

## MINUTES

### Task Force for the continuing Study of the Treatment of Persons with Mental Illness Who are Involved in the Criminal Justice System

May 17, 2012

10:00 a.m. – 12:30 p.m.

House Committee Room 0112, State Capitol

#### Call to Order – 10:09 a.m.

The Task Force for the Continuing Study of the Treatment of Persons with Mental Illness who are Involved in the Criminal Justice System meeting was called to order at 10:09 a.m. by Kathleen McGuire, Chair of the Task Force.

#### Introductions and Welcomes

Introductions were made around the room. Task Force members and guests introduced themselves.

#### Minutes Approval

Janette Drake moved that the April 19, 2012 minutes of the Task Force for the Continuing Study of the Treatment of Persons with Mental Illness who are Involved in the Criminal Justice System be approved as provided. Michele Manchester seconded. Motion passed.

#### **Not Guilty by Reason of Insanity (NGRI) Education Curriculum** Treatment of the Persons found NGRI at the Colorado Mental Health Institute at Pueblo (CMHIP)

Ken Locke, M.D. began by describing what the psychosis is and stated that most of the people who become psychotic don't become murderers; however people who become psychotic are dangerous as they are not able to base their decisions on reality. Among the reasons why psychotic people become murderers is because their illness became more and more intense, especially if there is no protective factor of one's family to catch the signs of the illness before it becomes worse, which is especially true for young people. They commit a crime not realizing that it is a crime.

With acute psychosis, the feeling of being a human being gets fragmented. The meaning is getting lost and some symptoms are due to the attempt to bring the meaning back. The symptoms are not the cause. Psychotic mind is a different state of being, different state of mind. It is not uncommon to see the elemental battle of pure good and pure evil.

Dr. Locke described his experience of working in a minimum security ward as a psychiatrist for 46-47 patients. Dr. Locke believed one third of his patients on that ward could be treated in the community, however they were not being released. There was a culture that enabled institutionalization in the ward. The need for safety for the staff and the belief that institutionalized patients are easier to manage were behind that culture.

Dr. Locke described the elements of institutionalization to be an emphasis on denying routines in groups, erosion of self identity, "overdoing it by the staff", zero tolerance for angry and sexual behaviors, dullness, generic rewards, too much tolerance of primitive behavior, no programs to socialize and others.

The law suit against the hospital changed it all. The patients have constitutional rights to have treatment, personalized treatment plans, not just with medications but with social and psychological treatments. There were two outcomes: community-based services outreach department got funded, which allowed us to follow the cases around the state and to release people into community. We also continued with

individual therapies. One fourth of our patients is currently engaged in individual therapy. It became obvious that we had to confront the culture of institutionalization.

Kathy McGuire asked how long ago that was. Dr. Locke responded it was 10 years ago. Dr. Locke noted that the culture of institutionalization is still there. He admitted he had patients who were made worse by the institutionalization. He gave examples of patients who after releasing them back into the community didn't show any symptoms of aggressive behavior they showed when they were institutionalized.

In the past 10 years we are paying attention to our patients on an individual basis. There is a lot more than giving medication to people; there is individual therapy, education around the illness the person has to know the risks and how to handle those risks, work with substances, and work with sexual treatment team, forensic services team. Dr. Locke shared he is happy to be a part of the state hospital; he sees improvements in treatment, good personnel works here.

Michael Ramirez asked what happens to the other three quarters of the population that is not receiving individual treatment. Dr. Locke responded that not everyone is offered individual treatment. Dr. Jon Eggert added that individual therapy must meet a specific need. Not all the patients are ready for it, other forms of treatment such as group psychotherapy are offered. Generally, high risk population will get more of our resources. Individual psychotherapy will be targeted towards those who are high risk, high profile.

Barb Stevenson asked how common is it to have someone to spend the balance of their life in the state hospital. Dr. Locke responded it is very rare and it is not as common as it was in the past. Michele Manchester responded that on average people stay for 8-10 years.

Jon Eggert, Ed.D., gave a presentation on risk assessment and instruments used for conducting risk assessment. He started by saying that not all high profile cases are high risk. Risk assessment helps to determine what specific factors contributed to violence and aggression.

Three principles of effective treatment: risk (match level of service to level of risk), need (target criminogenic needs) and responsively (tailor treatment to the patient's Stage of Change, cultural background and learning style).

According to presented studies' findings the recidivism of those who are low risk increased after intensive services. Keeping people separated from the community supports, contacts any longer than necessary makes it more difficult for them to reintegrate into society. There is no need to keep someone who is low risk locked up longer than necessary.

Kathy McGuire added that the evidence based practices prove that treating someone who is low risk too much can have an adverse outcome.

The main instruments used by CMHIP are VRS (Violence risk scale) and VRS-SO (Sex offender version). Some other instruments used by CMHIP include HCR20, VRAG, PCL-R and STATTC.

VRS and VRS-SO benefits were reviewed:

1. Static factors (don't change)- gender, stability of family upbringing, age, age at first violent convictions, number of juvenile convictions
2. Dynamic factor (related to violence)- criminal personality, violent lifestyle, criminal attitudes, work ethic, criminal peers, interpersonal aggression, emotional control, weapon use, violence during an incarceration, insight into violence, mental illness, substance abuse, stability of

relationship, community support, released to high risk situations, violence cycle, impulsivity, cognitive distortion. The top three factors are substance abuse, criminal attitudes and criminal peers.

3. Measures treatment gains and reduction of risk
4. Used throughout the Colorado Mental Health Institute at Pueblo (CMHIP)

Michael Ramirez asked if there are any specific categories of mental illness that are being looked at. Dr. Jon Eggert responded that it is generally more serious chronic mental illnesses such as schizophrenia, bipolar disorder, etc.

Lenya Robinson asked for some clarification regarding the mental health factor. Dr. Eggert responded that prevailing attitude is that we don't try to change someone into a moral individual, but decrease their violence and aggression for them to be able to live in the community.

CMHIP is training its treatment teams to target dynamic factors working towards controllable, attainable, measurable and positive goals. Michele Manchester added that shifting staff culture is important.

Michael Ramirez asked how sanctions are used and how well they work. Dr. Eggert and Michele Manchester gave examples of privilege system in place- point store, etc. The treatment team can pull a particular privilege, for example being in the building unsupervised. A patient needs to meet a certain objective to regain the lost level of privilege.

Dr. Locke added that a person who is pre-contemplative requires a different treatment approach than the person who is contemplative. A pre-contemplative person doesn't recognize he has a problem, however if you show how negative behavior changes are in his own interest, than you have less need for sanctions and more likelihood of success.

### **Subcommittee Updates**

#### *Medication, Health Care, and Public Benefits*

Susie Walton updated the group on the work of the Medication, Health Care, and Public Benefits subcommittee. The subcommittee met this morning: Mike Lewis and Vicky Rogers presented the final draft of the document outlining the problem of the disincentive for work for people residing in alternative care facilities that are Medicaid certified. The document includes information on what the situation used to be, how it is harming clients, includes scenarios, etc. The subcommittee is hopeful to present the document to John Berry, the head of long term care in Colorado. The subcommittee hopes to resolve the problem on the lowest level by simple policy interpretation that will allow individuals to keep more of their personal care moneys and an incentive to work. Kathy McGuire commended the group for a job well done.

#### *Juvenile Justice Subcommittee*

Michael Ramirez gave an update on Juvenile Justice Subcommittee work. The subcommittee continues to focus on the competency issues related to juveniles. We will meet in July to pull together all of our findings and will produce a summary and recommendations to this Task Force.

### **What's Happening at Your Agency?**

Chris Habgood reported that the Division of Behavioral Health is hosting its 9<sup>th</sup> Annual Regional Offender Treatment training on June 7, 2012 in Denver. He reminded that Doug Muir is the new Division Director.

Ashley Tunstall informed the group that the Division of Youth Corrections is hosting its Provider Symposium on June 7<sup>th</sup> and 8<sup>th</sup> in Vail. Over 500 people registered for the training. The symposium will focus on trauma.

Michele Manchester shared that a new Superintendent William May is starting with CMHIP on June 1<sup>st</sup>.

### **Other Updates**

Michael Ramirez shared that a train the trainer training on a model for family advocacy will be taking place on June 12-14<sup>th</sup>. We are moving to a more structured curriculum, that might help the community to see the common themes.

Mr. Ramirez also shared his thoughts on the issue of the effects of medication on juveniles early on and the recent research that some medications provided to juveniles may be detrimental to them. They engage in criminogenic behavior and stay in the system long term. Ashley Turnstall added that the issue of high utilization of psychotropic medication is currently gaining momentum and will continue to be a topic of discussion at DYC. Dr. Lock added that the sooner you treat psychotic illness the better, however there is a lot more caution today when using antidepressants in adolescents and children. We are dealing with developing brain; they can bring long term unfavorable results. Michael Ramirez noted this topic might be a topic of discussion for the subcommittee.

Jon Eggert, Ed.D. mentioned a UK study on the correlation between a cognitive disorder and developing schizophrenia.

Lenya Robinson added that providers often prescribe medications to treat the behavior issues and are not focusing on the core issues such as trauma. It is a developing brain and we don't entirely know what the outcomes of medication will be. ADHD, ADD are often connected with trauma. She suggested that the effective treatment of trauma should be included in the entire system. Early trauma, chronic trauma has a tremendous effect on the developing brain. More emphasis on that would benefit the entire system.

Trauma training will be offered by DBH on May 21, 8:30-4:00 pm in Pueblo. The training is open to everyone. Additional trainings will be offered in the future. Ashley Tunstall suggested if the video conferencing is available for this training to please redistribute the training announcement for participants from other areas to be able to attend.

Michele Manchester reminded that two to three patients will be presenting at the next meeting.

She also asked if any members of this committee would like to tour CMHIP facility to see the whole process and patients' progression.

### **11:47 a.m. – Adjourn**

The Task Force for the Continuing Study of the Treatment of Persons with Mental Illness who are Involved in the Criminal Justice System was adjourned at 11:47 a.m.