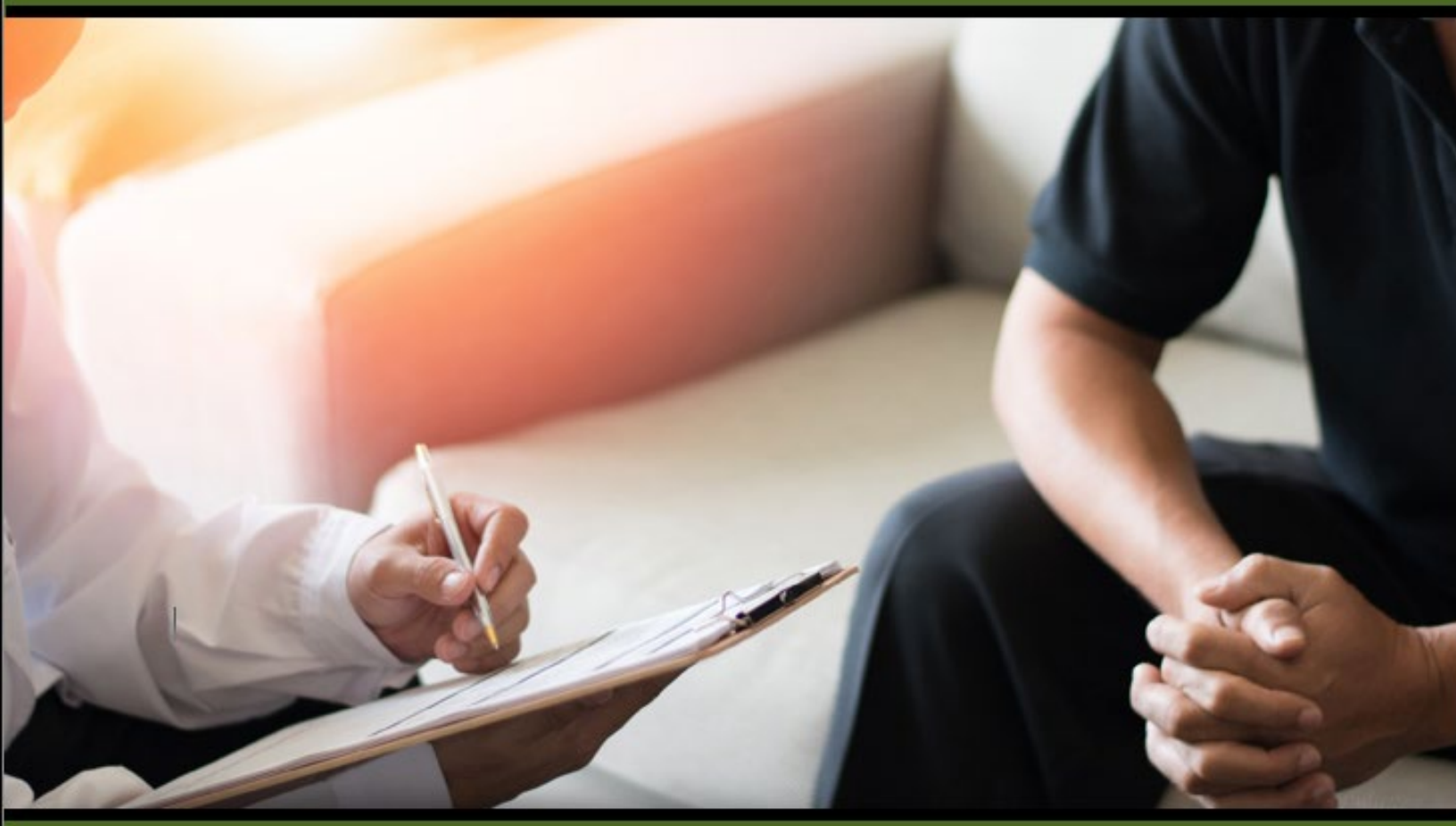

Best Practices for Behavioral Health Services in Jail Settings

Behavioral Health and Habilitation Administration
Office of Forensic Mental Health Services
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DSHS
WASHINGTON STATE
Department of Social and Health Services

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Acknowledgements

The preparation of this guidebook involved the contributions of many people including the Department of Social and Health Services' Office of Forensic Mental Health Services, Washington State Health Care Authority, the Washington State Office of the Attorney General, Disability Rights Washington, Washington Association of Sheriffs & Police Chiefs, Spokane County Detention Services, Clark County Sherriff's Office, and our community partners.

Disclaimer

This guidebook is for informational purposes only and is not intended for legal or clinical decision-making, nor is it a legally binding policy document.

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Behavioral Health and Habilitation Administration

DSHS
WASHINGTON STATE
Department of Social and Health Services

Dear Reader,

The Office of Forensic Mental Health Services, or OFMHS, is a division of the Department of Social and Health Services' Behavioral Health and Habilitation Administration which oversees the state's adult forensic mental health system.

As part of DSHS' Behavioral Health and Habilitation Administration, OFMHS strives to transform forensic behavioral health throughout Washington state by partnering with communities and law enforcement in areas such as mental health resources in jails, competency restoration, diversion programs, and community resources to better support people living with mental illnesses who encounter the criminal court system. The program provides forensic services, defined broadly as the intersection of the law and behavioral health. These services include competency evaluations, care and treatment for competency restoration, forensic navigator services, diversion work, and more.

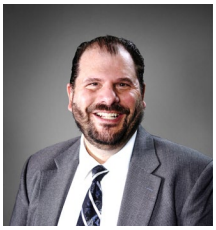
This guidebook is designed to assist our stakeholders which include law enforcement, courts, jails, behavioral health providers and others in the importance of collaboration. As the Assistant Secretary of the Behavioral Health and Habilitation Administration, I am encouraged by the commitment of all the professionals dedicated to the goal of ensuring people in need of treatment get the services they require prior to becoming involved with the criminal court system. The Best Practice for Behavioral Health Services in Jails Settings guidebook provides a good resource for obtaining this goal.

Sincerely,

Sjan Talbot, MA, CDE®, Acting Assistant Secretary
Behavioral Health and Habilitation Administration

Office of Forensic Mental Health Services

DSHS
WASHINGTON STATE
Department of Social and Health Services



Dear Reader,

The mission of the Department of Social and Health Services is to partner with people to access support, care, and resources. We do this through programs such as food, cash, and medical assistance, vocational rehabilitation, long-term care, behavioral health treatment and developmental disabilities services.

For our most vulnerable citizens who are incarcerated with a behavioral health condition it is imperative that we provide best practice standards and guidelines for assessment and treatment. This guidebook draws from national and local best practices to offer a pathway for jails across the state of Washington in ensuring the highest level of care and safety of individuals in jails experiencing mental illness, substance use disorders, cognitive and developmental disabilities, and/or co-occurring disorders.

Working with jails is a key component of our work and is intertwined with numerous transformational efforts to improve how we assist Washington's most vulnerable citizens. Those efforts include crisis intervention training, co-responder programs, mobile crisis response teams, increasing crisis capacity and residential supports, and forensic and diversion navigators. As with all our programs, the work for this guidebook involved input from key partners across the state and will provide a foundation both now and moving forward.

Sincerely,

Thomas Kinlen, PhD

Director, Office of Forensic Mental Health Services
Behavioral Health and Habilitation Administration

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1. INTRODUCTION

1.1 Overview

More than 70% of people in U.S. jails and prisons have at least one diagnosed mental illness or substance use disorder or both, and up to a third of incarcerated people have a serious mental illness (National Center for State Courts, 2022). In the state of Washington, 58% of adult Medicaid enrollees booked into jails in 2013 had a mental health treatment need, 61% had a substance-use disorder treatment need, and 41% experienced co-occurring treatment needs (Henzel, Mayfield, Soriano & Felver, 2016). People with co-occurring mental health and substance use disorders (SUD) experience greater difficulties under correctional supervision, may stay incarcerated longer, have increased difficulty managing in correctional settings, and recidivate more quickly post release (Osher, D'Amora, Plotkin, Jarrett & Eggleston, 2012). According to a 2020 study by Zgoba, Reeve, Tamburello, and Debilio, people who are incarcerated and have a substance use disorder are at higher risk of recidivism than those without a substance use disorder, independent of whether they have a mental health condition. Furthermore, suicide remains the leading cause of death in jails, accounting for 49 deaths per 100,000 people in 2019 (Carson, 2021).

Competency to stand trial, also referred to as adjudicative competence, refers to a defendant's ability to participate in legal proceedings related to an alleged criminal offense (Mossman et al., 2007). In Washington, 'incompetency' refers to when "a person lacks the capacity to understand the nature of the proceedings against them or to assist in their own defense as a result of mental disease or defect" (RCW 10.77.010). Incompetence can occur during any stage of legal proceedings and "no incompetent person shall be tried, convicted, or sentenced for the commission of an offense so long as such incapacity continues." (RCW 10.77.600). When court-ordered, the state must determine whether a person is competent to stand trial, and if not, attempts to restore competency may be pursued.

The Trueblood et. al. v Washington State DSHS class action suit enforces a person's constitutional right to timely competency evaluation and restoration services. The class members are people who are in jail and awaiting court-ordered competency to stand trial evaluation and/or restoration services (for more information, visit the Trueblood resources webpage). Pursuant to the lawsuit, the parties entered into a settlement agreement of contempt that was approved by the Court in 2018, part of which requires the state to develop guidance and best practices for diversion and stabilization of class members and potential class members in jail to be reviewed and endorsed by Disability Rights Washington under Washington's designated protection and advocacy system.

Washington state continues to work towards identifying needs and services for jails in the state. Two recent efforts are the Joint Legislation Task Force on Jail Standards and the Jail Modernization Project. The Legislature established the 18-member multidisciplinary Washington State *Joint Legislative Task Force on Jail Standards* to make recommendations on statewide minimum jail standards, oversight, and other policy changes to ensure jail conditions meet state and federal constitutional and statutory standards and the restoration of a statewide authority to set mandatory minimum jail standards and conduct inspections of jails for compliance and enforcement of those standards. The task force learned from experts in jail operations, conditions, standards and oversight. To gather up-to-date information, a survey was conducted with 80% of jails responding. The task force's final report was submitted to the Washington State Legislature in December 2023.

Washington State funded a jail modernization project in which a process was designed for a task force to collaborate on recommendations for ways to modernize Washington jails. Two dozen organizations

participated with input from those with lived and professional experience. Considerations included co-occurring behavioral health, jail atmosphere, work force retention and systemic issues, including diversion and community re-entry programs. The task force will report their findings and recommendations to the legislature by December 31, 2025.

In July of 2025, House Bill 1359 went into effect which calls for a review of laws related to criminal insanity and competency to stand trial. This bill creates a task force to review the entirety of RCW 10.77 which is inclusive of reviewing diversion and reentry in statute. DSHS/BHHA was tasked by the legislature to appoint the majority of the task force and has collaborated with Washington State Association of Counties (WSAC) to organize the flow and structure of the workgroup. Internally, BHHA has compiled groups across fields, facilities, and expertise to identify deficiencies, contradictions, or unclear language and to create recommendations for improvement for the DSHS representatives to present in the legislatively requested work team. A significant area of focus is reviewing 10.77.072 which references and guides the diversion navigator program. The task force will report their findings and recommendations to the legislature by December 2026.

Drawing from national and local best practices, the purpose of this guidebook is to provide guidance to jails across the state of Washington regarding the care and safety of people in jails who are living with a mental health condition, substance use disorders, cognitive and developmental disabilities, and/or co-occurring disorders. Training and general policy recommendations are also provided. The goal is to promote the best possible care and safety of Trueblood class members, reduce the number of people who become or remain class members, and timely serve those who become class members. This guidebook contains the gold standard for best practices in jail settings. We acknowledge that the ability to achieve these practices is impacted by access to resources, relationships with community partners, and many other factors. These are practices to strive for, to identify behavioral health conditions and provide recovery services to people in detention facilities.

1.2 Guidebook Preparation

In preparing the guidebook, we considered factors relevant to the diverse needs of people involved in the criminal court system and of the communities and jails throughout the state of Washington.

These considerations were:

- Awareness of the disparity of resources and the needs of the many jails in Washington.
- The need for guidance to be broad enough to apply to all jails, while also comprehensive enough to be useful. The inclusion of external resources is provided for additional information on individual topics.
- Individual section topics within this guidebook may overlap with others. For example, the practice of conducting initial mental health screenings is relevant to nearly all aspects within the continuum of care. Screening is a key element of diversion efforts, continuity of care, release planning, identification of need and access to treatment, as well as restrictive housing policies and suicide risk management procedures.
- Given the variance of programming in the different jails in Washington, some facilities may have already successfully implemented evidence-based practices while others have not.
- The importance of including the perspectives of people with lived experience in the identification of best practices and recommendations.

1.3 Organization of the Guidebook

The guidebook is organized by topic area, as follows:

- Background: Describes the context of the issue through relevant statistics and other information.
- Guidance: Based on national best practice standards and evidence-based practice, these are the workgroup's recommendations for each chapter topic.
- Training: These are recommended training requirements and competencies.
- List of Resources: These are resources that in many cases contain links to material relevant to the guidebook section. (Comprehensive resource and reference sections can be found in the back sections of the guidebook).

It is recommended to refer to the electronic version of the guidebook to access relevant hyperlinks to resources and ensure that the most recent version of the guidebook is accessed. The most up-to-date version of this guidebook is available on the Jail Technical Assistance Resources website.

We welcome your feedback about this guidebook. For questions or comments, please email the DSHS Jail Technical Assistance Team: jailassistance@dshs.wa.gov.

You may also write to us at:
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Behavioral Health and Habilitation Administration/ Department of Social and Health Services
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2. ABOUT THE JAIL TECHNICAL ASSISTANCE PROGRAM

2.1 Background

The Department of Social and Health Services' Jail Technical Assistance Program provides informational and training support to Washington jails. The program is integral to the Trueblood class action suit Contempt Settlement Agreement.

The Office of Forensic Mental Health Services (OFMHS) was created in 2015 when the Washington State Legislature signed it into law (RCW 10.77.146). The OFMHS is part of the Behavioral Health and Habilitation Administration within the Washington State Department of Social and Health Services and is headquartered in Olympia. This office is responsible for transforming adult forensic mental health services throughout Washington state by working with varied partners in areas such as correctional staff, mental health resources in jails, competency restoration, diversion programs, and community resources to better support people living with a mental health condition who come into contact with the criminal court system. DSHS provides a number of services and supports to achieve the goal of establishing a high quality and cohesive adult forensic mental health system. OFMHS provides forensic evaluations, assistance, training, and consultation for competency restoration, assistance, training and consultation for not guilty by reason of insanity (NGRI) treatment services, and liaison services to effectively coordinate efforts with system partners to meet shared goals. The agency additionally provides ongoing training and technical assistance to improve quality and timeliness of adult forensic mental health services, data management and resource allocation, training and certification of evaluators, and quality monitoring and reporting. DSHS works in collaboration with community partners to implement robust diversion efforts to assist in diverting people living with a mental health condition from entering the criminal court system.

For more information regarding services and resources, please visit the Jail Technical Assistance webpage.

3. IDENTIFICATION OF NEED AND ACCESS TO TREATMENT

3.1 Background

According to Washington State Institute for Public Policy, 49.5% of the jail population has behavioral health needs (WSIPP, 2024). Nationally, 30% of people in jail reported having a cognitive disability (Bronson, Maruschak, & Berzofsky, 2015). People booked into jail can present in a variety of conditions, to include arriving in mental health crisis. Early detection can help ensure that immediate needs (e.g. risk of self-directed violence, substance use withdrawal) are addressed as soon as possible. Other advantages include timely access to appropriate treatment, which may prevent common consequences of disorder manifested behavior such as rule infractions and/or being housed in restrictive housing. Identification of need and access to treatment begins with screening and assessment.

3.2 Guidance

We recommend that jails establish a program for the identification of need and access to treatment for all people booked into jail. Ideally, the program should begin at intake and should continue throughout the person's time in the jail. All aspects of the identification of need and access to treatment should be defined by written policy and procedures.

Screening and assessment are used to identify need and access to treatment. These different but related procedures are characterized as follows:

Screening entails the use of interviews or measures for the early identification of people who are at potentially high risk for a specific condition or disorder. The process is generally brief and narrow in scope and can indicate a need for further evaluation or early intervention. The process may be administered as part of a routine clinical visit and is neither diagnostic nor a definitive indication of a specific condition or disorder. In practice, screening tools often solicit self-reported information from the person at the time of booking.

Assessment provides a more complete clinical picture of a person's behavioral health. This entails a comprehensive focus on the person's functioning across multiple domains and can aid diagnosis and/or treatment planning. The process commonly integrates results from multiple psychological tests, clinical interviews, behavioral observations, clinical record reviews, and collateral information. Staff can use screening results to determine the choice of instruments for additional assessment.

Screening:

- Universal screening should be completed for each person as early in the intake process as feasible; at a minimum, screening should address the following:
    - Mental status, including history of mental health, brain injury, or other cognitive disability
    - Suicide/self-harm
    - Danger to others
    - Personal care
    - Psychiatric history, including psychiatric treatment and medication
    - Substance use history
    - Legal history
    - Demographic information, including preferred language
    - Screener observations, including a person's appearance, behavior, ease of movement, speech, and orientation

- Screenings should be conducted throughout the period of incarceration based upon individual need/request (e.g., changes in assessed symptoms, staff observations of change in condition).
- Screening instruments should be applicable to the intended population and have evidence of validity and reliability.
- Screening instruments should prioritize follow-up assessment and services to ensure that people with the most need are seen as soon as possible.
- A healthcare professional should perform the screening or assessment. If the jail chooses to have jail staff who are not healthcare professionals perform the screening, those staff members should be trained by a healthcare professional in how to conduct the screening and the screening tool to be used. Healthcare professionals should provide oversight of the training and implementation of the screening process as well as the quality assurance of the screening process.
- Screening should occur in a private location, such as an interview room or medical examination room. Jail and health care staff should be aware of relevant legal obligations under state and federal health care confidentiality laws (e.g., HIPAA). Ensured privacy will also generally elicit more accurate and thorough information from the person being screened.
- Jails should consider establishing protocols for pre-booking diversion of people in acute psychiatric distress. Acute psychiatric distress can be defined as people who are severely agitated and/or behaviorally disruptive due to symptoms of psychosis or other severe disorder (e.g., mania from bipolar disorder).
- See section 14 for more information on diversion.

Note: See the resource section of the guidebook for links to screening and assessment instruments, some of which may be located within listed resource guides. Screening and assessment instruments are generally available for purchase from their sources while others in the public domain may have no cost.

Assessment:

- Should screening results indicate a potential need for treatment, a comprehensive assessment should be conducted. The choice of assessment instrument(s) should be supported by current standards and evidence that support the validity and reliability of the instrument or method.
- Clinical, social, and community support needs should be identified.
- All reasonable efforts should be made to obtain the person's physical and behavioral health records for review to promote continuity of care. This may be done in coordination with jail medical and behavioral health personnel as applicable.
- A qualified professional should perform the assessment.
- Assessments should occur in a private location, such as an interview or medical examination room.
- People who have been screened and have indicators that demonstrate a need for mental health and/or substance-use disorder assessment must receive the needed assessment.
- People who have been assessed and found to be in need of mental health and/or substance-use disorder treatment must receive further evaluation by a qualified mental health or substance-use disorder professional without undue delay.
- The facility must provide people with access to treatment services in accordance with their treatment plan, including timely access to psychiatric medication if indicated, and should proactively remove barriers to treatment.
- Treatment plans should be monitored and revised according to the person's need and progress in treatment.

- If screening or assessment indicates that a person was prescribed medication for mental health or substance-use disorder treatment in the recent past, the facility should verify this medication and provide it to the person for bridging purposes until further assessment is done.
- If a person is assessed to benefit from medication for mental health or substance-use disorder by a jail-based provider in collaboration with the consenting person, the facility should include medication as part of the treatment plan and provide medication to the person without undue delay or restriction.
- Healthcare professionals who are providing screening, assessment or treatment should meet in a private location and must avoid whenever possible more public locations including a cell front, a dayroom with adjacent occupied cells, or the hallway.
- If the facility is unable to provide the level of behavioral health services in accordance with the person's assessed needs, the facility should consider a referral to a county designated crisis responder; whatever the results of the DCR evaluation, the facility should make all efforts to transfer the person to a facility that can provide the needed level of care. To facilitate transfer to care, jails should establish procedures and collaboration with the court of jurisdiction, assigned prosecutor, and defense counsel.
- Options such as diversion from the criminal prosecution in favor of treatment options, expedited admission into a state psychiatric facility for those awaiting competency evaluation or restoration (see Triage section of the guidebook), or collaboration with the court of jurisdiction pursuant to the Involuntary Treatment Act should be considered when appropriate.
- Clinical behavioral health and medical staff should coordinate with correction staff to ensure relevant clinical information is recorded in the person's chart and shared within the facility to promote continuity of care while remaining in compliance with pertinent privacy of information policies, rules, regulations, and laws.

3.3 Training

Staff who are responsible for intake screening should participate in initial and annual training that focuses on the following minimal areas and competencies:

- How to use the selected screening tool(s)
- How to interview people with mental health and/or substance-use disorders
- How to identify people with the most pressing need for follow-up
- How to communicate the need for further assessment/precautions
- How to conduct thorough documentation

Staff who are responsible for clinical assessment, creation of treatment plans, and/or implementation of clinical treatment for mental health and/or substance use disorders should maintain professional qualifications required for administering the assessments and treatment modalities. Staff who are responsible for service referral or care coordination should receive initial training on the referral process used by the facility in coordination with community partners. All staff involved in screening, assessment, treatment provision, and/or service referral should receive initial and annual training on information privacy practices, HIPAA, 42 Code of Federal Regulations Part 2, and all other relevant local, state, or federal laws and regulations pertaining to privacy of information and information sharing.

3.4 Resources

DSHS, BHHA. *Screening and Assessment Training for Jails*
https://www.dshs.wa.gov/sites/default/files/BHSIA/FMHS/OFMHS-JTA-Screening-and-Assessment.pdf

National Commission on Correctional Health Care. (2015). *Standards for mental health services in correctional facilities.* Chicago, IL: National Commission on Correctional Health Care. https://www.ncchc.org/mental-health-2/

Substance Abuse and Mental Health Services Administration. (2017). *Guidelines for successful transition of people with mental or substance use disorders from jail and prison: Implementation Guide* (SMA)-16-4998. https://store.samhsa.gov/sites/default/files/sma16-4998.pdf

Substance Abuse and Mental Health Services Administration. (2019). *Screening and assessment of co-occurring disorders in the justice system.* HHS Publication No. (SMA)-15-4930. https://store.samhsa.gov/sites/default/files/pep19-screen-codjs.pdf

4. CRISIS DE-ESCALATION IN CUSTODY SETTINGS

4.1 Background

Violence in jails is a significant problem nationwide and results in both fatal and nonfatal injuries. Of the nonfatal assaults and violent act injuries, more than one-third (37%) occurred while restraining someone or interacting with a person during an altercation (Konda, Tiesman, Reichard, & Hartley 2013).

De-escalation is the reduction of the intensity of a conflict or potentially violent situation. A combination of the use of both verbal and non-verbal de-escalation techniques are typically used to prevent escalation or to de-escalate an escalated situation. A broader term, crisis intervention, is the strategic practice of immediate and short-term psychological care aimed at assisting people in a psychiatric crisis to restore self-control. A psychiatric crisis is when a person has any or all the following:

- Thoughts/actions of self-directed violence (suicide) or physical harm to others
- Acute psychotic symptoms
- Deterioration in mental status

(National Alliance on Mental Illness of Virginia, 2018)

Steps can be taken to reduce risk, including skilled and strategic interpersonal interaction of jail staff with people who are in custody. Jail staff actions/reactions have a direct impact on crisis de-escalation outcomes, and the behavior of staff may trigger pre-existing traumas. According to the Substance Abuse and Mental Health Services Administration (2019), "individual trauma results from an event, series of events, or set of circumstances experienced by an individual as physically or emotionally harmful or life-threatening with lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being" (para. 1). Trauma is often under-reported and under-diagnosed. Trauma symptoms can include inattention, disorganization, depression, problem eating behaviors, and impulsivity. In a 2006 study, incarcerated people who had a mental health diagnosis (24%) were three times as likely as those without (8%) to report having been physically or sexually abused in their past (James, & Glaze 2006). Trauma-informed care is treatment that is directed by:

- A thorough understanding of the profound neurological, biological, psychological, and social effects of trauma and violence on a person and,
- An appreciation for the high prevalence of traumatic experiences in people who receive mental health services.

Given the vulnerability of people in jail who have experienced trauma and/or have serious mental conditions, and the well-documented risks associated with working in a jail, it is essential for jail staff to develop and maintain the skills necessary to prevent conflict to the extent possible, and to de-escalate conflict when it reaches crisis-level intensity.

4.2 Guidance

The workgroup recommends that jails develop programs to guide the practice of conflict prevention and crisis de-escalation that are defined by written policy and procedure. Jails should consider developing these policies and defined procedures using evidence-based models to ensure all jail staff are prepared to effectively identify and manage escalating behavior and strategically de-escalate behavior that has reached a high level of intensity. Jails should develop individual, departmental, and organizational training plans to attain a well-trained operative workforce. Jail staff should be able to demonstrate a broad application of the effective use of de-escalation strategies as well as techniques that serve to prevent escalation from occurring.

Several crisis de-escalation programs are offered by a variety of organizations. Despite the number of available programs, it is important that the content of the selected program is specific to the profession that will be implementing it. For example, if the de-escalation program is intended to be implemented by jail staff, the training should include content that is pertinent to situations that jail staff might encounter. Additionally, the selected program should include but not be limited to the following:

- Strategies and techniques that can be applied to prevent the escalation of conflict.
- Strategies and techniques that can be applied to de-escalate conflict that has already escalated.
- Awareness of common situations that can lead to escalation including staff interaction.
- How to use techniques to increase staff self-regulation and manage difficult emotions.
- How to use evidence-based, verbal techniques to increase the ability of a person-in-crisis to self-regulate.
- How to use postures and positioning to communicate non-threatening interaction and avoid further escalation.

Interaction and Individual Outcome

Although crisis de-escalation is aimed primarily at managing conflict, it is also desirable to provide therapeutic interactions to help facilitate better outcomes for people in jail. Increasing the frequency of therapeutic interactions and decreasing the frequency of non-therapeutic interactions leads to improved individual outcomes. Therapeutic interactions are recommended and include the following:

- **Listening and Observing**
  Understand where the person is *in the moment* through listening and observing the person's words, feelings and actions. The staff should present as interested in the person and actively attending to the person's verbal and non-verbal output.
- **Accurate Reflection of What is Stated**
  Offer a level of validation using a nonjudgmental stance; this allows the person to know that they have been understood in a meaningful way.
- **Positive Verbal and Non-Verbal Communication to Appropriate Behavior**
  Provide positive appraisal of appropriate behavior.
- **Giving Positive Items After Appropriate Behavior**
  Provide rewarding items (e.g., book, coloring book) after appropriate behavior. This is most effective when paired with positive verbal and non-verbal communication.
- **Prompting**
  A prompt is guidance provided around an observed behavior or action. Prompt the person to extinguish their behavior by explaining the outcome of their action(s).
  - A negative prompt describes the undesired behavior(s).
  - A positive prompt describes desired behavior(s).
  - Always follow a negative prompt with a positive prompt. For example, "Your cell needs to be cleaned to jail standards. When you clean it, you will be in compliance and will be able to have TV privileges."

Non-therapeutic interactions are not recommended and include the following:

- Negative verbal communication – "That was dumb" or "You're crazy."
- Should statements – "You should clean up after yourself."
- Taking something away – "You're obviously not listening; give that to me."
- Reinforcing undesirable or dangerous behaviors – "You're funny when you don't take your meds. You know we can't make you take medication, right?"

Denial of Request

Sometimes it is necessary to deny a request made by a person. There may be situations that take place when a person requests goods or privileges that the staff is not supposed to or cannot give. Some effective strategies for denial of request include the following:

- **VDSP**
  - **V** – Validate
  - **D** – Defer (to a rule, not a person)
  - **S** – Suggest an alternative
  - **P** – Positive prompt

- **VDSP example:** A person requests to make a phone call while in restricted housing.
  - **V** – "It looks like you would like to make a phone call."
  - **D** – "According to procedures, people in restricted housing must wait until their hour out to use the phone."
  - **S** – "It would be great if you could wait to make your phone call in an hour when you are scheduled for your time out."
  - **P** – "There is paper available if you would like to write a letter until you can make a phone call during your scheduled time out."

Atypical Behavior

Sometimes people present with atypical behaviors. Responding in an ineffective way can be harmful and/or delay recovery. The following types of interactions are not recommended:

- Arguing with people
- Challenging their delusions (unless done with an established therapy protocol)
- Reinforcing delusions
- Reinforcing atypical behavior
- Playing a role in a person's delusion

Interactions and Aggression

Gilligan (2003) in his prison research identified shame/humiliation as core elements in violence. He asserted that the primary motive or basis for violent behavior is to extinguish or avoid painful feelings of shame and humiliation and replace them with feelings of pride. When working with people the use of therapeutic techniques is essential. Therapeutic interactions are those that support a person's recovery and well-being and/or aid in diffusing conflict.

Cause of Aggression:

- Feeling at the mercy of an uncaring system or staff member.
- Aversive staff interactions such as:
  - Being directed
  - Being denied (ineffectively)
  - Having items taken away unnecessarily
  - Non-therapeutic interactions
- Feeling they're in a system with no hope of being discharged.

Preventing Aggression:

- Develop a trauma-informed approach to individualized care.
- Increase the frequency of therapeutic interactions.
- Decrease the frequency of non-therapeutic interactions.

De-escalation high-risk situations

INSERT is one technique for de-escalating high-risk situations. The following steps can be used to achieve safer outcomes:

I-Identify
Identifying escalating behavior(s) informs us on strategies to use and the proper approach.

N- Needs assessment
A needs assessment entails listening to what the person is saying to try and figure out what the unmet need is. This could be something as simple as just needing to be heard.

S- Safety approach
The safety approach encourages maintaining a safe distance, considering body language and positioning, identifying items that can be used to harm, and locating the nearest unimpeded exit(s).

E- Engage
Engage the person using the VDSP framework (validate, defer, suggest an alternative, positive prompt). Repeat as needed.

R- Reinforce
Reinforce self-regulation. Remind the person of past successes and empower them to make good decisions by offering choices.

T-Teaching moment
This includes debriefing and finding out what worked and what could have been done different/better. This includes meeting with the person involved and debriefing with them. Use this as a learning moment for the staff and person involved, as well as the broader team.

Regulating your responses/actions in high-risk situations

It is only natural for us to have a response to intense and/or escalated situations. The **3As** provide recommendations for regulating your responses/actions. The **3As** are:

Accept that this is happening to you and happening right now. It will not go away until you acknowledge the presented danger.

Adapt to what is happening. Assaults don't happen the way you expect them to; each situation is different and unique.

Act decisively and professionally. Use the adrenaline generated from your body's response to impede the attack and escape. The sooner you act, the sooner you escape.

4.3 Training

Staff who work in correctional settings should receive initial and annual training on strategies to prevent escalation, to de-escalate conflict, and on the use of force. Jails should remain fully committed to this training and should be well informed of the latest ideas, trends, and emerging issues in the corrections field. The goal is to keep conflict from becoming a crisis.

4.4 Resources

CIT International has contact information for each State. Washington state contact information can be requested by emailing admin@citinternational.org

CIT International. *CIT International Guide to Best Practices in Mental Health Crisis Response*. https://www.citinternational.org/bestpracticeguide/

National Alliance on Mental Illness (NAMI).
Crisis Intervention Team (CIT) Programs. https://www.nami.org/Advocacy/Crisis-Intervention/Crisis-Intervention-Team-(CIT)-Programs
Correctional Officers De-escalation Education (CODE).
Navigating-A-Mental-Health-Crisis.
https://www.nami.org/wp-content/uploads/2023/07/Navigating-A-Mental-Health-Crisis.pdf

National Institute of Health/National Library of Medicine.
Correctional Officers and the Incarcerated Mentally Ill: Responses to Psychiatric Illness in Prison (2016).
https://pmc.ncbi.nlm.nih.gov/articles/PMC4351153/
The Prevalence of Mental Illnesses in U.S. State Prisons: A Systematic Review (2015).
https://pmc.ncbi.nlm.nih.gov/articles/PMC4182175/
Creating trauma-informed correctional care: a balance of goals and environment (2012).
https://pmc.ncbi.nlm.nih.gov/articles/PMC3402099/

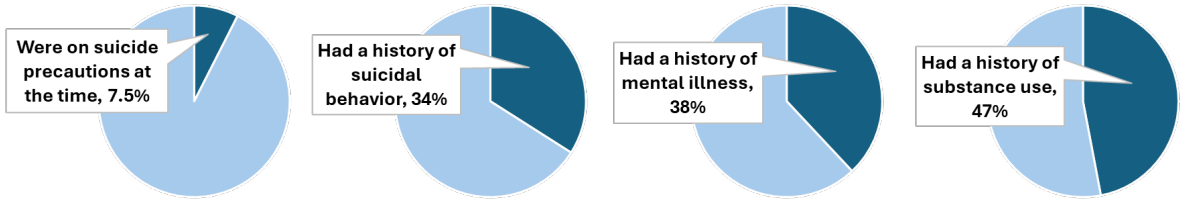
Substance Abuse and Mental Health Services Administration. (2020). *National Guidelines for Behavioral Health Crisis Care.* https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-services-executive-summary-02242020.pdf

University of Nebraska, Criminology and Criminal Justice Facility Publications. (2018). *Examining the Sources of Violent Victimization Among Jail Inmates*.
https://digitalcommons.unomaha.edu/cgi/viewcontent.cgi?article=1162&context=criminaljusticefacpub

5. SUICIDE RISK ASSESSMENT AND MANAGEMENT

5.1 Background

Suicide remains the leading cause of death in jails, accounting for approximately one-third of all jail deaths from 2000 to 2014 (Noonan, 2016). According to a national study on jail suicides (Hayes, L. M., 2010):



Other research has shown that a history of co-occurring substance abuse and mental health conditions are linked to suicide attempts among incarcerated populations (Gates et al., 2017), suggesting the need for enhanced screening and evaluation of environmental settings. Even with screening, there is no single factor that indicates a heightened probability of suicide attempts. Prevention is pivotal to saving lives.

Numerous factors contribute to suicides and non-fatal suicide attempts in jails. Some risk factors can be mitigated by making changes to the environment. For example, the vast majority (over 90%) of people who die in jails die by hanging, primarily by use of bedding (Hayes, L. M., 2010). Reviewing jail facilities for ligature risk can reduce accessibility to the means for a suicide. Other contributing factors may not be as simple to identify and address. They include individual risk factors and experiences, which can be assessed with thorough screening, evaluations, and monitoring as part of a comprehensive system of care.

5.2 Guidance

Awareness and Prevention Approach

Suicide is preventable. Striving to prevent suicide is the responsibility of all jail staff and others who interact with people at the jail. Effective prevention strategies used by staff are essential to the health and safety of everyone in the jail. Jails should have a comprehensive suicide prevention program designed to identify people at risk for suicide and to ensure appropriate measures are provided.

The facility's culture should be one that views suicide as preventable, promotes suicide risk awareness, and encourages intentional prevention strategies. For example, facility staff can assist with risk management, qualified staff can provide suicide assessments, and administrators can assist with ensuring screening, assessments, and prevention procedures are in place and implemented.

If it is determined at any time that a person is at risk of suicide, staff should immediately initiate suicide precaution protocols. Suicide precautions are specific precautionary interventions initiated when a person is believed to be at an increased risk of suicide or self-injurious behavior. These precautions commonly include but are not limited to observation and monitoring, means restriction (including contraband search), and a referral to mental health treatment.

Screening and Assessment

Screening and assessment should be considered as a routine, ongoing process, not a one-time event: People can become suicidal at any time. From the same study on national jails, 70% of suicides take place within the first 4 months of admission:

- 25% of suicides take place within 24 hours of admission.
- 25% take place between 2 and 14 days of admission.
- 20% take place between 1 and 4 months.

Although remaining diligent during the first two weeks after admission is prudent, the evidence suggests that staff must practice suicide awareness at all times (Hayes, L. M., 2010). For example, after adjudication and return to jail, people may experience feelings such as lack of control over their future, hopelessness, and/or shame. They may become vulnerable to suicidal thoughts and/or behavior after difficult experiences such as receiving bad news, experiencing humiliation or rejections, during confinement in restrictive housing and/or isolation, or pending release after a prolonged incarceration. Jail staff play a critical role in suicide risk management by recognizing, documenting, and making referrals based on their observations of a person's experiences prior to self-harming thoughts and/or behaviors.

As noted earlier, most suicides in jails occur when people are *not* on suicide precautions. Everyone must always maintain a mindset of prevention and not rely solely upon information gathered at intake alone.

Screening

Screening should entail the collection of information including:

- Known history of suicide risk
- Current and historical use of alcohol/drugs
- Current mental status
- Historical medical and mental health information to include a history of pregnancy
- Recent losses or traumatic events
- History of suicide or suicide attempts of close friends or family members
- Current threats and/or plans to commit suicide
- Information from the arresting officer regarding whether the person is presently a medical, mental health, or suicide risk

Note: This is not an exhaustive list of all that a screening should include. Please see resources below.

Assessment

The assessment process should be conducted by a qualified mental health professional to determine:

- The level of suicide risk that the person presents at the time of the assessment
- The degree of suicide precautions that should be taken
- Whether the person should be transferred to an inpatient mental health facility or program

People should be checked periodically for any changes in their condition that may warrant modifications to treatment approaches or suicide precautions. Additionally, a schedule should be established for consistent follow-up assessments after release from suicide precautions. See listed resources for additional information.

Means Restriction

Means restriction entails measures taken to reduce access or accessibility to the means and methods of suicide or deliberate self-harm, thus lowering the number of suicides/suicide attempts. Examples of means restriction include:

- Intentional housing designs to reduce or eliminate ligature points
- Issuing anti-ligature clothing and bedding
- Restricting supplies and/or objects that can be used for self-harm or suicide attempts
- The use of monitoring to reduce or eliminate the amount of time that a person is out of observation

Although critical in an emergency, means restrictions such as the removal of standard clothing or bedding is a last resort that should be avoided when possible and should last only as long as the present emergency (Hayes, L. M., 2017).

Safety Planning

Safety planning is an important intervention tool used to help those who struggle with suicidal thoughts. A safety plan is a written, prioritized list of coping strategies and resources for reducing suicide risk. Safety planning is a collaborative effort between a treatment provider and the person and should be created with input from both parties.

The basic steps of safety planning in a jail setting should include but not be limited to:

1) Recognizing the warning signs of suicide, and other associated behaviors
2) Using the person's own coping strategies
3) Methods to distract from suicidal thoughts
4) Contacting mental health professionals or agencies for assistance
5) Reducing the availability of means to attempt suicide

Communication

Effective communication between disciplines is an integral part of a comprehensive suicide prevention program. According to the National Commission on Correctional Health Care, information gathered by staff members should be used to frequently assess a person's level of suicide risk (2015). For example, the arresting officer should be attentive to the person's statements and behavior at the time of the arrest, during transport and at the time of intake, and should communicate crucial information to jail staff. Additionally, communication should occur across all staff regardless of job duties regarding observations which may be signs of a person's self-harming thoughts and/or behaviors.

While intake screenings reflect suicide risk at the time it is conducted, they may not accurately determine suicide risk throughout a person's time spent incarcerated. Ongoing assessments are critical to effective suicide prevention. These assessments may consist of observations made by any staff member in the facility or formal evaluations completed by mental health staff. Additionally, situational information pertaining to the person's life circumstances (e.g. adjudication, bad news, and release after a long period of incarceration) should be considered part of an ongoing assessment. (NCCHC, 2015).

Transportation

Facilities that provide transportation should develop written policies and procedures to minimize self-harm during transportation. As mentioned earlier, a person's risk of suicide can change at any time including prior to or during transportation. Means restriction and maintaining a mindset of prevention should always be considered, whether in a secure facility or during transport.

Observation and Monitoring

Observation is a key component in any suicide prevention program. Historically there have been two types of observation protocols:

- **Constant Observation:** Requires that the person is continuously in view without disruption.
- **Close Observation:** Protocols vary with differing amounts of time allowed between direct observations of the person depending on the facility policy (though typically no longer than about 10 minutes in a jail setting).

Brain damage resulting from strangulation due to an attempted suicide can occur within four minutes, and death can occur within five to six minutes (NCCHC, 2015). Given the very short window of time during which a person can complete suicide, it is recommended that the frequency and duration of monitoring should be determined by a qualified mental health professional and should be derived from individual risk factors. If clinical assessment allows for close observation, the times between observations should be varied but should never exceed 10 minutes in a jail setting (Hayes, L. M., 2017).

Note: Video monitoring may be used as a supplement to observe people but should not be used as a replacement for direct observation protocols (NCCHC, 2015).

Housing

There are several considerations when it comes to housing a person with an elevated risk of self-harm and/or suicide. Jails should consider:

- Restriction of potentially dangerous personal property
- Paying special attention to potential ligature points
- The type of bedding provided for the person
- The ability to see and monitor the person inside of their cell without obstruction
- Ensuring frequent social contact with jail staff
- Location and proximity relative to staff and medical professionals for medical and mental health rounds

The importance of social interaction with people who are potentially suicidal should not be underestimated. Jails should avoid physically segregating or unnecessarily restraining people who are suicidal. Such practices can heighten a person's sense of alienation and further isolate them from the benefits of social interaction and staff supervision. Housing assignments should promote staff interaction (Hayes, L. M., 2017).

Note: For information on making housing "suicide-resistant" see the resource section of this guidebook.

Intervention

The survival of a person after a suicide attempt often depends on a rapid and effective response by staff. Jails should establish a suicide response protocol that allows for the quickest and most effective intervention while maintaining staff safety. All staff who routinely interact with people should be trained in first aid and CPR. Personnel who make the initial discovery of a person engaging in self-harm must immediately notify additional staff members to assist in assessing the situation, securing the scene, and notifying medical personnel. The facility should have a readily available medical emergency response kit to bring to the scene. The kit should include items such as a pocket mask, first aid kit, a rescue tool for cutting ligatures, etc.

Staff should never assume that the victim is deceased and should initiate life-saving measures until medical personnel arrive. While not all suicide attempts result in the need for emergency medical intervention, all people who attempt suicide should receive immediate intervention and assessment by qualified mental health staff (Hayes, L. M., 2017).

Reporting

The facility should have a written policy and defined procedures for the reporting of all attempted and/or completed suicides. The policy and procedures should address notification of the chain-of-command, all appropriate outside authorities, and the victim's family. Staff who encountered the person before the incident should provide a written statement regarding their full knowledge of the person and the incident (Hayes, L. M., 2017).

Mortality/Morbidity Review

We recommend that jails establish a system for the review of suicide attempts and suicide deaths. There should be an inquiry regarding:

- The circumstances leading up to and at the time of the event,
- Relevant facility procedures,
- Relevant training of staff involved,
- Services/reports involving the victim's medical and mental health, and
- Any recommendations regarding the physical environment, staff training, policies and procedures, and/or medical and mental health services.

Ideally, the review should be conducted by an outside agency (Hayes L.M., 2017). Given that these incidents are stressful for staff as well as other people, appropriate support should be offered to everyone without delay. Examples of support include providing people with access to mental health services, providing staff with access to services such as employee assistance programs, and using a critical incident stress debriefing (CISD) team.

Note: CISD teams exist in many jurisdictions and may be accessible through established partnerships. Additionally, many employee assistance programs provide crisis intervention services intended to assist both administrators as well as facility staff.

5.3 Training

Training is an important component of any suicide prevention program. In a 2024 interagency review of the Washington Department of Corrections Suicide prevention protocols, DSHS found that training for correctional personnel should include standard training in suicide prevention as well as mental health training. A report by Lindsey Hayes, recommended that jail staff who have routine contact with people who are incarcerated should receive a minimum of eight hours of initial standard training in suicide prevention as well as two hours of refresher training annually thereafter (2017).
According to Hayes (2017), initial training should cover the following topics

- Mindset pertaining to suicide prevention
- The tenets of suicide prevention
- Relevant statistics and research on individual suicides
- How the correctional facility environment is conducive to suicidal behavior
- Warning signs and symptoms
- Screening and assessment

- Safety planning
- Risk and protective factors
- Recognizing suicide risk despite individual denial
- The facility's policies and procedures regarding the suicide prevention program
- Liability issues

The two-hour refresher should cover the same topics and include review of any changes regarding the facility's suicide prevention program and discussion of any recent suicide attempts or completed suicides in the facility (Hayes, L. M., 2017).

As found in the previously mentioned interagency review by DSHS, mental health training for jail staff should be interdisciplinary, reflect the jail environment, and be regularly reviewed to incorporate new information and identify any gaps. Some examples include mental health first aid, trauma informed care, and training on direct and indirect observation.

"Joint training exercises in which correctional and health staff participate together can promote a confident attitude toward suicide prevention among all staff and underscores that suicide prevention involves a holistic, multidisciplinary approach…[It] instills the philosophy that all professionals, regardless of credentials or agency affiliation, have an equal responsibility for inmate suicide prevention and can learn from one another's backgrounds, insights, and experiences (p. 23, NCCHC 2019)".

Note: For additional information regarding staff training on suicide prevention protocols, see the resources section of the guidebook.

5.4 Resources

Hayes, L. M. (2017). Guide to developing and revising suicide prevention protocols within jails and prisons. https://www.ncchc.org/wp-content/uploads/Suicide-Prevention-2017.pdf

Hayes, L. M. (2010). National study of jail suicide: 20 years later. https://static.prisonpolicy.org/scans/SuicideStudy-20YearsLater.pdf

National Commission on Correctional Health Care. (2019). *Suicide Prevention Resource Guide National Response Plan for Suicide Prevention in Corrections*. https://www.ncchc.org/wp-content/uploads/Suicide_Prevention_Resource_Guide.pdf

National Institute of Corrections: *Suicide in Corrections.* (2025). https://nicic.gov/resources/resources-topics-and-roles/topics/suicide-corrections

National Institute of Mental Health (NIMH)-Suicide Prevention: *Transforming the understanding and treatment of mental illnesses.* https://www.nimh.nih.gov/health/topics/suicide-prevention

Trotta, J. (2024). Four ways to address ligature risks in patient rooms and beyond. https://www.vizientinc.com/newsroom/blogs/2024/four-ways-to-address-ligature-risks-in-patient-rooms-and-beyond

6. INVOLUNTARY ADMINISTRATION OF MEDICATION

6.1 Background

There are occasions when a person in custody would medically benefit from taking prescribed psychotropic medications (e.g., antipsychotic medications typically used to treat psychosis). On such occasions the person may provide informed consent for taking prescribed medication, or they may decline. Although not all people who decline antipsychotic medication can be compelled to involuntarily take it, in certain circumstances they can. Typically, there are three circumstances in which a jail can administer antipsychotic medication to a person involuntarily. First, in the case of a psychiatric emergency. Second, in the case of a court order commonly referred to as a Sell Order (*Sell v. U.S.*, 2003). Third, a person can be administered antipsychotic medication involuntarily as a result of a non-judicial hearing commonly referred to as a Harper Hearing (*Washington v. Harper*, 1990)

6.2 Guidance

Under Washington law, courts may enter Sell Orders that require jails to maintain involuntary medication begun at a treatment facility for competency restoration. Jails therefore should have a process to manage Sell Orders that include written policy and defined procedures. Jails should consider developing written policies and defined procedures for conducting Harper Hearings and ensure they meet the standard of due process. All jails, regardless of size and location, should have a written policy for the involuntary administration of emergency antipsychotic medications that include defined procedures. Medications used in the community to manage psychiatric emergencies should be available in jails.

Psychiatric Emergency

In some cases, a psychiatric emergency may exist which places the person in custody or jail staff at risk of serious harm. Examples may include aggressive behavior, assaultive behavior, or self-harming behavior that present a direct and immediate threat due to a behavioral health condition for which antipsychotic medications are the indicated treatment. In these circumstances medication may be administered without the person's consent, but only in the short term and after the appropriate steps have been taken. Facilities should have policies and procedures to address psychiatric emergencies and the administration of antipsychotic medication under those circumstances.

The determination for emergency administration of medication should be made by a licensed physician, physician's assistant, or psychiatric advanced practice registered nurse. This healthcare provider should:

1. First attempt to obtain informed consent from the person.
2. Ensure monitoring occurs for adverse reactions or side effects after administering the medication.
3. Document the factors that lead to the decision to administer emergency medication.
4. Before administering medication, or as soon as possible afterwards, consult with a licensed physician, a psychiatric advanced practice registered nurse (ARNP) or physician's assistant (PA).

Sell Order

A Sell Order is a court authorization to administer medications involuntarily for the purpose of restoring competency to stand trial. In *Sell v. United States*, 2003, the United States Supreme Court held that the Constitution allows the government to administer antipsychotic medications involuntarily to a person

who is incarcerated when necessary to assist them in achieving competency to stand trial for serious crimes. (539 U.S. 169 (2003)). The process is typically as follows:

1. The defendant is evaluated for competency to stand trial. If the defendant is determined to be competent, the criminal legal process continues. If the defendant is found incompetent to stand trial, the court will enter an order for restoration to competency.

2. Following the order to restore competency, the defendant will typically be transported to a facility for restoration.

3. Once at the facility for restoration, if the defendant declines medications over three continuous days, or has a pattern of inadequate medication compliance lasting approximately one week, and it is the opinion of the treating licensed physician, psychiatric ARNP or PA that the defendant cannot be restored without medication, then the treating medical practitioner will send a letter to the court requesting a Sell hearing (unless the Court has indicated that a hearing has already been scheduled).

4. If a Sell hearing is scheduled, the defendant will be transported back to the jail where he or she was previously held to attend the hearing.

5. Following the Sell hearing, the defendant will be returned to the restoration facility. If the defendant returns from the Sell hearing with an order for the forced administration of medication, the facility should comply with the court order.

6. If the defendant returns from the Sell hearing (a) without an order for the forced administration of medication, and (b) the defendant continues to decline to take medication, and (c) it is opined in the competency evaluation that the defendant will not be restored without medication compliance, a report will be submitted to the court indicating the clinically relevant information and rendering an opinion on the defendant's current capacities to stand trial.

7. If the defendant is restored to competency following a Sell order for involuntary medication, the defendant will be transported back to the originating jail for the continuation of the criminal legal process.

Note: Jails should have a treating physician, PA, or psychiatric ARNP available who can diagnose and prescribe psychiatric medication to meet constitutional requirements for treatment. In such circumstances that a facility is unable to provide a prescriber, Sell hearings are typically initiated while the person receives restoration services at another facility.

Additionally, special attention should be given to the specific language in the court order and the potential obligation of the jail to continue enforcing the order if a person returns to jail from a restoration facility.

Under Washington law, a court may enter a Sell order for purposes of competency restoration and for maintaining the level of restoration in the jail following the restoration period. RCW 10.77.665. The law further requires that "…if the defendant is discharged [from a restoration facility] to the custody of a local correctional facility, the local correctional facility must continue the medication regimen prescribed by the facility, when clinically appropriate, unless the defendant declines to cooperate with medication and an involuntary medication order by the court has not been entered." RCW 10.77.405(1)(a)(iii).

Harper Hearing

The facility may engage in a formal non-judicial process to assess the need for involuntary administration of antipsychotic medications to a person who has a serious mental illness and is gravely disabled or poses a likelihood of serious harm to self, others, or property; and the treatment is in the person's medical interest (*Washington v. Harper*, 1990). The hearing is held at the request of a person's treating licensed physician, ARNP or PA and overseen by a special committee of jail mental health staff. It does not require following the more stringent "rules of evidence" required in judicial proceedings and the person is not entitled to having an attorney present but is entitled to a lay advocate to assist them in presenting their wishes and evidence. The process typically is as follows:

1. A hearing may be requested if:
    a. The person has a serious mental illness; and
    b. The treating licensed physician, ARNP or PA believes that the person is a serious danger to self or others; and
    c. The involuntary administration of antipsychotic medication is in the person's medical interest.

2. A special hearing committee is then convened, which generally must include a non-treating physician, ARNP or PA, a psychologist, and another staff member who usually acts as the committee chairperson running the hearing. None of these committee members may be involved with the person's treatment or diagnosis.

3. The person is given notice of the hearing and an opportunity to identify and present witness testimony and other evidence, often with the assistance of the lay advocate.

4. The person's attorney should be given notice of the hearing and have an opportunity to provide information or opinion, but the person does not have the right to have an attorney represent them at the hearing.

5. The lay advocate must attempt to meet with the person prior to the hearing to discuss their wishes.

6. The hearing should be held in a confidential setting, and the person must be given the opportunity to be present. The lay advocate should be present whether or not the person is present. The lay advocate represents the person's wishes and position at the hearing, although the person does not have to rely on the lay advocate.

7. After the hearing, a determination is made regarding whether sufficient evidence supports the requirements needed for involuntary administration of medication. The decision is made by committee majority vote, though the non-treating physician, ARNP or PA must vote in favor of involuntary medication for it to be approved.

8. The person must be notified of the decision and given information and an opportunity to appeal if they disagree with the decision.

Note that the lay advocate should be someone who understands the psychiatric issues enough to sufficiently protect the person's right to due process. The sufficiency of the lay advocate should be seriously questioned if the advocate fails to present or question evidence on behalf of the person; fails

to present their reasons for objecting to medication; presents any testimony or evidence against them; or otherwise lacks meaningful participation.

Individual right to refuse antipsychotic medication

People may choose to accept or decline antipsychotic medications, and their choice should be considered and respected. However, there may be times when a person's decision to decline medication may pose a risk to health and safety and may not be in the person's medical interest.

6.3 Training

Staff who participate in the administration of emergency antipsychotic medications should receive initial and annual training on pertinent laws, the procedural steps for the administration of emergency medications as determined by the facility, as well as for any other pertinent facility policies and/or procedures.

Staff who participate in the process of managing Sell orders should receive initial and annual training regarding the pertinent case law, the procedural steps for obtaining a Sell order, and specific facility policy and procedure for Sell orders.

Staff who participate in Harper hearings should receive initial and annual training regarding pertinent case law, the procedural steps for conducting a Harper hearing, and specific facility policy and procedure regarding Harper hearings.

6.4 Resources

Washington v. Harper, 494 U.S. 210 (1990) https://www.loc.gov/item/usrep494210/

Sell v. United States, 539 U.S. 166 (2003). https://www.loc.gov/item/usrep539166/

RCW 10.77.665 -Involuntary medication of serious offenses.

RCW 10.77.405-Mental condition evaluations—Reports and recommendations required—Discharge of defendant when determined competent to stand trial.

7. USE OF RESTRICTIVE HOUSING

7.1 Background

The use of restrictive housing is one of the most challenging subjects facing correctional officials. Jails face important, difficult questions about how to house people in a manner that is safe for everyone involved while also remaining lawful, humane, and cost effective. Many of these concerns are localized. It is beyond the scope of this guide to provide a one-size-fits-all solution for all jails in Washington. Many terms used for the practice of restrictive housing (e.g., isolation, segregation, solitary confinement) are often applied inconsistently and can lead to confusion. For the purposes of this guide, DSHS adopts the U.S. Department of Justice's (2016) definition of restrictive housing as "any type of detention that involves three basic elements: removal from the general inmate population, whether voluntary or involuntary; placement in a locked room or cell, whether alone or with another inmate; and inability to leave the room or cell for the vast majority of the day, typically 22 hours or more" (p. 3).

Note: The original terms used to describe restrictive housing (i.e. solitary confinement) used in the research cited and/or referenced in the background section were retained in an effort to maintain academic integrity. The guidance section uses the term restrictive housing as defined above.

Research indicates that solitary confinement is associated with adverse mental health outcomes (Walker et al., 2014), including risk for self-directed violence. Research conducted by Kaba et al. (2014, p. 442) that examined incidents of self-harm among people in custody at the New York City jail over an approximate two-year time span indicated that in the group studied:

- 7.3% of admissions included any solitary confinement.
- 53.3% of people who engaged in self-harm were subject to solitary confinement.
- 45.0% of people who engaged in acts of potentially fatal self-harm were subject to solitary confinement.

Despite the challenge of consistently practicing the appropriate use of restrictive housing, jails should be aware that the risks to people placed in restrictive housing are well documented, as are the potential legal liabilities that result from harm.

In an effort to provide guidance to correctional health professionals in the use of solitary confinement, the NCCHC has published a position statement which indicates: "Prolonged (greater than 15 consecutive days) solitary confinement is cruel, inhumane, and degrading treatment, and harmful to a person's health," and "Juveniles, [people with a mental health condition], and pregnant women should be excluded from solitary confinement of any duration" (NCCHC, 2016).

Similarly, the American Psychiatric Association (2017) has suggested: "Prolonged segregation of adult inmates with serious mental illness, with rare exceptions, should be avoided due to the potential for harm to such inmates. If an inmate with a serious mental illness is placed in segregation, out-of-cell structured therapeutic activities (i.e., mental health/psychiatric treatment) in appropriate programming space and adequate unstructured out-of-cell time should be encouraged. Correctional mental health authorities should work closely with administrative custody staff to maximize access to clinically indicated programming and recreation for these individuals" (p. 1)

7.2 Guidance

It is recommended that jails address and limit the use of restrictive housing for people with serious mental illness by implementing defined written policies and procedures. Before placing a person with

serious mental illness into restrictive housing, jail staff must perform an individualized assessment of the actual risk they pose to safety or security, while considering whether reasonable modifications of policies or practices would mitigate or eliminate the risk. A jail must also perform an individualized assessment to screen for indicators that make placement into restrictive housing potentially clinically inappropriate. The jail should exhaust all other less restrictive alternatives before placing a person with serious mental illness into restrictive housing. Such alternatives may include placements like step-down housing and/or mental health housing. Placement of people with serious mental illness into restrictive housing must not result in the denial of adequate mental health treatment.

The American Psychiatric Association (2022) proposed that "Serious mental illness is a mental, behavioral or emotional disorder (excluding developmental and substance use disorders) resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. Examples of serious mental illness include major depressive disorder, schizophrenia and bipolar disorder."

Discerning between intentional rule violating behavior and behavior that is symptomatic of serious mental illness can be challenging, but necessary. Jails should ensure that the discipline system in the jail does not explicitly or unintentionally punish mental health symptoms and should ensure the jail does not discipline people with serious mental illness for incidents of self-harm. Jails should implement a system to review all potential sanctions/infractions to consider whether serious mental illness played a role in the incident and whether sanction is an appropriate or effective response.

Jails should develop a post-seclusion review protocol, which focuses on both the person who is incarcerated and the care team. Jails, including mental health staff and/or care teams, should participate in a post-seclusion review process within 24 hours to debrief and assess the safety and stability of a person in less restrictive housing. This review should include an interview with the person to identify what efforts were or could have been made to avoid restrictive housing and assess for interventions and strategies to assist in reducing future events.

People residing in restrictive housing who request mental health services should receive access to a provider to evaluate needs as soon as feasible. Any clinical meetings or services offered should occur in a private therapeutic setting (e.g., not at cell front).

People with serious mental illness who are placed in restrictive housing should be seen and assessed regularly, ideally at least weekly, to identify mental health status, decompensation, or other developing needs. It is recommended that jails use multi-disciplinary teams to formally assess people at least weekly to determine if they can be removed from restrictive housing. As the U.S. Department of Justice (2016) has written, "best practices include housing inmates in the least restrictive settings necessary to ensure their own safety, as well as the safety of staff, other inmates, and the public; and ensuring that restrictions on an inmate's housing serve a specific penological purpose and are imposed for no longer than necessary to achieve that purpose" (p. 1).

<u>Note from Disability Rights Washington:</u> Restrictive housing of individuals with serious mental illness may violate federal constitutional and statutory law. Under the Eighth and Fourteenth Amendments to the United States Constitution, jails must refrain from keeping inmates with serious mental illness in conditions of confinement that risk or cause serious harm. (See, e.g., Brown v. Plata, 563 U.S. 493 (2011); Coleman v. Wilson, 912 F. Supp. 1282 (E.D. Cal. 1995). Housing people with mental illness in restrictive housing may also violate the Americans with Disabilities Act. Under the ADA, jails must provide those with disabilities, including mental illness, equal access to jail services, programs, and activities and must

do so in the most integrated setting appropriate to individuals' needs. Restrictive housing often denies people the opportunity to participate in and benefit from jail services and activities. For more information, see Cresson findings, U.S. Department of Justice, 2013, Investigation of the state correctional institution at Cresson and notice of expanded investigation.
https://www.justice.gov/sites/default/files/crt/legacy/2013/06/03/cresson_findings_5-31-13.pdf

7.3 Training

Jail staff who routinely interact with people in jail should:

- Receive initial and annual training on the facility's policies and procedures that direct the use of restrictive housing.
- Complete crisis intervention team (CIT) training for correctional officers and crisis de-escalation training, which may provide correctional officers with a better understanding of mental health conditions and crisis management.
- Receive initial and annual training on the process of using a seclusion review team as well as pertinent facility policies and procedures.

7.4 Resources

American Psychiatric Association (2017). APA Position statement on segregation of prisoners with mental illness. https://solitarywatch.org/wp-content/uploads/2018/09/APA-Position-Paper.pdf

Kaba F, Lewis A, Glowa-Kollisch S, Hadler J, Lee D, Alper H, Selling D, MacDonald R, Solimo A, Parsons A, Venters H. *Solitary Confinement and Risk of Self-Harm Among Jail Inmates*. https://pmc.ncbi.nlm.nih.gov/articles/PMC3953781/

National Commission on Correctional Health Care. (2016). *NCCHC Position statement: Solitary confinement*. https://www.ncchc.org/wp-content/uploads/Solitary-Confinement-Isolation.pdf

National Commission on Correctional Health Care. (2015). *Standards for mental health services in correctional facilities.* Chicago, IL: National Commission on Correctional Health Care. https://www.ncchc.org/mental-health-2/

U.S. Department of Justice (2016). *Report and Recommendations concerning the use of restrictive housing.* https://www.justice.gov/archives/dag/report-and-recommendations-concerning-use-restrictive-housing

8. SUBSTANCE USE DISORDER TREATMENT AND MANAGING WITHDRAWALS

8.1 Background

It is not uncommon for people admitted to jail to have a substance-use disorder. A report by Wilson (2000) estimated that 70% of people incarcerated in local jails either had committed a drug offense or used drugs regularly and more than 35% of those were under the influence at the time of arrest. Some who have used substances near the time of admission into jail may suffer withdrawal symptoms that can be life threatening.

The opioid crisis is of particular concern in the United States and Washington state. Recidivism, medical issues, opioid withdrawal illness, and an extremely high risk of overdose death are all consequences that can result from failing to treat opioid-use disorders. Drug overdose has become the leading cause of death by injury in the United States (Grande & Stern, 2018).

Note: For the purposes of the study mentioned above, overdose death is considered death by injury.

There is increased interest in providing people who are incarcerated with the opportunity to address their substance use disorders. For example, some jails have taken the initiative to combat the opioid crisis through the use of medicated assisted treatment (MAT) programs or medications for opioid use disorder (MOUD). Medications are being used to medically assist withdrawal management and to initiate treatment services that will be continued in the community. According to the NCCHC Jail-Based Medication-Assisted Treatment Guidelines, medication combined with psychological support improves recovery outcomes (NCCHC, 2018).

Snohomish County Jail began a pilot MAT program in January 2018, in efforts to reduce the high demand of medical beds. Staff reported a decrease in medical bed acuity and that MAT program medications were proven to be less expensive than the medications previously used for detox comfort. This pilot has encouraged other jails to follow suit (NCCHC, 2018, p.28).

Snohomish County jail has continued with this MAT program following the original pilot. In 2025 there were approximately 100 patients receiving either Subutex or Naltrexone through a contracted behavioral health provider or through jail medical services. There is a Subutex nurse whose main duty is to administer medication to the patients in the program. Providing patients with Subutex for treatment of their opiate withdrawal symptoms continues to reduce the medical bed acuity. Also, in 2025 the jail had approximately 25 patients who were receiving Methadone through a contracted behavioral health provider who sends a nurse into the jail every day to administer medication to their patients.

In addition to MAT programs, many Washington state jails have pursued additional policies toward the prevention of opioid overdose death in their facilities. It has become increasingly common for first responders, jails, and other disciplines in the community to have access to opioid antagonists such as intranasal naloxone (Narcan®). Synthetic opioids such as fentanyl are exceptionally dangerous as they are 1000 times more potent than morphine (NLM, 2023). Access to opioid antagonists is potentially lifesaving.

8.2 Guidance

We recommend that jails establish comprehensive programs for substance use screening, treatment, withdrawal management, and prevention of opioid overdose death of people in jail. Such programs should be defined by written policy and procedure. Jails should contract with or have personnel on staff

who specialize in the treatment of substance-use disorder (SUD), the administration of opioid antagonists, and withdrawal management (which may need evaluation from a medical professional). This workgroup recommends the following:

- Trained staff should screen for substance use and withdrawal from substance use as part of the intake procedure for all people admitted to jail.
- Those found to need withdrawal management should receive appropriate services without delay. Withdrawal management refers to the medical and psychological care of people who are experiencing withdrawal symptoms because of ceasing or reducing use of their drug of dependence. Medically managed withdrawal protocols should be in place to support screening for withdrawal severity, substance use, polysubstance use (the use of multiple substances), monitoring, and medical management of symptoms.
- People who through screening are found to need a full assessment should receive an assessment by a SUD professional as soon as feasible. People should be clinically assessed by a qualified provider to determine whether medically assisted treatment is an appropriate option.
- Jails should recognize the possibility of the surreptitious introduction of opiates which may not be revealed in searches and should have counter measures readily available e.g. intranasal naloxone.
- The results of the SUD assessment should be discussed with the person who is incarcerated, and a treatment plan should be encouraged and created in collaboration with them.
- SUD education and treatment should be provided to people in the facility.
- When indicated, SUD treatment should be included as part of release planning to ensure continuity of care. Special considerations should be made for people who are being released on weekends to ensure continued treatment in the community.
- Jails that choose to use MAT programs should have appropriately trained staff and a qualified prescriber. It is important to have a trained professional determine the correct medication, dosage, and length of treatment for the best chance of success for the person. This will also require collaboration with a community provider to ensure a warm hand off, upon release, for continued care and treatment in the community.

Note from Disability Rights Washington: In addition to the benefits of a MAT program, jails should closely consider their potential legal obligation to provide MAT. This issue is increasingly being litigated.

8.3 Training

Given the prevalence of substance use issues in jails, all jail staff should receive initial and annual training to recognize the signs and symptoms of substance use (occasional use of substances), and substance use disorder (chronic, habitual, or patterned substance use, (Cleveland Clinic, 2024)) as well as signs and symptoms of withdrawal. Jail staff who conduct intake screenings for substance use should receive initial training on the use of the screening instrument used at the facility and the procedures for ensuring continuity of care (e.g., referrals when indicated). Jail administration should ensure that staff are trained on the administration of opioid antagonists to prevent opioid overdose death.

8.4 Resources

Centers for Disease Control and Prevention (2023). *Overdose prevention* https://www.cdc.gov/overdose-prevention/?CDC_AAref_Val=https://www.cdc.gov/drugoverdose/deaths/opioid-overdose.html

Grande, L., & Stern, M. (2018). *Providing medication to treat opioid-use disorder in Washington State jails*. https://faculty.washington.edu/mfstern/WAJailOpiateResponse.pdf

National Commission on Correctional Health Care. (2018). *Jail-based MAT: Promising practices, guidelines*. https://www.ncchc.org/wp-content/uploads/Jail-Based-MAT-PPG-web.pdf

National Library of Medicine (2009). *Clinical Guidelines for Withdrawal Management and Treatment of Drug Dependence in Closed Settings*. https://www.ncbi.nlm.nih.gov/books/NBK310652/

RTI International (2019). *A Primer for implementation of overdose education and naloxone distribution in jails and prisons.* https://harmreduction.org/wp-content/uploads/2020/09/A-primer-for-implementation-of-OEND-in-jails-and-prisons-Wenger-2019-RTI.pdf

SAMHSA (n.d.) Medication-assisted Treatment Inside Correctional Facilities: Addressing Medication Diversion. https://store.samhsa.gov/sites/default/files/pep19-mat-corrections.pdf

Substance Abuse and Mental Health Services Administration (2019). *Opioid overdose prevention toolkit*. https://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit/SMA18-4742

Washington Association of Sheriffs and Police Chiefs (WASPC). Jail Ressources Page. https://www.waspc.org/index.php?option=com_content&view=article&id=157:jail-resources&catid=20:site-content&Itemid=234

9. COMPETENCY EVALUATION PROCESS

9.1 Background

Competency to stand trial (CST), or adjudicative competence, is the legal construct that refers to a criminal defendant's ability to participate in legal proceedings related to an alleged offense (Mossman et al., 2007). The U.S. Supreme Court established the current legal standard for determining competency to stand trial in *Dusky v. U.S.,* 1960. The standard of CST is whether a defendant lacks the "sufficient present ability to consult with [their] lawyer with a reasonable degree of rational understanding and whether [they have] a rational as well as factual understanding of the proceedings against [them]." (*Dusky v. U.S.*, 1960). In Washington, 'incompetency,' or being not competent to stand trial (NCST), means "a person lacks the capacity to understand the nature of the proceedings against [them] or to assist in [their] own defense as a result of mental disease or defect." (see RCW 10.77.010) NCST may occur during any stage of legal proceedings and "no incompetent individual shall be tried, convicted, or sentenced for the commission of an offense so long as such incapacity continues." (RCW 10.77.600). A person found to be NCST may be ordered by a court to undergo restoration services to restore their competency so that the criminal case may proceed.

Competency Evaluation Process

Forensic evaluations may be conducted in inpatient facilities, jails, or in community settings. In Washington, most forensic evaluations are conducted by DSHS employees, and the interviews occur in jail. State statute requires that the evaluator's report includes the following (per RCW 10.77.400):

- A description of the nature of the evaluation
- A diagnosis or description of the current mental status of the defendant
- If the defendant has a mental health condition, or a developmental disability, an opinion as to competency
- An opinion as to the defendant's competency, and an opinion regarding insanity, if insanity is claimed, and an evaluation and report by an expert or professional person has been provided that meets statutory criteria (RCW 10.77.505 provided that no opinion shall be rendered under this section (3)(d), unless the evaluator or court determines that the defendant is competent to stand trial
- When directed by the court, if an evaluation and report by an expert or professional person has been provided concluding that the defendant lacked the capacity at the time of the offense to form the mental state necessary to commit the charged offense, an opinion as to the capacity of the defendant to have a particular state of mind which is an element of the offense charged
- An opinion as to whether the defendant should be evaluated by a DCR under the Involuntary Treatment Act (ITA).

The evaluation is then submitted to the court, and if the court finds that the defendant is competent to stand trial, the case proceeds. If the court concludes that the defendant is not competent, the court may order the defendant to receive restoration services. For most misdemeanors, the court will generally dismiss the case and potentially refer the defendant for an evaluation under the ITA. However, the court may, in certain situations, order competency restoration on misdemeanors that meet the statutory definition of a "serious offense." (RCW 10.77.650). If the person is restored to competency, the case proceeds.

Note: Providing someone with restoration services so that they are competent to face criminal charges is not the same as providing appropriate mental health treatment. Restoration services are time-limited

and have the specific purpose of helping a person understand their criminal charges, court proceedings and processes and how to assist their attorney in their defense. Restoration often includes medication, but it is not the full array of treatment services typically provided in a treatment setting.

The Health Care Authority, in collaboration with DSHS, currently manages several community-based competency restoration programs (i.e., outpatient), meaning that people facing felony or misdemeanor charges who are waiting in jail for restoration services may be eligible for release into the community on condition of participation in these programs. These programs are commonly referred to as "Outpatient Competency Restoration Programs," or OCRP.

The role of forensic evaluators differs from that of treatment providers. Professionals in the role of forensic evaluators assess issues including, but not limited to, defendants' competence to stand trial, their mental state at the time of the offense (i.e., insanity), and their risk for future violent behavior. Treatment providers are responsible for psychological intervention or treatment of people in both criminal and civil cases who require treatment (e.g., competency restoration or civil commitment) or who request these services.

9.2 Guidance

Jails should have a program in place to support people who need competency to stand trial evaluations that include written policy and defined procedures. Because prolonged time in jail for people with serious mental illness has been known to contribute to negative effects, jails should ensure that staff closely monitor people waiting for competency evaluation and restoration services. If a person who is awaiting these services has not had any follow up contact from OFMHS in seven days, the jail should email OFMHSCOURTORDERS@dshs.wa.gov to let DSHS know. If a person is assessed to be decompensating, they may be a good candidate for expedited admission (Triage Consultation and Expedited Admission) or for evaluation by a DCR. If the person is waiting for restoration services but is assessed to be improving (for example, due to established compliance with psychiatric medication), it may be productive to speak with prosecution and defense counsel about possibly seeking an updated competency evaluation.

Another area in which jails can support people regarding their competency services is with missing or delayed court orders. At times, there may be a delay in receiving a court order for competency services and OFMHS may not know if a person is waiting. To ensure the timeliness of forensic evaluation or admission, if the jail believes any person has been waiting for a competency service more than:

- seven days (for admission to an inpatient facility for competency restoration or evaluation services) **or**
- more than 14 days (for an in-jail competency evaluation)

and OFMHS has not reached out to the jail for scheduling (evaluation or admission), please let the department know at ofmhscourtorders@dshs.wa.gov. Most likely OFMHS is missing that court order.

Note: RCW 10.77.625 states "(1) A city or county jail shall transport a defendant to a state hospital or other secure facility designated by the department within one day of receipt of an offer of admission of the defendant for competency evaluation or restoration services. (2) City and county jails must cooperate with competency evaluators and the department to arrange for competency evaluators to have reasonable, timely, and appropriate access to defendants for the purpose of performing evaluations under this chapter to accommodate the seven-day performance target for completing competency evaluations for defendants in custody."

9.3 Training

Staff who are responsible for managing the CST referral process used by the facility should receive initial and annual training on the process used at the facility as well as DSHS's early admission process (Triage Consultation and Expedited Admission). This training should include but not be limited to policies and procedures pertaining to professional visitors, confidential location where CST evaluations are conducted, and appropriate security precautions.

9.4 Resources

Department of Social and Health Services, State of WA. (2024, April). *Outpatient Competency Restoration Program*. https://www.dshs.wa.gov/sites/default/files/BHSIA/FMHS/011%20-%2024%20OCRP%20One%20Pager.pdf

Heath Care Authority, State of WA. (2024, October). https://www.hca.wa.gov/assets/program/fact-sheet-involuntary-treatment-act.pdf

Luxton, D.D., (2019). Washington State Legal System Guide to Forensic Mental Health Services

RCW 10.77.400- Plea of not guilty due to insanity—Doubt as to competency—Evaluation—Bail—Report—Competency to stand trial status check.

RCW 10.77.405- Mental condition evaluations—Reports and recommendations required—Discharge of defendant when determined competent to stand trial.

RCW 10.77.625- Competency evaluation or restoration services—Offer of admission—City or county jail to transport defendant.

RCW 10.77.645- Competency restoration—Procedure in felony charge.

RCW 10.77.655- Competency restoration—Procedure in nonfelony charge.

Washington State Health Care Authority. (2024, Nov. 1). *Outpatient Competency Restoration Program Annual Report*. https://www.hca.wa.gov/assets/program/outpatient-competency-trueblood-2024.pdf

10. EARLY ADMISSION PROCESS (Triage Consultation and Expedited Admission)

10.1 Background

There may be times when a person who is awaiting forensic services while in jail may benefit from a prioritized transfer to a state psychiatric hospital. The Department of Social and Health Services' Office of Forensic Mental Health Services operates a Triage Consultation and Expedited Admission (TCEA) system to facilitate the expedited admission of people to a state psychiatric hospital for evaluation for competency to stand trial or competency restoration services. To be admitted under the TCEA system, a person must meet specified criteria that would justify prioritizing the admission. The TCEA system is not appropriate for people in need of emergency medical services, as they should be referred for immediate medical attention. For more information about the process, visit the OFMHS TCEA website.

10.2 Guidance

Jails should have a program in place for the identification and management of people who may meet criteria for TCEA that includes written policy and procedures. Emphasis should be placed on gathering comprehensive historical and current information pertaining to the person admitted to the jail who may be referred for TCEA.

Criteria

To be considered for expedited admission, one must meet the following criteria:

1) Active suicidal intent, or actions such as suicide attempt(s) or serious self-inflicted injury; and/or
2) Active assaultive behavior toward staff or other residents, due to symptoms of a thought or mood disorder; and/or
3) An inability to meet one's basic needs that puts one's health at risk, such as not eating or drinking for a significant period of time which could lead to medical consequences.

People who meet the criteria above are considered to be at an elevated risk of self-harm or harm to others and would benefit from an expedited admission to an inpatient psychiatric care facility.

Note: If a person is at imminent risk of harm due to a mental health condition and is legally eligible for possible release from jail into an evaluation and treatment facility, the local DCR should evaluate the person and, if needed, facilitate emergent admission to a psychiatric facility. DCRs are available 24/7 to evaluate for risk of harm.

Referral Procedure

In order to make a referral from jail the triage consultation and expedited admission request form must be completed and submitted to the email address listed on the form. It should be completed in its entirety with as much descriptive information as possible. Providing detailed information that helps paint the historical and present picture of the referent's symptomology and behavior will assist staff responsible for admission decisions. A referral may also be made by another entity, such as a prosecutor or defense counsel, in which case the OFMHS will contact the jail to gather additional information.

Note: After submission of the form and supporting documentation, a confirmation of receipt will be sent to the referent within 24 hours (excluding weekends and holidays).

An OFMHS clinician will review the referral packet and make a recommendation as to whether the person should receive expedited admission.

The referral will be sent to the chief medical officer or designee of the respective state hospital for approval or denial of expedited admission within 24 hours of the clinician's review. A final decision by the CMO or designee will be made within 48 hours of receipt.

If the referral is approved for expedited admission, the state hospital admission staff will be notified. OFMHS will notify the defense counsel and prosecutor of the expedited admission. The state hospital admission staff will coordinate with the referring jail to arrange for admission into the forensic unit at the psychiatric hospital.

If the referral is denied, the CMO or designee will notify OFMHS, which will in turn notify the referent, the defense counsel, and prosecutor. In this case, the person who was referred for consideration of expedited admission remains on the waiting list.

10.3 Training

Jail staff who screen people should participate in initial TCEA training and annually thereafter. This training is offered by DSHS OFMHS.

10.4 Resources

Department of Social and Health Services. *Triage Consultation and Expedited Admission*. https://www.dshs.wa.gov/bha/triage-consultation-and-expedited-admission

Department of Social and Health Services. *Forensic Mental Health Triage Consultation and Expedited Admission Guide for Jail Staff.* https://www.dshs.wa.gov/sites/default/files/BHSIA/FMHS/Washington%20State%20Users%20Guide%20to%20TCEA%20for%20Jail%20Staff.pdf

11. TRANSITION PLANNING AND CONTINUITY OF CARE

11.1 Background

Connecting or (in many cases) re-connecting people with community care providers after release from jail or as part of a diversion program requires significant planning. The amount of transition planning required to assure continuity depends on several factors including the severity of mental health symptoms, the intensity of treatment provided at the facility, and the level of functioning of the person upon release (Metzner, 2002). Given that people who experience serious mental illness often benefit from significant community support and that transitions from jail can occur with very short notice, transition planning should begin as soon as possible (Metzner, 2002). Especially of note, if a person is prescribed medication while in jail, the jail is generally required to provide a supply of that medication at release that is sufficient to allow the person to obtain a new source of medication (see *Wakefield v. Thompson*, 1999).

11.2 Guidance

Transition planning should begin at intake with initial screening and assessment of the person's needs and should continue with the development of individualized treatment plans and the prioritized delivery of programming and services. Jails should ensure to the extent feasible that the delivery of needed programming and services begin in jail and continue into the community with as little disruption as possible. It is important that transition planning also includes screening and assessment for co-occurring disorders upon intake, when appropriate, to ensure that people are connected to community services accordingly. All aspects of transition planning and continuity of care should be specified by written policy and procedure. The services may vary based on a jail's resources and staffing levels.

Treatment planning

An individualized treatment plan should be created based upon results from the screening and assessment process and should serve as a plan to address the person's needs both while in custody as well as upon transition into the community. The results of screening and assessment should be incorporated into treatment planning and transition planning. The practice of initial screening and assessment is described earlier in the guidebook and should be referenced as needed for further detail. Jails should also make regular and proactive efforts to communicate with a person's outside care provider if one exists to create an effective treatment plan. Treatment plans should be revised as needed based upon newly identified/prioritized needs and/or the person's progress in treatment. Also, given that some people may have short stays in jail or unexpected release dates, treatment planning should address in-custody programs and services while also incorporating transition planning and referral to programs and services in the community.

Continuity of care

According to van Walraven, Oake, Jennings & Forster, (2010), continuity of care is evaluated through the examination of three domains. The first domain is the individual-provider relationship; continuity exists to the extent that the provider is the single point of contact for the person over time. The second domain is continuity of information, which exists to the extent that the provider has access to and uses past information in current care plans for the person. The third domain is management continuity, which exists to the extent that care between providers is seamless and coherent. Care between providers is measured both within the facility (e.g. medical, behavioral health, custody), as well as between facility providers and outside providers (e.g. behavioral health, community housing, medical). Not all jails in Washington have the same access to medical and mental health services which can impact release planning.

Care planning and documentation

There should be evidence of personalized care that formally begins at intake; however, every effort should be made to identify and document the antecedents to arrest and all pertinent information thereafter. A care planning/record management process should be established in which needs are consistently identified, addressed in a timely fashion, and documented for continuity of care.

Evaluations

When a person is referred/ordered for evaluation or specialty consultation, they should receive those services in a timely manner. If the provider decides to pursue an alternative plan of care, clinical justification for the alternative plan should be written and documented in the person's record to promote continuity of care (NCCHC, 2015).

Return from off-site

There are times when a person will need to travel off-site for care, whether it's to a medical hospital, psychiatric hospital, or other off-site location. When they return from an off-site location, care plans and/or discharge instructions should be reviewed and implemented or, if the provider decides to pursue an alternative plan of care, a clinical justification for that plan should be written, all of which should be documented in the person's record (NCCHC, 2015).

Record keeping

Regardless of digital, paper, or a combination of both formats, facilities should maintain a centralized recordkeeping process to consolidate all information pertaining to individual care. Practices that allow for the storage of pertinent individual care records in different locations should be avoided to the extent feasible to prevent missing or conflicting information which can lead to fractured care.

Note: For the purposes of this guidebook, records are considered those records necessary for providing people with comprehensive and continuous care (e.g., recent and current treatment plans, lab results, discharge instructions) and not necessarily records that are archived per facility policy.

Communication

Jails should consider the following to support continuity of care for community transition:

- Ensure that people in their care are aware of the jail's transition planning resources and continuity of care policies, and that they understand how to access that assistance.
- Prepare releases of information to appropriate community-based treatment and service providers.
- Establish formal agreements with community providers that improve access to information including but not limited to medical and mental health records.
- Establish formal agreements with community providers that improve physical access to the jail and ensure that providers can meet and build relationships with people prior to release.
- Collaborate with community providers to improve access to immediate community appointments.
- Create protocols regarding information sharing between disciplines and between agencies that clearly establish what information will be shared, and under what circumstances it will be shared (e.g., policy, memorandum of understanding).
- Provision of care and planning for release should include a person's family or personal support system when feasible and appropriate.

Transition Planning

Transition planning practices can vary from facility to facility depending on available resources and community partners. Below are transition planning best practices:

- The periods of time following release (the first hours, days, and weeks) should be viewed as critical and should be addressed strategically in the transition plan.
- The application and enrollment process should be started for people who are eligible for income support and benefits (e.g., Medicaid, food benefits).
- Transition plans should be created in collaboration with and signed by the person, which may increase the measure of ownership in the plan.
- Planning for the immediate period following release should be collaborative and the planned community services should match the person's identified needs. Transition planning must consider the services needed (e.g. prescribed medication, behavioral health/medical treatment, and legal obligations), service frequency, and the intensity of those services. Other critical partners such as adult mobile crisis teams and designated crisis responders should be considered.
- Warm hand-offs (e.g. transporting a person to community services and transferring care to another provider) should be conducted to the extent possible.
- Jails should assist in identifying community providers to address transition care needs.
- People leaving jail should be educated on the importance of transition planning and aftercare.
- People should be provided with a personalized transition kit at the time of release. Transition kits should be provided by the jail or community partners depending on the availability of resources.

A personalized transition kit

Should include the following:

- A list of prescribed medications and how to use them
- Medication in an amount sufficient to ensure that there is reasonable time to obtain a new supply after release
- Identification when possible or a referral to obtain identification
- A list of service providers including their location and contact information
- Referral information to include contact information, location, date, and time of any appointments made prior to release
- A plan of what to do in the event of a missed appointment
- A reentry plan that addresses how the person will meet each of their identified needs
- Results of laboratory and diagnostic tests (when applicable and available)
- Toiletries/self-care items
- Additional items and information that can assist with reentry

Other considerations

Personalized transition kits may contain other items intended to improve the measure of continuity of care which may increase the chances of a person's successful transition. For example, some facilities have developed Naloxone distribution programs and provide it as a strategy to prevent opioid overdose after release.

Jails should proactively assist people who may be unable to request assistance with continuity of care or transition planning.

HIPAA and CFR 42 Part 2 provide federal standards and regulations that must be adhered to when sharing protected health information (PHI). This should be addressed by written policy and should include initial and refresher training for staff who have access to PHI.

Data Collection and Analysis

The purpose of data collection and analysis is to monitor and improve system functioning and to improve individual-level outcomes. Performance indicators should be established and consistently monitored to analyze system functioning. Data should be collected, analyzed, and reported in user-friendly reports to inform partners of individual-level outcomes. A system of quality assurance should be established at each respective agency/provider to identify strengths and weaknesses of newly implemented cross-system approaches.

11.3 Training

- Staff who are responsible for the documentation of individual-related information should receive initial training in documentation practices (e.g. creation, routing, and storage).
- Jails should train all staff who participate in transition planning. Jail staff includes corrections, behavioral health providers, health services and any other positions who may be involved in release planning.
- Jails should implement cross training between internal disciplines as well as outside community agencies to coordinate transition planning and inter-agency collaboration.
- Training topics should be selected that bridge internal and partner agency information and resources with the overarching goal of improving transition outcomes.

11.4 Resources

Code of Federal Regulations 82 FR 6115. (2017). *42 CFR Part 2 Confidentiality of Substance Use Disorder Patient Records*. https://www.ecfr.gov/current/title-42/chapter-I/subchapter-A/part-2

Health Care Authority Medicaid suspension webinars. https://www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/medicaid-suspension

Substance Abuse and Mental Health Services Administration. (2017). *Guidelines for successful transition of people with mental or substance use disorders from jail and prison: Implementation Guide*. https://store.samhsa.gov/product/Guidelines-for-Successful-Transition-of-People-with-Mental-or-Substance-Use-Disorders-from-Jail-and-Prison-Implementation-Guide/SMA16-4998

Substance Abuse and Mental Health Services Administration. (2019). *Screening and Assessment of Co-Occurring Disorders in the Justice System.* https://library.samhsa.gov/sites/default/files/pep19-screen-codjs.pdf

U.S. Department of Health and Human Services. (n.d.). *Summary of the HIPPA Privacy Rule.* https://hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html#:~:text=The%20Privacy%20Rule%20protects%20all,health%20information%20(PHI).%22

Transition Planning: Guidelines for successful transition of people with mental or substance-use disorders from jail and prison. https://store.samhsa.gov/product/guidelines-successful-transition-people-mental-or-substance-use-disorders-jail-and-prison

Individual level

National Institute of Corrections. (2018). *Adult Pre-Release Handbook: Pre-Release Information for an Informed Re-Entry and a Successful Transition.* https://jailsupportcenter.org/document/adult-pre-release-handbook-pre-release-information-for-an-informed-re-entry-and-a-successful-transition/

University of Illinois Education Justice Project. *Mapping Your Future: A Guide to Successful Reentry (National Edition)*. https://educationjustice.net/wp-content/uploads/2023/10/Mapping-Your-Future-National-Final.pdf

GAINS Jail Re-Entry Checklist: A checklist that addresses multiple domains pertaining to re-entry that can be used as a re-entry planning tool. https://www.neomed.edu/wp-content/uploads/CJCCOE_I4_GAINS.pdf

Facility level

Council of State Government Justice Center. (2012). *Collaborative Comprehensive Case Plans*. https://nationalreentryresourcecenter.org/resources/collaborative-comprehensive-case-plans-update-release

National Institute of Corrections, Urban Institute Justice Policy Center. (2012). *Case Management Strategies for Successful Jail Reentry.* https://www.urban.org/sites/default/files/publication/25886/412671-Case-Management-Strategies-for-Successful-Jail-Reentry.PDF.

National Resource Center on Justice-Involved Women. (2016). *Jail Tip Sheet #8: Support Women's Successful Transition and Reentry from Jails*. https://cjinvolvedwomen.org/resources/jail-tip-sheet-8-support-womens-successful-transition-and-reentry-from-jails/

Policy Research Institute. (2019). *Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison.* https://www.prainc.com/wp-content/uploads/2019/05/GuidelinesSuccessfulTransition2019-508.pdf

Community level

National Institute of Corrections. *Transition from Jail to Community*. https://nationalreentryresourcecenter.org/resources/transition-jail-community-tjc

Urban Institute Justice Policy Center. (2008). *Release Planning for Successful Reentry A Guide for Corrections, Service Providers, and Community Groups.* https://assets.aecf.org/m/resourcedoc/UI-ReleasePlanningforSuccessfulReentry-2008.pdf

U.S. Department of Justice Office of Justice Programs. (2007). *Short-term Strategies to Improve Reentry of Jail Populations: Expanding and Implementing the APIC Model*. https://ojp.gov/ncjrs/virtual-library/abstracts/short-term-strategies-improve-reentry-jail-populations-expanding

U.S. Department of Veterans Affairs. *Incarcerated Veterans*. https://www.benefits.va.gov/persona/veteran-incarcerated.asp

Washington State Health Care Authority. (2022). *Report to the Legislature Jail Transition Services*. https://app.leg.wa.gov/ReportsToTheLegislature/Home/GetPDF?fileName=HCA%20Report%20-%20Jail%20Transition%20Services_cfcd70da-f7fb-4cf7-9b28-c8afde0c1ef2.pdf

12. CORRECTIONS STAFF WELLNESS

12.1 Background

Correctional officers and other jail staff experience various stressors that can affect psychological wellness, lead to compromised job performance and, eventually, job burnout (de Terte & Stephens, 2014). Research on correctional officer wellness and safety as summarized by Brower (2013) suggests that stressors for correctional officers come from four primary areas. These are:

- **Inmate-related** stressors, which include the threat of physical harm, exposure to violent people daily (Morgan, 2009) and dealing with inmate criminal activity such as inmate-on-inmate violence, gang activity, drug use, sex, and manipulation (Brower, 2013).
- **Occupational** stressors, which include environmental conditions such as working in a closed/secure facility, restricting freedom-of-movement, and little natural lighting (Brower, 2013).
- **Organizational/administrative** stressors, which include "inadequate training, politics, shift assignments, heavy workload, lengthy internal investigations and decision making regarding disciplinary action, lack of administrative support, and poor supervision/leadership" (Brower, 2013, p. 6).
- **Psycho-social** stressors, which include but are not limited to personality-related attributes of the correctional officer, work-family conflict, and the public's misconceptions of corrections work (Brower, 2013).

All of these stressors can lead to problems with physical and emotional well-being. For example, one of the consequences of continuous job stress is low job satisfaction, which has been linked to increased absenteeism, job turnover (Byrd, Silverman, Cochran, & Blount, 2000), and burnout (Whitehead, 1989). Further, correctional officers may experience chronic problems with their sleep, contributing to cognitive impairments (e.g., errors) and mood disturbances (i.e., anxiety and depression) (Crawley, 2004 and Swenson, 2008 as cited in Ferdik F.V., & Smith, H.P., 2017). Correctional officers may also experience physical health problem including cardiovascular disease, high blood pressure, and diabetes at a higher rate than other professions (e.g., police officers, crisis counselors) (Dowden & Tellier, 2004; Morgan, 2009, as cited in Brower, 2013).

12.2 Guidance

We recommend that jails establish and maintain programs for correctional staff wellness that are defined by written policy and procedure. Staff wellness programs should address the sources of stress (e.g., population-related, occupational, organizational/administrative, psycho-social) and should encourage the development of psychological resilience among the workforce in the jail. Jails, along with prisons and police departments nationwide, have implemented various types of programs and approaches to help staff improve and maintain wellness. Some of the programs that should be considered for implementation include:

- **Employee Assistance Programs** typically provide employees of an organization with resources for wellness. Resources may include the provision of confidential counseling, legal assistance, critical incident response, substance-use disorder treatment, debt counseling, and other services.
- **Colleague Support Programs** offer support at the workplace to address both critical incidents and day-to-day work stressors. Colleagues can offer support from a perspective of familiarity with the demands of the workplace and can bridge the gap between supports for those who are hesitant to speak with behavioral health professionals.

- **Critical Incident Response Teams** can be comprised of outside providers, internal sources, or a combination of both. Typically, response teams provide support by offering debriefing of incidents and help people and their families cope with the impacts of the incident.
- **Organizational/Administrative Practices** that may improve measures of corrections staff wellness include those that convey understanding of the challenges associated with working in a jail and demonstrate the value of staff. Examples include but are not limited to providing adequate training in relevant domains (e.g., psychological first aid, supervisor training), allowing for voluntary rather than mandatory overtime, maintaining adequate staffing levels, and encouraging open lines of communication between line staff and upper management.

Further, the workgroup recommends that jails implement policies to ensure that all staff have a reporting system in place that encourages seeking help without retribution or stigmatization. Jails should also ensure that brochures, pamphlets, and other relevant wellness and behavioral health resources are readily available to staff. See the resources listed in this section of the guidebook for more detailed information as well as resources for implementing corrections staff health and wellness programs.

12.3 Training

Jails should ensure that all corrections staff receive initial and annual training on staff physical and emotional well-being. Training should include, at minimum:

- The potential sources of stress
- Signs of stress
- The risks associated with unmitigated exposure to stress
- The effects of trauma
- Programs available to staff members to address psychological resilience and physical health

Jails should ensure that staff who participate in support programs (e.g., colleague support, critical incident response team) are qualified and receive adequate training commensurate with their level of responsibility, to include supervisor training.

12.4 Resources

U.S. Department of Justice Office of Justice Programs National Institute of Justice. (2000). *Addressing Correctional Officer Stress: Programs and Strategies*. https://www.ojp.gov/pdffiles1/nij/183474.pdf

National Institute of Corrections. *Wellness for Corrections and Supervision Professionals*. (n.d.). https://nicic.gov/resources/resources-topics-and-roles/topics/wellness-corrections-and-supervision-professionals

13. TELEHEALTH VIA VIDEOCONFERENCING IN JAILS

13.1 Background

Technology continues to change the way that behavioral health services are delivered. When video teleconferencing is used for health-related services, it is typically referred to as telehealth or telemedicine. These terms are often used interchangeably but telehealth is considered broader in scope, including all forms of information and communication technology in the provision of healthcare. Telehealth is expanding access to assessments (to include forensic assessments such as competency to stand trial), case management, connections to treatment providers, and more (CSG, 2021).

While there will be situations in which an in-person encounter is necessary, the use of telehealth in correctional facilities can improve access to care, impact financial efficiencies, and may provide services more quickly (Schorn et al., 2023). Additionally, as the demand for competency to stand trial evaluations continue to climb in Washington state, telehealth has become an important tool in conducting forensics assessments, such as court-ordered competency to stand trial evaluations (Luxton, Lexcen & McIntyre, 2019). DSHS has established secure telehealth services with several jails in the state to provide forensic evaluators, attorneys, and others, the capability to participate in competency to stand trial evaluations from distant locations. This provides the benefits of greater efficiency at completing court-ordered competency to stand trial evaluations by allowing evaluators to more quickly conduct and complete the evaluation.

13.2 Guidance

Jails should collaborate with partners, including advocacy groups, to assess needs, develop budget priorities and cost estimates for needed infrastructure to support telehealth, and establish and support internal telehealth "champions" to facilitate implementation. Written policies and procedures should be developed to address the safety of staff and participants during telehealth sessions and during transport. Policy must also ensure telehealth practices follow applicable federal and state law pertaining to data and information security. All telehealth services provided by covered health care providers and health plans must comply with the health insurance portability and accountability act (HIPAA) rules. These standards protect a person's health information. Covered health care providers and health plans must use technology that complies with HIPAA for the provision of their video communication products or other remote communication technologies for telehealth.

When conducting DSHS forensic assessments and evaluations via telehealth, DSHS-approved software applications must be used. This ensures that information communicated is safeguarded and that the application is secure for transmission of category 4 data (confidential information requiring special handling). DSHS-licensed Microsoft Teams is the approved software application for telehealth, and "Zoom for Healthcare" is approved for use when MS Teams is not available. If the telehealth session is initiated by a jail, written attestation must be on file stating that the communications service has been approved for use with category 4 data before communicating DSHS confidential information.

The security of the space and telehealth equipment should be assessed. The equipment could be vandalized or potentially used as a weapon or self-harm device (e.g., a power cord used for strangulation or hanging). Securing the telehealth equipment, such as placing the monitor, camera, and cords within an acrylic case is an important consideration.

The use of videoconferencing should ensure that each person can understand and express themselves adequately and should not cause any undue distress. Videoconferencing must be accessible for each person who uses it.

If a jail is interested in exploring telehealth for forensic evaluations and speaking to the OFMHS telehealth team about the technology and support that DSHS provides. Please contact the OFMHS Operations Administrator at jailassistance@dshs.wa.gov

13.3 Training

Jails should ensure that staff facilitating telehealth sessions receive initial and annual training on applicable policies and procedures, to include:

- How to set up and use the equipment
- Procedures for starting and ending a session
- Safety procedures including transport
- HIPAA/category 4 data requirements and confidentiality
- Necessary accommodations to ensure a successful assessment

13.4 Resources

Bureau of Justice Assistance. (n.d.). *Using Telehealth for Behavioral Health in the Criminal Justice System.* https://www.ojp.gov/library/publications/using-telehealth-behavioral-health-criminal-justice-system

Department of Health & Human Services. (n.d.). *Best Practice Guides*. telehealth.hhs.gov. https://telehealth.hhs.gov/providers/best-practice-guides

Northwest Regional Telehealth Resource Center(n.d.). *TeleBehavioral Health 101 Series* – https://nrtrc.catalog.instructure.com/programs/telebehavioral-health-101-series

Schoenbach, N., & Sullivan, S. (n.d.). *A Complete Guide to Correctional Telemedicine.* https://nij.ojp.gov/library/publications/implementing-telemedicine-correctional-facilities#:~:text=Telemedicine%20has%20been%20under%20development,used%20based%20on%20facility%20needs.

Telehealth: If you are interested in learning about the legal and practical considerations regarding use of this technology, please refer to the peer-reviewed article: Luxton, D. D. & Lexcen, F. (2018). Forensic competency evaluations via videoconferencing: A feasibility review and best practice recommendations. https://psycnet.apa.org/record/2018-14402-002

U.S. Department of Health and Human Services. (n.d.). *Summary of the HIPPA Privacy Rule.* https://hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html#:~:text=The%20Privacy%20Rule%20protects%20all,health%20information%20(PHI).%22

Washington State Telehealth implementation guide.
https://www.dshs.wa.gov/sites/default/files/BHSIA/FMHS/DSHSTelehealthGuidebook.pdf
Also visit the DSHS Telehealth Resource Site for more information:
https://www.dshs.wa.gov/bha/telehealth-resources

14. DIVERSION PROGRAM GUIDANCE

14.1 Background

Successful screening and assessment early in the criminal court process (including pre-trial) are essential to diverting people into treatment programs. Diversion programs are often run by a municipal police department, county sheriff's office, tribal law enforcement, court of limited jurisdiction, or behavioral health organization/outside agency designed to enable people to avoid criminal charges or a criminal conviction by alternatively engaging in a treatment program.

The Sequential Intercept Model (Munetz & Griffin, 2006) (See **Figure 7.**) provides a framework for conceptualizing the interface between the criminal court and mental health systems. The sequential intercept model has several key objectives that include (Munetz & Griffin, 2006):

- Preventing initial involvement with the criminal court system
- Decreasing admissions to jail
- Engaging people in treatment as soon as possible
- Minimizing time moving through the criminal court system
- Connecting people to community treatment options
- Decreasing the rate of return to the criminal court system

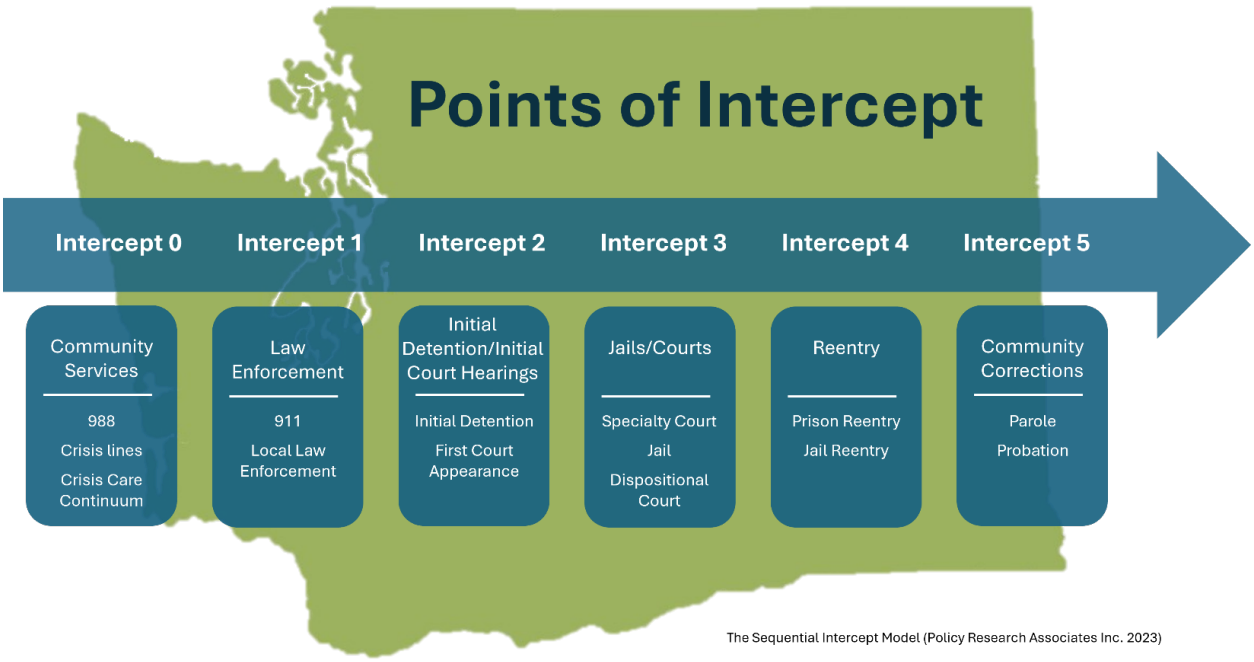


Figure 7. The Diversion (Sequential) Intercept Model (Policy Research Associates, 2023).

Pre-arrest diversion

Pre-arrest diversion is the first point of interception for people with behavioral health needs. Law enforcement and emergency service professionals are often the initial point of contact for people in crisis. At times law enforcement officers may find it difficult to immediately access behavioral health services or be unaware of available resources. Crisis Intervention Teams and police-mental health co-

responder teams serve to bridge the resource gap and are trained to link people with mental health needs to treatment without arrest.

Police diversion programs are built on partnerships between mental health providers in the community and designated law enforcement entities, with the aim of recognizing and responding to mental health symptoms, de-escalating or not escalating situations, avoiding police use of force, decreasing stigmatization, and when appropriate, connecting people to treatment rather than sending them to jail.

Note: RCW 10.31.110 allows for arrest diversion for any criminal charges when the person is known to have a mental health condition. It also requires local prosecutors and law enforcement to develop guidelines with the input of defense counsel and disability rights advocates on how best to use this arrest discretion.

Post-arrest diversion

Post-arrest diversion helps people with behavioral health needs receive treatment through various alternatives to incarceration. While programs that divert people to treatment incur healthcare system costs, providing treatment in the community is typically less expensive than serving people in jail. There is also the potential for large cost offsets because diversion can prevent further criminal court involvement. Jail diversion helps reduce expenditures associated with unnecessary arrests and detentions.

Post-arrest diversion options include the use of mental health screening tools after arrest to quickly identify people who have behavioral health needs and refer them to appropriate services and supports in the community. In addition, established diversion programs, including prosecutorial diversion models, exist in some jurisdictions. Finally, specialized courts, including drug, mental health, and veterans' courts, have shown to be an effective way to divert people with behavioral health needs from incarceration and into treatment (Sarteschi, Vaughn, & Kim, 2011). These voluntary programs operate both pre- and post-adjudication and allow participants to access treatment as an alternative to incarceration.

Additionally, there will be occasions when people are brought to jail while experiencing symptoms of severe mental health symptoms. Other times, a person may decompensate while in custody to the point that their safety or health is at risk. In such cases, if the person is in custody, will not agree to care, and is legally eligible, referring the person for evaluation by a DCR for involuntary civil commitment may be warranted.

Also, OFMHS has established a diversion navigator program. These navigators work to identify Trueblood class members who are in jail and who may be eligible and willing to engage in services, for diversion programs pursuant to RCW 10.77. People may be eligible if they have had two or more cases dismissed in the preceding 24 months due to incompetency to stand trial findings and are at risk of another incompetency finding for their current charge. Diversion navigators seek to identify people with the goals of diverting them from the competency process and breaking the cycle of criminal re-offense by offering wraparound services and assisting them for up to six months while they engage in services.

14.2 Guidance

We recommend that jail administrators become familiar with the Sequential Intercept Model (Munetz & Griffin, 2006) and use the model to inform practices. Jails should learn about existing diversion programs and should collaborate with entities that guide diversion practices in their local jurisdiction (e.g., law enforcement, defense counsel, courts, prosecuting attorney, community mental health) to establish

consensus on diversion criteria and to expand opportunities for prosecutorial diversion where they do not exist. Some jurisdictions have found it beneficial to use co-responders, therapeutic courts, and jail transition teams to help with diversion efforts, which should be considered during collaboration efforts. Specialized therapeutic courts are a resource-heavy means of allowing participants to access treatment and potentially avoid conviction and further incarceration in exchange for an often-lengthy period of intense, court-based supervision. People who have been found not competent to stand trial may not be able to access specialized therapeutic courts due to competency issues.

14.3 Training

Facilities should provide initial and ongoing training as needed to jail staff who have intake screening responsibilities to screen for suitability for diversion. Jail staff should receive initial training on any screening instruments that are used for determining initial suitability for diversion.

Jail staff who conduct screenings should receive initial and ongoing training regarding the criteria used by the jurisdiction to determine suitability for diversion. Jail staff should also receive training about how to identify people who may be appropriate for diversion at any point throughout incarceration and should understand diversion resources available in their area.

14.4 Resources

Joplin Consulting (2016). *Jail diversion for people with mental illness in Washington state* https://www.ofm.wa.gov/sites/default/files/public/legacy/reports/Jail%20Diversion%20for%20People%20with%20Mental%20Illness%20in%20Washington%20State%20Study.pdf

American Jail Association website www.americanjail.org provides useful information about several issues important to jails. There are several links to resources on topics such as addressing the opioid crisis, treating mental illness in jails, reducing pre-trial population, and prosecutor-led diversion.

Washington Association of Designated Crisis Responders (DCR) https://wadcr.org/ The Washington Association of Designated Crisis Responders establishes a network for sharing of information among Designated Crisis Responders and promotes the professional growth of DCRs through the development of a program of continuing education.

The Sequential Intercept Model - Policy Research Associates (2023)
https://www.prainc.com/sim/

Diversion Navigators work to identify people in jail, who may be eligible and willing to engage in services, for diversion programs pursuant to RCW 10.77.
https://www.dshs.wa.gov/sites/default/files/BHSIA/Diversion-Navigator-One-Pager-2024.pdf

15. QUALITY MANAGEMENT

15.1 Background

Most organizations, including jails, run more smoothly and efficiently when there are procedures specifying workflow, corrective actions, and improvement efforts. A lack of continuity is often found within organizations that pay little attention to standards of work or quality management: they support a culture of reactivity where proactive improvement efforts are rarely pursued. Toward the opposite end of the spectrum are organizations that are consistently able to produce repeatable work products, processes are standardized, systems are managed quantitatively, and processes are continuously improved (Dijkman, Lammers & de Jong, 2016).

Jails can better ensure safety and care for incarcerated people with mental health conditions when quality management concepts and procedures are systematically applied. These general concepts and processes include:

Quality management is comprised of four components: quality planning, quality assurance, quality control, and process improvement.

> **Quality planning** is the strategic targeting of organizational processes and products for analysis within the overarching construct of quality management, the goal being optimal organizational functioning and repeatable product quality.
>
> **Quality assurance** is the practice of evaluating system operation as a proactive means of ensuring consistent quality product delivery. Performance indicators should be identified to effectively measure system health. Performance indicators are points within a system where quantifiable measurements can be taken for the purpose of assessing the health of a system.
>
> **Quality control** is a process in which a product of a system is examined to evaluate whether the product meets a defined standard. Quality control is an exercise in retrospective analysis that isn't intended to catch failures before they happen but rather serves as an impetus for another component of quality management, process improvement.
>
> **Process improvement** is a proactive method of improving processes within an organization to reduce waste, increase efficiency, and increase the overall quality of a product. Improvement efforts are typically aimed at systems rather than individual people, the rationale being that it's more likely an inefficient system than a person causing the problem.

15.2 Guidance

The workgroup recommends that jails implement a program for quality management that is established by written policy and procedure. Each system, product, and outcome significant to the safety and care of people with mental health conditions in jail should be considered for quality management. Jails may have unique systems in place to manage the safety and care of incarcerated people living with mental health conditions. Therefore, performance indicators that are specific to unique facility processes may be different than the following examples and will need to be identified based on the processes for individual jails.

For many jails, the following key indicators of quality should be monitored, evaluated, reported out regularly, and should be used to drive process improvement efforts as applicable:

- Number of intakes

- Number of people flagged for mental health follow-up pursuant to the intake screening
- Number of people flagged AND seen for follow-up by mental health practitioner(s)
- Findings of health care screenings related to mental health, suicide risk, and cognitive disabilities
- Number of referrals to mental health services by other sources (e.g., correctional officers, medical, self-referral, or collateral sources)
- Whether mental health referrals are processed and people seen for follow-up within specified timeframes (for those people not seen within the timeframe, tracking of actual time to be seen)
- Number of people referred to a psychiatric provider
- Whether people are seen by the psychiatric provider within specified timeframes (for those not seen within the timeframe, tracking of actual time to be seen)
- Whether people who have a current verified prescription for psychiatric medication at booking have those medications, or therapeutically equivalent medications, provided to them by the jail within 24 hours
- Whether people are seen for follow-up for developmental/cognitive disabilities and tracking of what follow-up was provided
- Number of people referred to a hospital due to acute mental health issues
- Number of people receiving behavioral health services or those whom behavioral health staff consider as being on the behavioral health case load
- Number of suicide attempts
- Number of people who died by suicide
- Records related to the use of restraint
- Records related to people with disciplinary charges or sanctions who are receiving behavioral health services
- Number of people with individual treatment plans
- Number of people attending group therapeutic programming and efforts by staff to encourage consistent participation
- Number of people with known or suspected behavioral health issues or developmental/cognitive disabilities placed in restrictive housing and what reasons were given for this placement
- Number of residents transferred in and out of a behavioral/mental health unit or an acute housing unit
- Number of disability-related complaints or requests for accommodations and the resolution

15.3 Training

All jail employees should receive initial training on the concepts of quality management to create a culture of continuous improvement. Those employees charged with specific quality management responsibilities should receive initial and ongoing training commensurate with their responsibilities. For more information regarding planning and continuous improvement, refer to the Washington State Department of Social and Health Services Office of Planning and Continuous Improvement.

15.4 Resources

Schiff, G.D., & Shansky, R. (2006). *Continuous Quality Improvement*. https://www.ncchc.org/wp-content/uploads/Continuous-Quality-Improvement.pdf

Washington State Department of Social and Health Services Office of Planning and Continuous Improvement. https://www.dshs.wa.gov/office-of-the-secretary/planning-and-continuous-improvement

Bureau of Justice Statistics website www.bjs.gov is a source for criminal justice statistics. There are links to statistical information on a variety of subjects to include prison and jail demographics, prevalence of mental health problems, rates of incarceration, and much more.

16. ADDITIONAL RESOURCES

American Academy of Psychiatry and the Law (AAPL): According to the website, www.jaapl.org is intended to be a forum for the exchange of multidisciplinary ideas. Content includes correctional psychiatry, psychiatric evaluation of people involved with the criminal or civil legal system, ethics, the philosophy of law, legal regulation of psychiatric practice, education and training in the field, and research into causes and treatment of behavioral problems that manifest themselves particularly in people who are in contact with the legal system. Also see the AAPL practice resource for prescribing in corrections. https://jaapl.org/content/jaapl/46/2_Supplement/S2.full.pdf

American Jail Association website www.americanjail.org provides useful information about several issues important to jails. There are several links to resources on topics such as addressing the opioid crisis, treating mental illness in jails, reducing pre-trial population, and prosecutor-led diversion.

Bureau of Justice Statistics website www.bjs.gov is a source for criminal justice statistics. There are links to statistical information on a variety of subjects to include prison and jail demographics, prevalence of mental health problems, rates of incarceration, and much more.

Brief Jail Mental Health Screen: A screening tool developed by Policy Research Associates that can be used to screen people coming into jail who need further mental health assessment. https://www.prainc.com/?product=brief-jail-mental-health-screen-

Centers for Disease Control and Prevention: https://www.cdc.gov/overdose-prevention/index.html

© National Center on Institutions and Alternatives, 2017A checklist of structural design strategies intended to create suicide-resistant housing (Appendix A). https://www.bcso-ma.us/Homepage_files/4-4-23_suicidereport.pdf

Crisis Intervention Team International: CIT International has contact information for each state. Washington state contact information can be requested by emailing admin@citinternational.org. Also see CIT guide to best practices in mental health crisis response.

Department of Social and Health Services. (2024, April). *Outpatient Competency Restoration Program*. https://www.dshs.wa.gov/sites/default/files/BHSIA/FMHS/011%20-%2024%20OCRP%20One%20Pager.pdf

GAINS Jail Re-Entry Checklist: A checklist that addresses multiple domains pertaining to re-entry that can be used as a re-entry planning tool. https://www.neomed.edu/wp-content/uploads/CJCCOE_I4_GAINS.pdf

Guiding Principles to Suicide Prevention in Correctional Facilities
© National Center on Institutions and Alternatives, 2017
A list of essential components of suicide prevention programs in correctional facilities that includes guidance on everything from intake into the facility to effective use of language and optimal mindset. https://www.ncchc.org/wp-content/uploads/Suicide-Prevention-2017.pdf

Guide to Developing and Revising Suicide Prevention Protocols within Jails and Prisons
© National Center on Institutions and Alternatives, 2017. Useful information about suicide prevention protocols that covers the topics of staff training, identification/referral/evaluation, communication, housing, levels of observation/management, intervention, reporting, and follow up/morbidity review. https://www.ncchc.org/wp-content/uploads/Suicide-Prevention-2017.pdf

International Critical Incident Stress Foundation, Inc. website www.icisf.org provides links to education, training, consultation, and other resources pertaining to crisis intervention.

Joplin Consulting: Jail diversion for people with mental illness in Washington State is a study conducted by Joplin Consulting for the State of Washington Office of Financial Management.

National Alliance on Mental Illness: https://www.nami.org/get-involved/law-enforcement-and-mental-health website provides information on Crisis Intervention Team Programs.

National Commission on Correctional Health Care web site www.ncchc.org provides information on a wide range of correctional health related topics to include preventing opioid overdose death in jail, substance-use disorder treatment, jail-based medication-assisted treatment, women's health care in a correctional setting, solitary confinement, and many more. Part of the NCCHC stated mission is to improve the quality of healthcare in jails. Several position statements, guidelines, and management tools are available for review. The NCCHC is also supported by a number of national organizations to include American Jail Association, American Bar Association, National Sheriff's Association, American Psychiatric Association, American Psychological Association, and many more.

National Criminal Justice Reference Service: a correctional resource on equipment and technology, officer wellness, public safety officers' benefits program, training, and violence in facilities. https://www.ojp.gov/topics/corrections

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Office of Forensic Mental Health Services website provides useful information and contact information for forensic mental health services in the state of Washington. https://www.dshs.wa.gov/bha/office-forensic-mental-health-services

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Telehealth: If you are interested in learning about the legal and practical considerations regarding use of this technology, please refer to the peer-reviewed article: Luxton, D. D. & Lexcen, F. (2018). Forensic competency evaluations via videoconferencing: A feasibility review and best practice recommendations. https://psycnet.apa.org/record/2018-14402-002

Washington State Telehealth implementation guide. https://www.dshs.wa.gov/sites/default/files/BHSIA/FMHS/DSHSTelehealthGuidebook.pdf

Also visit the DSHS Telehealth Resource Site for more information: https://www.dshs.wa.gov/bha/telehealth-resources

Transition Planning: Guidelines for successful transition of people with mental or substance-use disorders from jail and prison. https://store.samhsa.gov/product/guidelines-successful-transition-people-mental-or-substance-use-disorders-jail-and-prison

Triage Consultation and Expedited Admission: Visit the website for more information on the referral process for inmates on a court order awaiting forensic services from the state hospital whom the staff believe requires additional psychiatric intervention. https://www.dshs.wa.gov/bha/triage-consultation-and-expedited-admission

Washington Association of Designated Crisis Responders (DCR) https://wadcr.org/ The Washington Association of Designated Crisis Responders establishes a network for sharing of information among Designated Crisis Responders and promotes the professional growth of DCRs through the development of a program of continuing education.

Washington Association of Sheriffs & Police Chiefs website www.waspc.org provides several resources for the law enforcement community and citizens of Washington state. WASPC's stated mission is to lead collaboration among law enforcement executives to enhance public safety. Resources include forms, model policies, procedures, and guidelines, as well as links to additional community, jail, and law enforcement resources.

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17. GLOSSARY

CFS: Center for Forensic Services

CISD: Critical incident stress debriefing

Competency Restoration: The process of helping a person regain or achieve the capacity to understand the nature of the proceedings against them and assist an attorney in their defense.

Co-responder Program: Programs that use behavioral health professionals who respond alongside law enforcement officers to crisis situations for the general purpose of diversion of people with mental illness from incarceration to treatment as appropriate.

DCR: Designated crisis responder

DDP: Developmental disability professional

ESH: Eastern State Hospital

Felony Flip: When a defendant's felony charges are dismissed, and a civil commitment is pursued.

Forensic Commitment: The act of involuntarily placing an adult defendant in a secure facility due to incompetence to proceed or insanity and the need for care due to dangerousness or self-neglect.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): A federal law that protects patients' health information and gives patients more control over how their health information is used.

Incompetent to Proceed, Incompetent to Stand Trial: A mental illness or developmental disability renders the defendant incapable of effectively helping in their defense or understanding the nature of the proceedings against them.

Interdisciplinary Team: A team comprised of members across disciplines intended to increase continuity of care.

Involuntary Civil Commitment: Involuntary civil commitment is the involuntary placement of an adult pursuant to RCW 71.05 for the purpose of treating a mental illness that renders the person dangerous or at risk of self-neglect.

Jail Transition Team: A team responsible for the transition of people who are incarcerated into the community.

NGRI: Not guilty by reason of insanity

QMS: Quality Management System

Sell Order: A judicial order for the authorization to administer medications involuntarily for the purpose of restoring competency to stand trial.

Specialty court or Therapeutic court: Courts that use a program or programs that are structured to hopefully achieve both a reduction in recidivism and an increase in the likelihood of rehabilitation, or to reduce child abuse and neglect, out-of-home placements of children, termination of parental rights, and substance abuse and mental health symptoms among parents or guardians and their children through

continuous and intense judicially supervised treatment and the appropriate use of services, sanctions, and incentives (see Definitions RCW 2.30.020).

Trauma-informed care: A treatment approach used to engage people with histories of trauma.

Trier of fact: (Or finder of fact), is a person, or group of people, who determines facts in a legal proceeding.

Warm hand-off: In the context of a jail setting, a warm hand-off is the person-to-person transition of care of a person from incarceration to a formal or informal care provider.

WATCH: Washington State Patrol's criminal history database

WSH: Western State Hospital

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