



Washington State Department of Social and Health Services

# Best Practices for Behavioral Health Services in Jail Settings

Behavioral Health Administration  
Office of Forensic Mental Health Services  
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## Acknowledgements

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## 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.



Dear Reader,

It is our pleasure to provide this Jail Technical Assistance guidebook in an effort to assist you to more fully understand the diverse needs of individuals experiencing mental illness who are involved in the criminal justice system.

The Department of Social and Health Services provides services to roughly one in four Washingtonians. Our agency mission is to transform lives. A large part of this mission is to do our part to help transform behavioral health in Washington state.

DSHS, through its Behavioral Health Administration, oversees two state adult psychiatric hospitals (Eastern and Western State Hospitals), and a smaller facility for children with acute mental illness (Child Study and Treatment Center). Also within BHA is the Office of Forensic Mental Health Services, which provides competency evaluations, care and treatment for competency evaluation, restoration and hospital diversion services.

The OFMHS Division has focused its efforts on improving access to services that assess an individual's competency to stand trial, including the timeliness of these services, which has been challenging as the demand for them continues to increase.

Our goal is to ensure that people in need of treatment get the services they need prior to being criminally justice involved. We are working with other state and local partners to create greater access to necessary community services so those in a mental health crisis can get the help they need where they work, live, play and worship, rather than a state hospital that is likely far from their home and support networks.

As part of that work, we are also working with our partners to build more access to local inpatient beds within the individual's home community. Creating more bed capacity in the community will allow us to turn our existing state hospitals into forensic centers of excellence to serve individuals coming through the criminal justice system.

This guidebook is designed to help others gain a better understanding of how our partners across law enforcement, the courts and the jails can play a critical role in providing services for individuals who are, or become at risk of becoming involved in the criminal justice system.

It is my hope that this guidebook is a useful tool for all who read it and an inspiration to join the behavioral health transformation in our state.

Sincerely,



Cheryl Strange

Secretary

Department of Social and Health Services

Department of Social and Health Services

## Behavioral Health Administration

Transforming  
Lives



Dear Reader,

The Behavioral Health Administration is under the umbrella of the Department of Social and Health Services and our work is deeply intertwined with our state's jails and law enforcement agencies. While our Office of Mental Health Services focuses on competency evaluations, competency restoration and diversion services, the state's two adult psychiatric hospitals (Eastern and Western) also care for forensic patients who enter our hospitals first through interactions with law enforcement, and then through our court systems and jails.

As you will see in this guidebook, about 44 percent of individuals who are inmates live with mental health conditions. Of those, 26 percent are considered to have serious psychological distress. The early identification and treatment of these individuals increases both their safety and the safety of fellow inmates and jail staff.

This guidebook helps bridge the continuum of care by offering recommendations for jails on mental health screenings and assessments, psychiatric medications, reconnecting people with community services, and more. Our experts within DSHS and our community partners share with you their knowledge on how to work with those with persistent and severe mental illnesses in jail settings to enhance their care and wellbeing.

It is the ultimate goal of all of us to break the cycle of recidivism, to provide people with the levels of psychiatric care and treatment they need when they are with us, and to reintegrate them back into their communities with levels of support greater than they experienced before they entered our facilities. This guidebook will help us get there.

Sincerely,

A handwritten signature in black ink that reads "Sean Murphy". The signature is stylized and written over a circular stamp or watermark.

Assistant Secretary

Behavioral Health Administration



Transforming  
Lives



Dear Reader,

The mission of the Department of Social and Health Services is to transform lives. This transformational work occurs within the various communities, facilities, and agencies throughout the state with our most valuable resource — Washingtonians.

For our most vulnerable citizens who are incarcerated with a behavioral health issue, 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 navigators. As with all of 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

Director, Office of Forensic Mental Health Services

Behavioral Health Administration

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## INTRODUCTION

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### 1.1 Overview

On any given day in the United States, approximately 400,000 people with mental illnesses are incarcerated in jails and prisons, and more than 500,000 people with mental illnesses are under correctional control in the community (National Leadership Forum on Behavioral Health/Criminal Justice Services, 2009). 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 illness and substance use disorders 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). Furthermore, suicide remains the leading cause of death in jails, accounting for approximately one-third of all jail deaths from 2000 to 2014 (Noonan, 2016).

Competency to stand trial, also referred to as adjudicative competence, refers to a criminal defendant's ability to participate in legal proceedings related to an alleged offense (Mossman et al., 2007). In Washington, 'incompetency' refers to when a person lacks the capacity to understand the nature of the proceedings against him or her or to assist in his or her 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 10.77.050). When court-ordered, the state must determine whether an individual is competent to stand trial, and if not, attempts to restore competency may be pursued.

The *A.B. by and through Trueblood et. al. v Washington State DSHS, No. 15–35462* class action suit enforces an individual's constitutional right to timely competency evaluation and restoration services. The class members are those who are in jail and awaiting court-ordered competency to stand trial evaluation and/or restoration services (for more detailed information, visit the Office of Forensic Mental Health Services [web page](#)). 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 approved by Washington's designated Protection and Advocacy System (Disability Rights Washington).

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 individuals in jails experiencing mental illness, 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 class members, reduce the number of people who become or remain class members, and timely serve those who become class members.

## 1.2 Guidebook Preparation

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

These considerations were:

- Awareness of the disparity of resources and 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 are 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 relevance of peer perspectives and lived-experience in 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.
- 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).
- 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.

It is recommended that the user refer to the electronic version of the guidebook in order 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 DSHS/OFMHS website, located at: <https://www.dshs.wa.gov/bha/office-forensic-mental-health-services>

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

You may also write to us at:

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## ABOUT THE JAIL TECHNICAL ASSISTANCE PROGRAM

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### 2.1 Background

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

The Office of Forensic Mental Health Services was created in 2015 when the Washington State Legislature signed it into law ([RCW 10.77.280](#)). The OFMHS is part of the Behavioral Health Administration within the Washington State Department of Social and Health Services and has headquarters in Lacey. The mission of this office is to establish and maintain oversight over a forensic system of mental health that includes the criminal justice community, the courts, and those who are accused of a crime and living with a mental illness. The goal is the creation and management of a cohesive system that allows for the provision of public safety, protection of constitutional rights, and timely mental health services.

DSHS provides a number of services and supports to achieve the goal of establishing a high quality and cohesive forensic mental health system. OFMHS provides forensic evaluations, competency restoration, 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 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 preventing individuals with mental illness from entering the criminal court system.

For more information regarding services and resources, please visit the Jail Technical Assistance webpage: [www.dshs.wa.gov/bha/office-forensic-mental-health-services/jail-technical-assistance-program](http://www.dshs.wa.gov/bha/office-forensic-mental-health-services/jail-technical-assistance-program)

## IDENTIFICATION OF NEED AND ACCESS TO TREATMENT

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### 3.1 Background

Approximately 44% of individuals in jail in the United States have a mental health disorder and of those, 26% meet the threshold for serious psychological distress (Zeng, 2019). Additionally, 30% of individuals in jail reported having a cognitive disability (Bronson, Maruschak, & Berzofsky, 2015). Individuals 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 Resources

National Commission on Correctional Health Care. (2015). *Standards for mental health services in correctional facilities*. Chicago, IL: National Commission on Correctional Health Care.

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.

Substance Abuse and Mental Health Services Administration. (2015). [Screening and assessment of co-occurring disorders in the justice system](#). HHS Publication No. (SMA)-15-4930. [PDF file].

### 3.3 Guidance

We recommend that jails establish a program for the identification of need and access to treatment for all individuals booked into jail. Ideally, the program should begin at intake and should continue throughout the individual'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 individuals 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 incarcerated individual at the time of booking.

*Assessment* provides a more complete clinical picture of an individual. This entails a comprehensive focus on the individual'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.

### 3.3.1 Screening:

- Universal screening should be completed for each individual as early in the intake process as feasible. At a minimum, screening should address the following:
  - Mental status, including history of mental illness, 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
  - Screener observations, including person's appearance, behavior, ease of movement, speech, and orientation
- Screenings should be conducted throughout the period of incarceration as needed based upon individual need (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 in order to ensure that individuals 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 regularly 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 and assessment should occur in a private location, such as an interview room or medical examination room. Jails and health care staff should be aware of relevant legal obligations under state and federal health care confidentiality laws (e.g., HIPPA). Ensured privacy will also generally elicit more accurate and thorough information from the individual being screened
- Jails should consider establishing protocols for pre-booking diversion of individuals in acute psychiatric distress.

**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 are available free of cost.

### 3.3.2 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 individual'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 in interview room or medical examination room.
- Individuals 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.
- Individuals 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 individuals 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 individual's need and progress in treatment.
- If screening or assessment indicates that an individual was prescribed medication for mental illness or substance-use disorder treatment in the recent past, the facility should verify this medication and provide it to the individual for bridging purposes until further assessment is done.
- If an individual is assessed to benefit from medication for mental illness or substance-use disorder by a jail-based provider in collaboration with the consenting individual, the facility should include medication as part of the treatment plan and provide medication to the individual without undue delay or restriction.
- Healthcare professionals who are providing screening, assessment or treatment should meet with patients in a private location and must avoid whenever possible locations including a cell front, a dayroom with adjacent occupied cells, or the hallway.
- In the event that the facility is unable to provide the level of behavioral health services in accordance with the individual'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 individual to a facility that can provide the needed level of care. In order 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 individual'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.

### **3.4 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 individuals with mental illness and/or substance-use disorders
- How to identify individuals with the most pressing need for follow up
- How to communicate 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 illness 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.

## **CRISIS DE-ESCALATION IN CUSTODY SETTINGS**

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### **4.1 Background**

The rates of inmate-to-inmate and inmate-to-officer violence is a significant problem nationwide and results in both fatal and nonfatal injury. Of the nonfatal assaults and violent act injuries, more than one-third (37%) occurred while restraining an inmate or interacting with an inmate during an altercation (Konda, Tiesman, Reichard, & Hartley 2013).

Steps can be taken to reduce risk to inmates and staff, including skilled and strategic interpersonal interaction of jail staff with incarcerated individuals. Jail staff actions/reactions have a direct impact on crisis de-escalation outcomes, and the behavior of staff may trigger pre-existing traumas for individuals in custody. 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). In a 2006 study, jail inmates who had a mental health problem (24%) were three times as likely as jail inmates without (8%) to report having been physically or sexually abused in their past (James, & Glaze 2006).

Given the vulnerability of individuals in jail who have experienced trauma and/or have serious mental illness, 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 Resources**

Substance Abuse and Mental Health Services Administration. (2009). Practice guidelines: Core elements in responding to mental health crises. Retrieved from <https://store.samhsa.gov/system/files/sma09-4427.pdf>

National Alliance on Mental Illness (<https://www.nami.org/get-involved/law-enforcement-and-mental-health>)

CIT International has contact information for each State. Washington State contact information can be requested by emailing [admin@citinternational.org](mailto:admin@citinternational.org)

CIT International Releases Groundbreaking Guide to Best Practices in Mental Health Crisis Response: <http://www.citinternational.org/bestpracticeguide>

### **4.3 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 different 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 individuals 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 individual is *in the moment* through listening to and observing the individual's words, feelings and actions. The staff should present as interested in the individual and actively attending to the individual's verbal and non-verbal output.

#### Accurate Reflection of What is Stated

A level of validation using a nonjudgmental stance. This allows the individual to know that he or she has been understood in a meaningful way.

#### Positive Verbal and Non-Verbal Communication to Appropriate Behavior

Positive appraisal of an appropriate behavior.

#### Giving Positive Items After Appropriate Behavior

- Identify rewarding items (e.g., book, coloring book).
- Most effective when paired with a positive verbal and non-verbal communications.

#### Prompting

- Explaining the consequences of behaviors
  - Negative prompt describes the undesired consequence(s)
  - Positive prompt describes desired consequence(s)
  - Always follow a negative prompt with a positive prompt

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

- Negative verbal communication – “That was dumb.”

- 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 an individual. There may be situations that take place when an individual requests goods or privileges that the staff is not supposed to or cannot give. Some effective strategies for denial of request include the following:

- Strategies
  - V – Validate
  - D – Defer (to a rule, not a person)
  - S – Suggest an alternative
  - P – Positive prompt
- **Example:** Individual 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, individuals 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.

### Bizarre Behavior

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

- Arguing with individuals
- Challenging their delusions (unless done with an established therapy protocol)
- Reinforcing delusions
- Reinforcing bizarre behavior
- Playing a role in an individual’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.

#### 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
- Being in a system with no perceptible hope for discharge

Preventing Aggression:

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

**Trauma and Trauma-Informed Care**

**Trauma:** “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” (SAMHSA, 2019, para. 1). Trauma is under-reported and under-diagnosed. Trauma symptoms can include inattention, disorganization, depression, problem eating behaviors, and impulsivity.

**Trauma Informed Care:** Mental health treatment that is directed by:

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

**What is a psychiatric crisis?**

A **psychiatric crisis** is when a person has any or all of 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)

**What is crisis intervention?**

**Crisis intervention** is the strategic practice of immediate and short-term psychological care aimed at assisting individuals in a psychiatric crisis to restore self-control.

**What is de-escalation?**

**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 de-escalate an escalated situation.

**4.4 Training**

Staff who work in correctional settings should receive initial and annual training on strategies to prevent conflict escalation and to de-escalate conflicts that have reached crisis-level intensity. Ideally, 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.

## SUICIDE RISK ASSESSMENT AND MANAGEMENT

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### 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), 38% of those who completed suicide had a history of mental illness, 47% had a history of substance abuse, and 34% had a history of suicidal behavior. Only 7.5% were on suicide precautions at the time they died by suicide. Other research has shown that 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.

Numerous factors contribute to the high rate of suicides and non-fatal attempts in jails. Some risk factors are environmental and can be mitigated by making changes to the individual's 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). Making changes to the environment (e.g., making cells suicide-resistant, discontinuing issuing sheets) reduces accessibility to the means for a suicide attempt. Other contributing factors are not as simple to manage. They include individual risk factors and experiences, which can be assessed with effective screening, evaluations, and monitoring as part of a comprehensive system of care.

### 5.2 Resources

Hayes, L. M. (2011). Guide to developing and revising suicide prevention protocols within jails and prisons [PDF file]. Retrieved from <http://www.ncianet.org/wp-content/uploads/2015/05/Guide-to-Developing-and-Revising-Suicide-Prevention-Protocols-within-Jails-and-Prisons.pdf>

Hayes, L. M. (2010). National study of jail suicide: 20 years later [PDF file]. Retrieved from <https://info.nicic.gov/nicrp/system/files/024308.pdf>

National Commission on Correctional Health Care. (2015). *Standards for mental health services in correctional facilities*. Chicago, IL: National Commission on Correctional Health Care.

### 5.3 Guidance

#### 5.3.1 Awareness and Prevention Approach

The manner in which staff approach suicide prevention is essential for successful suicide prevention and risk management in jails. Suicide is preventable and is everyone's responsibility. For example, jail staff can assist with screening and risk management and administrators can assist with assuring that screening, assessments, and prevention procedures are in place, including means restriction within facilities.

The facility's culture should be one that views suicide as preventable, promotes suicide risk awareness, and encourages intentional prevention strategies. Jails should have a comprehensive suicide prevention program designed to identify suicidal individuals and to ensure appropriate care is provided.

If at any time staff determines that an individual is a suicide risk, staff should immediately initiate suicide precaution protocols. Suicide precautions are specific precautionary interventions initiated when an individual 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 referral to mental health staff and treatment.

### 5.3.2 Screening and Assessment

Screening and assessment should be considered as a routine, ongoing process, not a one-time event: individuals can become suicidal at any time during confinement. Approximately one quarter of suicides take place within 24 hours of admission, another quarter take place between 2 and 14 days of admission, and approximately one-fifth take place between 1 and 4 months (Hayes, L. M., 2010). 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 of the lack of control over their future, hopelessness, and/or shame. They may become vulnerable to suicidal thoughts and/or behavior after receiving bad news, after 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 individuals' antecedent to self-harming thoughts and/or behaviors. As noted earlier, most suicides in jails occur when persons are *not* on suicide precautions. Thus, staff should always maintain a mindset of prevention and not rely too heavily upon information gathered at intake alone.

#### 5.3.2.1 Screening

Screening should entail collection of information about:

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

#### 5.3.2.2 Assessment

The assessment process should be conducted by a qualified mental health professional to determine the level of suicide risk that the individual presents at the time of the assessment, the degree of suicide precautions that should be taken, and whether the individual should be transferred to an inpatient mental health facility or program. Individuals 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 follow-up assessments after release from suicide precautions. See listed resources for additional information.

#### 5.3.3 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 anchoring points, issuing clothing and bedding that is difficult to make into ligatures, restricting supplies and/or objects that can be used for self-harm or suicide attempts, and the use of monitoring to reduce or eliminate the amount of time an individual is out of observation. Although critical in an emergency, means restrictions such as the removal of a 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., 2011).

### **5.3.3.1 Safety Planning**

Safety planning is an important intervention tool used to help those who struggle with their suicidal thoughts and urges to survive. 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 a patient.

The basic steps of a safety plan with practicality in the jail setting include:

- (a) Recognizing the warning signs of a suicidal crisis
- (b) Using the individual's own coping strategies
- (c) Methods to distract from suicidal thoughts
- (d) Contacting mental health professionals or agencies
- (e) Reducing the availability of means to attempt suicide

### **5.3.4 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 an individual's level of suicide risk (2015). For example, the arresting officer should be attentive to the individual's statements and behavior at the time of the arrest, during transport and at the time of intake, and should communicate pertinent information to jail staff. Additionally, jail staff should communicate across disciplines regarding pertinent observations of the individual that may be an antecedent to self-harming thoughts and/or behaviors: the use of the interdisciplinary team concept would work well in this situation.

While intake screenings reflect suicide risk at the time of the screening, they may not accurately determine suicide risk throughout an individual's time spent incarcerated, which makes ongoing assessment critical to effective suicide prevention. Ongoing assessment 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 individual's life circumstances (e.g. adjudication, bad news, and release after a long period of incarceration) should be considered part of an ongoing assessment. Information pertinent to an individual's suicide risk should be shared among disciplines in order to maintain an effective suicide prevention program (NCCHC, 2015).

### **5.3.5 Transportation**

Facilities that provide transportation to individuals should develop written policies and procedures to prevent deliberate self-harm during transportation to the extent possible. As mentioned earlier, an individual's risk of suicide can change at any time to include prior to or during transportation. For example, a recently sentenced individual may experience an increased risk of self-harm during transportation from the courthouse to the jail. The principles of means restriction and maintaining a mindset of prevention should be considered whether in a secure facility or transporting an individual in a vehicle.

### **5.3.6 Observation, Monitoring, and Housing**

#### **5.3.6.1 Observation and Monitoring**

Observation is a key component in any suicide prevention program. Historically there have been two types of observation protocols: constant and close observation. As the name implies, constant

observation requires that the individual is continuously in view without disruption. Close observation protocols vary with differing amounts of time allowed between direct observations of the individual depending on the particular facility policy: typically no longer than about 10 minutes in a jail setting. Brain damage resulting from strangulation due to an attempted suicide can occur within 4 minutes, and death can occur within 5 to 6 minutes (NCCHC, 2015). Given the very short window of time during which an individual 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 of an individual's need allows for close observation, the times between observations should be varied (e.g. 5 min, 9 min, 7 min.) but should never exceed 10 minutes in a jail setting (Hayes, L. M., 2011).

**Note:** Closed-circuit television may be used as a supplement to observation of individuals, but should not be used as a replacement for direct observation required of close and/or constant observation levels (NCCHC, 2015).

### 5.3.6.2 Housing

There are a number of considerations when it comes to housing an individual with an elevated risk of self-harm and/or suicide. Jails should restrict potentially dangerous personal property and pay special attention to protrusions (potential anchoring points) and the type of bedding provided to individuals at risk of suicide. Other considerations include the ability to see and monitor the individual inside of their cell without obstruction and ensuring frequent social contact with jail staff. Ideally, an individual on suicide precaution should be housed in a location that is close to staff and convenient for medical and mental health rounds.

The importance of social interaction with individuals who are potentially suicidal should not be underestimated. We recommend that jails avoid physically segregating or unnecessarily restraining suicidal individuals. Such practices may be detrimental because they can heighten an individual's sense of alienation and further isolate them from the benefits of social interaction and staff supervision. Housing assignments should maximize staff interaction, and not the segregation or isolation of the individual. (Hayes, L. M., 2011).

**Note:** For information on how to make housing "suicide-resistant" see the resource section of this guidebook.

### 5.3.7 Intervention

The survival of an individual after a suicide attempt may depend on a rapid and effective response by staff. We recommend that jails establish suicide response protocol that allows for the quickest and most effective intervention while maintaining staff safety. Staff who routinely interact with individuals should be trained in first aid and CPR. Staff who make the initial discovery of an individual engaging in self-harm should immediately notify additional staff members who should assist in assessing the situation, securing the scene, and notifying medical personnel. The facility should have a medical emergency response kit available, which should immediately be brought to the scene if necessary. 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 dead and should initiate life-saving measures until medical personnel arrive. While not all suicide attempts result in the need for emergency medical intervention, all individuals who attempt suicide should receive immediate intervention and assessment by qualified mental health staff (Hayes, L. M., 2011).

### 5.3.8 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 came into contact with the individual before the incident should provide a written statement regarding their full knowledge of the individual and the incident (Hayes, L. M., 2011).

### 5.3.9 Mortality/Morbidity Review

We recommend that jails establish a system for the review of serious 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, training of involved staff that is relevant, 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., 2011). Given that these incidents can be very stressful to staff as well as other individuals, appropriate support should be offered to both staff and individuals without delay. Examples of support include providing individuals with access to mental health services, providing staff with access to services such as employee assistance programs, and utilizing 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.

## 5.4 Training

Jail staff who have routine contact with individuals should receive at minimum eight hours of initial standard training in suicide prevention as well as two hours of refresher training annually thereafter (Hayes, L. M., 2011).

According to Hayes (2011), 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., 2011).

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

## INVOLUNTARY ADMINISTRATION OF MEDICATION

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### 6.1 Background

There are occasions when an incarcerated individual would medically benefit from taking medications (e.g., antipsychotic). On such occasions the individual may provide informed consent for taking prescribed medication, or they may refuse. Although not all individuals who refuse medication can be compelled to involuntarily take antipsychotic medication, in certain circumstances they can. Typically, there are three circumstances in which a jail can administer antipsychotic medication to an individual 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, an individual 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 Resources

[Washington v. Harper, 494 U.S. 210 \(1990\)](#)

[Sell v. United States, 539 U.S. 166 \(2003\)](#)

[RCW 71.05.215](#)

[RCW 10.77.092](#)

[RCW 10.77.065](#)

### 6.3 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.

#### 6.3.1 Psychiatric Emergency

In some cases, a psychiatric emergency may exist which places the individual 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 disorder for which antipsychotic medications are the indicated treatment. In these circumstances medication may be administered without the individual'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 or Advanced Registered Nurse Practitioner. This healthcare provider should:

1. First attempt to obtain informed consent from the individual

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 psychiatrist or psychiatric ARNP if the healthcare provider handling the emergency decision is not a psychiatrist or psychiatric ARNP

The law in Washington that provides the legal definition of psychiatric emergency is RCW 71.05.215. It states:

An emergency exists if the individual presents an imminent likelihood of serious harm, and medically acceptable alternatives to administration of antipsychotic medications are not available or are unlikely to be successful; and in the opinion of the physician, physician assistant, or psychiatric advanced registered nurse practitioner, the individual's condition constitutes an emergency requiring the treatment be instituted prior to obtaining a second medical opinion.

Note: The definition of psychiatric emergency described in RCW 71.05.215 provides useful guidance in what legally constitutes a psychiatric emergency, but does not apply to individuals not committed under RCW 71.05.

### **6.3.2 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 mentally ill criminal detainee if necessary to render that defendant competent 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 1) refuses medications over three continuous days, or 2) has a pattern of inadequate medication compliance lasting approximately one week, and it is the opinion of the treating psychiatrist that the defendant cannot be restored without medication, then the treating psychiatrist 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 refuse 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 psychiatrist available who can diagnose and prescribe psychiatric medication in order 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 individual 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 10.77.092. 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 refuses to cooperate with medication and an involuntary medication order by the court has not been entered.” RCW 10.77.065(1)(a)(iii).

### 6.3.3 Harper Hearing

The facility may engage in a formal non-judicial process to assess the need for involuntary administration of antipsychotic medications to an individual who (1) has a serious mental illness and (2) is gravely disabled or poses a likelihood of serious harm to self, others, or property; and the treatment is in the individual’s medical interest (*Washington v. Harper*, 1990). The hearing is held at the request of an inmate’s treating psychiatrist 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 individual 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 individual has a serious mental illness; and
  - b. The treating psychiatrist believes that the individual is a serious danger to self or others; and
  - c. The involuntary administration of antipsychotic medication is in the individual’s medical interest.
2. A special hearing committee is then convened, which generally must include a psychiatrist, 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 inmate’s treatment or diagnosis.
3. The inmate 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 inmate’s attorney should be given notice of the hearing and have an opportunity to provide information or opinion, but the inmate does not have the right to have an attorney represent them at the hearing.
5. The lay advocate must attempt to meet with the inmate prior to the hearing to discuss the inmate’s wishes.

6. The hearing should be held in a confidential setting and the inmate must be given the opportunity to be present. The lay advocate should be present whether or not the inmate is present. The lay advocate represents the inmate's wishes and position at the hearing, although the inmate does not have to rely on the lay advocate.
7. After the hearing, a determination is made regarding whether or not sufficient evidence supports the requirements needed for involuntary administration of medication. The decision is made by committee majority vote, though the non-treating psychiatrist must vote in favor of involuntary medication for it to be approved.
8. The inmate must be notified of the decision and given information and an opportunity to appeal if the inmate disagrees with the decision.

Note that the lay advocate should be someone who understands the psychiatric issues enough to sufficiently protect the inmate'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 inmate; fails to present the inmate's reasons for objecting to medication; presents any testimony or evidence against the inmate; or otherwise lacks meaningful participation.

#### **6.3.4 Individual Rights**

Individuals may choose to accept or decline antipsychotic medications, and their choice should be considered and respected. However, there may be times when an individual's decision to decline medication may pose a risk to health and safety, and may not be in the individual's medical interest. The decision to proceed with the involuntary administration of medication requires weighing the rights of an individual to refuse antipsychotic medicine against the likelihood that the administration of antipsychotic medication is medically necessary (RCW 71.05.215). A number of considerations should be addressed when administering medication involuntarily, which include the following:

- Documentation of and adherence to the components required in accordance with [RCW 71.05.215](#)
- Ensuring that the rights of individuals are respected
- Steps to manage how involuntary medications are ordered
- Assuring safety during the administration of medications
- Following established written protocols and defined procedures for the involuntary administration of medications

#### **6.4 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.

## USE OF RESTRICTIVE HOUSING

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### 7.1 Background

The use of restrictive housing is one of the most challenging subjects facing correctional officials today. Jails face important, difficult questions about how to house individuals in a manner that is safe for incarcerated individuals and staff while also remaining lawful, humane, and cost effective. Many of these concerns are localized, and it is beyond the scope of this guide to provide a one-size-fits-all solution for all jails in Washington regarding this complicated topic.

Many different 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) that examined incidents of self-harm among New York City jail individuals over an approximate two-year time span indicated that "Although only 7.3% of admissions included any solitary confinement, 53.3% of acts of self-harm and 45.0% of acts of potentially fatal self-harm occurred within this group" (p. 442). Despite the challenge of consistently practicing the appropriate use of restrictive housing, jails should know that the risks of restrictive housing to incarcerated individuals are well known (as are the potential legal liabilities that result from harms).

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 an individual's health," and "Juveniles, mentally ill individuals, 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 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 permitted. 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 Resources

American Psychiatric Association (2017). Position statement on segregation of prisoners with mental illness [PDF file]. Retrieved from <https://www.psychiatry.org/file%20library/about-apa/organization-documents-policies/policies/position-2012-prisoners-segregation.pdf>

National Commission on Correctional Health Care. (2015). *Standards for mental health services in correctional facilities*. Chicago, IL: National Commission on Correctional Health Care.

National Commission on Correctional Health Care. (2016). Position statement: Solitary confinement. Retrieved from <https://www.ncchc.org/solitary-confinement>

U.S. Department of Justice (2016). Report and recommendations concerning the use of restrictive housing. Retrieved from <https://www.justice.gov/dag/file/815551/download>

### 7.3 Guidance

It is recommended that jails address and limit the use of restrictive housing for individuals with serious mental illness by implementing defined written policies and procedures. Before placing an individual with serious mental illness into restrictive housing, jail staff must perform an individualized assessment of the actual risk an inmate poses to safety or security, while taking into account whether reasonable modifications of policies or practices would mitigate or eliminate the risk. A jail must also perform an individualized assessment to screen inmates 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 other 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.

**Definition:** The American Psychiatric Association (2018) 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 symptoms of mental illness 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 on individuals 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 individual and the care team. Jails, including mental health staff or care teams, should participate in a post-seclusion review process within 24 hours to debrief and assess safety and stability of an individual in less restrictive housing. This review should include an interview with the individual to identify what efforts were or could have been taken to avoid restrictive housing and assess for interventions and strategies to assist in reducing future events.

Individuals 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).

Individuals 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 individuals 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).

**Note from Disability Rights Washington:** 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 inmates 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 [U.S. Department of Justice, 2013](#).

## 7.4 Training

Jail staff who routinely interact with individuals in jail should receive initial and annual training on the facility’s policies and procedures that direct the use of restrictive housing. Jail staff who routinely interact with individuals in jail should 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 illness and crisis management. Jail staff who interact with individuals in jail should receive initial and annual training on the process of using a seclusion review team as well as pertinent facility policies and procedures.

## SUBSTANCE USE TREATMENT AND DETOXIFICATION IN JAILS

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### 8.1 Background

Many people admitted to jail have substance-use disorders. A report by Wilson (2000) estimated that 70% of individuals incarcerated in local jails either used drugs regularly or had committed a drug offense, 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 may be life threatening. Of particular concern in the United States and Washington state is the opioid crisis. 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 (Grande & Stern, 2018). Further, 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 a societal interest in providing incarcerated persons with the opportunity to address their substance-use disorders. For example, some jails have taken the initiative to combat the opioid crisis through the utilization of Medicated Assisted Treatment or MAT programs (NCCHC, 2018). 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. Snohomish County Jail began a pilot program in January 2018, in efforts to reduce their high demand of medical beds. The study is too new to have findings on recidivism, however, staff reports a decrease in medical bed acuity and reports that MAT medications have proven to be less expensive than the medications previously used for detox comfort. Other out-of-state counties were able to show a reduction in recidivism rates (NCCHC, 2018).

In addition to MAT programs, some jails have pursued policies toward the prevention of opioid overdose death in their facilities. It has become increasingly common for first responders and other disciplines in the community to have access to opioid antagonists such as intranasal naloxone (Narcan®), and many jails have adopted these procedures as well. According to the Centers for Disease Control and Prevention (2019), synthetic opioids such as fentanyl are exceptionally dangerous as they are 50-100 times more potent than morphine. Because opiates may be surreptitiously introduced into jails and may, unbeknownst to the user, include synthetic opioids such as fentanyl, access to opioid antagonists is potentially life saving.

### 8.2 Resources

Centers for Disease Control and Prevention (2019). Opioid overdose. Retrieved from <https://www.cdc.gov/drugoverdose/opioids/fentanyl.html>

Grande, L., & Stern, M. (2018). Providing medication to treat opioid-use disorder in Washington State jails [PDF file]. Retrieved from <http://faculty.washington.edu/mfstern/WAJailOpiateResponse.pdf>

National Commission on Correctional Health Care. (2018). Jail-based MAT: Promising practices, guidelines. Retrieved from <https://www.ncchc.org/jail-based-MAT>

RTI International (2019). A Primer for implementation of overdose education and naloxone distribution in jails and prisons [PDF file]. Retrieved from [https://harmreduction.org/hrc/wp-content/uploads/2019/09/Naloxone-Prison-Primer\\_v2.pdf](https://harmreduction.org/hrc/wp-content/uploads/2019/09/Naloxone-Prison-Primer_v2.pdf)

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

### 8.3 Guidance

We recommend that jails establish comprehensive programs for substance use screening, treatment, withdrawal management, and prevention of opioid overdose death of individuals 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) (e.g. SUD professionals), the administration of opioid antagonists, and withdrawal management (which may need evaluation from a medical professional).

- Screening for substance use and withdrawal from substance use should be part of the intake procedure for all individuals admitted to jail
- Those found to be in need of withdrawal management (detoxification) should receive appropriate services without delay. Medically managed withdrawal protocols should be in place to support screening for withdrawal severity and polysubstance use, monitoring, and medical management of symptoms
- Individuals who through screening are found to be in need of a full assessment should receive an assessment by a SUD professional as soon as feasible. Individuals should be clinically assessed by a qualified provider to determine whether MAT 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 individual and a treatment plan should be created in collaboration with the individual
- SUD education and treatment should be provided to individuals in the facility
- When indicated, SUD treatment should be included as part of release planning to ensure continuity of care

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

- Jails that choose to utilize 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 individual. This would also require collaboration with a community provider to ensure a warm hand off, upon release, for continued care and treatment in the community.

### 8.4 Training

Given the prevalence of substance use issues in jails (to include a percentage of individuals in jail covertly using illicit substances), the workgroup recommends that all jail staff receive initial and annual training to recognize the signs and symptoms of substance use as well as signs and symptoms of withdrawal. Jail staff who conduct intake screenings for substance use issues should receive initial

training on the use of the screening instrument used at the facility and the facility procedures for ensuring continuity of care (e.g., referrals when indicated). Jail administration should ensure that an adequate number of staff are trained on the administration of opioid antagonists to prevent opioid overdose death.

## COMPETENCY EVALUATION PROCESS

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### 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 his lawyer with a reasonable degree of rational understanding and whether he has a rational as well as factual understanding of the proceedings against him." (*Dusky v. U.S.*, 1960). In Washington, 'incompetency,' or being not competent to stand trial (NCST), means an individual lacks the capacity to understand the nature of the proceedings against him or her or to assist in his or her 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 10.77.050). A person found NCST may be ordered by a court to undergo restoration services to restore their competency so that the criminal case may proceed.

#### 9.1.1 Competency Evaluation Process

Forensic evaluations may be conducted in inpatient facilities, jails, or in community settings. In Washington, the majority of forensic evaluations are conducted by DSHS employees and the interviews occur in a jail. State statute requires that the evaluator's report include the following (pursuant to RCW 10.77.060):

- A description of the nature of the evaluation
- A diagnosis of the mental status of the defendant
- 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 10.77.060(3)(d))
- An opinion as to whether the defendant should be evaluated by a [Designated Crisis Responder](#) (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 receive restoration services. For most misdemeanors, the court will generally dismiss the case and potentially refer the defendant for an evaluation under the ITA. If the individual 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 adequate and appropriate mental health treatment. Restoration services are time-limited and have the specific purpose of helping a person understand the criminal charges, the court process and players, and how to assist an attorney in their defense. Restoration often includes medication, but it is not the full array of treatment services typically provided in a treatment setting.

As of July 1, 2020, Health Care Authority, in collaboration with DSHS, will be managing three community-based competency restoration programs (i.e., outpatient), meaning that persons 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. For more information about these programs, please contact Health Care Authority.

The role of forensic evaluators differs from that of treatment providers. Professionals who take on the role of forensic evaluators evaluate 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 individuals in both criminal and civil cases who require treatment (e.g., competency restoration or civil commitment) or who request these services.

## 9.2 Resources

Luxton, D.D., (2019). Washington State Legal System Guide to Forensic Mental Health Services [PDF file]. Retrieved from

<https://www.dshs.wa.gov/sites/default/files/BHSIA/FMHS/WAStateLegalSystemGuidetoForensicMentalHealth.pdf>

[RCW 10.77.060](#)

[RCW 10.77.065](#)

[RCW 10.77.078](#)

[RCW 10.77.086](#)

[RCW 10.77.088](#)

## 9.3 Guidance

Jails should have a program in place to manage competency to stand trial evaluations that includes written policy and defined procedures. Because prolonged time in jail for people with serious mental illness is known to have negative effects, jails should ensure that staff closely monitor people waiting for competency evaluation and restoration services. If an individual is assessed to be decompensating, the person may be a good candidate for expedited admission (Triage Consultation and Expedited Admission) or for evaluation by a designated crisis responder. If the individual is waiting for restoration services but is assessed to be improving (for example, due to established compliance with psychiatric medication), it might be productive to speak with prosecution and defense counsel about possibly seeking an updated competency evaluation.

Note: RCW 10.77.078 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.”

## 9.4 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.

## EARLY ADMISSION PROCESS (Triage Consultation and Expedited Admission)

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### 10.1 Background

There may be times when an individual 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 individuals to a state psychiatric hospital for evaluation for competency to stand trial or competency restoration services. In order to be admitted under the TCEA system, an individual 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 those individuals should be referred for immediate medical attention. For more information about the process, visit the [OFMHS TCEA website](#).

### 10.2 Resources

Triage Consultation and Expedited Admission - TCEA. (n.d.). Retrieved from <https://www.dshs.wa.gov/bha/triage-consultation-and-expedited-admission>

### 10.3 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 individual admitted to the jail who may be referred for TCEA.

#### 10.3.1 Criteria

In order to be considered for expedited admission, an individual must meet the following criteria:

- 1) Active suicidal intent, or behavior such as suicide attempt(s) or serious self-inflicted injury; and/or
- 2) The individual's health is at risk because of an inability to meet basic needs, such as not eating or drinking

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 an individual is at *imminent* risk of harm due to a mental disorder, and is legally eligible for possible release from jail into an evaluation and treatment facility, the local [designated crisis responder](#) should evaluate the individual and, if needed, facilitate emergent admission to a psychiatric facility. DCRs are available 24/7 to evaluate for risk of harm.

#### 10.3.2 Referral Procedure

In order to make a referral from jail the [Triage Consult Form](#) must be completed and submitted to the email address listed on the form. The form 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 help those 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 person who made the referral within 24 hours (excluding weekends and holidays).

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

The referral will be sent to the chief medical officer or designee of the respective state hospital for approval or disapproval 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 jail, the defense counsel, and prosecutor. The individual who was referred for consideration of expedited admission remains on the waiting list.

## **10.4 Training**

Jail staff who screen individuals should participate in initial TCEA training and annually thereafter. This training is offered by the OFMHS. For more information, email: [jailassistance@dshs.wa.gov](mailto:jailassistance@dshs.wa.gov) or visit the Jail Technical Assistance Program [web](#) page.

## TRANSITION PLANNING AND CONTINUITY OF CARE

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### 11.1 Background

Connecting or (in many cases) re-connecting individuals 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 illness, the intensity of treatment provided at the facility, and the level of functioning of the individual upon release (Metzner, 2002). Given that people who experience serious mental illness often require 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 an individual 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 individual to obtain a new source of medication (see *Wakefield v. Thompson*, 1999).

### 11.2 Resources

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.

### 11.3 Guidance

Transition planning should begin at intake with initial screening and assessment of the individual'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. All aspects of transition planning and continuity of care should be specified by written policy and procedure.

#### 11.3.1 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 individual'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 in order to create an effective treatment plan. Treatment plans should be revised as needed based upon newly identified/prioritized needs and/or the individual's progress in treatment.

**Note:** Given that some individuals may have very short stays in jail, treatment planning may address in-custody programs and services while also incorporating transition planning and referral to programs and services in the community.

#### 11.3.2 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 individual over time. The second domain is continuity of information, which exists to the extent that the provider has access to and

utilizes past information in current care plans for the individual. 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).

### **11.3.3 Care planning and documentation**

There should be evidence of individual 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 system where the needs of individuals are consistently identified, identified needs are addressed in a timely fashion, and documentation of having done both is available for review is a vital component of continuity.

### **11.3.4 Evaluations**

When an individual is referred for evaluation or specialty consultation, the individual should receive those services in a timely manner. The results of the referral should be reviewed by the ordering physician and if any care recommendations were made they should be implemented without undue delay. In the event that the attending physician decides to pursue an alternative plan of care, a clinical justification for the alternative plan should be written and documented in the individual's record (NCCHC, 2015).

### **11.3.5 Return from off-site**

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

### **11.3.6 Record keeping**

Whether electronic, paper, or a combination of both, facilities should maintain a centralized recordkeeping system 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 in order to prevent missing information, conflicting information, and fractured care.

**Note:** For the purposes of this guidebook, records are considered those records necessary for providing individuals 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.

### **11.3.7 Communication**

Jails should consider the following in order to support continuity of care:

- Ensure that individuals 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
- To the extent possible, jail staff prepare releases of information to appropriate community based treatment and service providers
- To the extent possible, 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 incarcerated individuals 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

### **11.3.8 Transition Planning**

- 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 individuals who are eligible for income supports and benefits (e.g., Medicaid, food benefits)
- Transition plans should be created in collaboration with the individual and should be signed by the individual, 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 individual's identified needs regarding type (e.g. peer support specialists, prescription medication, behavioral health treatment, legal obligations), frequency and intensity
- Warm hand-offs (e.g. transporting an individual to community services and handing off care to a live individual) should be conducted to the extent possible
- Jails should assist individuals in identifying community providers to address their needs
- Individuals should be educated on the importance of transition planning and aftercare
- Individuals should be provided with an individual transition kit at the time of release

### **11.3.9 An individual transition kit should include the following:**

- A list of prescribed medications and how to use them
- Medication in an amount sufficient to ensure the individual has 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 individual will meet each of their identified needs
- Results of laboratory and diagnostic tests
- Toiletries

### **11.3.10 Other considerations**

Individual transition kits may contain other items intended to improve the measure of continuity of care and/or increases the chances of an individual's successful transition. For example, some facilities have

developed Naloxone distribution programs and provide individuals with Naloxone as a strategy to prevent opioid overdose after release.

Jails should proactively assist those individuals who may be unable to request assistance with continuity of care or transition planning due to serious mental illness or cognitive disability in receiving those services.

HIPAA and CFR 42 Part 2 provide federal standards and regulations that must be adhered to when sharing the protected health information (PHI) of individuals. This should be addressed by written policy, and annual and refresher training to staff who interact with individual records and PHI.

### **11.3.11 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 stakeholders 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.

## **11.4 Training**

- Staff who are responsible for the documentation of individual-related information should receive initial training on documentation practices, routing of documents, and document storage
- Jails should train and utilize dedicated transition planners to the extent possible
- Jails should implement cross training between internal disciplines as well as outside community agencies to coordinate transition planning and inter-agency knowledge
- Training topics should be selected to improve internal and inter-agency systems with the overarching goal of improving individual outcomes

## CORRECTIONS STAFF WELLNESS

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### 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 include the threat of physical harm, exposure to violent people on a daily basis (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 include environmental conditions such as working in a closed/secure facility, restricting freedom-of-movement, and little natural lighting (Brower, 2013).

**Organizational/administrative** stressors 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 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).

Any and 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 Resources

National Institute of Justice Addressing Correctional Officer Stress: Programs and Strategies  
<https://www.ncjrs.gov/pdffiles1/nij/183474.pdf>

Health and Wellness for Corrections Professionals. (n.d.) Retrieved from  
<https://nicic.gov/health-and-wellness-for-corrections-professionals>

Correctional Officer Wellness and Safety Literature Review  
<https://s3.amazonaws.com/static.nicic.gov/Public/244831.pdf>

### 12.3 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., inmate-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 potentially many other services.
- **Peer Support Programs** offer support at the workplace to address both critical incidents and day-to-day work stressors. Peers are able to offer support from a perspective of familiarity with the demands of the workplace and can bridge the gap between no services and formal services 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 providing prompt debriefing of incidents and help individuals and their families cope with the aftereffects of the incident.
- **Organizational/Administrative Practices** that may improve measures of officer wellness include those that convey understanding of the challenges associated with working in a jail and demonstrate value of the staff members. 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 assure that all staff have a reporting system in place that encourages seeking help without retribution and reduces the stigmatization of seeking help. Jails should also ensure that brochures, pamphlets, and other relevant 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.

## 12.4 Training

Jails should ensure that all jail staff receive initial and annual training on staff wellness. Training should include, at minimum, the potential sources of stress, signs of stress and the risks associated with unmitigated exposure to stressors, and the programs available to staff members to increase psychological resilience and physical health.

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

## VIDEOCONFERENCING IN JAILS

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### 13.1 Background

The use of videoconferencing (VC) to conduct assessments and consultations within jails, legal, and correctional settings is becoming increasingly popular (Luxton, Lexcen, & McIntyre, 2019). While VC may not always be preferable to in-person interventions in correctional facilities, it can improve access to care providers for clinical treatment and interventions. More recently in Washington, VC is used for conducting forensics assessments, such as court-ordered competency to stand trial evaluations (Luxton, Lexcen & McIntyre, 2019).

The Washington State Department of Social and Health Services has established secure VC links between DSHS's competency restoration facilities, DSHS forensic evaluators, and several county jails. These links provide the capability for forensic evaluators to conduct competency to stand trial evaluations from distant locations. Attorneys may attend evaluation interviews in person with their defendants, by telephone, or remotely via videoconferencing, if needed. The new VC capability 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 because of reduced travel times.

### 13.2 Resources

Luxton, D. D. (2017). Washington State Telehealth implementation guide. Retrieved from: <https://www.dshs.wa.gov/sites/default/files/BHSIA/FMHS/DSHSTelehealthGuidebook.pdf>

### 13.3 Guidance

Jails should consult with stakeholders, including consumers and advocacy groups, to assess needs, develop budget priorities and cost estimates for needed infrastructure to support VC capabilities, and establish and support local (within agency) telehealth "champions" to facilitate implementation.

Jails should address the safety of staff and individuals during VC sessions and transport as well as data security and applicable HIPAA requirements by written policies and procedures.

The security of the space and VC 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). Hardening of the VC equipment, such as placing the monitor, camera, and cords within an acrylic glass case should be considered.

The use of videoconferencing should be evaluated for clinical appropriateness on an individual basis, ensuring that videoconferencing allows each individual to understand and to express themselves adequately, and that the use of videoconferencing does not cause any undue distress to the individual.

### 13.4 Training

Jails should ensure that staff involved with videoconferencing receive initial and annual training on applicable policies and procedures, how to set up and use the equipment, and safety procedures including individual transport. Training should also include HIPAA requirements when VC is used in the delivery of health services.

## DIVERSION PROGRAM GUIDANCE

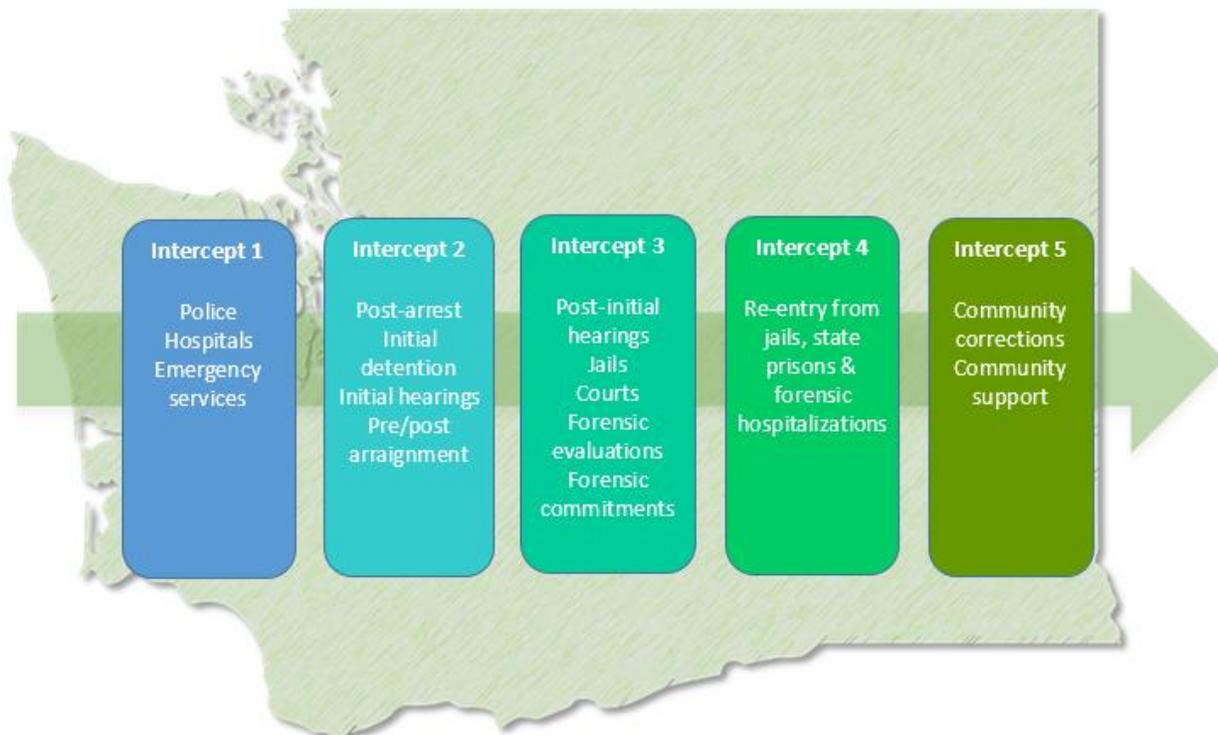
### 14.1 Background

Successful screening and assessment early in the criminal justice 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 individuals 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 justice and mental health systems. The intercept model has several key objectives that include (Munetz & Griffin, 2006):

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

**Figure 7.** The Diversion (Sequential) Intercept Model.



**Note:** An Intercept 0, which refers to community services such as community crisis centers and mobile outreach teams, has also been proposed (Policy Research Associates, 2018)

### 14.1.1 Pre-arrest diversion

Pre-arrest diversion is the first point of interception for individuals with behavioral health needs. Law enforcement and emergency service professionals are often the initial point of contact for individuals in crisis. Periodically 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 illnesses 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 identifying serious mental illness, de-escalating or not escalating situations and avoiding police use of force, decreasing stigmatization, and when appropriate, linking an individual to treatment rather than booking them into jail.

**Note:** RCW 10.31.110 allows for arrest diversion for any criminal charges when the individual 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 utilize this arrest discretion.

### 14.1.2 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 criminal justice settings. There is also the potential for large cost offsets because diversion can prevent further criminal justice 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 individuals 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 individuals are brought to jail while experiencing symptoms of severe mental illness. Other times, an individual may decompensate while in custody to the point that their safety or health is at risk and they will not agree to care. In such cases, if the individual is in custody and is legally eligible, referring the individual for evaluation by a [DCR](#) for involuntary civil commitment may be warranted.

## 14.2 Resources

Joplin Consulting (2016). Jail diversion for people with mental illness in Washington state [PDF file]. Retrieved from

<https://www.ofm.wa.gov/sites/default/files/public/legacy/reports/Jail%20Diversion%20for%20People%20with%20Mental%20Illness%20in%20Washington%20State%20Study.pdf>

### 14.3 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 the competency issues.

In many cases it is preferable to focus efforts on pre- or post-arrest diversion programs that focus on thorough release planning with an eye towards earlier resolution of a criminal case. Additionally, jails should have behavioral health professionals on staff (or on contract) who can assess individuals who may meet criteria for involuntary civil commitment as described in [RCW 75.05.153](#) (e.g., presents an imminent likelihood of serious harm or is in imminent danger because of being gravely disabled).

### 14.4 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 individuals who may be appropriate for diversion at any point throughout incarceration, and should understand diversion resources.

## QUALITY MANAGEMENT

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### 15.1 Background

Most organizations, including jails, run more smoothly and efficiently when there are procedures specifying workflow, corrective actions, and improvement efforts. Discontinuity 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 the safety and care for incarcerated individuals with mental health conditions when quality management concepts and procedures are systematically applied. These general concepts and processes include:

**Quality management:** 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 in order 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 in order 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 an individual causing the problem.

### 15.2 Resources

Schiff, G.D., & Shansky, R. (2006). Continuous Quality Improvement [PDF file]. Retrieved from <https://www.ncchc.org/filebin/Resources/Continuous-Quality-Improvement.pdf>

### 15.3 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 individuals with mental illness in jail should be considered for quality management. Jails may have unique systems in place to manage the safety and care of incarcerated individuals 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 individuals flagged for mental health follow-up pursuant to the intake screening
- Number of individuals 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 individuals seen for follow-up within specified timeframes (for those individuals not seen within the timeframe, tracking of actual time to be seen)
- Number of individuals referred to a psychiatric provider
- Whether individuals are seen by the psychiatric provider within specified timeframes (for those not seen within the timeframe, tracking of actual time to be seen)
- Whether individuals 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 individuals are seen for follow-up for cognitive disabilities and tracking of what follow-up was provided
- Number of individuals referred to a hospital due to acute mental health issues
- Number of individuals receiving mental health services or those whom mental health staff consider as being on the mental health case load
- Number of suicide attempts
- Number of suicides
- Records related to use of restraint
- Records related to individuals with disciplinary charges or sanctions who are receiving mental health services
- Number of individuals with individual treatment plans
- Number of individuals attending group therapeutic programming and efforts by staff to encourage consistent participation
- Number of individuals with known or suspected mental health issues or cognitive disabilities placed in restrictive housing and what reasons were given for this placement
- Number of inmates transferred in and out of mental health unit and acute housing unit and where they were transferred
- Number of disability-related complaints or requests for accommodations and the resolution

## 15.4 Training

All jail employees should receive initial training on the concepts of quality management in order 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](#).

## RESOURCES

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**American Academy of Psychiatry and the Law (AAPL):** According to information on the website, [www.jaapl.org](http://www.jaapl.org) is intended to be a forum for the exchange of multidisciplinary ideas. Content includes correctional psychiatry, psychiatric evaluation of individuals 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 individuals who are in contact with the legal system. Also see the [AAPL practice resource for prescribing in corrections](#).

**American Jail Association** website [www.americanjail.org](http://www.americanjail.org) provides useful information about a number of issues important to jails. There are a number of 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](http://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 individuals coming into jail for the need for further mental health assessment.

### **Checklist for the “Suicide-Resistant” Design of Correctional Facilities**

© National Center on Institutions and Alternatives, 2011

A [checklist](#) of structural design strategies intended to create suicide-resistant housing.

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

**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.

**Centers for Disease Control and Prevention:** A website <https://www.cdc.gov/drugoverdose/index.html> that provides information on opioid overdose and prevention and related topics.

### **Guiding Principles to Suicide Prevention in Correctional Facilities**

© National Center on Institutions and Alternatives, 2011

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.

### **Guide to Developing and Revising Suicide Prevention Protocols within Jails and Prisons**

© National Center on Institutions and Alternatives, 2011

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/mortality-morbidity review.

**International Critical Incident Stress Foundation, Inc.** website [www.icisf.org](http://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](http://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. A number of 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](#).

**National Institute of Corrections:** a resource for [de-escalation training](#) for correctional workers. [Health and wellness for corrections professionals](#). Correctional officer wellness and safety [literature review](#).

**National Institute on Drug Abuse website:** [www.drugabuse.gov](http://www.drugabuse.gov)

**National Institute of Justice:** Programs and strategies for addressing correctional officer stress <https://www.ncjrs.gov/pdffiles1/nij/183474.pdf>. Also see the [guidebook for mental health screens](#) for corrections, which provides examples of two mental health screening instruments, instructions for completing the instruments, as well as discussion about the research that led to the development and validation of the screening instruments.

**Office of Forensic Mental Health Services website** provides useful information and contact information for forensic mental health services in the State of Washington.

**Providing medication to treat opioid use disorder in Washington State jails:** A 2018 study on the [treatment of opioid-use disorders in jail](#).

**Quality Management:** A resource for correctional health professionals on the practice of [continuous quality improvement](#).

**RTI International:** A primer for implementation of overdose education and naloxone distribution in jails and prisons. Located at [https://harmreduction.org/hrc/wp-content/uploads/2019/09/Naloxone-Prison-Primer\\_v2.pdf](https://harmreduction.org/hrc/wp-content/uploads/2019/09/Naloxone-Prison-Primer_v2.pdf)

**Substance Abuse and Mental Health Services Administration:** Opioid overdose prevention toolkit. Retrieved from <https://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit/SMA18-4742>

**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. *Professional Psychology: Research and Practice*. 49(2), 124-131. DOI: 10.1037/pro0000179

Washington State Telehealth implementation guide. Retrieved from: <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/resources>

**Transition Planning:** Guidelines for successful transition of people with mental or substance-use disorders from jail and prison: [Implementation Guide](#).

**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.

**Washington Association of Designated Crisis Responders (DCR) [WADCR](#):** 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](http://www.waspc.org) provides a number of 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.

## GLOSSARY

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**CFS:** Center for Forensic Services

**CISD:** Critical incident stress debriefing

**Competency Restoration:** The process of helping an individual regain or achieve the capacity to understand the nature of the proceedings against him or her and assist an attorney in his or her 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 individual's 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.

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

**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 individual pursuant to RCW 71.05 for the purpose of treating a mental illness that renders the individual dangerous or at risk of self-neglect.

**Jail Transition Team:** A team comprised of individuals responsible for the transition of incarcerated individuals 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 [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 an individual, or group of individuals, 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 an individual 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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