

# Chapter 8: Criminal Justice Issues

The purpose of this chapter is to describe mental health and substance abuse services for adults involved in the criminal justice system, including existing resources, strengths of current programs, and needs. The chapter includes narrative information gathered through focus groups and personal interviews, as well as existing data from ODMHSAS and other sources.

Adults come into contact with the criminal justice system first through the police, then with the jails, then with district attorneys and the courts, then, if found guilty and sentenced, with the prisons and jails, and finally, if court-ordered, with probation or parole. At each of these contacts, concerns related to the identification and treatment of mental illness and substance abuse may become important; thus, an analysis of the criminal justice system from this perspective requires attention to each stage of the process.

## A. Existing Resources

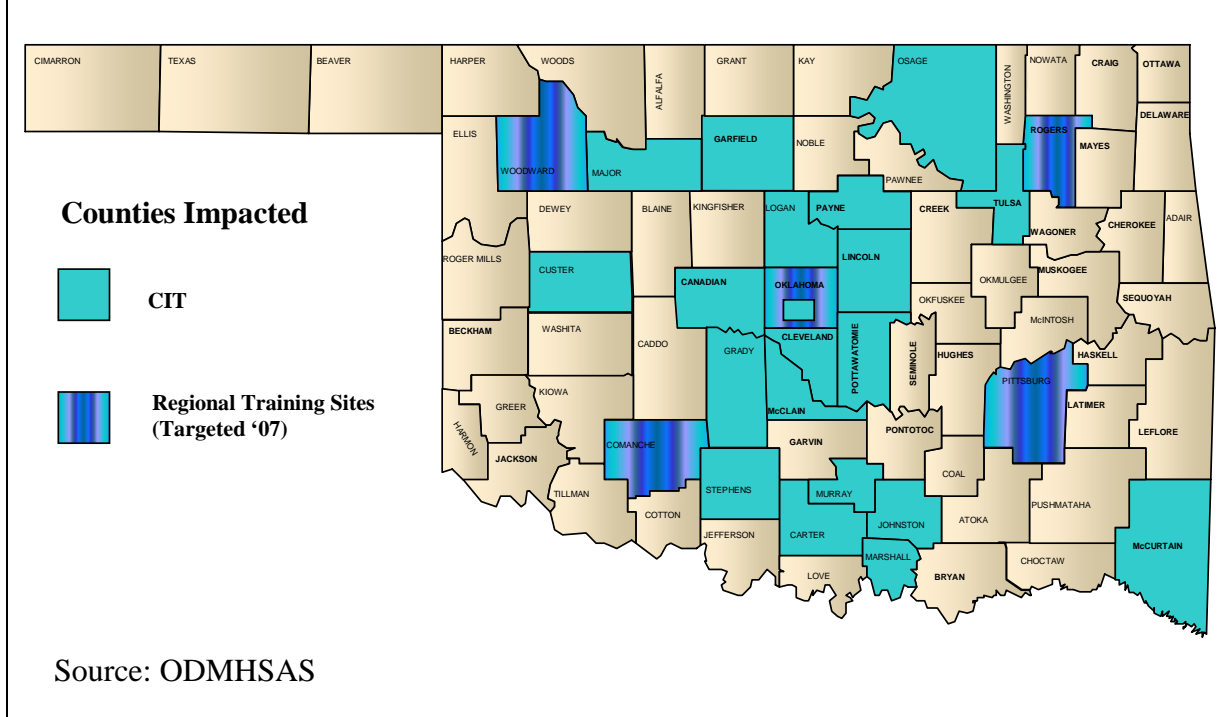
Police forces, jails, the courts, and the Corrections system have developed programs to address problems of mental health and substance abuse, both in collaboration with, and independently of, the Department of Mental Health and Substance Abuse Services. These are described in this section.

Law enforcement agencies are implementing specialized approaches to improve their responses to individuals in psychiatric crises. ODMHSAS, in partnership with the Oklahoma Police Chiefs Association, Oklahoma City Police Department, the Oklahoma Mental Health Consumer Council, consumers, and NAMI OK, provides training and technical assistance statewide for jurisdictions wanting to implement the Crisis Intervention Team (CIT) model, as developed by Memphis, TN. This gives officers a context for understanding mental health issues, and practical strategies and techniques for intervening safely in a psychiatric emergency.

The Tulsa Police Department adopted a strategy which includes a substantial commitment to training, a unique role for the police officer as the initial crisis responder and the added benefit of having access to a well established mobile crisis team comprised of mental health professionals who are available as secondary responders upon the officers' request.

Exhibit 8.1 highlights the counties in Oklahoma that have law enforcement officers trained in CIT or other formalized training in psychiatric emergency responses.

## Exhibit 8.1. Crisis Intervention Training of Police by County



To assist DUI offenders with drug and alcohol assessments and treatment, the ODMHSAS Alcohol and Drug Substance Abuse Course (ADSAC) was established. The ADSAC is a statutorily authorized program to establish certification, assessment and curricula requirements for ADSAC instructors and assessors. The ODMHSAS ADSAC staff collaborates with the Oklahoma Department of Public Safety (DPS) in working with individuals who have had their driver’s license revoked due to drug- or alcohol-related violations. In addition, ODMHSAS has collaborated with DPS to establish a data sharing protocol to provide ADSAC assessors with prior DUI conviction information.

The state’s first mental health court was established in Oklahoma County in 2002. There are now five in the state, with more under development. Mental health courts work to divert people with mental health problems who are accused of non-violent crimes from jail by re-directing them into services. Participants must enter into a plea arrangement and sign a participant performance contract indicating their responsibilities and the consequences of not meeting those responsibilities. A multi-disciplinary team provides support, linkages and monitoring to participants.

ODMHSAS operates a statewide drug court program; there are currently 50 drug courts in operation, with additional courts in various stages of development. The 50 drug courts include 38 adult drug courts, 10 juvenile drug courts, and 2 family courts. Case



either substance abuse or mental health problems or both, although these are often not formally identified and even less commonly treated. When individuals enter the facility, there is a brief screening for mental health difficulties by a triage nurse. However, if the individual chooses not to self-identify, they will not be referred for assessment and possible treatment, unless they are later identified by jail staff who observe acting-out behavior. The county contracts for the services of a small mental health team including a psychiatrist. If individuals are assessed, they may receive psychotropic medications. Generally, these are older antipsychotic medications because of budget restrictions. Other interventions are limited to brief counseling in response to a crisis. Individuals may also be placed in a special observation unit if there is a high risk of suicide. Because of close monitoring, the jail has been able to reduce the suicide rate. With the exception of two Alcoholics Anonymous groups, there are no addiction services. There are no provisions for helping individuals access community services upon release. Staff recognize that the need is much greater than can be met by available resources. They recognize that persons with lower intelligence who also have mental health or substance abuse problems are particularly likely to fall through the cracks in the community system of care.

ODMHSAS collaborates with the Oklahoma Department of Corrections (DOC) to provide several avenues of substance abuse treatment for state prison inmates. The ODMHSAS contracts with established substance abuse programs to provide screening and assessment at the State's prison intake facility and to provide residential treatment services at several prisons. Treatment services are also provided at specific community correction centers and for individuals in the probation and parole system.

A national study by the Bureau of Justice Statistics (BJS) released in September 2006 found that 56 percent of state prison inmates and 64 percent of inmates in local jails have a mental health problem. A mental health problem is defined by either a mental health diagnosis or treatment occurring within 12 months prior to the inmate interview or symptoms of a mental health disorder as specified by the DSM-IV. This study also found that 66 percent of state prison inmates and 67 percent of inmates in local jails have substance dependence or abuse (BJS, 2006a).

On June 30, 2005, 9,585 inmates were in the custody of local jails in Oklahoma (BJS, 2006b). Applying the prevalence estimates from the 2006 BJS study results in an estimated 6,134 jail inmates with a mental health problem and 6,422 with a substance use disorder. On June 20, 2005, 21,518 inmates were in Oklahoma state prisons (both state and contract facilities; DOC, 2005a). Applying the prevalence estimates from the 2006 BJS study results in an estimated 12,050 inmates with a mental health problem and 14,202 with a substance use disorder.

During FY 2005, a total of 4,572 Oklahoma prison inmates received substance abuse treatment from a private prison (therapeutic community) or a residential substance abuse program at a state prison. The 4,572 number does not include offenders participating in AA or NA programs, which are considered voluntary faith-based services (personal communication with Bud Clark, July 20, 2006).

According to the Oklahoma Department of Corrections, approximately 36 percent of prison inmates have a history of, or are currently diagnosed with, mental illness. Seventy-two percent female inmates, and 32 percent male inmates, fall in that category. Approximately 22 percent currently receive treatment, or need and refuse treatment, for a

serious mental illness. These numbers/percentages have dramatically increased since 1998. As of June 2005, approximately 5,000 inmates take psychotropic medication as prescribed, and about 20 percent of inmates diagnosed with mental illness refuse to take recommended medication. Overall, 57 percent of prison inmates diagnosed with mental illness were incarcerated for non-violent offenses (68% of female inmates, and 54% of male inmates). The percentage of inmates who were first-time offenders was 47 percent (DOC, 2005b).

Specialty mental health units have been created at three state prisons, Joseph Harp and Oklahoma State Penitentiary for men, and Mabel Bassett for women. Joseph Harp and Oklahoma State Penitentiary's units are physically separate from the general population. Mabel Bassett's unit is located within a building that houses general population inmates. These units provide acute care and intensive mental health treatment for the most severely ill inmates in housing areas that are segregated from the general population, where inmates with mental illness often are vulnerable. All three units accept inmates from other prisons. Joseph Harp also has an intermediate care unit. At Joseph Harp and Mabel Bassett, inmates are seen daily by mental health staff, have access to medication, receive individual and group counseling and are assisted with pre-release planning. Inmates housed on the mental health unit at Oklahoma State Penitentiary receive similar services; however, the 23-hour-per-day lock-down status of the facility limits frequency of access to services.

The DOC, as noted in its Strategic Plan for 2006 – 2010, is addressing the need to improve offender re-entry services. Upon incarceration, a case plan is to be developed for each inmate to address their eventual re-entry into the community. Areas to be addressed include substance abuse, cognitive behavioral therapy, and education. Through effective case management, and positive outcomes of cognitive-behavioral therapy and psychoeducation, it is believed that the individual can be moved more quickly through the system. This will foster the successful transition from inmate to community member, and also reduce the costs incurred by continued incarceration or re-offense without proper treatment (DOC, n.d.a).

With newly appropriated funds by the state legislature, ODMHSAS and DOC are collaborating to strengthen discharge planning for inmates preparing to re-enter the community and linkage to needed mental health services and supports. Specialized treatment services for inmates with co-occurring mental health and substance abuse disorders are also being initiated.

## **B. Strengths**

While the service needs of people who have mental health and/or substance abuse problems and criminal justice involvement cross a wide range of agencies and jurisdictions, there are a variety of existing resources and new, innovative initiatives that are beginning to make inroads to address these needs. There are also new and intensified efforts at cross-system collaborations that show promise in developing a continuum of approaches to meet the multi-faceted needs of this population at the state and local levels.

The police/mental health partnership discussed earlier is one of Oklahoma's strengths. As shown in Exhibit 8.1, above, law enforcement agencies in twenty-one counties have sought training and assistance. These agencies realized that they were not prepared to meet peoples' needs in the most humane and sensitive manner and wanted to

improve their effectiveness. The adoption of this initiative was influenced by problems police encountered in situations involving people with mental health problems, by the successes of similar programs in nearby jurisdictions, and by the active promotion by local consumers and family members.

In Tulsa, the Police Department adopted an approach that represents a significant expansion of the Memphis CIT model described above. Under the Tulsa Mental Health Response Officer (MHRO) model, all new officers receive most of the Memphis CIT model curriculum as a part of their initial training, and MHROs receive an additional 40 hours of training. Each class includes twenty police officers, as well as mental health professionals to facilitate cross-training; 100 officers have received the training-to-date. The goal is to have 150 officers - 25 percent of the police force-with MHRO training.

On a local level, collaborative relationships between law enforcement and mental health agencies have been developed, which greatly contributes to a better understanding of the problems faced by both systems. One example of this collaboration can be found in Tulsa with the Police Department and the COPES (Community Outreach Psychiatric Emergency Services) team, which works with both the police and the Tulsa Jail Diversion program. Teams of two- a mental health therapist and a case manager - are generally on call 24 hours a day, seven days per week, to respond to psychiatric emergencies. COPES responds to about 6,000 calls annually. They are often at the scene with police, who will allow the COPES team to take control over the situation. Their goal is to engage the individuals' trust, to inform them about their choices, and to assist them in getting access to available services. Tulsa police cooperate regularly with both the COPES team and the PACT teams to avoid unnecessary arrests.

Tulsa also has a courthouse-based jail diversion program, funded by a SAMHSA grant, which seeks to identify persons who have been arrested and jailed who require mental health services. The goal is to work with the judge presiding over the individual's case and to offer recommendations for pre-trial release or community sentencing, including ordering individuals to accept treatment. In addition, staff works to assure access to medications while in jail and to link individuals to community services upon release. The four-person staff does not have the resources to identify and assist all persons who enter the criminal justice system in Tulsa and are in need of mental health services.

Oklahoma County has a jail diversion program, the Day Reporting Program, limited to non-violent offenders. Individuals are identified at jail intake and recommendations are made to the presiding judges regarding appropriateness for screening and assessment at Northcare CMHC. Individuals admitted to the program are released from jail and live at home, reporting each weekday for up to 70 days. They receive treatment and rehabilitation services and report in by telephone on evenings and weekends. After disposition, they are offered additional services by Northcare. The program is considered successful, but is only able to serve 60 men and women at a time.

Outcomes of adult drug courts have been evaluated by staff in the ODMHSAS Decision Support Services Division. Between FY2002 and FY2005, the retention rate of active and graduate participants was 75.2 percent. To assess outcomes, comparisons were made between graduates' characteristics at entry and at graduation on a number of indicators. The findings were as follows:

- an 84.4 percent decrease in unemployment;
- a 59.7 percent increase in income;

- a 19.5 percent decrease in the percent of participants without a high school diploma;
- a 20.5 percent increase in the number of participants who had children living with them; and
- graduates with methamphetamine as their drug of choice had better outcomes on unemployment, income, and child custody, than graduates with another drug of choice.

Comparing the recidivism rate, measured by re-arrest, of drug court graduates to that of successful standard probation offenders or released prison inmates, indicates the following:

- drug court graduates were 63 percent less likely to be re-arrested than successful standard probation offenders; and
- drug court graduates were more than two times (or 131%) less likely to be re-arrested than released prison inmates.

Oklahoma County has developed a Mental Health Court. Like the Day Reporting Program, briefly described above, it is only able to serve a limited population. To be eligible, individuals must enter a guilty plea and agree to a sentence if they fail to complete a performance contract. Once all parties (the client, the judge, the district attorney, and the public defender) have signed off on the agreement, the client is assigned to the Court case manager who links the person to mental health and substance abuse services. The program also has a probation officer assigned to all its clients. The program can serve up to 25 clients, generally for one year. Over the two and one-half year life of the program, there have been 22 graduates whose charges were dismissed. Eleven persons have had their probation revoked. Other counties have since begun mental health courts.

As described above, two prisons, Joseph Harp Correctional Center and Mabel Bassett Correctional Center, have developed extensive mental health services in designated, separated housing areas. At Joseph Harp, prisoners are assessed for level of acuity and assigned to one of three units which are separate from the general prison population. These include a Mental Health Unit for intake and acute care, in which individuals are largely confined to a cell; a transitional care unit, in which individuals receive individual and group treatment; and an intermediate care unit, in which individuals have the greatest freedom of movement. If they are successful in the latter unit, inmates are transferred to the general population at Joseph Harp or another prison. Individuals may remain on a mental health unit for their entire stay if they are considered too vulnerable to be placed in the general population. Treatment includes both medication and rehabilitation. There is also a separate Habilitation unit for individuals who are developmentally disabled, some of whom are also mentally ill. Clients with whom we met were very positive about the program and the staff, but commented on the lack of recreational opportunities and were concerned about what services and supports would be available to them upon release. While prison mental health staff were proud of what they have accomplished, they were concerned that they did not have the resources to reach more individuals and to provide a stronger program to individuals they work with.

Joseph Harp also has residential substance abuse programs that are valued by participating clients. The Lifeline program is quite structured; clients meet with staff four

days a week. The focus is on understanding situations that trigger the craving for drugs or alcohol, as well as examining past behavior and belief systems and changing poor prior patterns. The program also works with individuals on reconnecting with family and planning for release, and AA and NA groups are offered. One concern raised by participants is that the program is too small to serve everyone in need. They also expressed concerns returning to their home communities, particularly in rural areas, where the police believe they are likely to re-offend and where follow-up substance abuse services are difficult to access. Both staff and clients commented on the differences between Joseph Harp and other prisons. A large part of the population is receiving some type of service. For example, an estimated 440 prisoners are on psychiatric medications. A new geriatric unit is in the planning stages. The diversity of population promotes tolerance and respect for disabilities. Both inmates and correctional officers will identify persons who show signs of serious mental health problems to the staff. There are picnic tables in the yard and family events around them. As one person expressed it, "Here you can relax. You don't have to worry about being cut for your tennis shoes."

Similar services are provided to female inmates at Mabel Bassett. There is a separate mental health unit, as well as a large proportion of general population receiving mental health and substance abuse treatment services. Approximately half of the entire prison population at this facility is receiving psychiatric medications. In addition to individual and group treatment provided by mental health professionals, outside volunteers provide self-help, arts and crafts and current events groups. Some of these services have been provided through partnerships with the Oklahoma Mental Health Consumer Council and the Oklahoma Chapter of the National Alliance for the Mentally Ill. Mabel Bassett also has two residential substance abuse treatment programs. Clients were very positive about the Substance Abuse Treatment (SAT) program available to medium security inmates assessed as having a substance abuse treatment need. The SAT structure is similar to the Lifeline program at Joseph Harp. In addition, three program graduates stay on the unit to act as mentors, which is viewed as a very important, supportive feature of this program. Participants were concerned about limited access to this program. The federally funded residential substance abuse treatment program available to minimum security inmates was poorly regarded by participants. Participants' primary dissatisfaction with this program involved the stipulation that inmates in this program are not permitted to have contact with inmates not in the program (a requirement of the grant) and participants' perception that some inmates have roles that give them undue influence over others, which undermines the therapeutic value of the program.

In order to support community re-entry, mental health programs at Joseph Harp and Mabel Bassett have focused on establishing eligibility for Medicaid and Supplemental Security Income prior to release. Staff have received SSI eligibility training and working relationships have been established with the local Social Security offices to assure that applications receive priority attention. At Joseph Harp, most such applications have been approved the first time they are submitted, which contrasts with the typical outcome for SSI applications in Oklahoma. Recent staffing shortages at Joseph Harp have disrupted this program. With monies recently approved by the legislature and the support of the Oklahoma Department of Mental Health and Substance Abuse Services, facilities with mental health units are planning to expand their discharge

planning efforts for persons with serious mental illness being discharged to the community.

The Department of Corrections, in collaboration with ODMHSAS and OHCA, are working with Mathematica Policy Research to develop new procedures to assure that persons who are seriously mentally leaving correctional institutions are enrolled in the Medicaid program. This should enable them to access mental health services more easily because providers can be assured that there is a source of payment for these services. Thus, they should be better able to obtain psychiatric medications and other follow-up treatment to assist in re-entering the community. This program is sponsored by the Substance Abuse and Mental Health Service Administration.

An innovative inter-disciplinary team of health and human services professionals provides re-entry services for high risk/high needs prison inmates under the age of 35, including those with mental health problems, who will be returning to Oklahoma County. Project Protect is a collaboration among several county agencies, funded by a federal grant. The staff makes contact with inmates who are within six months of release, and offer a range of services to help people transition, including vocational training, assistance with applying for government benefits, lining up treatment providers, arranging for housing, and other services. They also maintain follow-up contact with people after they are released.

## **C. Needs and Existing Barriers**

### **Unmet Needs**

The unmet need for behavioral health treatment, particularly substance abuse, is demonstrated by the large number of addiction-related arrests, as well as prior drug and alcohol use among jail and prison detainees. There is also evidence of high rates of treatment for serious mental illness prior to incarceration in both jail and prison.

According to the Oklahoma Department of Corrections, Oklahoma ranked 12th among the states in total uniform crime rate per 100,000 population, with 4,743 violent and property crimes per 100,000 population (DOC, n.d.b). Among all states, Oklahoma had the highest rate of female imprisonment rates in 2004: 129 per 100,000 female residents were imprisoned in 2004, totaling 2,300 imprisoned females (Frost, Greene & Pranis, 2004).

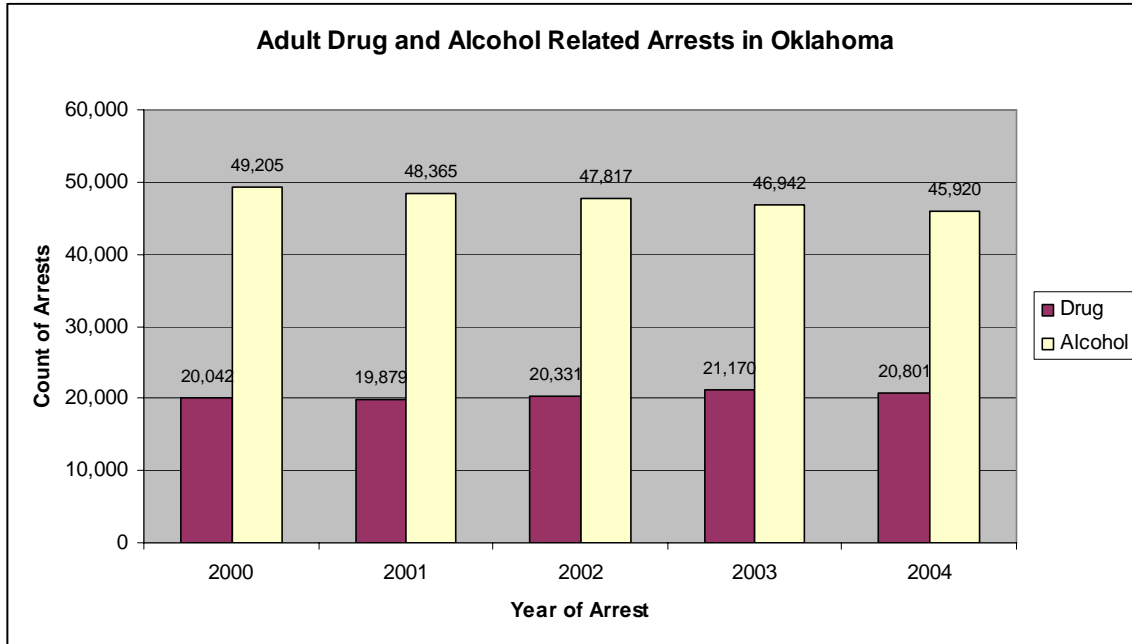
The State of Oklahoma, 2004 Uniform Crime Report (UCR), reported 22,714 arrests for drug abuse violations in Oklahoma in 2004. Possession of marijuana constituted 49.1% of the total drug abuse arrests, while sale of marijuana accounted for 4.9% of arrests. Possession of opium, cocaine and derivatives comprised 14.7% of the total drug abuse arrests; sale of opium, cocaine and derivatives equaled 2.9% of the total drug abuse arrests. Alcohol-related arrests (driving under the influence, drunkenness, and other liquor law violations) accounted for 29.0% of all arrests in 2004. This percentage represents the arrest of 45,920 adults and 1,773 juveniles (OSBI, 2006).

ODMHSAS routinely receives data from the Oklahoma Department of Public Safety (DPS) to provide data to the DUI Assessors licensed by ODMHSAS. Using those data, Exhibit 8.3 was developed to evaluate the number of DUI and drug convictions as a result of a motor vehicle or public place violation. These data do not include the number

of convictions resulting from a violation of failing a blood alcohol limit test. The number of convictions related to motor vehicle or public place drug or alcohol violations increased during FY2003 to 26,108 from the 20,000 convictions that occurred in each of the other four years.

Exhibit 8.3. Oklahoma Department of Public Safety					
Number of Drug or Alcohol Convictions by Year					
Motor Vehicle Violation Type	Fiscal Year				
	2000	2001	2002	2003	2004
DUI - Under 21	3,076	1,804	1,630	1,543	1,483
DUI	4,098	4,111	5,627	7,419	5,511
Felony Drug Possession	1,222	1,817	1,956	2,912	1,954
Misdemeanor Drug Possession	2,408	2,427	2,833	2,989	2,024
Drinking or Using Drugs in Public Place	2,663	2,892	2,527	4,223	3,878
Refused Test in Public Place	7,090	6,748	7,367	7,022	6,675
Total	20,557	19,799	21,940	26,108	21,525

Exhibit 8.4 illustrates that the number of drug-related arrests among adults in Oklahoma has been relatively consistent at 20,000 from 2000 through 2004. Alcohol-related arrests have been declining slightly since 2000, going from 49,205 in 2000 to 45,920 in 2005 (OSBI, 2001; OSBI, 2002; OSBI, 2003; OSBI, 2004; OSBI, 2006).



From 2000 through 2004, the number of drunk driving deaths increased from 229 to 278, respectively. In 2003, 38 percent of all traffic fatalities in Oklahoma were alcohol-related, compared to 40 percent nationally. Exhibit 8.5 shows the number of traffic fatalities for Oklahoma, alcohol-related fatalities, and fatalities in crashes where blood alcohol concentration (BAC) was 0.08 or above. The data in the table are related to fatalities that occur in crashes where at least one driver or non-occupant (pedestrian or pedalcyclist) involved in the crash had a positive BAC value.

Exhibit 8.5. Traffic Fatalities in Oklahoma

Year	Total	Alcohol-Related	Percent of Total	Highest BAC was 0.08+	Percent of Total
2000	650	229	35	194	30
2001	682	270	40	234	34
2002	739	251	34	215	29
2003	668	255	38	220	33
2004	774	278	36	245	32

Source: Alcohol Alert, Oklahoma Drunk Driving Statistics.  
<http://www.alcoholalert.com/drunk-driving-statistics-oklahoma.html>

With funding from the federal National Institute of Justice and Center for Substance Abuse Treatment, the Oklahoma and Tulsa County Jails were sites for the Arrestee Drug Abuse Monitoring (ADAM) projects. The ADAM project was designed to evaluate drug usage among new arrestees through the use of surveys and urinalysis. Data collection occurred one time each quarter for 14 consecutive days, eight hours per day. Exhibit 8.6 contains the percent of arrestees who tested positive for any drug (marijuana, cocaine, heroin, methamphetamine or pcp). A total of 4,313 arrestees were surveyed from the first quarter of 2002 through the third quarter of 2004 (ODMHSAS, STNAP Phase III, 2005).

Exhibit 8.6. Oklahoma ADAM Results									
Percent Positive for Any Drug									
Year	Oklahoma County			Tulsa County			Statewide		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
2002	72.1%	72.1%	72.1%	73.4%	72.2%	77.2%	72.6%	72.2%	73.7%
2003	74.0%	72.5%	78.0%	71.8%	71.2%	73.2%	72.8%	71.8%	75.3%
2004	74.5%	78.4%	64.1%	70.3%	68.4%	75.9%	71.4%	70.9%	72.6%
Total	73.1%	73.0%	73.4%	71.8%	70.7%	75.0%	72.4%	71.8%	74.2%

The results from the ADAM studies indicate 72 percent of all arrestees in Oklahoma and Tulsa counties used at least one drug prior to arrest, with females slightly higher than males (74.2% vs. 71.8%, respectively). The rate of arrestees in Oklahoma County had a higher rate than the arrestees in Tulsa County (73.1% vs. 71.8%, respectively). Among arrestees surveyed at both county jails, 49 percent tested positive for marijuana, 24.7 percent for cocaine, 4.6 percent for heroin; 16.5 percent for methamphetamine, 3 percent for PCP and 31 percent tested positive for multiple drugs.

Of the 2,367 arrestees that completed the ADAM survey at the Tulsa County site, 28.5 percent reported having had inpatient or residential substance abuse treatment and 15.8 percent reported having had outpatient treatment at some prior time. When asked about prior mental health treatment, 13.5 percent reported having stayed at least overnight for mental health treatment at a psychiatric unit of a hospital or other facility.

### Incarcerations

In 1999, ODMHSAS conducted a survey of 870 prison inmates in Oklahoma, as part of the State Treatment Needs Assessment Project (STNAP), funded by the federal

Center for Substance Abuse Treatment (ODMHSAS, STNAP Phase I, 1999). Exhibit 8.7 indicates that an estimated 97.1 percent of inmates used alcohol and 41.9 percent reported using illicit drugs in their lifetime. When asked about past 30 day use, 12.4 percent reported using illicit drugs.

Exhibit 8.7. PREVALENCE OF USE AMONG PRISON INMATES IN OKLAHOMA, BY DRUG							
Drug	Total Population	Population Estimates			Rate Estimates (%)		
		Lifetime	Last 18 Months	Last 30 Days	Lifetime	Last 18 Months	Last 30 Days
Alcohol	20,669	20,063	4,577	277	97.1	22.1	1.3
Illicit Drugs	20,669	18,438	8,661	2,567	89.2	41.9	12.4
Marijuana	20,669	18,183	6,909	2,285	88.0	33.4	11.1
Cocaine	20,669	12,644	1,631	78	61.2	7.9	0.4
Inhalants	20,669	3,876	277	66	18.8	1.3	0.3
Hallucinogens	20,669	10,653	286	0	51.5	1.4	0.0
Stimulants	20,669	10,449	1,920	337	50.6	9.3	1.6
Sedatives	20,669	8,749	1,337	17	42.3	6.5	0.1
Heroin	20,669	5,300	407	66	25.6	2.0	0.3

Exhibit 8.8 contains the estimated percent of prison inmates in need of substance abuse treatment by sex and time incarcerated. Among inmates incarcerated less than 18 months, an estimated 44.3 percent needed substance abuse treatment. Among inmates incarcerated 18 months or longer, more males were in need of treatment than females (19.4% vs. 6.9%, respectively).

Exhibit 8.8. Inmate Need for Treatment		
Gender	Months Incarcerated	Percent In Need of Treatment
Female	Less Than 18	53.1
Female	18 or more	6.9
Male	Less Than 18	41.7
Male	18 or more	19.4
Total	Less Than 18	44.3
Total	18 or more	19.6

In addition to conducting surveys with prison inmates, 382 probationers and parolees were surveyed to evaluate use of substances and the need for substance abuse treatment. The following table indicates an estimated 32.2 percent reported alcohol use in the past 30 days and 10.5 percent reported illicit drug.

Exhibit 8.9. PREVALENCE OF USE AMONG PROBATIONERS AND PAROLEES IN OKLAHOMA, BY DRUG	
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Drug	Total Population	Population Estimates			Rate Estimates (%)		
		Lifetime	Last 18 Months	Last 30 Days	Lifetime	Last 18 Months	Last 30 Days
Alcohol	31,471	30,493	22,462	10,125	96.9	71.4	32.2
Illicit Drugs	31,471	26,682	12,524	3,309	84.8	39.8	10.5
Marijuana	31,471	25,720	10,807	2,888	81.7	34.3	9.2
Cocaine	31,471	14,352	3,306	270	45.6	10.5	0.9
Inhalants	31,471	3,941	416	50	12.5	1.3	0.2
Hallucinogens	31,471	11,866	1,675	47	37.7	5.3	0.1
Stimulants	31,471	13,408	3,502	689	42.6	11.1	2.2
Sedatives	31,471	8,921	2,673	669	28.3	8.5	2.1
Heroin	31,471	3,312	223	124	10.5	0.7	0.4

Evaluation of all survey respondents under the Oklahoma Department of Corrections (DOC) supervision indicated an estimated 25.6 percent of all inmates and 28.3% of probationers and parolees were in need of substance abuse treatment. Using this estimate and number of inmates who participated in a DOC-approved substance abuse treatment program (4,572), an estimated 951 (17.2%) inmates have unmet substance abuse treatment need. This is a conservative estimate of unmet need because the estimate of need is dated and the results are based on self-report. The ADAM results show that 72% of arrestees are using drugs or alcohol at the time of arrest. If we assume that this rate (rather than 25.6%) should be used to estimate the need for addiction treatment, this would result in an unmet need of 10,960. This is a high estimate. The actual unmet need is probably between 951 and 10,960.

### **Policies**

In October 2005, the Oklahoma Board of Corrections issued a resolution recognizing the needs of people with mental illness who “come into conflict with the law as a direct result of the challenge created by their mental illness”. The resolution acknowledges the need for increased funding in order to offer the necessary services, and urges government officials to develop and implement legislation and policies that support effective community-based health services, such as Programs of Assertive Community Treatment (PACT). It calls for further development of drug courts and jail diversion programs, and commits the Department of Correction to work with other agencies on better discharge and re-entry services, and to work collaboratively across agency and jurisdictional lines to improve mental health and substance abuse services available to people with criminal justice system involvement.

The seriousness and complexity of this constellation of problems was highlighted by the convening of an Emergency Summit on Mental Illness, Substance Abuse, and Criminal Justice in November 2005, hosted by NAMI-Oklahoma. One of the summit’s goals was to develop an action plan to be distributed to the Legislature and relevant agencies to serve as a vehicle for systems change.

In order to meet the multi-faceted needs of adults with mental health and/or substance abuse problems who are involved in the criminal justice system, respondents said that there are a number of policy issues across several agencies that need to be examined and aligned. The criminal justice system involves multiple agencies and

jurisdictions that may impact upon people served by ODMHSAS, including local law enforcement, criminal courts, family courts, jails, prisons, and probation and parole. Participants said that by focusing on policy coordination among the many organizations involved, outcomes for people with mental health and substance abuse problems can be improved, and problems within each of these systems that are exacerbated by lack of access to mental health and substance abuse services can be alleviated.

Focus group participants from the criminal justice, mental health, and substance abuse fields agreed on one major barrier; as one person put it, “ There is a punitive environment in the state; the public wants people punished, not treated.” It was noted that Oklahoma has high rates of incarceration and that people are frequently incarcerated for low-level crimes that are dealt with through community service and fines in many other states. Both prison and jail officials said that they had many inmates with mental health problems “who shouldn’t be here.”

Respondents from the behavioral health field said that jails and prisons have very different approaches to dealing with people with mental illness and/or substance abuse problems than do community providers. People with substance abuse problems are not generally viewed by the corrections system as having health problems, they are simply seen as drug offenders. The official DOC website (<http://www.doc.state.ok.us/Programs/progwebpg.htm>) for Programs states: “All SAT’s utilize cognitive behavioral theory to address substance abuse not as a disease, but as a behavior that can be addressed.” It was noted that local jails may not have policies taking into account the mental health status of inmates who violate rules or act out, so many people are punished for experiencing symptoms and lose “good time” from their sentence. The DOC only recently enacted changes in disciplinary policies and procedures that required facility staff to consider the inmate’s mental status before considering disciplinary action.

Parole recommendations, which must be reviewed and approved by the Governor, are the responsibility of the Pardon and Parole Board. The Board is considered to be conservative in its parole recommendations, having a lower rate of parole recommendations than the national rate. In preparation for parole hearings, staff of the Board investigate each eligible individual and prepare reports about the crimes for which the person was sentenced and their record while in prison. If persons with serious mental illness have incidents of misconduct in their record, this will be reported to the Board. If these incidents are a consequence of their mental illness, that information is not in the record and cannot be taken into account by the Board. In general, investigators and the Board are not aware of an individual’s history of mental illness. By contrast, the Board is aware of addiction problems and will recommend substance abuse treatment as a condition of parole where it believes this is appropriate. Department of Corrections staff believe that virtually no one who receives treatment for mental illness while in prison is paroled. They typically serve their full sentence and then are released with no parole supervision. Since one important role for parole officers is to assist parolees in receiving necessary services, this increases the likelihood that the persons’ re-entry into the community will be without adequate services and supports. Even if they were under parole supervision, there are not parole officers available with specialized training in working with parolees with serious mental illness.

Participants from both the criminal justice and behavioral health systems stressed the need for policies that would make it a priority to re-direct as many people with mental health and substance abuse problems as possible into treatment rather than incarceration. Similarly, participants felt there was a need for policy changes within the Department of Corrections, the Oklahoma Health Care Authority and other agencies to ensure that all inmates with mental illness or substance abuse problems have access to sufficient, high-quality behavioral health services while they are incarcerated.

Individuals with psychiatric disabilities enrolled in the Medicaid and Supplemental Security Income programs lose their enrollment when they go into prison. When they leave prison, it is difficult to re-establish enrollment in either or both programs. As a result, many are without the means to pay for medications and other mental health services, or to pay the costs of housing, food, and other necessities..

Staff in a re-entry program for people leaving state prison pointed out that policies within the criminal justice system create almost insurmountable barriers for inmates following their release. “The system is set up to have people fail,” a staff member said. “When they are released, they have obligations to the court, such as court-ordered fees, court costs, and fines. They even have to pay for their transportation to prison and for the public defender; they have to pay their room and board while imprisoned. The child-support meter doesn't stop either. They're behind the eight ball. They can work off their payments by sitting in jail for five dollars a day.”

### **Practices/Services**

Consumers, family members and local behavioral health providers noted that, particularly in rural areas, many local police agencies have not received training on how to respond effectively to people in mental health or substance abuses crises, and that this results in unnecessary arrests and sometimes in mistreatment of people. Focus group participants said that there are not sufficient jail diversion programs across the state to re-direct people into services rather than incarceration, which they believed was both better for consumers and a more cost-effective use of tax dollars. They also said that there is a need for forensic PACT teams to help people with mental health and criminal justice involvement reintegrate into the community or to help them avoid further criminal justice involvement.

Consumers in the community who have had criminal justice system involvement reported that their needs were not understood or met, that some had suffered withdrawal symptoms because medications were abruptly stopped or changed, and that they were treated poorly and sometimes goaded by police or correctional staff because of their mental health status. Many also said they were released without enough medication to carry them over to their first mental health appointment in the community. There was a consensus among these respondents that being in jail or prison invariably made their mental health problems worse.

Concerns were raised about the small number of mental health courts across the state and the restrictive criteria that make many people ineligible to participate. It was also noted that in some mental health courts, the judge requires a guilty plea, leaving people with criminal records in order for them to get the services they need. Respondents noted that while many people seen in mental health court have substance abuse problems, and many people in drug court also have mental health issues, the two initiatives are not

linked. It was pointed out that at least one drug court refuses to accept people who have co-occurring mental health diagnoses. Others noted that when people going through drug court are mandated to residential treatment, they received no help in gaining admission to a treatment facility, which often do not have the capacity to serve the number of people seeking treatment.

Respondents from all groups said that there are not nearly enough mental health and substance abuse services inside jails and prisons, and that many of the services that do exist in these facilities are inadequate both in the numbers of people they are able to serve and the types and quality of services available. The Department of Corrections is only able to treat inmates with the most severe conditions, and others may get only medications or no treatment at all. In the past, when inmates with mental health issues are unable to follow rules or orders, their mental illness was not taken into account, and they are punished for violating codes of conduct, were often placed in solitary confinement, lose credit for good behavior, and often end up serving their full sentences.

Except in the specialty mental health prison units in three facilities, psychiatric medication is the primary treatment available for inmates with psychiatric problems, and primarily older drugs are used because of cost issues. In addition, respondents reported that even within the specialty units, funding is lacking and there are more people who could benefit from services than are able to be accommodated. In both Joseph Harp and Mabel Bassett Correctional Centers, there is very limited psychiatric time. Each facility has a single psychiatrist responsible for prescribing and monitoring the medications of hundreds of patients. In other prison facilities, there is less staffing, although there is extensive use of psychiatric medications. The same is true for substance abuse services, where Alcoholics Anonymous or Narcotics Anonymous may be the only services available, although not DOC-approved, and access to these is limited due to security restrictions. Inmates with mental health and substance abuse problems said that they needed more group sessions and more time for individual therapy. Within prison mental health units, staff reported that inmates are often afraid of doing too well, because they fear being sent back into the general population, where they feel vulnerable and unable to protect themselves.

Most inmates who participated in focus groups within correctional facilities were desperate for more time with their families. For example, women housed in the Mabel Bassett correctional facility said they cannot afford contact with their children, nor are there services to bring children to mothers. Many participants interviewed longed to share a picture with relatives; at one facility such a program existed, but was terminated. A serious problem for family reintegration after release is available housing for mothers and children.

People with mental health and substance abuse histories face a complex array of re-entry problems when they are released from jail or prison. As noted in Chapter X, housing is a particular problem. Depending on the nature of their convictions, these individuals are barred from public housing for at least three years after release; some are barred for life. Mental health and substance abuse service providers, clients, and professionals within the criminal justice system all raised this issue. Some criminal justice professionals stated that various sub-groups of people with criminal justice histories and mental health or substance abuse problems “have no options except to live under bridges.” A re-entry worker said that he was contacted by a prison asking for help

placing an 80 year old inmate who was a sex offender. The man was not ambulatory, but no nursing home would take him, and the prison had no place to release him to.

Access to jobs is also a major barrier; many professions are closed to people with felony convictions, and employers generally are not eager to hire ex-convicts, let alone those with mental health and substance abuse histories. Since many people leave prison responsible for large fines, their difficulty in making a living leaves them vulnerable to being returned to prison. It was also noted that because it takes so long to receive Social Security Disability benefits, many inmates waiting for approval leave prison with no income. This leaves people with no way to pay for medication upon their release.

### **Workforce Development and Training**

Focus group and personal interview participants stressed the need for expanded training on mental health and substance abuse issues for local law enforcement officers and correctional staff who interact with people with mental health and /or substance abuse problems on a daily basis. A lack of needed information on the part of these staff can jeopardize their safety and the safety of the person in custody, and can lead to counter-productive interventions for people with mental health and substance abuse problems. While many local law enforcement agencies have had staff participate in CIT training, others have not, and people with mental illness in those communities who participated in focus groups indicated that they felt at risk from the police. It was noted that most degree programs in criminal justice either do not address mental health issues at all, or that they erroneously teach that mental illness is a cause of crime. Both staff and inmates on specialty mental health units in prisons said there is a large unmet need among correctional staff for training on mental health issues; this echoed one of the findings of the Oklahoma Board of Corrections' resolution.

Mental health staff working with people in jails or prisons said there is an urgent need for additional staff. Some noted that between dealing with crises and spending inordinate amounts of time on paperwork, their capacity to respond to clients' mental health needs is stretched too thin. In one facility, the psychiatrist is only 20% time, and there is a need for a half-time psychiatrist just to fulfill basic requirements that inmates receive two hours with a psychiatrist over the course of a year.

### **Organization/Collaboration**

While there is increasing cross-system collaboration on the state level and in some communities, there is still much more that remains to be done. Respondents pointed out that the success of local diversion programs including drug courts and mental health courts depends on the enthusiastic involvement of district attorneys and judges, not all of whom are sympathetic to these concerns. Participants noted that while initial discussions about collaborative efforts to systematically address the many issues involved in diversion and adequate treatment in jails and prisons were started at the November 2005 Emergency Summit, few concrete actions have resulted from those meetings.

### **Data**

Both correctional staff and behavioral health staff emphasized the need for a common database to share information about the psychiatric histories of arrestees and

inmates. Ideally, respondents said, there should be a database shared nationally in order to track cases and follow up to ensure people are receiving the appropriate care.

Evaluations of Medicaid reinstatement for released offenders have found that very little data are collected by DOC about mental health services in electronic format; therefore it is not possible to determine how many released inmates have mental health diagnoses or how many received mental health services in prison. Since July of 2003, however, DOC has collected electronic data concerning participation and completion of substance abuse treatment programs, as well as faith-based programs (AA/NA). There was a call for DOC to improve data collection in this area.

### **Financing**

In its 2005 resolution concerning mental health and criminal justice issues, the Oklahoma Board of Corrections noted that there are “indications that the criminal justice system has become the primary service provider for offenders with mental illness, although it has not received sufficient funding to meet the needs of this population.” The lack of adequate funding to meet the needs of people with mental health problems in various parts of the criminal justice system was a major theme of respondents.

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