incentive-based program provides mentally ill offenders with intensive mental health treatment services including therapeutic and recreational activities, staff interaction, and progressive increases in out-of-cell time. Individualized treatment plans are designed to alleviate psychiatric symptoms and help offenders develop successful self-management skills and prosocial behavior. Offenders with medical problems or Americans with Disabilities Act (ADA) accommodations are included.

Target Population

CDOC uses a coding process to identify and track offenders who have mental health treatment needs. The psychiatric needs level codes (P codes) range from 1 to 5, with 3-5 indicating moderate to severe needs. The OMI program targets offenders coded P3-5.

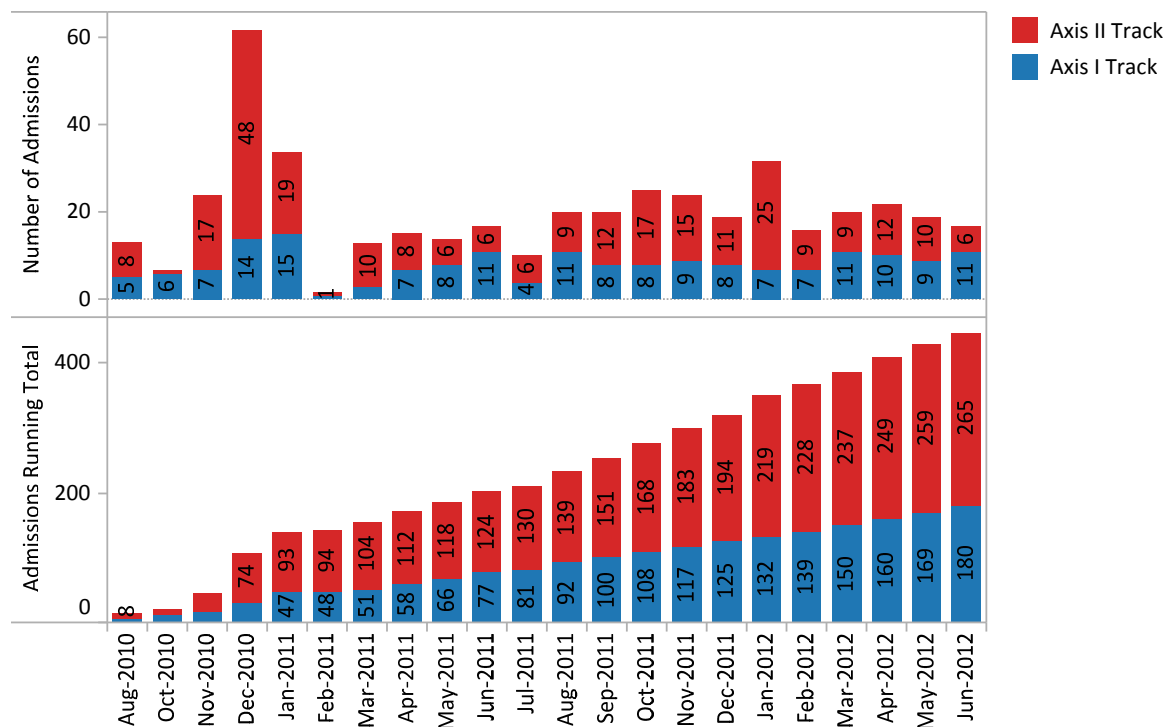
Offenders in the program have been placed in administrative segregation and have been diagnosed with

- a major mental illness (primarily Axis I disorders, based on the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision; DSM-IV-TR*);
- an adjustment disorder or an Axis II disorder (based on the *DSM-IV-TR*) that impairs their ability to function in the general population.

More than half of offenders meet criteria for Axis II personality disorders, which are ingrained personality traits and patterns of behavior that are dysfunctional but are not considered major mental illnesses. Frequent examples of these disorders among CDOC offenders include antisocial personality disorder, narcissistic personality disorder, and borderline personality disorder. Many of the offenders considered for this program also meet criteria for an Axis I diagnosis that may be likely to cause significant impairment in an offender's ability to function effectively due to interfering symptoms, such as depression, schizophrenia, bipolar disorder, or a wide variety of other diagnoses that can cause significant disability (see Figure 1).

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

Figure 1. Admissions by Axis Track



Priority is given to those with the highest mental health treatment needs (e.g., Axis I major mental illness, risk of self-injury, etc.) among the referral pool of male offenders with a P code of 3-5 who are classified as administrative segregation. High-need offenders are placed and managed on special units and encouraged to participate in treatment, although they may resist and have a right to refuse treatment. Some offenders may fail to recognize mental health problems, may deny problems because of perceived stigma or vulnerability associated with mental illness, or they may be paranoid and distrust treatment providers.

Mental health supervisors identify the most appropriate referrals for the program. Administrative segregation offenders with mental illnesses may be referred to this program from San Carlos Correctional Facility (SCCF), Sterling Correctional Facility (SCF), or CSP. The final selection is based on clinical need and approved by a multidisciplinary CSP facility team (case manager supervisor and staff from custody and control, intelligence, mental health, and medical).

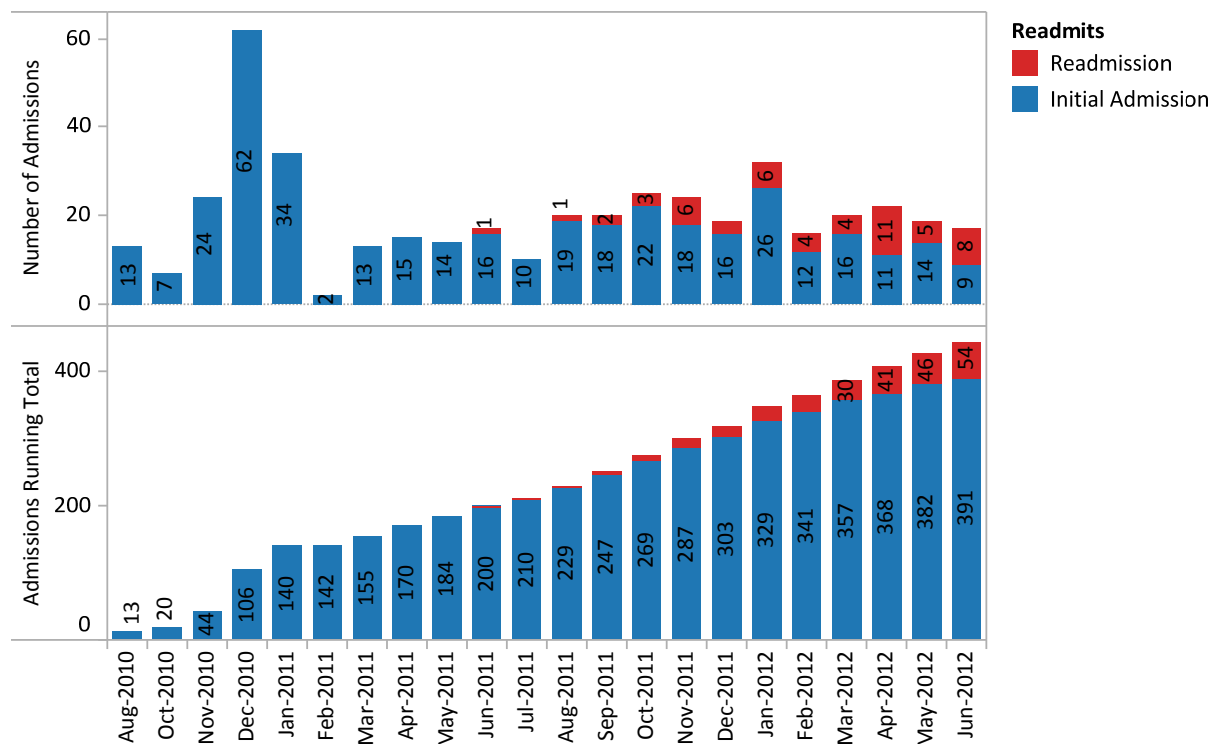
Enrollments

As of June 2012, offenders were spending a median of 16 months in administrative segregation prior to placement in the OMI program. As the Department works toward reducing the average number of mentally ill offenders in administrative segregation, the time until placement also will decrease.

Total admissions, including new admissions and readmissions, have climbed steadily since the program began (see Figure 2). Offenders who are unsuccessfully terminated are moved to a different unit, where

they continue to receive standard mental health treatment. The average number of days from termination until readmission in FY 2012 was 144 days. Of the 172 offenders who were unsuccessfully terminated from the CSP OMI Program as of June 30, 2012, 93 had been readmitted as of December 31, 2012.

Figure 2. FY 2011 and FY 2012 Admissions



A total of 156 offenders were enrolled in the OMI program as of June 30, 2012. The OMI population increased in the second half of 2012, after a plateau earlier in the fiscal year (see Figure 3). Figure 4 shows offenders' length of stay in treatment, indicating that most offenders remain in the program 6 months or less.

Figure 3. FY 2011 and FY 2012 End-of-Month OMI Population

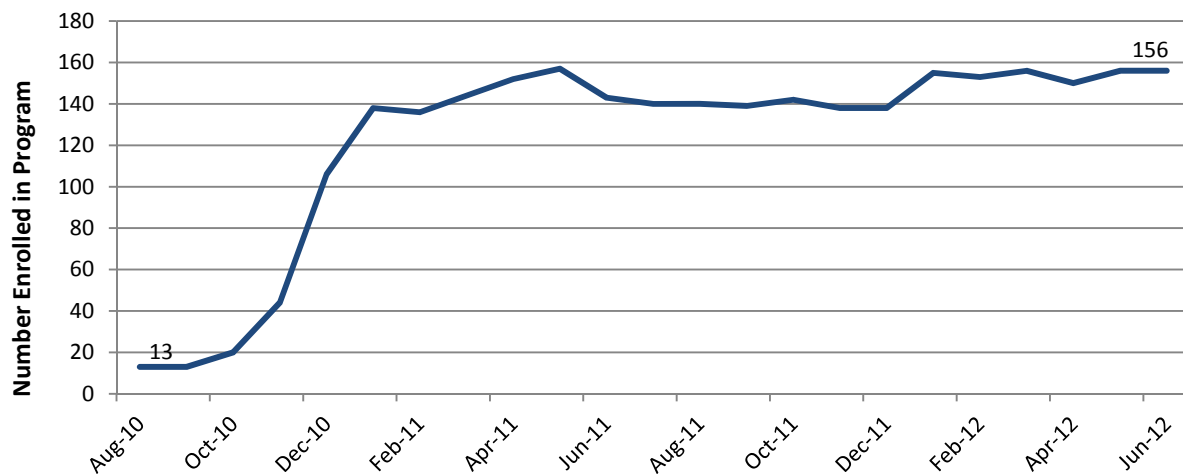
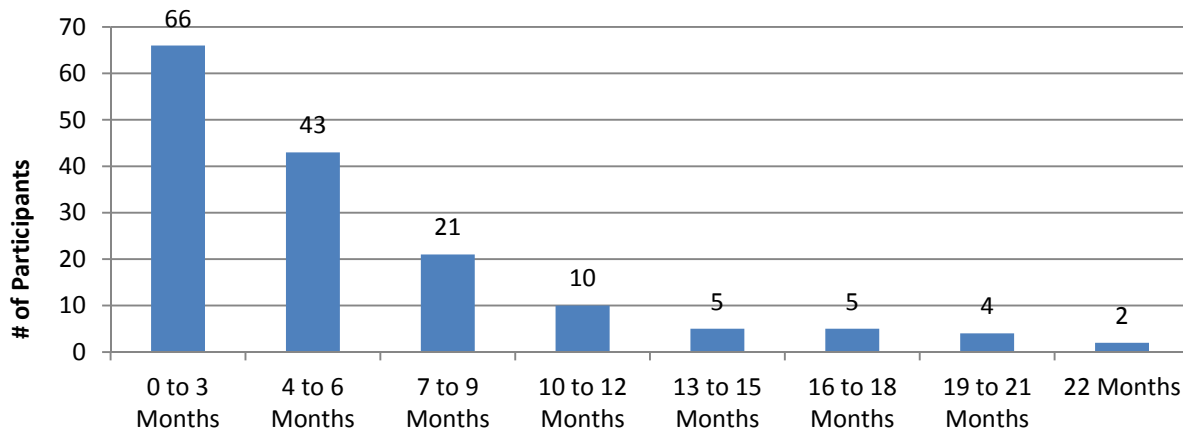


Figure 4. Duration of Treatment for June 30, 2012 Participants (N = 156)



Program Terminations

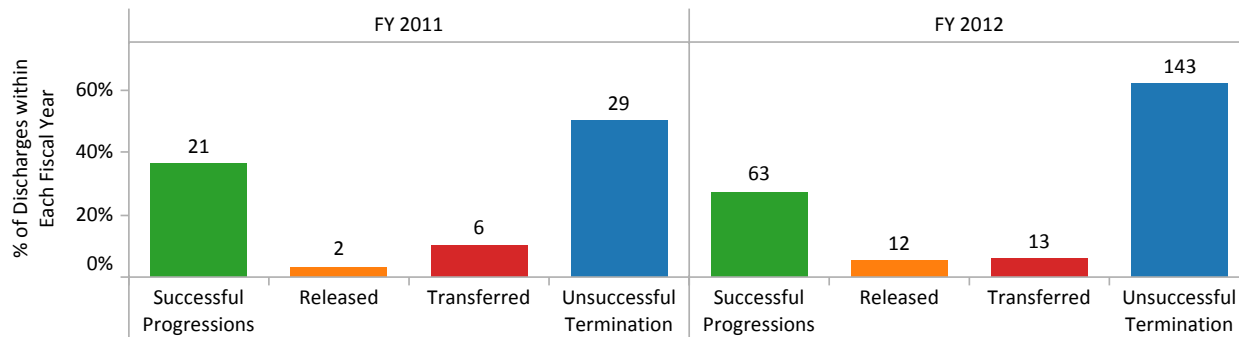
Discharges from the OMI Program are classified into four types:

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

The number of successful progressions increased in FY 2012 and unsuccessful terminations rose as well, compared to FY 2011; releases and transfers remained relatively low (see Figure 5). Length of stay increased among all discharge types in FY 2012 compared to the previous year (see Figure 6), and most offenders leaving the program successfully progressed to CCF (see Figure 7). Progressions to the CCF

OMI program slowed in the latter part of FY 2012 when the program stopped accepting new admissions, and progressions to the general population increased then.

Figure 5. Discharge Type by Fiscal Year



Note: The numbers in each category represent all program terminations and do not include offenders still enrolled in the program as of June 30, 2012.

Figure 6. Length of Stay by Discharge Type

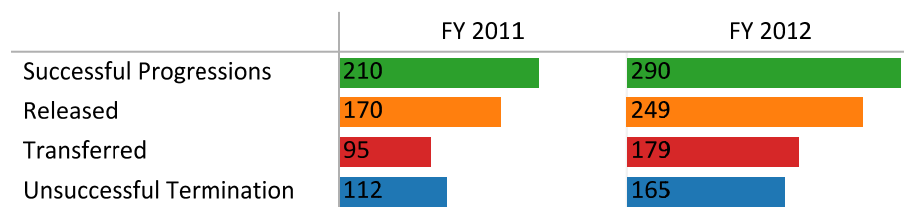
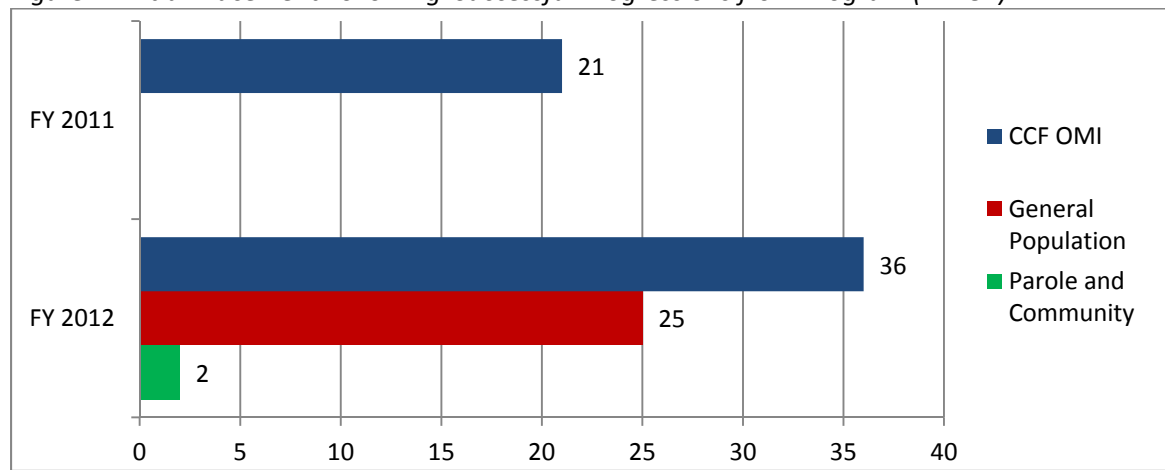


Figure 7. Initial Placement Following Successful Progressions from Program (N = 84)



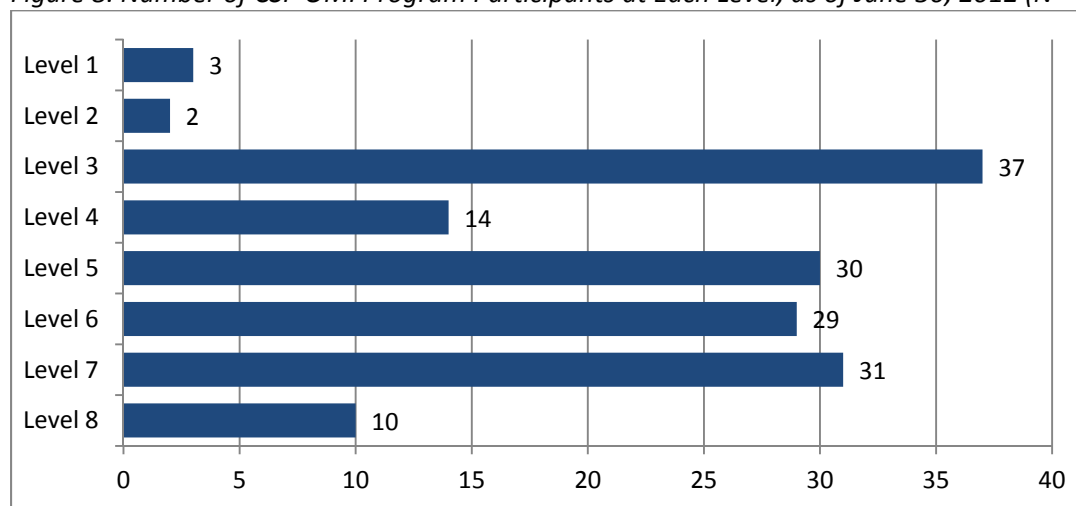
Incentive System

The program utilizes a structured incentive-levels system that rewards appropriate, cooperative behavior with increasing privileges. During this reporting period, the program employed a 12-level system (eight levels at CSP and four levels at CCF) in which offenders were progressed or regressed on an individual basis, taking into account their diagnosis, seriousness of rule infractions, and motivation to

engage in treatment. Within each level, offenders have the opportunity to address personal concerns, criminogenic needs, or irrational belief systems in a more intense environment where individual attention is provided.

At Level 1, offenders experience the most restrictions, including the lowest duration of exercise (5 hours per week) and phone time (20 minutes once per month), fewest number of visits (1 per month), and least amount of money approved for canteen purchases (\$5.00 per week, only to be spent on hygiene items and stamps). (Offenders generally start at Level 3 upon admission.) As offenders progress through the levels, they may be less restrained when escorted to groups or activities (beginning at Level 6) and can participate in unrestrained groups and activities (starting at Level 7). Table 1 displays the privileges that offenders achieve as they progress through the eight management levels, and Figure 8 shows the number of program participants at each level as of June 30, 2012.

Figure 8. Number of CSP OMI Program Participants at Each Level, as of June 30, 2012 (N = 156)



Although operated in an administrative segregation facility, offenders in the OMI program have access to programs and services not available to other offenders in administrative segregation, as a result of \$1.4 million approved by the Joint Budget Committee in March 2010 to fund personal services and operating expenses for the program. Offenders receive increased opportunities for out-of-cell time (depending on their privilege level) and are able to participate in group activities and treatment programs, may access the gymnasium for recreational activities, and may participate in structured social activities. Offenders at the lower levels continue to receive individual treatment outside of their cells until they are stable enough to begin group treatment.

Those who present a risk to others are restricted to participation in groups in therapy booths—individual enclosures with wire mesh on the front and sides that allow for sight and sound interaction. Booths are arranged for group programming on some of the units. Offenders who demonstrate reasonable self-control may participate in group activities while restrained at treatment tables. At the least restrictive levels of the incentive system, offenders may participate in group activities without security restraints.

Table 1. Overview of Privileges at Each CSP OMI Level, as of June 2012

	Exercise & Shower	Phone Sessions	Non-Contact Visits	Contact Visits	Canteen Amt	Canteen Restriction	TV	Work	# of OMI in Grp Tx ^a	Unesc Moves	Unrestr Rec	Gym	Unrestr Rec Tx
Level 1	1hr/day 5 days/wk	20-min call/mth x1	1/mth	No	\$5/wk	Hygiene & stamps only	No	No	No	No	No	No	No
Level 2	1hr/day 5 days/wk	20-min call/mth x4	2/mth	No	\$20/wk	Hygiene & stamps only	Yes	No	No	No	No	No	No
Level 3	1hr/day 5 days/wk	20-min call/mth x6	4/mth	No	\$25/wk	No	Yes	Yes	6 Booths (R) 4 Tables (R)	No	No	No	No
Level 4	1hr/day 5 days/wk	20-min call/mth x6	4/mth	No	\$25/wk	No	Yes	Yes	6 Booths (R) 4 Tables (R)	1 at a time	No	No	No
Level 5	1hr/day 7 days/wk	20-min call/mth x6	6/mth	No	\$25/wk	No	Yes	Yes	6 Booths (½ R) 8 Tables (½ R)	1 at a time	No	No	No
Level 6	1hr/day 7 days/wk	20-min call/mth x8	6/mth	No	\$25/wk	No	Yes	Yes	6 Booths (½ R) 8 Tables (½ R)	1 at a time	2 at a time	No	No
Level 7	1hr/day 7 days/wk	20-min call/mth x8	6/mth	No	\$35/wk	No	Yes	Yes	6 Booths (½ R) 8 Tables (½ R)	1 at a time	2 at a time	2 at a time	4 at a time
Level 8	1hr/day 7 days/wk	20-min call/mth x10	6/mth	Yes	\$35/wk	No	Yes	Yes	6 Booths (UR) 8 Tables (UR)	1 at a time	4 at a time	4 at a time	8 at a time

^aR=fully restrained; ½ R=leg restraints will not be secured to table; ¼ R=leg restraints will not be used at therapy tables OR wrist restraints will not be utilized in therapy booths; UR=unrestrained.

Treatment Planning

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

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

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

Therapeutic Interventions

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

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

Offenders who present a risk of self-injury are encouraged to participate in DBT as well as cognitive skills development related to anxiety management and coping skills. Originally these offenders were placed in one day hall to provide a safe and structured environment where they could help each other reduce

feelings of anxiety and have limited abilities to obtain objects with which to self-harm. Despite strict safeguards (e.g., screening porters, covers on the bottom of cell doors, and hooks on sewer traps), offenders' self-harming behaviors increased, so these offenders were integrated into regular OMI day halls. Again, self-injurious behaviors escalated as self-harming offenders shared their "techniques." When these offenders were placed in regular treatment day halls, the exposure to other offenders with a variety of mental issues created a highly stressful environment that again led to more self-inflicting behaviors. As a result, self-injurious offenders were placed in regular cell houses where they received individual treatment (while still remaining in the program), and the behaviors decreased.

Note that many offenders meet diagnostic criteria in more than one area and may move between treatment groups based on current symptom severity and behavior.

Following are descriptions of specific treatment groups offered for mentally ill offenders in the CSP OMI Program:

Anger Management: The Colorado Extended Anger Management Program is designed to address the offense-specific treatment of assaultiveness. Success depends predominantly on active participation and the completion of homework assignments related to the offender's thinking and behavior. The intent of the material is to expose participants to the cognitive process and how it applies to anger management.

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

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

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

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

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

a greater whole. In this stage, the goal of treatment is for the client to move from a sense of incompleteness toward a life that involves an ongoing capacity for experiences of joy and freedom.

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

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

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

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

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

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

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

Wellness Recovery Action Plan (WRAP): The WRAP plan is designed to provide a concrete, written reminder to an individual and his/her support systems regarding signs and symptoms of mental illness, effective approaches to maintaining health and stability, useful interventions, and treatments. Sharing in

a group format allows individuals to benefit from the insight and experiences of others, so they can enhance their own WRAP.

See Table 2 for an overview of program statistics. Note that group attendance tracking did not begin until late in FY 2011.

Table 2. Overview of FY 2012 CSP OMI Program Statistics

Fiscal Year 2012		Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
# Sessions Scheduled ^a	Rec Tx	40	76	76	81	95	108	123	132	137	136	140	123	1,267
	Grp Tx	193	234	223	238	263	268	259	286	283	266	284	264	3,061
	Indiv Tx	93	71	70	137	143	142	127	170	242	168	187	132	1,682
	Total	326	381	369	456	501	518	509	588	662	570	611	519	6,010
# Tx Canceled by Fac Needs ^b	Rec Tx	4	10	23	22	20	10	16	24	9	20	16	33	207
	Grp Tx	44	18	70	44	54	19	26	44	16	35	13	54	437
	Indiv Tx	5	1	12	20	17	4	3	1	10	12	4	3	92
	Total	53	29	105	86	91	33	45	69	35	67	33	90	736
# Sessions All OMI Refused ^c	Rec Tx	1	1	3	3	1	3	1	2	2	2	2	0	21
	Grp Tx	5	13	11	8	6	8	4	3	1	3	4	2	68
	Indiv Tx	7	8	6	4	12	6	18	7	12	13	11	7	111
	Total	13	22	20	15	19	17	23	12	15	18	17	9	200
# Sessions Conducted ^d	Rec Tx	35	65	50	56	74	95	106	106	126	114	122	90	1,039
	Grp Tx	144	203	142	186	203	241	229	239	266	228	267	208	2,556
	Indiv Tx	81	62	51	111	113	131	103	162	218	143	171	121	1,467
	Total	260	330	243	353	390	467	438	507	610	485	560	419	5,062
# Direct Clinical Hours ^e	Rec Tx	35	65	50	55	76	96	113	111	134	123	133	98	1,089
	Grp Tx	208	261	195	256	279	319	300	310	345	299	347	263	3,382
	Indiv Tx	55	44	48	72	64	83	76	132	172	106	152	107	1,111
	Total	298	370	293	383	419	498	489	553	651	528	632	468	5,582

^aSessions scheduled include sessions that were conducted and those that were not conducted due to facility needs (e.g., lockdown, staff unavailability) or refusal by all scheduled offenders.

^bFacility needs include cancellations due to staff unavailability, facility lockdown/shakedown, and other unexpected interferences not related to offenders' behaviors.

^cThe number of offenders in Recreation and Group Therapy sessions vary. The numbers in this table for either one of these treatments indicate the number of sessions in which all offenders who were originally scheduled refused to attend; the numbers in this table do not provide information on the number of offenders who did not receive treatment.

^dThe number of offenders in Recreation and Group Therapy sessions vary; the numbers in this category for either one of these treatments indicate the number of sessions conducted without providing information on the number of offenders who attended sessions; individual therapy sessions conducted are equal to the number of offenders seen during one-on-one therapeutic contacts.

^eThe numbers in this table for any of the treatments indicate the time clinicians devoted to therapy sessions without providing information on the number of offenders who attended these sessions.

CCF OMI Program

Offenders who successfully progress to Level 7 or 8 in the CSP OMI incentive-levels system may be recommended for a progressive move into the CCF OMI program (Levels 9-12), where they are reclassified as close custody. Offenders are able to complete any core treatment requirements begun at CSP and receive additional therapies based on individual treatment needs. The CCF OMI program emphasizes the application of coping, social, and cognitive skills to assist with daily conflict resolution and the development of prosocial behaviors as offenders prepare for progression to the general population/community placements. Group programming includes the discussion of specific life scenarios with an emphasis on anger management, irrational thinking, and challenging perceptions. CCF OMI program participants also receive drug and alcohol education and participate in transition-specific groups through the Wellness Recovery Action Plan (WRAP). Transition plans originally developed at CSP are reviewed and updated with a focus on issues related to living in lower-security facilities. For those

moving to community placements, planning includes positive adjustment to the community, access to mental health services and disability benefits if applicable, and successful management of stress and conflicts.

Figures 9-11 provide information on placement/status, current facility, and current classification only for offenders who transitioned to the CCF OMI program from the CSP OMI program.

Beginning in late 2011, the number of offenders participating in the CCF program was reduced to concentrate staffing at CSP. Therefore, components of the CCF program needed for offenders to transition to a general population setting were increased in the CSP portion. New offenders were no longer accepted into the CCF OMI program in 2012.

Figure 9. Classification/Status After Leaving CCF OMI Program (N = 57)

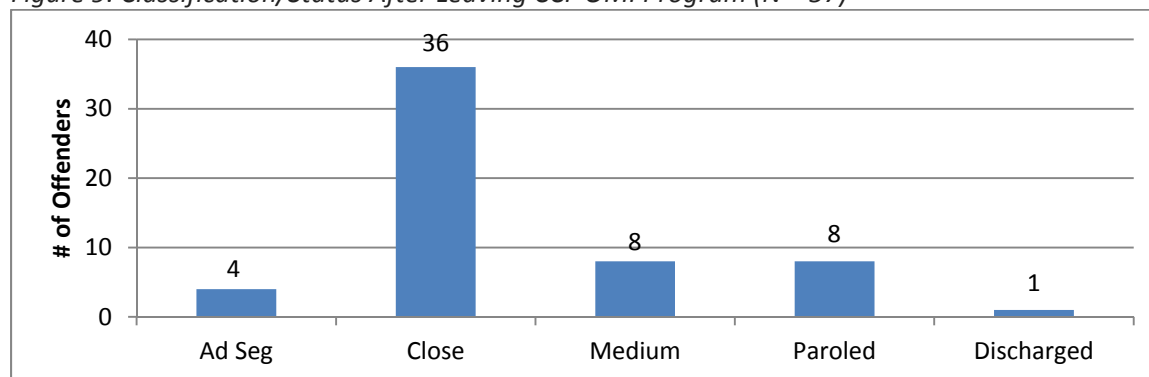


Figure 10. Current Facility for Former CCF OMI Participants (N = 57)

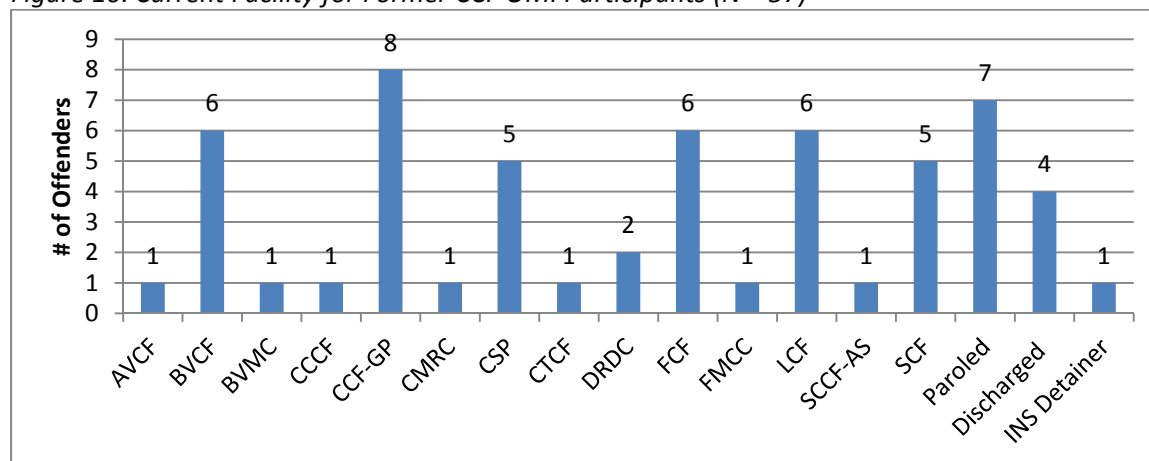
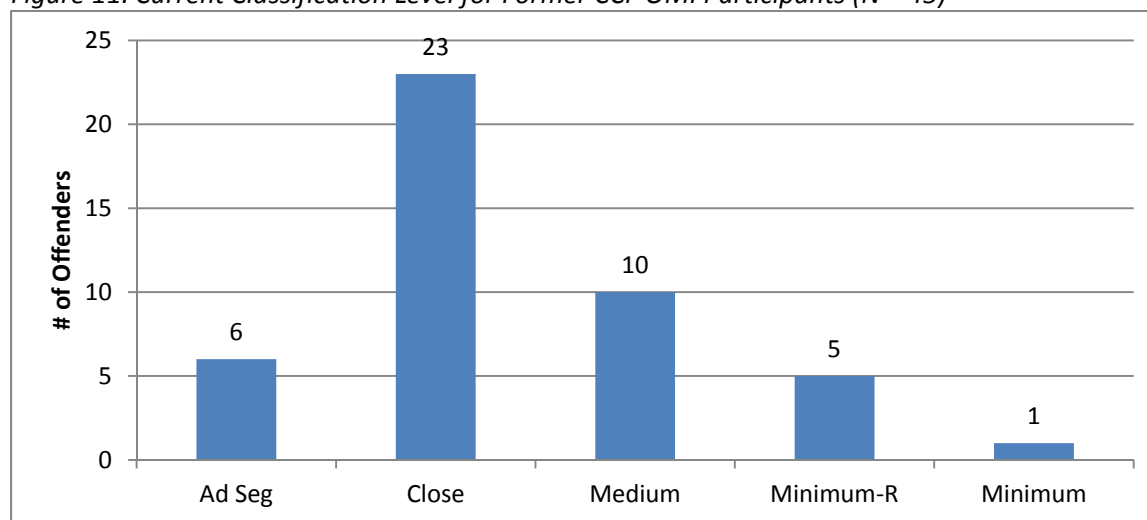


Figure 11. Current Classification Level for Former CCF OMI Participants (N = 45)



Note. Twelve offenders on parole, detainer, or discharged are not shown.

Improving Outcomes and Future Directions

The Department is working with an expert consultant, Dr. Joel Dvoskin of the University of Arizona, to ensure that we are targeting the correct population and using a model that will deliver the intended outcomes for this program. However, at our agency's strategic planning session in May of this year, we reported that 61% of those who left the program were unsuccessfully terminated. Of all offenders who had been admitted to the program as of June 30, 2012, 35% still remained in treatment. It is important to keep in mind the difficulty of evaluating the success rate of a long-term program in its early years, before a "track record" has been established and procedural issues have been resolved, and it is neither uncommon nor unexpected to have an initially high failure rate in long-term residential programs. We anticipate improvements early in 2013 and have examined strategies to decrease the unsuccessful termination rate by 30% by December 31, 2013. Executive Director Tom Clements testified before the Joint Judiciary Committee on January 18, 2013, reaffirming the Department's commitment to improving the mental health treatment of all offenders and particularly those currently or formerly in administrative segregation.

A number of factors have been limiting the program's success:

- **Dropouts:** Research shows it is a common occurrence for people to drop out of mental health treatment for a variety of reasons such as impulsive or disorganized behaviors, pessimistic attitudes regarding treatment effectiveness, or sensitivity to treatment side effects (Edlund et al., 2002).
- **Lack of treatment readiness:** Sometimes offenders are not psychologically ready to begin treatment, or as they progress in treatment motivation begins to deteriorate (Preston & Murphy). In response to these variables, offenders act out behaviorally so they can be removed from treatment. If we take into consideration the dynamics of treatment resistance, regressing an offender to a lower level is a better approach than removal from a therapeutic program. At the lower levels, the therapist can spend additional time and effort educating offenders about the effectiveness of treatment, build the essential therapeutic alliance, and facilitate commitment and trust. As clinicians take an active role in removing offenders' attitudinal obstacles for therapeutic change, program completion rates will increase.

- *Administrative segregation environment:* It is difficult to operate a mental health treatment program in an administrative segregation environment. Designed with security in mind, the atmosphere is not necessarily conducive to behavior change. In addition, due to the highly restricted movement and facility design with segregation at the forefront, it has been challenging at best to conduct group treatment sessions.
- *Facility separation:* Another factor believed to be limiting successful progressions is the disconnect that occurs between program components as a result of the physical separation between CSP and CCF. In order to fully utilize the incentive-level system to progress and regress offenders, it is essential that the program components be co-located within the same facility. This enables mental health staff to determine the best location within the facility/program based on the client's needs and behavior, compared to Offender Services making decisions about interfacility moves. Additionally, intrafacility moves can happen swiftly, whereas interfacility moves may take weeks to occur. A large body of research clearly demonstrates that incentives and consequences should be applied immediately after a behavior to have maximum effectiveness. In the new program, offenders progress through an eight-level system (rather than 12) based on successful completion of specific criteria outlined in each level. Offenders who withdraw from treatment through therapeutic noncompliance or inappropriate behaviors regress to lower levels.

As a result of the funding provided by the Legislature in 2010, 29 positions were allocated for the OMI program at CSP/CCF. The program has been renamed the Residential Treatment Program (RTP) and on January 4, 2013, was consolidated at CCF North, where 240 beds and 29 clinician positions have been allocated to treatment for serious mental illness. CCF was selected as the best location because it can house offenders at all custody levels, yet has more space for treatment groups and outdoor recreation than CSP, which will increase opportunities for out-of-cell time and increase therapy hours. This change will allow the Department to better focus intensive resources on the intended target population—mentally ill offenders who might otherwise be in administrative segregation at CSP. Among other improvements planned and underway:

- It is imperative that the Department create a self-injurious unit to provide immediate and specialized assessment and treatment for offenders who engage in self-harming behavior. The Department had one completed suicide among incarcerated inmates last fiscal year and three suicides already this year; our goal is a 25% reduction in serious suicide attempts systemwide. However, given the Department's experiences with self-injurious offenders (described earlier in the report), thoughtful consideration and meticulous planning are necessary before this unit can be operational.
- A 16-bed unit will be housed at CCF for offenders who have completed all levels of the residential program and are ready to begin reintegration to facilities. This program will include an in-reach component that will allow offenders leaving the program at CCF to meet with the clinicians at their receiving facility through videoconferencing. Minimal physical plant changes were made to create office space and treatment group rooms using existing open spaces.
- Recognizing the importance of a multidisciplinary approach to the success of this program, the Department supports an ongoing effort to train all CCF corrections staff on *Mental Health First Aide*. This training is designed to teach staff of all disciplines better skills for working with offenders who have major mental illness. All CCF staff completed this training between November 15, 2012, and January 1, 2013.

A portion of the Department's FY 2013 strategic plan specifically focuses on behavioral health. A key element is the improvement of behavioral health services for offenders. Specific activities under this strategic objective include:

- Revision of the psychological needs level to enable better distinction between offenders with major mental illness (MMI) and those who may have some mental health treatment needs;
- Changes to the special needs unit at CSP/CCF in accordance with the results of a thorough review;
- Improvement of physical plant and staff interventions to reduce suicide attempts and self-injurious behavior.

In recent years, state departments of corrections and jails have seen a dramatic increase in the number of offenders with mental illness. A national study found 24 percent of offenders in state prisons had a recent history of a mental health problem (James & Glaze, 2006). Based on concerns regarding offenders with MMI in administrative segregation, the Department recognizes the need to track the number of offenders who have MMI in the system. Currently the Department tracks all offenders who need mental health services, without a separate designation for those who have MMI. In order to report accurate statistics related to this population, the CDOC is revising P-code qualifiers to meet this need.

MMI is defined as those chronic mental disorders that cause longstanding problems with emotional regulation and/or reality testing, which leads to poor functioning in multiple domains, including social, occupational, and relational. MMIs include psychotic disorders such as schizophrenia, schizoaffective disorder, and psychoses not otherwise specified. Bipolar disorder and major depression are also considered MMIs.

Offenders in the CDOC with MMI often need higher-level care at our special needs facilities when their illnesses are unstable or improperly managed. Incarcerated individuals without a diagnosis of an MMI can still suffer significant symptoms of mental distress, often as a result of difficulty adjusting to prison life, suffering losses on the outside, or struggling with the "internal politics" of prison culture. Individuals in the CDOC have a high prevalence of personality disorders, particularly antisocial, narcissistic, and borderline personality traits which, by definition, lead them to be more impulsive, less tolerant of frustration and perceived disrespect, more emotionally labile, and generally without mature coping mechanisms to deal with the bumps and bruises of life. As a result, these individuals without an MMI might suffer significant emotional and/or behavioral decompensation and require further assessment and treatment at our special needs facilities to see if there might be an underlying, previously undiagnosed mental illness or whether there might be particular mental health or psychiatric remedies available to help stabilize them and get them back on track for placement in a regular facility. This is why there may a large number of individuals occupying beds at SCCF or our infirmaries who do not have a diagnosis of an MMI but still may have significant psychological symptoms requiring attention and treatment.

In the RTP, measures such as admissions, discharges, length of stay, readmissions, and outcomes (i.e., being successfully managed in the general population) will be tracked carefully to monitor progress of the new program, and we expect to see a decrease in the number of offenders with MMI in segregation. By distinguishing offenders with MMI from those with mental health treatment needs, we will be better equipped to target the most vulnerable inmates for the program.

References

- Edlund, M., Wang, P., Berglund, P., Katz, S., Lin, E., & Kessler, R. (2002). Dropping out of mental health treatment: Patterns and predictors among epidemiological survey respondents in the United States and Ontario. *American Journal of Psychiatry*, 159, 845-851.
- James, D. J., & Glaze, L. E. (2006). *Mental health problems of prison and jail inmates* (NCJ 213600). Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics.
- Preston, D. L., & Murphy, S. (n.d.). *Motivating treatment-resistant clients in therapy*. Retrieved from <http://www.csc-scc.gc.ca/text/pblct/forum/e092/e092i.pdf>