

**Individuals with Mental Illness in the
Camden County Criminal Justice System:**

*An Analysis of the Implications of a Tragedy and
Recommendations for Cross Systems Improvements*

Conducted for:

The County of Camden

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Introduction

On January 27th, 2004, Mr. Joel Seidel, a 65-year-old individual suffering from serious and persistent mental illness, was beaten to death while incarcerated in the Mental Health Unit of the Camden County Correctional Facility (CCCF). The facts and circumstances surrounding this tragic event have raised numerous issues and concerns relative to the care, safety and treatment of individuals suffering from mental illness in the Camden County criminal justice system; the utilization of the CCCF as a mental health treatment facility; and, the roles and responsibilities of other levels and branches of government. The undersigned was engaged by the Camden County Board of Chosen Freeholders to review this matter and to formulate cross systems recommendations that might lead to the enhancement of said care, safety and treatment and that might also reduce the likelihood of a repetition of such a tragedy.

A holistic understanding of the nature of the problems identified in this study and the means and methods of solutions to those problems must be viewed in the following context:

- The problems associated with the intersection of the mental health and criminal justice systems identified in this report are not at all unique to Camden County but are State-wide and Nation-wide in incidence and prevalence;
- All levels (Federal, State, County and Municipal) and branches (Executive, Legislative and Judicial) have important roles and responsibilities in this area inclusive of policy, finance, regulation, oversight and direct operations – no one level or branch can unilaterally effectuate needed change or improvements;
- The best solutions are cross-systems and collaborative in nature involving the different disciplines involved at the local level working together with shared values and a shared vision.

This report is conceptualized from the standpoint as to what the County of Camden might strive to achieve in the way of overall improvements. The report is not intended to relieve other levels and branches of government or the general community of their responsibilities in this same vein. All must take ownership and responsibility for the problems identified if real and sustainable improvements are to be achieved.

Methodology

Information for this report was gathered from a broad variety of sources including contacts and interviews with key local and state stakeholders, a review of numerous local documents and reports bearing upon the specific incident as well as issues pertaining to the intersection of mental health policy and services with those of criminal justice and corrections in Camden County, numerous press articles; and, a review of the national literature on this topic. The undersigned was assisted in this regard by a post doctoral and a post masters degree student both affiliated with Rutgers, The State University of New Jersey who are co-authors of this document.

Specific discussions were held with elected and appointed officials of Camden County responsible for criminal justice, corrections and related public responsibilities including;

- Members of the Board of Chosen Freeholders;
- The Deputy County Administrator, Warden of the CCCF and members of the staff of the Facility;
- Senior members of the Camden County Judiciary and court system;
- Senior members of the Office of The County Prosecutor and Staff;
- The President of PBA Local 351 representing the corrections officers employed at the CCCF; and
- The President of the Camden County Chiefs of Police Association.

The undersigned is indebted to David Owens, Deputy Camden County Administrator, for facilitating and arranging these meeting and contacts and with providing key documents and reports on an expeditious basis.

In addition to the above, meetings and contacts were also conducted with local planners, advocates, service providers, consumers and their families including:

- The Mental Health Association in southwestern New Jersey;
- The Camden Planning and Advocacy Council (CPAC) – Camden County Mental Health Board;

The Camden Mental Health and Criminal Justice Report

- The Camden County Criminal Justice Planning Committee;
- Members of the New Jersey Chapter of the National Association for the Mentally Ill (NAMT);
- Members of the staff of the New Jersey Office of the Public Defender;
- Members of the staff of the New Jersey Mental Health Law Project;
- Leadership and staff of Steininger Behavioral Care Services (SBCS) – the agency under contract to provide behavioral care services to inmates of the CCCF; and
- Members and staff of the New Jersey Mental Health Association.

The undersigned is especially indebted to Mary Lynne Reynolds, Executive Director of the Mental Health Association in Southwestern New Jersey for arranging for the undersigned to meet with groups of consumers, families and advocates; to Chuck Steinmetz of the Camden Planning and Advocacy Council (CPAC) for arranging a meeting with a committee of the Camden County Mental Health Board and providing key documents relative to mental health services in the County of Camden; to Carolyn Beauchamp, Executive Director of the Mental Health Association of New Jersey for including the undersigned in policy meetings on this topic; and, to Dr. Len Altamura, CEO of SBCS for providing key documents and identifying national web sites and literature that were of great assistance in the preparation of this document.

Finally, meetings were held with the leadership of the New Jersey Division of Mental Health Services and the Center for Mental Health Services & Criminal Justice Research of Rutgers, The State University of New Jersey. The Directors of these organizations provided invaluable insights into the issues at hand as well as a national and state perspective of the fundamental and underlying issues.

Local data and documents reviewed included:

- Camden County Correctional Facility 2003 Annual Report and Population Analysis;
- Report of the Internal Affairs Unit of the CCCF on the Death of Inmate Joel Seidel;
- National Institute of Corrections Technical Assistance Report #04J1081 – Local System Assessment for Camden County NJ Correctional Facility;

The Camden Mental Health and Criminal Justice Report

- A chronology of events prepared by the office of the Camden County Prosecutor;
- Superior Court, Law Division - Criminal Justice Process (Flow Chart), Camden County New Jersey;
- Classification Policy – Camden County Department of Corrections;
- Contract By and Between The County of Camden and Prison Health Services, Inc.;
- Statistical Reports for 2003 of health and medical services (including mental health); provided to inmates of the Camden County Correctional Facility;
- Reports dated January 12, 2004 and August 2, 2004 from the New Jersey Department of Corrections reflecting the results of inspections of the CCCF relative to compliance with *The Manual of Standards for New Jersey Adult County Correctional Facilities*;
- Correspondence from the National Commission on Correctional Health Care to the County of Camden dated July 2, 2002 reflecting achievement of accreditation;
- Various planning documents produced by the Mental Health Board of Camden County;
- Mental Health Association in Southwestern New Jersey- Recommendations Regarding the Incarceration of the Non-violent, Mentally Ill Offenders (July, 2004); and
- Numerous press articles appearing in the *Courier Post*.

With respect to a review of the national literature relative to the topic of the mentally ill in the criminal justice system, a bibliography of the sources utilized for this purpose is appended to this paper. The Undersigned is especially indebted to the Criminal Justice/Mental Health Consensus Project coordinated by the Council of State Governments. The web site of this initiative [www.consensusproject.org] contains invaluable information including interdisciplinary recommendations and most promising practices which were developed in partnership with the Association of State Correctional Administrators, Bazelon Center for Mental Health Law; Center for Behavioral Health, Justice and Public Policy; National Association of State Mental Health Program Directors, Police Executive Research Forum and the Pretrial Services Resource Center.

The recommendations made below in this report, although drawing upon the source material noted above and in the bibliography attached hereto, are exclusively those of the undersigned.

Summary of Circumstances Leading up to the Death of Joel Seidel

Mr. Joel Seidel was incarcerated on December 30, 2003 based upon a complaint that he had violated a restraining order issued by the Camden County Superior Court at the request of Mr. Seidel's family. It is reported that the complaint was intended to obtain the assistance and services that Mr. Seidel required based upon what the family perceived to be the deterioration of his mental status. They expressed their belief that the nature of his illness would not result in Mr. Seidel seeking assistance on his own accord and that he was at serious risk as a result of his behavior and life circumstances.

Bail for Mr. Seidel was set at \$1500 with a 10% cash option. Mr. Seidel remained in the CCCF from the date of his initial incarceration of December 30, 2003 until the date of his death on January 27, 2004 in lieu of the posting of \$150 in cash.

Upon admission to the CCCF, Mr. Seidel was screened by staff of Steininger Behavioral Care Services (SBCS). The latter is a subcontractor for mental health services to Prison Health Services, Inc who is under direct contract with the County of Camden to provide all necessary health care services to inmates of the correctional facility. The screening conducted and the application of the facility classification policy resulted in Mr. Seidel's placement in the Mental Health Unit. The latter is a special care unit located on Level 2 of the CCCF and contains an examination room, offices, and 18 single tiered cells opening upon a common area available to inmates placed in that unit.

During the period of his incarceration, Mr. Seidel had one court appearance on January the 13th 2004. Mr. Seidel is reported at that time to have opposed commitment to Lakeland Psychiatric Hospital (a Camden County operated inpatient facility) for a thirty (30) day evaluation as he stated he had already been evaluated. He also appeared to be in a bruised and weakened condition reportedly as a result of an altercation with another inmate in the Mental Health Unit. The Court obtained an initial psychological evaluation conducted by the SBCS at the Correctional facility but the Judge determined more information was required to assess Mr. Seidel's competency. The matter was continued for one (1) week, heard again on January 20,

2004 and continued again for an additional week. Continuances appear to have been issued with the intent of obtaining an adequate and appropriate evaluation of Mr. Seidel's mental status and competency for dispositional purposes.

During the period of Mr. Seidel's incarceration the Correctional Facility was severely overcrowded and inmate population exceeded the rated capacity of 1,267 inmates by approximately 500 (39%) on any given day. Overcrowding also affected the mental health unit resulting in at least double and triple and bunking of inmates in the eighteen (18) cells of this unit on a routine basis. On January 27, 2004, the day of his death, Mr. Seidel was placed in a cell with two (2) other inmates, one of whom is the individual alleged to have administered the beating that resulted in his death.

Initial Observations, Notations and Concerns

1. Mr. Seidel's incarceration at the CCCF was apparently viewed by his family as a gateway to the care and treatment he required as a result of his chronic mental illness. This was likely based on his history of resistance to traditional forms of treatment and care as well as a perception that there were no other viable alternatives. During the period spanning the incident and this report there are no programs or services in existence in Camden County that are designed expressly to divert appropriate mentally ill individuals from the criminal justice system at either the levels of the police, the CCCF or the Camden County courts.
2. Mr. Seidel's length of stay at the CCCF of almost one (1) month was contributed to by a lack of clarity and common understanding of records and procedures related to competency determinations and commitment of mentally ill individuals to inpatient facilities and other dispositional alternatives. Management of the CCCF report reduced access and increased waiting times for State services and facilities in this regard, especially those of the Ancora Psychiatric Hospital and Anne Klein Forensic Facility. State officials do not necessarily share this view.
3. There are indeed a significant number of inmates at the CCCF requiring mental health care at a variety of levels. Statistical reports compiled by SBCS for the month of

December, 2003 (the initial month in which Mr. Seidel was incarcerated) reveal that of the average daily population for that month of 1727 inmates, 224 or 13% were seen by a psychiatrist, 486 or 28% were seen by other mental health counselors, and a total of 271 or 16% were taking prescribed psychotropic medications. The meaning and implications of the latter item require further analysis. Consumers and others report that many inmates not suffering mental illness seek out psychotropic medications to help them sleep and deal with the situational anxiety induced by the correctional setting.

4. An analysis of the contracted responsibilities of the SBCS reveals an emphasis on initial evaluation, classification and placement as necessary into the CCCF Mental Health Unit along with the administration of prescribed psychotropic medications. Given the CCCF is generally intended to be one for short term incarceration (2003 data reveal that 59% of inmates stay seven (7) days or less), a program of long term treatment and therapy is not provided for.
5. The CCCF is an institution fully accredited by the National Commission on Correctional Health Care, and operates in substantial compliance with *The Manual of Standards for New Jersey Adult County Correctional Facilities* as inspected by the New Jersey Department of Corrections. Yet, overcrowding in the Mental Health Unit clearly contributes to a dangerous and anti-therapeutic environment and was unquestionably a contributing factor to the incident at hand. Individuals who are incarcerated often experience shock, fear, disorientation and depression and may be a danger to themselves or others. This is especially true of individuals with mental illness whose prescribed regimen of medication and therapy may also be disrupted. If such inmates are confined in close quarters with other mentally ill individuals who are exhibiting threatening or troublesome behavior, a volatile situation is likely to ensue. Furthermore, as noted in the Technical Assistance Report to the CCCF prepared by the National Institute on Corrections, overcrowding defeats sound classification and custody policies and practices so that there becomes insufficient segregation and observation of potentially violent or dangerous inmates in overcrowded situations.
6. The issue of the general overcrowding of the CCCF is beyond the scope of this study; however, means and methods to divert mentally ill individuals to more appropriate settings – especially those with low - level charges obviously needing mental health care

– are within the scope. As noted above, during the time frame of the events reported above, there were no explicit active programs designed to divert such individuals to more appropriate settings. In addition, there were no programs designed to assist mentally ill inmates who were discharged with reentry into the community in ways that would reduce or minimize the likelihood of re-incarceration. It is interesting and relevant to note, however, that the SBCS has received a grant from the New Jersey Division of Mental Health Services to design and operate a program in the latter regard that might ultimately extend to diversion services as well.

7. An investigation conducted by the internal affairs unit of the CCCF of events leading to Mr. Seidel's death concludes that certain assigned corrections officers did not follow established policy and procedure designed to maintain the safety and security of inmates and formal disciplinary actions were instituted against these individuals. The best designed services and facilities will not succeed unless established policy and procedure is carried out effectively. This raises the issues of training and supervision – not just for correctional officers but also for all stakeholders in this system. The undersigned did encounter middle-management level correctional officers at the CCCF who were quite knowledgeable and experienced in the care and custody of the mentally ill. The facility has more recently instituted a training program for corrections officers relative to the care and custody of mentally ill inmates.
8. The Camden County Mental Health Board, a statutorily prescribed entity charged with the responsibilities of planning and advocating for mental health services and allocating public funds for this purpose reports a general paucity of available mental health services for residents of Camden County. The Board attributes current overcrowding of juvenile and adult correctional facilities to be a result of an inadequate supply of community based mental health services. They also report high levels of activity and delays at designated mental health screening centers for Camden County (also reported as a State-wide issue in a document prepared by the New Jersey Psychiatric Association) and a high percentage of substance abusing individuals in the system.

All of the above is reflective of a dilemma that involves multiple levels and branches of government as well as multiple professional disciplines and fields of services. Policy and

practices often conflict, solutions are often controversial and expensive, and the target population of mentally ill offenders does not have a strong constituency to drive policy in the public arena. A review of the national and state literature reveals that this issue is not simply a Camden County issue but is statewide and national in scope.

Public policy in this area necessarily requires a balance between holding offenders, including individuals with mental illness, accountable for their behavior with providing a reasonable level of safety and care for those who must be in the criminal justice system. A key objective, as graphically demonstrated by the death of Mr. Seidel, is to have a sufficient and accessible supply of mental health services so that the criminal justice system, particularly the county correctional facility, is not used by default as a primary modality of mental health care for the seriously and persistently mentally ill. There are numerous challenges in meeting such an objective, not the least of which are the resistance to treatment that many seriously mentally ill individuals demonstrate as well as what is reported to be a general paucity of available, accessible and appropriate services for this population.

Mentally Ill Individuals in the Criminal Justice System: A National and State Overview

National Overview

The case of Joel Seidel is emblematic of a larger problem: the high proportion of individuals with mental health problems involved in the criminal justice system. Statistics reveal a national problem. Adult correctional populations have substantially higher percentages of mental illness than their counterparts in the general population (Ditton, 1999). The Bureau of Justice Statistics (BJS) reports that 16% of state prison and jail inmates and probationers have some type of mental illness (Ditton, 1999). This proportion is over five times greater than the 3% prevalence of mental illness found in the general population (Teplin, 1990).

Moreover, serious and persistent mental illness is over represented in the correctional population, especially in jails. Rates of schizophrenia, major depression, & mania are two to four times higher in jails than in the general population (Teplin, 1990; Council of State Governments, 2002). Not only is there a high prevalence of serious mental illness in this correctional setting, the need for continuum of care is evident. Since admission to jail, 10% of

inmates are admitted overnight to a mental health hospital or treatment program, 34% take prescribed psychotropic medications, and 41% receive some form of mental health services (Ditton, 1999).

Arrest rates are higher for those individuals showing mental health symptoms (Teplin, 1984). Charges may range from minor to serious offenses. Fifty-three percent of state prison mentally ill inmates and 30% of mentally ill jail inmates are serving time for a violent offense (Ditton, 1999). Yet a substantial amount of mentally ill offenders, especially those housed in jails (23%), are charged with less serious offenses, including misdemeanors (Ditton, 1999). Thus, jails consist of a population of a non-violent to violent mix of mentally ill offenders.

New Jersey Overview

Many states, such as New Jersey, are actively addressing the needs of the mentally ill offender population. As a direct result of the *C.F. versus Terhune* (CA 961840) class action suit (1999) in which mentally ill inmates sued the New Jersey prison administration, the New Jersey Department of Corrections' treatment of mentally ill inmates shifted dramatically (Cevasco & Moratti, 2001). As a result, their role changed from that of non-experts to active providers in the assessment and identification, treatment, and discharge planning of mentally ill offenders. Presently in New Jersey, incarcerated persons with mental health problems are identified by prison mental health staff at any time during their prison stay as "special needs inmates" (Cevasco & Moratti, 2001). These special needs inmates are individuals who need or receive "mental health treatment of some type" while in prison (Cevasco & Morrati, 2001, p. 166). This treatment can include a psychotropic medication regimen and/or individual or group counseling.

Of approximately, 19,000 inmates in NJ state prisons in 2002, 3,200 (16%) were identified as special needs inmates (Wolff, Maschi & Bjerklie, 2002). Serious mental illnesses, such as schizophrenia, psychotic disorders, and dementia, are more common disorders among the NJ state prison population. Rates of mental illness in New Jersey jails, 16%, (Wolff and Veysey, 2001), are similar to state prison and national prison estimates, 16%, (Ditton, 1999).

Source of the Problem

There are several identified sources to explain the disproportionate confinement of mentally ill offenders. First, a lack of alternative treatment options may lead to the criminalization of the mentally ill (Lamb & Weinberger, 1998).

De-institutionalization (Lamb & Weinberger, 1998; Robinson, 2000), the lack of access to community mental health services (Lamb & Weinberger, 1998), rigid involuntary commitment criteria (Husted & Nehemkis, 1995), and the lack of training/preparation for law enforcement officials to deal with encounters with mentally ill individuals, have been factors which are cited as leading to these higher arrest rates (Reuland, 2004).

Consequences of the Problem

Managing mentally ill offenders is a problem for both correctional and mental health systems and the wider community. High crime rates, offender recidivism, overpopulated jails and prisons, and the lack of preparation and services for offenders awaiting release are just a few of these problems. Moreover, by not meeting the needs of mentally ill offenders, the implications are far reaching for the mentally ill individual, such as in the tragic death of Joel Seidel. Particular to jails, inmate stays are significantly shorter and individuals are cycled through the system often too quickly for mental disorder to be identified and proper treatment implemented. This issue has generated conflict between County corrections and State mental health officials in Morris County and a tragedy somewhat similar to the one in Camden, occurred in Essex County.

In summary, there is a high prevalence of incarcerated mentally ill offenders, both nationally and in the state of New Jersey. The source of this problem has been attributed in part to the lack of community treatment options, which has resulted in this population being routed through the criminal justice system.

A Review of the National Literature: Most Promising Practices

Over the last three decades, improved responses to persons with mental illness have emerged within the mental health and criminal justice fields. These targeted interventions may occur at prebooking (i.e., police diversion or mental health courts) or postbooking (i.e., mental health courts, jail and prison mental health services and prison reentry programs) stages of criminal justice involvement. The most promising practices involve an element of collaborative planning, especially among criminal justice and mental health professionals, community officials, and mental health advocates (Reuland, 2004; Steadman et al., 2000). A description of community mental health services, police diversion programs, mental health courts, jail and prison mental health services, and prison reentry programs and the most promising practices within each category are outlined below.

Community-based Mental Health Services

One of the first steps in avoiding incarceration is to ensure that an established mental health system with a comprehensive continuum of care exists within the community (Council for State Government, 2002). The need for these services is underscored by the ongoing trend of deinstitutionalization, which has a core belief that people with mental illness should be treated in a less restrictive setting (Robinson, 2000). Community mental health services are advantageous because they can provide individuals with mental illness more opportunities to participate in society. The successful integration of patients from hospitals into the community relies on community-based services. While research is limited, there is evidence showing that mentally ill individuals can be self sufficient members of the community when possible and appropriate (Council for State Government, 2002).

The central concept of community mental health services is to avoid institutionalization, including imprisonment. Evidence suggests improved mental health programs decrease the number of criminal justice contacts by individuals with mental illness (Council for State Governments, 2002). The linkage between the mental health and criminal justice systems is crucial to successful services for individuals with mental illness. Cooperation between stakeholders in both systems appears to be the most significant factor among those communities

that have improved the response to individuals with mental illness (Council for State Governments, 2002).

A significant barrier that affects the outcomes of mental health services is the lack of affordable housing, which has become a crisis nationwide. (Note: This especially true in New Jersey given a very limited housing supply and high regional costs). Individuals with mental illness are among the poorest in this country and therefore are largely affected by this crisis. The lack of affordable housing inevitably leads to homelessness, which in turn can then lead to decompensation and the risk of becoming involved with the criminal justice system (National GAINS Center, 2001). The Council for State Governments (2002) recommends that community-based providers address housing through the development of housing resources and building partnerships to work towards a solution together.

National GAINS Center (2001) examined a program in California that addresses homelessness and its related outcomes. The *Community Mental Health Treatment Program* (CA) is a community mental health program that serves individuals with mental illness who are homeless, at risk of homelessness or incarceration, or recently released from jail or prison. The central goal of this program is to get patients off the street and into permanent housing followed by treatment. The integrated services approach emphasizes individualized treatment planning and relies on intensive collaboration among mental health services, criminal justice systems, and other related systems. Successful outcomes of this program include decreased days of homelessness, incarceration, and hospitalization among mentally ill individuals (National GAINS Center, 2001).

Police Prebooking Diversion Programs

Police are often the front line law enforcement officers who first encounter persons either having or suspected of having a mental illness (Teplin, 2000). Because of the critical gatekeeping role of the police, police prebooking diversion programs were developed to help reduce the needless incarceration of persons with mental illness by circumventing them from the criminal justice system and into mental health treatment (Reuland, 2004; Steadman et al, 2000;

Steadman et al, 2001; Teplin, 2000). There are two main types of specialized police responses (Steadman et al, 2000): police-based specialized police response (e.g., Memphis, Tennessee Crisis Intervention Team) and a mental-health-based specialized mental health response (e.g., Knoxville, Tennessee Mobile Crisis Unit). Police based response models in which police are the initial and only responders differ from mental health-based models in which mobile crisis teams provide a secondary response at the incident location.

The central concept behind police specialized responses to person with mental illness is for police officers to make proper community referrals in lieu of arrest (Steadman et al, 2000). The Mental Health Consensus Project outlines three core elements effective police specialized responses to persons with mental illness (Council of State Governments, 2002). These three core elements are: specialized police officer training, law enforcement partnerships with mental health community resources, and an additional role for specially trained police officers and are outlined below (Council of State Governments, 2002; Steadman et al, 2000).

The first essential element of police specialized responses is specialized training for police officers who will encounter persons with mental illness and police dispatchers who screen incoming calls to the police station. A team of instructors, which include local mental health service providers, people with mental illness and their family members, police department personnel, present the curriculum. Police officers become better prepared to deal with encounters with persons with mental illness because they learn to recognize the signs of symptoms of mental illness and learn crisis intervention skills through didactic and experiential exercises (e.g., role playing) (Reuland, 2004).

The second element of police specialized programs is the formation of partnerships between law enforcement officers and local mental health service providers. Police officers are given ready access (24 hours, 7 day a week) to emergency mental health services. This unrestricted availability of services allows police officers the option to refer individuals suspected of having a mental illness for an assessment and possible treatment instead of incarceration. Specially trained police officers may make linkages to a variety of community resources, such as crisis stabilization units, mobile crisis teams, homeless shelters, and substance abuse services (Council of State Governments, 2000).

The third element of police specialized responses is an expanded role for the specially trained police officers. Service is voluntary and team oriented. Specialized police officers often wear special pins or badges and often receive additional financial compensation. Although they are not trained as mental health professionals, these specially trained police officers provide an initial mental health assessment when encountering a person suspected of having a mental illness.

The most widely adapted program, the Memphis Crisis Intervention Team (CIT) represents a police-based specialized police response. Officers are trained in a team to assess and diffuse encounters with persons with mental illness and transport individuals suspected of mental illness to the psychiatric emergency services. One per cent (130) of 130,000 police officers are trained to respond to mental health emergencies in addition to their regular duties (Steadman et al., 2000). Police officers are provided 40 hours of specialized training by mental health and criminal justice personnel. Upon completion of this training, officers receive a crisis intervention medallion, which they wear on the scene, which signifies that they are the designated officer in charge. This program is deemed effective and time efficient because the mental health services available to the police have a single point of entry, a streamlined mental health intake process, and a no refusal policy (Steadman et al., 2000, 2001).

Mental Health Courts

Specialized mental health courts have been developed to address the issues of defendants with mental health problems facing court. The central concept behind mental health courts is to avoid criminalization and recidivism, and attempt to reduce the number of days in jail. This diversion approach is a court-based pre-booking or post-booking program. (Watson et al., 2001).

One of the key elements of mental health courts is the alliance between mental health professionals and court personnel in order to identify offenders with mental illness and to develop alternatives to incarceration (Watson et al., 2001). Originally established to address overcrowding, especially in jails, and the rising number of inmates with mental illness,

contemporary mental health courts vary significantly with the exception that participation in these programs is voluntary. Mental health courts have more of a supervisory capability than community based services because they provide more intense supervision of the defendant with mental illness through the court monitoring of treatment (Goldkamp and Irons-Guynn, 2000).

In an assessment of existing mental health courts (Watson et al., 2001), the mental health court in Broward County, Florida was reviewed. Established in 1997 as the first mental health court in the nation, the Broward County mental health court was developed by a mental health and criminal justice task force with the goal of reducing overcrowding and inadequate mental health services in jails. This court has a mechanism that can immediately divert an offender with nonviolent misdemeanors into treatment before a trial. The court considers the individual needs of the defendant and monitors ongoing treatment (Watson et al., 2001).

One significant issue of mental health courts is the fact that there is no perfect model to fit all jurisdictions and thus they vary in their features (Watson et al., 2001). For example, programs often vary in their way of settling criminal charges (as to whether they drop the charges after successful completion of the treatment program) and/or how noncompliant participants are handled (Goldkamp and Irons-Guynn, 2000). Goldkamp and Irons-Guynn (2000) note that the success of mental health courts depends on a combination of collaboration, due process, and the availability of appropriate mental health services (Watson et al., 2001). A challenge of the practice is the identification of mental illness, which must be timely and accurate (Watson et al., 2001).

In-Jail and In-Prison Mental Health Services

Jail administrators have a significant responsibility to provide a safe and secure environment within the jails. In addition, they must also assure that the constitutional rights of inmates are provided for, within the Eighth and Fourteenth Amendments, to provide mental health treatment during incarceration (Robinson, 2000). The central concept behind the provision of mental health services within jails and prisons is "to provide for the detecting, diagnosing, treatment, and referring of inmates with mental health problems and provide a

supportive environment during all stages of incarceration” (Robinson, 2000, p. 60). Further, as found in the *C.F. v Terhune* case (1999), some inmates cannot meet the functional requirements during incarceration without mental health treatment.

Jail mental health services are typically provided by private organizations, community mental health providers, or linked with university medical school psychiatry personnel (Steadman and Veysey, 1997). In their examination of jails and prisons in the nation, Steadman and Veysey (1997) found that small jails typically had very little to offer besides screening and suicide prevention services. Many of the larger prisons had a range of mental health services provided with the facility’s psychiatric inpatient programs. The range of mental health services found within jails and prisons included screening services, evaluation, suicide prevention, crisis intervention, psychiatric medications, therapy, and inpatient care in the jails (Steadman and Veysey, 1997).

Jo Robinson, Director of Jail Health Services, San Francisco Department of Public Health, developed 12 key elements that would satisfy the requirements necessary for an adequate jail mental health treatment program as follows (2000):

- Develop or maintain a mental health program that functions as an integral part of the correctional facility;
- Employ a psychiatrist;
- Have adequate staffing of other mental health professionals and sufficient support services for the staff;
- Provide a systematic program for screening all inmates for signs, symptoms, and history of mental illness at intake and then for evaluating those inmates who are believed to have a mental illness;
- Offer appropriate treatment services that include individualized treatment plans, alternatives to segregation, and increased supervision, and discharge planning;
- Appropriately supervise and re-evaluate the prescribing and administration of psychiatric medications;
- Have an appropriately licensed in-patient unit or written agreement with a hospital that can treat acute mental illness;

- Maintain accurate, complete and confidential mental health treatment records;
- Provide a program for identification, supervision, and treatment of inmates with suicidal tendencies;
- Adhere to local community standards of care;
- Maintain policies and procedures that govern the jail mental health treatment and that address applicable and mandated standards of care;
- Provide training to the custody and treatment of staff.

(For a more detailed description of each of these elements, see Robinson, 2000)

An example of an in-jail mental health service program reviewed by Steadman and Veysey (1997) is the Pinellas County (FL) Jail, which uses a private contractor to provide mental health services, required minimum staffing, professional liability insurance, and medication. A significant element of this program is the employment of a contract monitor for compliance to ensure accreditation standards and staffing patterns.

Jefferson County (Kentucky) demonstrate an innovative crisis intervention program that employs a crisis intervention team charged with assessment, stabilization, and the assurance of providing appropriate housing for inmates with mental disorders in crisis (Steadman and Veysey, 1997). The team consists of a mental health manager, a master's level clinical psychologist, and a certified psychiatric mental health nurse. This jail also sustains a suicide watch program, which provides training for inmates to participate in nightly rounds with correctional staff and receive training on how to recognize signs of depression or risky behavior. (Steadman and Veysey, 1997).

Cevasco and Moratti (2001) provide a description of several components of the mental health services system within the New Jersey prisons. One component is the stabilization units that are provided for inmates who are acutely ill and not in need of immediate hospitalization. The stabilization units are short term, from 3-10 days and are intended to evaluate and manage the inmate with mental health problems through intensive treatment and medication if necessary. The staffing on these units includes psychiatric nurses, social workers, a psychiatrist, and a

psychologist. On these units, there is 24-hour nursing coverage and daily evaluations by the psychiatrist and the psychologist. (Cevasco and Moratti, 2001).

Reentry Programs

In an intense assessment of jails across the country, Steadman and Veysey (1997) found that discharge planning was provided the least, in comparison to all mental health services provided in jails. Further, most jails in this study shared a belief that their responsibilities end when the inmate is released (Steadman and Veysey, 1997). Transition planning has been found to be the most valuable in jails, where, very often, the setting appears to be similar to psychiatric crisis centers, comprised of many individuals with mental health problems and are moving in and out of the setting rapidly (Osher et. al, 2002).

The central concept behind discharge or transition planning is to help the inmate achieve a successful reintegration into the community from jail. Key objectives include reducing recidivism rates, maintaining public safety, reducing the risk of increased psychiatric symptoms; and prevention/avoidance of substance abuse, suicide, and/or homelessness (Osher et. al, 2002). The key element in transition planning is the planning for community services during incarceration and the implementation of the plan at the time of release with follow-up services. For jail detainees, who may be released at any given moment and with little warning to jail staff, it is crucial for transition planning to begin at intake or as soon as possible. In Fairfax County, VA, the discharge planning provides emergency services to any individual released before their discharge plan is completed (Council of State Governments, 2002).

The American Association of Community Psychiatrists (AACCP), have advised using the terminology of 'transition,' which implies collaboration, continuation, and equal responsibility, as opposed to 'discharge' or 're-entry' (AACCP, 2001).

Steadman and Veysey (1997), describe the Offender Aid and Restoration Program in the Fairfax County, VA, Jail. This discharge planning program links detainees with mental health and related services, such as transportation or housing assistance, upon release. A private,

nonprofit organization provides the discharge planning services and works closely with the mental health unit of the jail, the judge, the booking staff, and the forensic unit of the jail. Discharge planning also includes maintaining family ties while incarcerated, which function as added support upon release. This piece includes family group therapy, support groups for families, and emergency funds to family members for necessities while the inmate is incarcerated. A significant best practice feature in the functioning of this program is that the detainees with mental illness work with the same professional from intake through discharge (Steadman and Veysey, 1997).

Funded by the Center for Mental Health Services and the Center for Substance Abuse Treatment and published by the National GAINS Center, the APIC model (Osher et. al, 2002) is proposed as a best practice model for transition planning in jails. The key elements are: *Assess* (inmate's clinical and social needs), *Plan* (services that will meet the needs), *Identify*, (community programs for needed services) and *Coordinate* (transition plan for implementation). Some of the objectives in this model include strong linkage to the community; consideration of cultural identity, primary language, age, and gender of the detainee being released; involvement of inmate in every stage of planning; assessment of inmate's benefits for post-release medical coverage, etc., and a reliance on all related systems working together in the transition planning.

In summary, this section provided a description of the most promising practices with community mental health services, police diversion programs, mental health courts, jail and prison mental health services in handling mentally ill offenders. In general, the most promising practices involve collaboration among criminal justice and mental health professionals, community officials, and mental health advocates (Reuland, 2004; Steadman et al., 2000).

Recommendations

The crafting of recommendations that would be effective for Camden County requires far more than simply identifying what has been reported to work well in other jurisdictions and proposing these be initiated in Camden County. There clearly needs to be a process in which at least core elements of a shared vision are agreed upon and clearly identified by stakeholders of the mental health and criminal justice systems. These stakeholders must be committed to improvements and reforms, willing to collaborate and to transcend turf issues and resource competition, and be prepared to persevere in their efforts. The process needs to continue over time in order to identify, develop, modify, oversee, evaluate and adjust program initiatives and other proposed solutions to the issues that have been identified. New initiatives need to be flexible to adjust the changing circumstances, demographics, public policy and fiscal issues that will affect the County of Camden in the future. A most critical determinant of ultimate success will be the development of the capacity to bring new initiatives to scale and to sustain them over time.

1. Create and Empower a Broadly Representative Leadership Body

It is clear and compelling from an examination of the nature, depth, and elements of the issues attendant to the death of Mr. Joel Seidel that a consensus of stakeholders and decision-makers is necessary in order to craft solutions that are feasible, acceptable, effective and sustainable. There is no one (1) single entity inside or outside the government that has the authority to unilaterally create and implement the kind of crosscutting, collaborative initiatives necessary to address the many issues that are presented. Further, programs and services that may have been found useful and successful in other jurisdictions cannot be transplanted whole into Camden or any other County without efforts to customize the initiative to fit the unique aspects, culture and style of the new jurisdiction.

A review of the national literature reveals that in all jurisdictions in which most promising practices have evolved, efforts were initiated with the creation of a broad based, multi-sector

cross-disciplinary and intergovernmental leadership body representative of the stakeholders of the criminal justice and mental health systems. The functions of such bodies vary somewhat from jurisdiction to jurisdiction, but the following represent the core functions that are recommended for consideration for a Camden County body that would address the issues of the mentally ill in the criminal justice system.

- Conduct strategic planning inclusive of an assessment of the needs of the system and the individuals served, public safety requirements, identification of existing services and resources; and, identification and prioritization of unmet need and problems to be resolved;
- Create a clearly stated mission, vision, goals and objectives for the Camden County System;
- Serve in an advisory and policy development capacity to key Camden County decision-makers;
- Serve as a venue or forum for both the membership of the proposed body and the general public for the identification and discussion of issues relevant to this subject;
- Design and develop new and promising initiatives with respect to policies, protocols, programs and services;
- Identify, recommend and prioritize training issues for personnel in all components of the criminal justice and mental health system;
- Evaluate ongoing programs and initiatives through both the establishment of an internal capacity and by contracting out for independent evaluations when necessary and appropriate.

Membership on this body should include leadership and staff of the Mental Health Board and Criminal Justice Planning Committee of Camden County. It should also include, but not be limited to, the following:

- A member of the Board of Chosen Freeholders of Camden County;
- The Camden County Superior Court— a judge and a senior staff person of the Superior Court designated by the Assignment Judge;

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- The Camden County Prosecutor and/or designee;
- Camden County Deputy County Administrator;
- Warden of the CCCF;
- Representatives of Advocacy Organizations such as the Mental Health Association in Southwestern New Jersey, New Jersey Chapter of the National Association for the Mentally Ill (NJ-NAMI), and the Mental Health Law Project;
- A member of the staff of the Public Defender;
- The President of the Chiefs of Police Association of Camden County;
- Representatives of consumers – individuals with first hand experience in both the mental health and criminal justice systems in Camden County – and their families; and
- Representatives of voluntary organizations serving mentally ill individuals in Camden County especially SBCS.

It is further recommended that the new body be initially co-chaired by a County Freholder and a senior Judge of the Superior Court. The body would need an allocation of staff and other resources to make it viable and to assure the continuity and efficacy of its endeavors. Finally, a specific time limited and joint charge from the chief elected officials and judiciary to the new body would be most desirable and might specifically include a more detailed examination and development of the following additional recommendations.

It is noted that the County of Camden, in cooperation with the Camden County Superior Court, has created a Criminal Justice Coordinating Council to address issues associated with mentally ill individuals in the criminal justice system. The new Council should be examined in light of the recommendations set forth above

- 2. Design, Develop and Implement Training Programs for all Individuals Professionally Engaged in the Camden County Criminal Justice System Designed to Increase their Knowledge and Effective Utilization of Mental Health Resources and Services for Individuals Served in that System**

It is vital that police officers, prosecutors, judges (Superior and Municipal courts), corrections officers and others be thoroughly familiar with policies, protocols, procedures, available services and resources for mentally ill individuals encountered in the criminal justice system. Training programs would need to be tailored to each group and content areas could include, but not be limited to:

- The Camden County mental health system - Available treatment facilities, services and resources;
- Statutory requirements affecting the mentally ill in the criminal justice system and those providing for care and custody for such individuals;
- State of New Jersey treatment facilities and resources;
- Procedures and requirements for competency evaluations and involuntary commitments;
- Best practices in communications and interactions with individuals with mental illness;
- Recognizing signs of decompensation and impending potentially aggressive or dangerous behavior;
- Methods of de-escalating crisis – administering appropriate restraints; and,
- Understanding the diverse cultural contexts of mental illness.

Training programs have been developed and utilized by a variety of entities for various sectors of the criminal justice and mental health systems both nationally and in New Jersey. The leadership body referenced above is recommended to examine what is available and select and tailor such programs to meet the needs of Camden County. Of particular interest might be programs utilized by the New Jersey Department of Corrections to train corrections officers to deal with mentally ill inmates and by NAMI for the training of police officers in this regard.

As noted above, the CCCF has instituted a program for corrections officers and the Training Academy for Police Officers offers some content in this area. Under the auspice of the leadership body noted in Recommendation 1 above, existing training programs should be evaluated and changes made as necessary and appropriate.

Finally, select public and private mental health service organizations might also wish to enhance the training of key personnel relative to mental illness and the law as well as legal procedures and requirements in this regard.

3. Create the Position of Ombudsman/Resource Specialist for the Mentally Ill Within the Camden County Criminal Justice System

Even in the best of circumstances, when resources are adequate and available and criminal justice personnel are trained and knowledgeable, it is very easy for mentally ill individuals to fall through cracks in the system. Further, given the complexity of the mental health and criminal justice systems and the lack of insight and resistance to treatment certain mentally ill individuals have into their condition due to their illness; it becomes imperative to employ a guide, monitor and/or advocate for the appropriate care, treatment and safety of such individuals.

It is recommended that the position of Ombudsman/Resource Specialist be created and housed within either the Superior Court or Camden County Government. The Ombudsman/Resource Specialist would serve as:

- A resource and consultant to the Court, Office of the Prosecutor, police and corrections officers, county officials and the Office of the Public Defender relative to the care, treatment safety and dispositional alternatives for individuals with mental illness in the criminal justice system;
- A liaison from the criminal justice system to community mental health and allied human service organizations, staff of any diversion/re-entry programs, family members of defendants and inmates, and other interested and appropriate parties; and
- An advocate for specific individuals engaged in the system.

The individual filling this position would be expected to work in the courts, the jail and the community to effectively discharge the above responsibilities.

The Ombudsman or "resource specialist" approach appears to be effective in serving victims of domestic violence in the Family Court and criminal justice system in many New

Jersey vicinages. A review of the latter programs might indeed be most helpful in considering and possibly crafting the position of Ombudsman/Resource Specialist in this instance.

4. With the Advice, Guidance and Assistance of the Leadership Body Noted above, along with that of Camden County Counsel and CCCF Officials, an Examination of New Jersey's Statutorily Prescribed Methods of Competency Evaluations and Involuntary Commitments Should be Undertaken to Determine if the Processes Currently Utilized in Camden County for these Purposes might be Expedited or Improved.

Delays in competency evaluations and needed commitments result in mentally ill inmates spending greater time in the CCCF which is geared, at best, for short time care of this population. Despite the best efforts of the CCCF and the SBCS, the Mental Health Unit in the CCCF is not and will not likely become, a desirable therapeutic milieu. Lengthy processes and delays (as clearly noted in the case of Mr. Seidel) escalate risks that are even further compounded when facility overcrowding is also an issue. N.J.S.A. 30:4-27.10b provides for an alternative method of involuntary commitment and N.J.S.A. 2C:4-5 permits an alternative to the use of State employed psychologists to determine inmate competency. The use of the proceeding may hold some benefit or improvement for the CCCF, inmates and their families.

In a related matter, CCCF officials report an increase in instances in which patients residing at the Ancora Psychiatric Hospital (a regional inpatient facility operated by the New Jersey Division of Mental Health Services) are incarcerated at the CCCF based upon complaints filed by staff of the hospital. This is a contentious practice and clearly compounds the challenge to the CCCF and the size of its population of mentally ill inmates.

The above issues are not necessarily unique to Camden County. The presence of a significant number of mentally ill inmates in county correctional facilities has become an issue in other counties (Morris County for example) and tragedies similar to the Seidel matter have also occurred in other Counties (Essex County for example). It is also suggested that Camden County take a leadership role to encourage the engagement of the New Jersey Association of Counties

(NJAC) to facilitate a dialogue between the New Jersey Department of Human Services – Division of Mental Health Services and the counties to explore the current problems in these areas and to determine if improvements might be made to enhance the care and safety of mentally ill individuals in the county criminal justice systems.

5. Strongly Support and Work With SBCS in Their Implementation and Operation of the Program Financed through a State Contract Issued Under the “Community Partnerships to Improve Services for Persons With Serious Mental Illness in the Criminal Justice System” Initiative

In November of 2002 the SBCS responded to a Request for Proposal issued by the New Jersey Division of Mental Health Services in the above regard. This proposal, which was ultimately funded, provides initially for a program of reentry or re-integration intended to assist discharged mentally ill CCCF inmates to make a successful readjustment to living in the community and to minimize the likelihood of re-incarceration or other negative outcomes. Further, in a subsequent stage of the initiative, a diversion program would also be established that would assist the police in working with mentally ill individuals that are encountered in the course of their work, and would help identify alternatives to incarceration for such individuals when possible and appropriate. The general approach in both of these efforts involves the utilization of a forensic case management team of highly trained individuals working directly with inmates, families, community agencies and all elements of the criminal justice system.

Based upon a review of the national literature, as noted above, these kinds of reentry and diversion programs have demonstrated significant potential in other jurisdictions. If successful in Camden County, this initiative might likely help reduce the serious overcrowding in the CCCF mental health unit, provide expanded dispositional alternatives for mentally ill individuals in the criminal justice system, and result in more appropriate placements, treatment and care. The undersigned believe that offenders who suffer from mental illness need to be accountable for their behavior, the public needs protection from those whose presence represent a legitimate threat; and, it would be inappropriate to divert all mentally ill offenders from incarceration. Yet, there clearly exists a group of significant size that seem to be incarcerated in lieu of available

community mental health services (Mr. Seidel for example) and/or whose offenses are minor, non-violent and clearly related to the lack of treatment for a documented serious and persistent mental illness. It is this latter group who are recommended to be targeted for diversion and allied programs.

A most important aspect of this program and/or any related initiatives undertaken would be to work with other state and county offices to arrange for an expeditious review of inmate eligibility for the Medicaid Program prior to discharge. The Federal Government appears to be moving to facilitate continued Medicaid eligibility for discharged inmates who were eligible upon admission. Currently, termination of eligibility and benefits occur upon incarceration and a new application must be made upon discharge. Medicaid is the Federal/State comprehensive health insurance program for low income individuals and families, and serves as the gateway for needed medications and treatment.

For the SBCS re-entry/diversion program to be successful, it will require the full support and legitimation of the County, Superior Court and local municipal police departments. It is recommended that the leadership body outlined in #1 above be fully connected to the progress and outcomes of this effort and serve in an advisory and policy development capacity to SBCS in its operation of same.

The involvement of SBCS in this effort brings numerous advantages given the size and scope of their presence in community mental health services in Camden County. The opportunities for enhanced access, co-ordination and integration of services are clearly presented.

As noted in the section above dealing with most promising practices in this area, there are numerous other models or alternatives that might be employed in addition, to or in concert with, the SBCS initiative. It is recommended, however, that any further initiatives evolve from the experience of SBCS with its new program, the results of its formal evaluation; the implementation of any other of the recommendations contained herein; and, the ongoing advice, guidance and recommendations of the leadership body noted above.

6. Review the Camden County Mental Health Plan and Work With CPAC, Mental Health Board and the Leadership Body Toward the Identification of Funding for New and Expanded Programs to Address Prioritized Unmet Service Needs – Especially Those That Might Prevent the Need for Incarceration

It is important to note that as potentially valuable and useful as diversion and reentry programs may be, they are not a substitute for discrete mental health and allied human services in such areas as outpatient, partial care, clinical case management, assertive community treatment, specialized and/or affordable housing, supported employment and others. Further, in an environment of limited services, the more effective and timely utilization of community mental health services by individuals in the criminal justice system leaves less available for other vulnerable populations.

The Camden County Mental Health Board as administered by CPAC is the body statutorily charged with planning for mental health services in Camden County. The Board has created a County Mental Health Plan that is updated on an annual basis. The referenced plan and related documents identify the unmet needs for mental health and allied services of residents of Camden County. Of particular note is the suggestion made by members of the Board that individuals not approved for commitment by the screening centers be connected with community services as it is believed that such individuals are at high risk of inappropriate involvement with the criminal justice system. Also noted are the significant number of individuals with co-occurring substance abuse and mental health issues.

The undersigned recognizes the difficulty presented in implementing this recommendation at any reasonable scale, given the restrictions and limitations on available governmental and private funds for this purpose. According to the Camden County Mental Health Board, the State Division of Mental Health Services administers \$14.6 M in contract funds for mental health services in Camden County and the County contributes an additional \$.34M for this same purpose. New or expanded funding of any magnitude does not appear to be

forthcoming at this time. Yet, not dealing with this issue may cost the county of Camden significantly more in human and financial terms over time.

Clearly, the unmet needs are considerable and could not be financially or practically addressed in any one fiscal cycle; however, the availability of a strategic and sequenced plan to address the highest priority items would be most desirable. Thus, a vision for improvements and enhancements might be created with a timetable and road map to address them in a reasonable, feasible and expeditious as possible manner.

7. Review and Revise as Necessary the Staffing Requirements of the Mental Health Unit of the CCCF, as well as Classification and Internal Security for Mentally Ill Inmates

Should all of the above recommendations be acted upon, it would still be necessary to incarcerate some number of individuals with serious mental illness. The following recommendations are intended to improve the custody, care and treatment of mentally ill inmates committed to the CCCF while they reside in the facility.

The National Institute on Corrections (NIC), as a part of their Technical Assistance Report to Camden County, recommends a review of staffing patterns, functions and positions for the CCCF. The undersigned would strongly recommend this effort begin with the Mental Health Unit as expeditiously as possible. Staffing by corrections officers of the unit should be fluid and assigned in consideration of both the number of inmates in the unit as well as the acuity level (severity of symptoms and behavior) of the inmates on that date. The SBCS personnel should assist in determining acuity levels. A consultant with special expertise in this area could be engaged to develop a template or formula for this purpose.

Understaffing in this unit causing inability to deal with the numbers or behaviors of inmates is an invitation to tragedy. The above recommended method of staffing is likely to be more complicated and expensive to administer than simply assigning a fixed staff complement

adjusted periodically for numbers of inmates, but might likely provide greater dividends in safety and appropriate inmate supervision and control.

As also pointed out in the NIC Report, overcrowding defeats classification. The tragic death of Mr. Seidel resulted in part from his placement in a triple bunking situation with an inmate with a history of violent behavior. It is recommended that the CCCF review its classification policy specifically as it applies to the mental health unit so that violent or predatory inmates are segregated in special cells away from those more vulnerable inmates and their interactions more closely monitored in common areas.

8. **Carefully Review with SBCS and Prison Health Services the Practices and Protocols Relative to the Maintenance of Patient Records and the Administration of Psychotropic Medication to Inmates of the CCCF**

A cursory observation of the record keeping system for patients screened for mental health needs and those residing in the Mental Health Unit of the CCCF reveals the use of somewhat antiquated technology that may not adequately fill the need for timely and accurate information required by treatment personnel, corrections officers, the courts and other relevant parties. A consultant is recommended be engaged to work closely with SBCS and CCCF leadership to review the current system and supporting technology and to make specific suggestions for upgrades and improvements.

In addition to the above, the policy and practice of the approved administration (or denial thereof) of atypical psychotropic medication to inmates should be carefully monitored. The so-called "atypicals" represent the latest generation of such medications, have proven to be more efficacious for certain individuals with certain mental illnesses, and are of considerably greater cost and expense. Given the risk based, capitated nature of the contractual agreements for health care (including behavioral care services) for CCCF inmates, this policy and practice should be closely monitored to assure that the formulary in use provides for, and inmates consistently receive, the medications most appropriate for their conditions. This does represent a complex issue given the short stays of most inmates in the CCCF and the fact that the high cost of

“atypicals” puts them out of the reach of many lower income and/or uninsured non-incarcerated individuals suffering from mental illness. This issue reinforces the importance of arranging for an expedited Medicaid eligibility determination of discharged inmates.

Given the above and related issues in light of the nature of the contractual relationships for health and behavioral care services at the CCCF, it is also recommended that the County of Camden reserve the right to review and approve any and all sub-contractual agreements for services issued by the primary vendor and engage a qualified consultant to periodically monitor performance in this regard.

9. Consider the Establishment of “Backup” Options to Accommodate Mentally Ill Inmates in Times of Severe Overcrowding Affecting the Mental Health Unit

Even with the implementation of all of the recommendations noted above, continued overcrowding of the Mental Health Unit of the CCCF is likely to recur for some period time. In order to avoid the serious risks and consequences associated with such overcrowding, it is strongly recommended that other options and alternatives for temporary care and custody for mentally ill inmates be explored and developed. This might include making arrangements with other county or state facilities that may have unused capacity for this purpose or developing programs that provide intense community supervision for non-violent offenders. The least desirable of such options would be the creation of a new facility in light of experience that shows that additional “beds” in a situation of this nature are quickly filled while the underlying problems, including facility overcrowding, continue unabated. Yet, as an absolute last resort, in the absence of any other viable alternative, the County may wish to explore unused space at Lakeland Hospital or other appropriate locations with pre-existing central core infrastructure (food, security, recreation area, etc.) that might handle the overflow or overcrowding in the mental health unit. This is envisioned as a small correctional unit, not a hospital, but might be used to accommodate those inmates that for whatever reason are likely to stay a longer period in the CCCF or may be particularly vulnerable. The contract with SBCS might be readjusted so that additional mental health services might be available in this setting as well. This should be considered a temporary, time limited arrangement that must be carefully monitored and

controlled; and, discontinued if possible when all other initiatives noted above are in place and working effectively. This is a problematic and expensive "last resort" option but it is still a better alternative, in the opinion of the undersigned, then to triple bunk inmates in the existing mental health unit.

Conclusion

The tragic death of Mr. Joel Seidel is representative of the local, state, national, and cross systems issues associated with the custody, care, safety and treatment of mentally ill individuals in the criminal justice system. This study delineates nine (9) recommendations set forth above that are drawn from the interviews and data noted, a review of the national literature, and an examination of the most promising practices employed in other jurisdictions as adjusted to the County of Camden. These recommendations are intended to:

- Develop alternatives to the incarceration of mentally ill individuals in the CCCF who do not need to be there, are not serious or violent offenders that threaten the public safety; and, whose minor offenses are more directly attributable to the nature of their illnesses;
- Provide more secure and appropriate care of mentally ill offenders while incarcerated at the CCCF;
- Provide for services to assist discharged inmates with mental illness to readjust to the community and thereby reduce the likelihood of re-incarceration; and
- Minimize the likelihood that a tragedy of this nature will occur again.

The achievement of the above will be dependent on the creation of a shared vision and collaborative effort as to the care and treatment of the mentally ill in the criminal justice system among all stakeholders and participants in the Camden County criminal justice and mental health systems. It will require new investments for services, expanded staff training and development and the time and thoughtful efforts of many leaders, professionals and citizens of the County of Camden. The tragedy of the death of Mr. Joel Seidel has created an opportunity for improvements. Most important in realizing this opportunity will be the crafting of solutions that are sustainable over time so that reforms and new initiatives do not fade away and do not need to be restudied and reinitiated following a future tragedy.

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