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**Improving Continuity of Mental Health Care for Women:**

**Jail Release to Community Re-entry**

Janin Khaleel

College of Nursing, Seattle University

A DNP project submitted in partial fulfillment of the

requirements for the degree of

Doctor of Nursing Practice

Seattle University

2022

Approved by: ________________________________ Date 6/09/22

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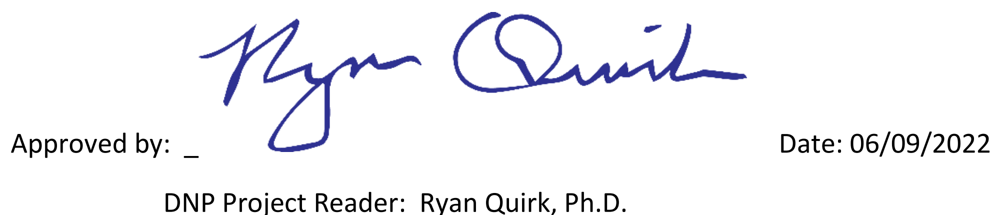

Approved by: _ Date: 06/09/2022

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**Acknowledgments**

I want to acknowledge that this project would not be possible without the help of my project mentor Dr. Colleen Woolsey Ph.D., ARNP, my project site mentor Dr. Ryan Quirk Ph.D., Deputy Chief Nurse Officer Shayla Holcomb RN, BSN, Division Director Danotra McBride, Regional Health Administrator Rebecca Cole, Program Manager Jeffrey Weldon, Shana Cantoni ARNP, and my Seattle University colleagues. Lastly, special thanks to my family and friends for your continuous support throughout this project.

## Abstract

**Introduction:** This formative Delphi study assesses 1) potential policy changes most needed to support mental health care continuity for women being released from two urban jails, 2) barriers to women obtaining mental health services after release, and 3) understanding what community resources are promoting continuity of mental health care after jail release.

**Methodology:** This is a policy project that uses the Delphi method. In phase one, a primarily qualitative survey was administered to jail health experts to explore project aims. Results were analyzed with thematic analysis, and themes were used to develop a primarily quantitative second survey with Likert scale questions. The second survey was administered to the same participant pool and was used to assess consensus on themes.

**Results:** 14 and 20 participants took the first and second surveys, respectively. Correspondingly, first and second survey participants included registered nurses (n=5; n=8), psychiatric evaluation specialists (n=5; n=6), nurse practitioners (n=1; n=2), release planners (n=1; n=1), medical doctors (n=1; n=1); court clinicians (n=1; n=0), and managers (n=0, n=2). Nine main themes resulted from thematic analysis: 1) access to mental health services within the jail, 2) jail-based communication, 3) interaction with the community, 4) resourcing, 5) assessment and prioritization, 6) capital transformation, 7) trauma and care, 8) enhancing continuity of mental health care, and 9) barriers to continuity of mental health care—nineteen subthemes and derivative questions met criteria for consensus in the second survey.

**Conclusion:** Many of the themes identified in the study are related to infrastructure, policy, and funding issues. Perceived issues identified by participants include psychiatric housing shortages within the jail, limited psychiatric intakes in the community, inadequate staffing to meet mental health care demands in the jail, and a need for enhanced inter-team communication within the organization. Barriers that participants identified in the community include housing, transportation, and inadequate insurance coverage.

***Key words:*** Jail health, women's mental health, mental health care continuity, community mental health services, barriers to care

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In the United States jails are local holding facilities for people yet to be sentenced or those sentenced to durations of less than a year; jails are operated under cities and counties and they are disproportionately full of people with mental health disorders, especially women, who upon release will struggle to access the care they need and continue to cycle through the justice system (Bronson & Berzofsky, 2017; King County Health & Human Services Transformation, 2016; Henzel et al., 2016). Two million times per year, people with mental health disorders are booked into jails in the United States, and the estimated prevalence of incarcerated people with mental health disorders is five times higher than in the general public (Bronson & Berzofsky, 2017; National Alliance on Mental Illness [NAMI], n.d.). In the U.S., 20.6% of the population has a mental health disorder compared to 44% of the jail population (Bronson & Berzofsky, 2017; Substance Abuse and Mental Health Services Administration [SAMSHA], 2020). The prevalence of depression, bipolar disorder, psychotic disorders, and PTSD among the jail population is higher than the general population (Bronson & Berzofsky, 2017; National Institute of Mental Health [NIMH], 2017a; NIMH, 2017b; NIMH, 2018; SAMSHA, 2020). This issue significantly impacts women. Women in jails are more likely to have mental health disorders than males; as much as 68% of women in jails have a history of a mental health disorder (Bronson & Berzofsky, 2017; NAMI, n.d.) However, very little research focuses on women's mental health care needs. In Washington State, the state this study occurs in, the disproportionate incarceration of people with mental health disorders is just as prevalent.

In one Washington study, 86% of people booked in jail were former Department of Social and Health Services (DSHS) or Health Care Authority (HCA) clients; women represented 27% of those clients (Henzel et al., 2016). Among the Medicaid enrolled population entering jail, 58% of people had mental health treatment needs (Henzel et al., 2016). Among enrollees who had been in jail, women were more likely to have treatment needs, 63% compared to 55% of men (Henzel et al., 2016). In addition, women

were more likely to have co-occurring mental health and substance use disorders (Henzel et al., 2016). This trend continues in the county focused on in this study.

In the county of focus, two urban jails were involved in this study. In 2021 the average secure daily population among both jails was 1,310 (King County Department of Adult and Juvenile Detention [DAJD], 2021c). Women made up 7.2% of that population; however, in the county of focus, among people with mental health disorders and four or more bookings, 20.2% were female (King County DAJD, 2021a; King County Health & Human Services Transformation, 2016). This indicates that women with mental health disorders are disproportionately at risk for reincarceration in the county. Without meeting mental health treatment needs and continuity of mental health care post-release, women with mental health disorders leaving jails are at risk for adverse outcomes.

People with mental health disorders are likely to experience adverse outcomes during and after jail. While in jail, they are at increased risk for more infractions, extended stays, and being held in restrictive housing, which can impact access to mental health care and suicide risk (Beck, 2015; Michelle Fleishman, 2013, National Institute of Justice [NIJ], 2016; Treatment Advocacy Center [TAC], 2014). After jail release, death rates are highest in the first 28 days back in the community, with 35.6% of deaths in one study occurring within the first 14 days (Alex et al., 2017). This time is vital for mental health services; however, people fall through the cracks of the correctional and healthcare systems. Once back in the community, they are likely to have high emergency department and hospital utilization and experience housing instability (Frank et al., 2014; King County Health & Human Services Transformation, 2016). For the community, this means high expenditures.

Washington has a more complex jail system where cities, counties, and tribes operate jails (BERK Consulting, 2014). Cities, counties, and the state each pay for different aspects of confinement (BERK Consulting, 2014). Due to limitations within corrections, they also pay to contract out services such as mental health services, which in the county of interest are provided by the participating organization in

this study (BERK Consulting, 2014). In 2013, the total criminal justice cost paid by the state, cities, and counties in Washington was $4.3 billion, constituting 74% and 41% of county and city general fund expenditures, respectively (BERK Consulting, 2014). In Washington State, in 2017, there was $2.1 billion in expenditures solely for the Department of Corrections (Office of Financial Management, n.d.). In the county of focus, the proposed budget for 2021 included $326.8 million for adult and juvenile detention and $85.5 million for healthcare services within the jails (King County Office of the Executive, 2021). In 2013, the cost per day per inmate was $194; however, costs are higher for inmates with mental health needs (BERK Consulting, 2014; Domino et al., 2004). Without changes to this broken system, communities will continue to pay to confine those with mental health disorders without getting them the treatment and support they need resulting in unnecessary costs and expenditures.

On the national and regional scale, women in jails disproportionately have unmet mental health treatment needs. This is important since women have different treatment needs than men, such as relational care and supportive relationships (Johnson et al., 2015). Women with mental health disorders also disproportionately cycle through the justice system (King County Health & Human Services Transformation, 2016). However, there is a lack of research on women with mental health treatment needs who encounter the justice system. Little is known about improving the continuity of mental health care for women leaving jail. This prompted a search of the literature to understand what barriers exist to accessing community mental health services within one month after jail release for women with mental health disorders?

## Background and Significance

The history of the criminalization of mental illness is complex. Nevertheless, looking at the history can help understand why providing mental health care within the jail context and linking to services post-release is an issue. Before moving into the literature review, the author will briefly touch on the history related to mental illness and incarceration.

**History of Mental Health Disorders and Incarceration**

From 1820 to 1840, prisons, almshouses, and asylums were part of the social response to crime, mental illness, and poverty (Kim, 2016). Incarceration of people with mental illness was common in the U.S. until the 1860s, after which reform related to Dorothea Dix's efforts led to mentally ill persons being transferred to psychiatric facilities (Douglas, 2021; TAC, 2014). This led to a sharp decline in the mentally ill population that was incarcerated and began the era of institutionalization, which lasted until the 1960s (Douglas, 2021). During this time, involuntary hospitalization, then in asylums, was based on treatment needs and recommendations from a mental health professional (Douglas, 2021). However, there were no clear admission criteria resulting in unnecessary hospitalization for some; there was also a public concern for the welfare of these individuals due to crowding, understaffing, abuse, and neglect (Douglas, 2021). Asylum populations peaked in the 1940s; at this time, the prevalence of mental illness in incarcerated populations was around 1% (Douglas, 2021; Kim, 2016). In the 1930s-1940s, public opinion shifted to community care models; however, asylum populations remained high until the 1960s (Douglas, 2021; Kim, 2016). The failure to provide adequate care and social services led to a decline in mental health hospitals during de-institutionalization.

De-institutionalization efforts began in the 1950s with the introduction of antipsychotic medications (Douglas, 2021). There was intent to move from state-funded institutions to federally funded community treatment centers; however, this did not come to fruition (Douglas, 2021; Kim, 2016; TAC, 2014). De-institutionalization led to the closing of mental health hospitals and more people needing outpatient mental health treatment; however, inadequate funding and community resources left people without good care or social services (Douglas, 2021; Kim, 2016; TAC, 2014). These failures created a vulnerable population at increased risk for homelessness, poverty, and criminal justice encounters (Douglas, 2021; Kim, 2016). Policies in the 1980s perpetuated this issue by limiting social safety nets for the poor and, at the same time enacting "tough-on-crime" policies, which led to

increased rates of incarceration of mentally ill persons (Douglas, 2021). Jails were never meant to provide the mental health treatment required of them. Failures in federal policies and issues in community health systems let people fall through the cracks and caused basic living needs not to be met (Douglas, 2021; Kim, 2016). This fractured system needs change to better serve people with mental health disorders, specifically disproportionately affected incarcerated women who have poorly understood needs.

## Literature Review

As mentioned, research, particularly about women, is lacking. Therefore, much of the presented research focuses on men and women. The literature review will focus on the following topics relevant to the continuity of mental health care for women leaving jail.

- treatment needs for people with co-occurring disorders and serious mental illness
- treatment and identification of mental illness while incarcerated
- critical time after release and service engagement
- barriers

### *Treatment Needs of People with Co-occurring Disorders or Serious Mental Illness*

In the general population in 2019, 5.2% of adults had a serious mental illness (SMI), which encompasses mental health disorders causing severe impairment such as schizophrenia, bipolar disorder, and some forms of depression (SAMSHA, 2020). However, in jails, 1 in 4 screened positive for SMI, meaning they will have significant mental health needs during release planning and transition back into the community (Bronson & Berzoksky, 2017). Women again are disproportionately affected, and 30% of women in jails screened positive for SMI (Bronson & Berzofsky, 2017). This is striking and important to consider in planning services for women on return to the community. Also, people with SMI are at increased risk of substance use issues (SAMSHA, 2020). Importantly, people with co-occurring substance use disorder (SUD) and mental health disorders are unlikely to receive treatment for both;

only 7.8% received SUD and other mental health services compared to 48.6% receiving either SUD treatment or mental health treatment, and 38.7% receiving mental health treatment alone (SAMSHA, 2020). Among female Medicaid enrolled clients booked in jail in Washington, 44% of women had co-occurring disorders (Henzel et al., 2016). Therefore, in-jail and post-release services need to be tailored to women with SMI and those with co-occurring disorders since this population is currently unlikely to get the appropriate treatment.

***Treatment and Identification of Mental Illness While Incarcerated***

Lack of treatment and identification of mental health disorders in jail populations is an important aspect of the issue with continuity of mental health care. Without meeting mental health needs in jail, people are likely to return to the community undertreated or untreated. This undertreatment could impact what kinds of services they need upon release. Jails, in particular, face challenges in screening for mental health disorders; obstacles to screening include poor information sharing, wariness of answering screening questions, and people arriving intoxicated or in crisis (Michelle Fleishman, 2013). Also, there are no consistent standards for mental health screening in jails, and in Washington, only 10% of surveyed jails used formal screening tools (Joplin Consulting, 2016). Without evidence-based standards for mental health screening in place, inmates are unlikely to receive the mental health treatment they need.

Even if inmates with mental health disorders are identified, jails only provide limited mental health services, typically focusing on those with SMI (BERK Consulting, 2014). People with less severe presentations are likely to go untreated (BERK Consulting, 2014). Of the people with current mental health problems in jail, only 35% received treatment while in jail (Bronson & Berzofsky, 2017). Medication alone is the prevailing treatment with limited counseling access (Bronson & Berzofsky, 2017). Medication alone is insufficient, considering that medication adherence during incarceration is low to medium (Farabee et al., 2019). In addition, jail populations are highly dynamic

due to short lengths of stays, typically nine days for misdemeanors, and high turnover (BERK Consulting, 2014). Jails tend to focus on stabilization, which involves managing a mental health crisis where the person is a harm to themselves or others, and referrals; yet poor community service infrastructure and lack of coordination render those referrals inadequate (BERK Consulting, 2014).

***Critical Time After Release and Service Engagement***

Ideally, people would leave incarceration adequately treated and be able to engage in community treatment quickly. However, this is not the case. People are leaving undertreated and untreated, making the timeliness of service engagement even more critical to prevent adverse outcomes and even death. In a New York study, post-release, 35.6% of deaths occurred within 14 days after release (Alex et al., 2017). Of post-release deaths, 37.3% were due to opioids and 8.5% to suicide or unintentional injury (Alex et al., 2017). Therefore, the first two weeks are critical, and this again highlights the importance of service engagement for people with co-occurring disorders who, as previously mentioned, are unlikely to get adequate treatment for both disorders (SAMSHA, 2020). Unfortunately, continuity of treatment post-release is currently lacking.

The prevailing mental health treatment during incarceration is psychiatric medications; unfortunately, after release, medication use is low (Bronson & Berzofksy, 2017; Farabee et al., 2019). Despite 56.5% of people having anticipated mental health treatment needs after release, only 15% receive mental health services upon community reentry (Begun et al., 2016). Of those who continue psychiatric medications, adherence was low after one-month post-release (Farabee et al., 2019). In a study of women leaving incarceration, key community informants reported that it typically takes women six months on average to engage in outpatient care, and they are usually not provided an adequate medication supply for that period (Pantalone et al., 2018). In another study, only 13% of adults with SMI received mental health services and psychiatric medications within 90 days post-release (Domino et al., 2019). Notably, contact with services in itself does not appear to be adequate. In Washington, among

Medicaid clients booked in jail, 50% had received outpatient mental health treatment in the prior year (Henzel et al., 2016). In the county of interest, among people with four or more bookings, 40.8% received treatment within three months prior to and one year after the first booking, with 23% using an outpatient treatment program (King County Health & Human Services Transformation, 2016). Despite around half of people receiving mental health treatment, they are continuing to come into contact with corrections. This shows that access to treatment alone is not the only factor in managing someone's mental health and preventing re-incarceration and that other barriers are interacting to cause this issue.

***Barriers***

**Interpersonal and Community Barriers.** Unmet mental health treatment needs are not a jail-specific issue. Of adults with mental health disorders, 26% report unmet mental health needs, and perceived unmet needs are higher for people with SMI, which is important since women in jail populations disproportionately have SMI (SAMSHA, 2020). People leaving incarceration report concern over their ability to receive mental health treatment in the community. Fifty-five percent of people with SMI leaving incarceration were concerned they would not be able to continue psychiatric medication after release (Farabee et al., 2019). On average, people leaving jail face 5.6 barriers to receiving mental health treatment during reentry into the community; barriers are also higher for mental health services than substance use treatment (Begun et al., 2016). These barriers can become insurmountable without assistance, and in Washington, currently, there is not a comprehensive reentry program that provides collaborative reentry case management, and no entity takes ownership of reentry services (BERK Consulting, 2014). Due to this considerable service gap, people are returning to the community without the assistance they need, leaving them to face barriers to continuity of their mental health care independently.

**Lack of Supportive Relationships.** A lack of supportive relationships is a barrier to women's mental health care continuity. Women in particular face many relational triggers that could lead to

mental health or substance use relapse. Triggers include returning to an abusive relationship or one where a partner uses drugs, returning to the same lifestyle, returning to family responsibilities, dealing with loss, antisocial peer groups, and fast living or drug use (Johnson et al., 2014). Lack of supportive relationships and community ties are also triggering, with only 16% of people being met by family members or friends on release (Farabee et al., 2019; Johnson et al., 2014; Kim et al., 2019). It is essential to address this lack of community support through future services.

**Housing.** In addition to a lack of supportive relationships, people with mental health disorders leaving jail lack access to basic needs such as housing. It is crucial to meet housing needs to prevent people from returning to deleterious environments, including homes where they are victimized, people are using drugs, or the previous environment led to the situation causing incarceration. As many as 6 in 10 people with SMI may have been unhoused before incarceration, and 59% of people with SMI leaving incarceration reported concern with housing (Farabee et al., 2019). In the county of interest, among people with cases filed in involuntary treatment court, 28% were experiencing housing instability; this increased to 41% among those with three or more previous involuntary treatment cases (Poon et al., 2019).

Similarly, among people with four or more jail bookings in the county of interest, 58.6% were experiencing housing instability (King County Health & Human Services Transformation, 2016). Finding housing for people leaving jail is also tricky. Housing is difficult to attain for people with mental health disorders due to barriers such as bias against people with criminal justice records, lack of housing, and lack of low barrier housing for people with co-occurring substance use disorder (Joplin Consulting, 2016). Low barrier housing focuses on harm reduction and does not prohibit people from living there despite income, criminal justice involvement, active alcohol or substance use, or resistance to receiving services (Washington State Department of Commerce, 2020). In a study in Washington, homeless previously incarcerated persons who received housing assistance had lower recidivism rates, higher

Medicaid coverage, and higher substance abuse treatment than those who did not receive housing assistance (Shah et al., 2013). Without meeting basic housing needs, it is not easy to imagine people putting their mental health first.

**Siloed Systems and Poor Community Connections**. Within the community, jail and mental health services are siloed, and systems for coordination are not in place. Community resources are lacking, which causes disruptions in treatment since people may only be released with two weeks of medication in hand and no way to fill prescriptions (Joplin, 2016; Kim et al., 2019; Michelle Fleishman, 2013; Pantalone, 2018). In addition, women with mental health disorders leaving jail report being deterred by the number of hoops they had to jump through to access services in the community (Johnson et al., 2014). No one entity takes responsibility for reentry services, and comprehensive case management is lacking. The lack of single entity ownership of the process is a considerable barrier due to the complexity of coordination and the need for collaboration between multiple organizations. Also, mental health and substance use status, treatment options, and criminal history can affect which community resources are available options (Kim et al., 2019). This system becomes confusing to navigate. Also, currently, behavioral health providers do not have easy access to the jail to coordinate the transition of care for their patients, and they may be unaware their client is in jail (Joplin Consulting, 2016). Lack of community resources is another barrier; especially lacking are residential treatment options, supportive housing options, and treatment for people with co-occurring disorders (Joplin Consulting, 2016). Once people connect with treatment, they are faced with community behavioral health providers who lack education and understanding of the unique health needs of justice-involved people (Joplin Consulting, 2016). Overall, inadequate infrastructure and lack of coordination are detrimental to the continuity of mental health care.

**Medicaid & Cost.** On top of the previously covered barriers, a frequently cited barrier to mental health treatment is the cost of mental health services (Begun et al., 2016; SAMSHA, 2020). There have

been efforts to enroll people in Medicaid before leaving jail to address this. Among individuals booked in jail in 2013, 31% were enrolled in Medicaid in the year before booking (Henzel et al., 2016). This is important since, in Washington, having Medicaid is associated with receiving more services upon release (Joplin Consulting, 2016). However, suspension of Medicaid on incarceration can lead to care delays upon release.

Additionally, many providers are unwilling to accept Medicaid (BERK Consulting, 2014). This population may also face health literacy issues making it difficult to understand what health insurance is or how to access the services (Joplin Consulting, 2016). Currently, targeted case management and Medicaid administrative match (MAM), which includes connecting people with community services, scheduling them for appointments, and even driving them to appointments, are covered by Medicaid (Joplin Consulting, 2016). However, this is not being taken full advantage of in Washington (Joplin Consulting, 2016). Overall, unmet treatment needs of people with co-occurring disorders and serious mental illness, issues with treatment and identification of mental illness while incarcerated, inadequate service engagement during the critical time after release, barriers of Medicaid and cost, interpersonal and community barriers, lack of supportive relationships, housing, siloed systems, and poor community connections, compound leading to reincarceration and high utilization of jails for people with mental health disorders, especially women.

***Reincarceration and High Utilizers***

Barriers interact, leading to a “revolving door to jail,” which impacts individuals, families, and the community.

> I have seen my brother in a stable state when he is off drugs and on his medication, and he is a productive member of society. But he was just sent out, and the crazy cycle started all over again. Off and on the streets, more emergency room visits, jail time, and chronic stress and worry for my parents, who love their son. The cost my brother has created in jail visits, court

> appearances, emergency room visits, not to mention the theft from stores, must be pretty astronomical. (Poon et al., 2019, p. 10)

People with mental health disorders are more likely to be reincarcerated, perpetuating mental health treatment disruptions in the community. Of jail inmates arrested 11 times or more, 56% of them had a history of a mental health disorder, and in a study of inmates with SMI, 44.7% were reincarcerated within six months (Bronson & Berzofsky, 2017; Farabee et al., 2019). This may be higher in the county of interest, where 94.3% of people booked four or more times had been flagged for chemical dependency (CD) or CD treatment, mental health treatment, mood, psychosis, trauma, or psychiatric medication use within the year (King County Health & Human Services Transformation, 2016). Additionally, in the county of interest, between 2013-2014, there were around 2,500 people classified as high utilizers cycling through jail four or more times per year (King County Health & Human Services Transformation, 2016). This data show that people with mental health disorders are more likely to cycle from the community back to jail. Most of them cycle back to jail for low-level crimes; of those high utilizers in the county of focus, 40.7% were arrested for non-compliance, followed by property crime, drugs, and assault (King County Health & Human Services Transformation, 2016). Another reason people may cycle in and out of jails is that "people in a mental health crisis are more likely to encounter the police than get medical help" (NAMI, n.d., p. 1).

This supports that barriers to mental health care continuity after release are multifactorial and brings into question how communities can address continuity of care for people cycling through jail while decreasing disruptions to treatment progress. Improving continuity of mental health care is especially important for women leaving jail who are more likely than men to have mental health treatment needs and have a high prevalence of SMI and co-occurring disorders (Bronson & Berzofsky, 2017; Henzel et al., 2016). As discussed previously, they are unlikely to receive treatment during or after release; additionally, they will experience numerous barriers to mental health care, including cost, lack

of housing, lack of supportive relationships, and lack of treatment for co-occurring disorders (Begun et al., 2016; BERK Consulting, 2014; Farabee et al., 2019; Johnson et al., 2014; King County Health & Human Services Transformation, 2016; Poon et al., 2019; SAMSHA, 2020). All these issues occur within a fractured system of siloed organizations. Importantly, there is a lack of research on this population's issues in continuing mental health care after release. There is a lack of research on what programs or policies help women achieve continuity of mental health care after release. Therefore, this project aims to address these issues.

## Project Purpose

The purpose of this formative evaluation is to collect data from community stakeholders that can be used to inform policies and programs in the county of focus to improve the continuity of mental health care for women re-entering the community after jail; these policies and programs can then be used to decrease reincarceration, hospital and emergency department utilization, and costs. This project has three aims. The aims are as follows.

1. To determine what mental health services or policy changes are most needed to support mental health care continuity for women being released from jail.
2. To understand the most pressing barriers that impact women's abilities to obtain mental health services after release.
3. To understand what community resources have helped promote continuity of mental health care after jail release.

## Theoretical Framework

The feminist theoretical framework is used in this project. Feminist theory is used because there are a disproportionate number of women with mental health issues in jails, and feminist theory helps consider how the needs of women have been marginalized in this community. Subsets of feminist theory, such as standpoint theory, highlight the importance of looking at systems and how they impact

women (Johnson, 2005). Feminist theory can also be combined with concepts of intersectionality. Intersectionality is vital to recognize in this population since they will have many overlapping identities, for example, being a person of color, a parent, or a previously incarcerated person. Intersectionality will help understand that there are complexities outside of being a woman that will impact their continuity of mental health care (Washington University in St. Louis, n.d.). Using feminist theory informs and grounds the project in the ways mentioned above. Since this is a formative qualitative study that will be used to develop future policies and programs, feminist theory addresses a vital element of the project: understanding something that there is little knowledge of, focusing on female perspectives and societal dynamics. The feminist framework will be used in conjunction with the Delphi method, explained in the next section.

## Methods

### Design - Delphi Method

This policy project utilized the Delphi Method. The Delphi Method uses a series of rounds or phases asking experts' opinions, working to identify consensus opinion with successive rounds (Barrett & Heale, 2020). Questions in successive phases are based on results from the previous phase (Barrett & Heale, 2020). Due to time constraints, this study employed two phases; both are described in detail in the methods section. In Delphi methods, anonymous results from the previous phase are shared with participants before the successive phase allowing for reflection; sharing of results will be done at the end of the study since the project was limited to two phases (Barrett & Heale, 2020). Consensus was predetermined before implementation to avoid bias and is defined later in the methods section.

### Setting

This project occured in the Pacific Northwest, focusing on stakeholders with expertise in mental health and social services for women re-entering the community from two urban jails. Both urban jails process a high volume of bookings and releases per month, posing challenges for care coordination and

release planning done by the organization, which staffs healthcare services, including release planning. The same organization staffs both jails' health services. The average daily population in secure detention for both jails combined was 1,310 for 2021 (DAJD, 2021c). In 2021 there were 14,208 bookings with 1,180 releases per month (DAJD, 2021c). Most people in the population were awaiting trial, and the average length of stay for adults in the secure population in 2021 was 34.98 days (Dailey et al., 2021; DAJD, 2021b). In July 2021, women made up 7.2% of the average daily population in secure detention; however, in previous years, women comprised around 11% of the average daily population in secure detention (DAJD, 2021a).

**Participants and Recruitment**

This Delphi methods study used purposive sampling to acquire expert opinions of people directly involved in providing services related to the project aims. Purposive sampling was done by inviting 200 potential participants in psychiatric, social services, and nursing employed by the organization serving both urban jails to participate in the study. Potential participants were included whether they worked at one or both urban jails. Recruitment emails written by the writer were forwarded to stakeholders by the Psychiatric and Social Services Manager, who served as the site contact. Included participants worked as one or more of the following: nurse, jail release planner, social worker, psychiatric evaluation specialist, or mental health provider, including nurse practitioners, social workers, or medical doctors. They also had experience working with women released from either of the urban jails who have one or more of the following mental health diagnoses: depression, anxiety, bipolar disorder, schizophrenia, and schizoaffective disorder. Potential participants excluded from the study include substance use disorder staff, jail diversion specialists, and pharmacy staff. Those who participated in one but not both surveys were not excluded. No incentives were administered to study participants. The same pool of potential participants were invited to participate in both phases.

**Ethical Considerations**

This study included participants from the organization staffing healthcare services within the urban jails; it was essential to ensure participant confidentiality. Informed consent was obtained electronically in Qualtrics prior to any data collection. The consent form explained the study and requested consent for participation and data collection. They were asked to give or deny their consent at the end of the page. If they gave consent for data collection, they could proceed with the survey. No other personnel were involved in the consent process. Since the study participants were employed within the organization, English proficiency was assumed, so consent was only provided in English. Participants were informed that they might withdraw at any time without consequence. To ensure confidentiality, no direct identifiers were collected, and the only indirect identifier that was collected was the current job role. This study was also approved by the organization's Research Administrative Review Committee (RARC) and determined to be non-human subject research by the Seattle University Institutional Review Board.

## Phase 1 Methods

### *Survey Instruments*

The first survey was a mixed-methods survey developed with organization stakeholders (Appendix A). This project is formative and focuses on a topic where research is lacking. Therefore, the first survey uses mixed methods focusing on open-ended qualitative questions to give participants the ability to express ideas that the researcher would not otherwise anticipate. They were asked one multiple choice question and a series of 13 open-ended qualitative questions related to the project aims (Appendix A). Questions included one demographic question: current job title.

### *Data Collection*

Data collection occurred in Qualtrics. Participants created a unique identifier; the intention for using a unique identifier was to maintain anonymity while being able to analyze and present data separately for participants that took both surveys.

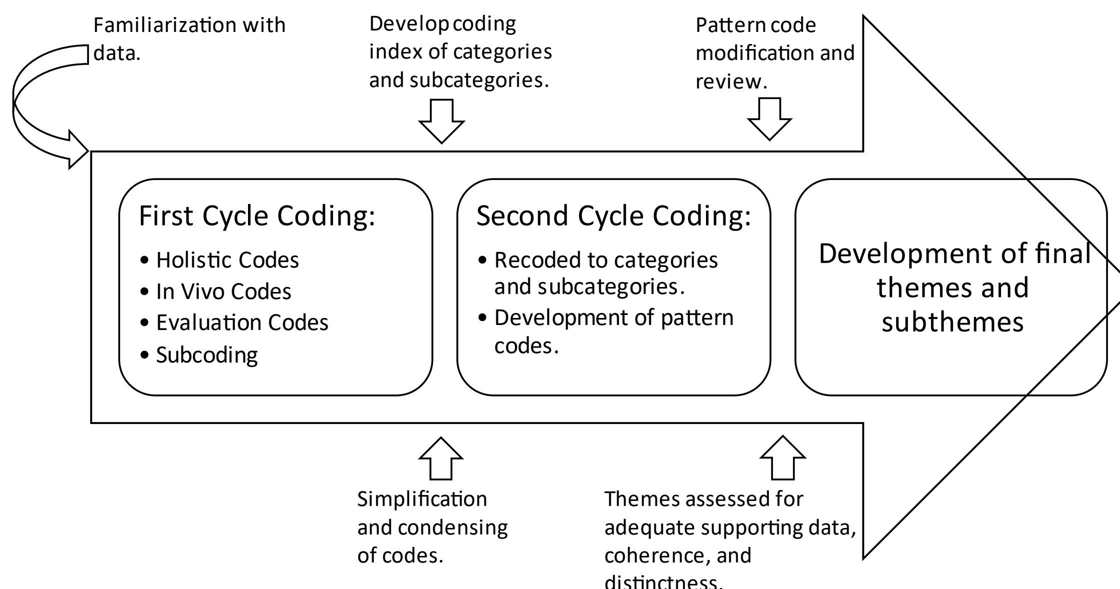
***Data Analysis***

Categorical data, including job roles, were analyzed in Excel to determine the proportion. To maintain anonymity, managers were grouped with the applicable job role. For instance, nursing managers were grouped with registered nurses, and psychiatric and social services managers were grouped with psychiatric evaluation specialists. If managers could not be grouped, they were presented under the manager category. For the single multiple-choice question proportion for yes or no responses was also determined in Excel. Qualitative data then underwent thematic analysis using the method of Braun and Clarke outlined by Kiger and Varpio (Kiger & Varpio, 2020).

Qualitative data obtained from open-ended questions were analyzed using thematic analysis done in Excel. Initial codes were generated using an inductive coding framework (Miles et al., 2020). Data extracts could be labeled to more than one code if relevant. First cycle coding methods used included holistic coding, subcoding, in vivo coding, and evaluation coding. For questions about specific community resources, the frequency that participants mentioned resources was determined instead of coding this data. If participants included more than a resource name or category, the additional information they provided was coded. After the first cycle of analysis, a second cycle analysis was performed. Data were recoded and collated to second cycle codes developed from modified first cycle codes. Pattern codes, referred to as themes, were further identified and modified during the second cycle as new connections emerged within the data. Codes that could not be coded under an identified theme were coded under an “uncategorized" theme. The method of qualitative data analysis is shown in Figure 1.

**Figure 1**

*Qualitative Data Analysis Method*




*Note.* This figure demonstrates the process of theme development from qualitative data analysis in this study.

**Phase 2 Methods**

***Survey Instruments***

The second survey, which was developed in conjunction with stakeholders, was formulated based on the first survey results. The goal of the second survey was to determine consensus on themes identified from phase one data analysis. However, based on the first survey participation and discussions with stakeholders, it was decided that the time commitment for the second survey should be decreased. Therefore, questions were not included for all the themes. While some questions were developed directly from a theme, some are derivative, and therefore consensus is not directly determined. The second survey included one demographic question: current job role. Twenty-nine five-point Likert scale questions were used to gauge consensus on themes and their derivatives. One qualitative question asked participants to recommend data that should be tracked related to the project issue.

***Data Collection***

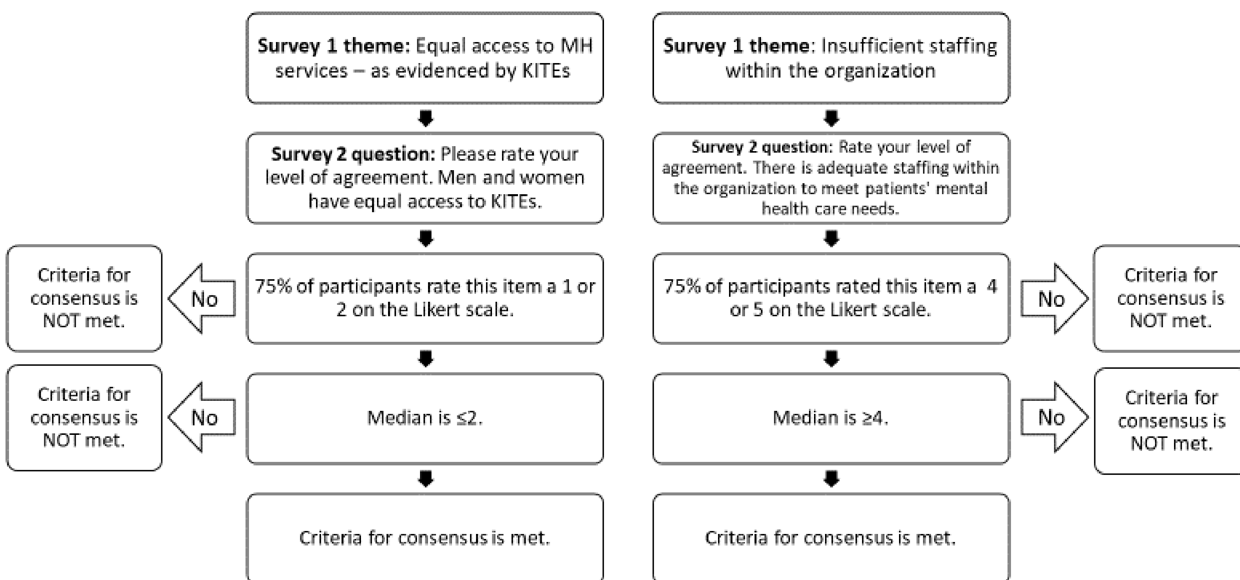
Data collection occurred the same as in phase 1.

### *Data Measures*

Prior to implementation, definitions for consensus were determined. For questions phrased in alignment with the theme, consensus amongst participants was achieved if 75% of participants rated an item as 1 or 2 on the Likert scale and the median was ≤2. For questions phrased in opposition, consensus amongst participants was achieved if 75% of participants rated an item as a 4 or 5 and the median was ≥4. Examples of how consensus was determined are included in Figure 2. If these requirements were not met, it was determined that consensus was not achieved amongst participants.

**Figure 2**

*Criteria for Determination of Consensus*




*Note. Left.* An example of a survey 2 question phrased in alignment with the survey 1 theme and the criteria for consensus. *Right*. An example of a survey 2 question phrased in opposition of the survey 1 theme and the criteria for consensus.

### *Data Analysis*

Only two participants could be matched to first survey participants based on their job role and unique identifier. Due to this limitation, results for participants that took both surveys were not analyzed and presented separately. Data for all second survey participants were analyzed and presented together. Managers were grouped similarly to in phase one data analysis. Medians and 75-percentile of the Likert-scale questions were calculated to determine consensus as described above. Standard deviation was also calculated. For the single qualitative question, the frequency of recommended data tracking types was measured. No coding was done.

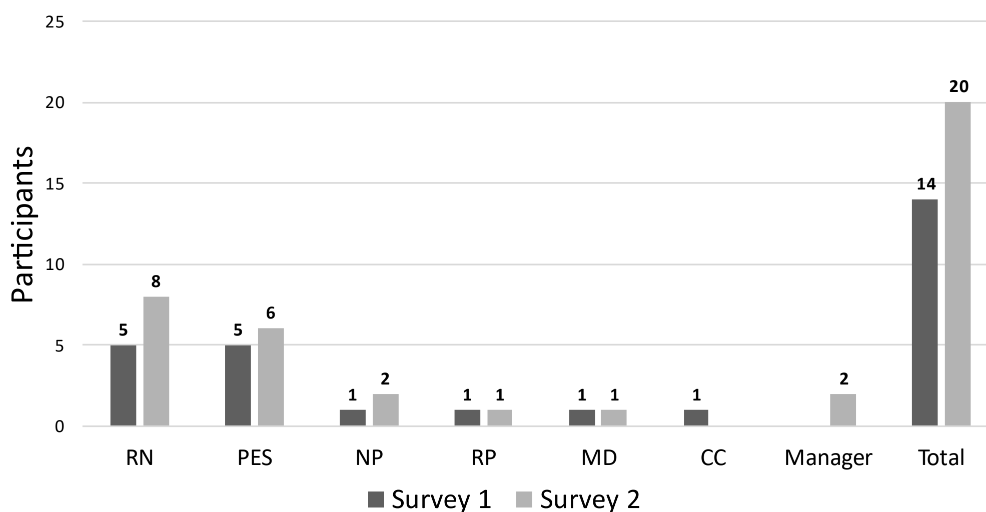
## Results

### Demographics

14 and 20 participants took the first and second surveys, respectively. As previously described, managers were grouped with relevant job roles to maintain anonymity. Correspondingly, first and second survey participants included registered nurses (n=5; n=8), psychiatric evaluation specialists (n=5; n=6), nurse practitioners (n=1; n=2), release planners (n=1; n=1), medical doctors (n=1; n=1); court clinicians (n=1; n=0), and managers (n=0, n=2). Job roles are included in Figure 3.

**Figure 3**

*Current Job Role Demographics for Participants in Survey 1 and 2*



*Note.* RN = registered nurse; PES = psychiatric evaluation specialist; NP = nurse practitioner; RP = release planner; MD = medical doctor; CC = court clinician. The manager category is used for managers that could not otherwise be grouped with another job role.

## Phase 1 Results

### *Quantitative Results*

There was one quantitative multiple-choice question. Participants were asked to respond yes or no to the following question, "Does your role involve connecting women with community mental health services?" Of the 14 participants, seven responded yes, and seven responded no. Responses by job role are included in Table 1. If participants responded no, they were not presented with the following question, "what community mental health services are you most frequently referring or connecting women with?"

**Table 1**

*Does your Job Role Involve Connecting Women with Community Mental Health Services?*

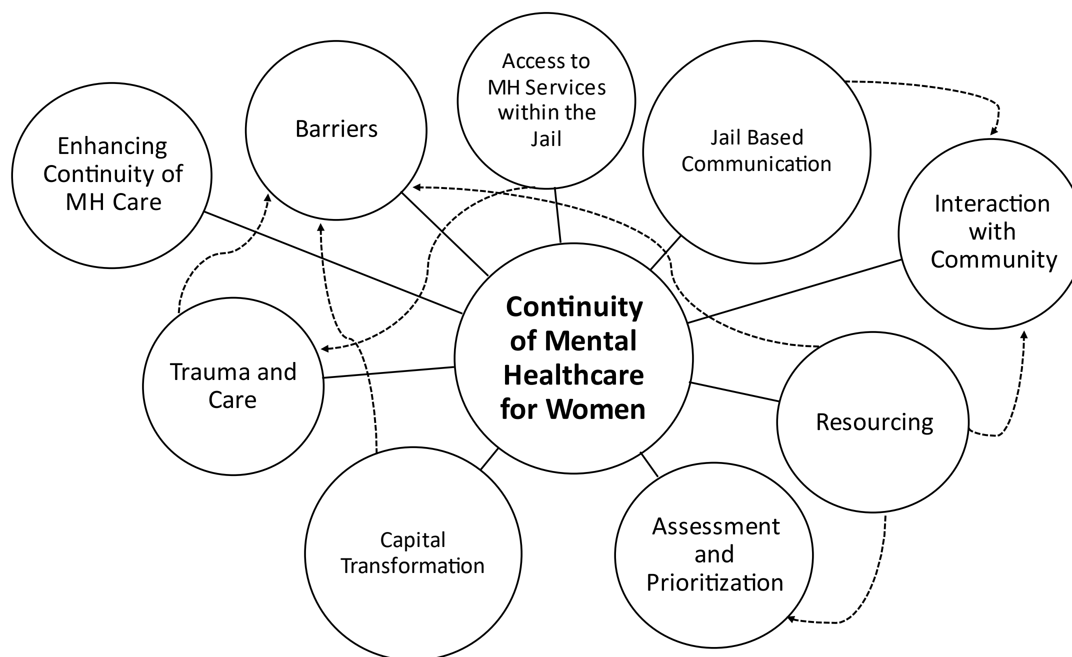
| Job Role | Response | |
|---|---|---|
| | **Yes** | **No** |
| Registered nurse | 1 | 4 |
| Psychiatric evaluation specialist | 3 | 2 |
| Psychiatric nurse practitioner | 1 | 0 |
| Release planner | 1 | 0 |
| Court clinician | 1 | 0 |
| Medical doctor | 0 | 1 |
| Total | 7 | 7 |

### *Themes*

Nine main themes emerged in the first survey. The main themes were 1) access to mental health services within the jail, 2) jail-based communication, 3) interaction with the community, 4) resourcing, 5) assessment and prioritization, 6) capital transformation, 7) enhancing continuity of mental health care, 8) trauma and care, and 9) barriers to continuity of mental health care. Themes and relations are shown in Figure 4 and reviewed in the following sections.

**Figure 4**

*Results of Survey 1 - Themes*




*Note.* MH = mental health; the trauma category includes events or circumstances women have experienced that are harmful physically or emotionally and re-traumatization, conscious or sub-conscious re-experience of a traumatic event (SAMSHA, 2022).

**Access to Mental Health Services Within the Jail**. This theme encompassed issues with the provision of mental health services within the jail. The subthemes were:

- “unladylike” vs. “silently languishing”
- detriment of limited psychiatric housing for women
- equal access to mental health services – as evidenced by Kites

Kites are written requests for services within the jail including mental health services.

The first subtheme was "unladylike" vs. "silently languishing." This subtheme used participant language to describe the issue; women who act outside of perceived gender “normal” behavior are more likely to be referred for mental health issues within the jail, and women without overt expressions

of mental illness are less likely to be referred for mental health issues. Gender normal behavior, in this sense, is a societal gender stereotype for expectations of conduct. Some participants contrasted behavioral expectations for women with those for men. One participant said, "I think a lot of women silently languish in general population, whereas our male patients tend to be more explosive, so they get attention and more regular follow up and are generally more on our radar." Another participant said,

> "There are also overt behavioral expectations that all uncouth behaviors equal mental health. Women have a higher standard for what is appropriate that is ridiculously different than males. This leads to a logjam where outspoken and behaviorally challenging women remain in psychiatric housing, and quietly and very ill women remain in general population. In this regard the "standards" of "ladylike" behavior drive access."

Another subtheme was the detriment of limited psychiatric housing for women. Participants reported fewer housing options for women in psychiatric housing, which may lead to women being held in more restrictive housing than their level of custody dictates, thereby impacting their access to mental health services. One participant said,

> "There are fewer housing options for women in custody both in general population and psychiatric housing. As such, women are often held in more restrictive environments than their custody level dictates, and many remain in psychiatric housing (which is more restrictive than general population) due to space limitations. This in turn can impact their access to services as jail location largely dictates what services are received."

The last subtheme was equal access to mental health services, as evidenced by Kites. The jailed person can fill out a Kite, a written request for services within the jail, including mental health services. Kites are one way to access mental health services within the jail, while staff may identify others as having a serious mental illness and transfer them to psychiatric housing. When asked, "are there

differences in male versus female appearing individuals being able to access mental health services within the jail," many participants reported no differences in access and then stated that men and women have equal access to Kites.

**Jail-Based Communication**. This theme encompassed occurrence and issues with communication between teams interacting in the jail. This included teams within the organization and communications surrounding the release, including the courts and the department of corrections. The subthemes were:

- internally siloed
- unpredictability of release
- occurrence of in-house collaboration

The first subtheme was internally siloed. Participants said teams were segregated and reported a desire for increased communication between teams. One participant said, "We are very siloed in my opinion, and I believe more routine case study discussion to understand roles would be huge." Another participant said, "Psych [psychiatric services team] and Nurse teams are sadly very segregated."

The second subtheme was the unpredictability of release. This is a complex issue since most people in both jails are awaiting pending charges or trials, including awaiting competency evaluation or restoration. Release can therefore be unpredictable, and there is often no advance notice of release per participants, which causes issues in planning for release. Participants said, "Often, we don't have advance notice of releases, so they don't even have a med supply." Another participant recommended, "Better communication by the courts regarding release as we often have no notice about someone's release and therefore do not have time to make a plan."

The last subtheme was the occurrence of in-house collaboration. While participants reported issues in communication, they also reported that there is collaboration occurring around providing mental health services, including collaboration around medications. Collaboration around medications

involves communication amongst teams within the organization and external organizations. The ability to get medications into a person's property for release can also be affected by resourcing, including the number of pharmacy staff and the availability of pharmacy staff at the time of day of release.

**Interaction with Community**. This theme encompassed communication between the organization and external organizations. It included the following subthemes:

- infrequently able to connect with outpatient mental health providers prior to release
- disconnect from community organizations
- occurrence of collaboration with external providers and services

The first subtheme was being infrequently able to connect with outpatient mental health providers prior to release. Participants reported that the organization did not have the capacity to contact outpatient providers prior to release for everyone. Related issues such as unpredictable release and difficulty successfully connecting with the outpatient provider were mentioned. Referring to collaboration with outpatient mental health providers, one participant said, "This rarely occurs because we do not have the capacity to contact all outpatient providers prior to release. You're also assuming we are able to reach someone when we do outreach, which is often unsuccessful." Another participant said,

> "Often women are here so briefly (I feel like we see more women on misdemeanor charges, and they are released quickly) that we just see them for assessment, end up leaving a voicemail, and often the patient is out before you hear back."

The second subtheme was a disconnect from community organizations. Participants reported that the external mental health system is disconnected, they are disjointed in communication with external organizations, or remarked on opportunities for increased communication. One participant said, "The vast number of community health centers, shelters and programs is incredibly confusing to navigate. It is often unclear to me how someone obtains various resources since there is not a centralized system." Another participant, when asked about services that would help women remarked

that there should be, "Formal liaisons between community mental health and [the organization]." The final subtheme was the occurrence of collaboration with external providers and services. While participants reported issues with communication with external organizations, they also reported that collaboration was occurring.

**Resourcing**. Resourcing included issues with staffing in the community and within the jail that impact mental health care services. The following subthemes were included:

- lack of intakes and long wait times in the community
- insufficient staffing within the organization
- release planners – connectors to community

Intakes are detailed assessments done by, in this case, behavioral health providers used to gather contextual information to develop an appropriate treatment plan. The first subtheme was the lack of intakes and long wait times in the community. Long wait times were also included as a subtheme under barriers to continuity of mental health care. One participant noted, "Since COVID, many agencies have lost staff, either they have quit or moved on to another job. Many are still short-staffed and having to limit the number of intakes they can schedule." Another participant, when discussing removing barriers to mental health care, stated that there is a need to, "Improve staffing at community service providers by increasing incentives to work (pay, benefits, lower caseloads)."

The second subtheme was insufficient staffing within the organization. Participants noted they do not have the capacity or staff resources to provide services to all patients or even every patient with a mental health concern. One participant noted, "Unfortunately, we typically don't have capacity to focus on the "well enough" for outpatient."

The last subtheme was release planners – connectors to the community. Release planners serve a vital role in connecting patients to community resources, which is mainly isolated to their job role. However, staffing within release planning is limited. One participant recommended, "Increase the

number of release planners in custody so that more patients have contact with them prior to release." Another participant said, "staff resources are not sufficient enough for release planning services to be provided to every patient with mental health concerns or problems."

**Assessment and Prioritization**. Assessment and prioritization included the following subthemes:

- services limited to patients with high-needs
- the desire to prioritize care
- staff approaches to mental health assessments

The first subtheme was services limited to patients with high needs. This was related to resource limitations. Participants remarked that services were limited to a subset of patients due to this limitation. One participant stated, "For high needs patients, psych staff may communicate the need/place a referral to release planning who will then complete their assessment and determine what service linkages can be made." Another said, "The scope of services we provide here are so extremely limited and unless someone meets criteria for ITA referral, when they are called for release, we pretty much send them out with a shelter list." When discussing cross-disciplinary communication during release planning, another participant said, "I would argue that this is very much limited to extreme outliers. In my experience there are categories of patient needs that are highlighted by RP services presently."

A second subtheme was a desire to prioritize care. Participants wanted to identify "tiered" individuals and have a hierarchy of patient focus. One participant stated,

> "We need to define a hierarchy of patient focus, defined by actuarial models of risk and vulnerability. I think mental health clinicians are great, but they are often not great at hard science and the only math they do is how much their heart beats when a specific case comes forth. I think we need boring facts and data to drive our focus."

Another participant, when discussing services that would help women said, "Identification of "tiered" individuals when booked."

The final subtheme was approaches to assessment vary by staff. Assessments were included with prioritization since assessments help determine which patients are prioritized for mental health services. Responses varied for the question, "what type of mental health assessment/assessment tool do you perform to determine what services women need after release?" A registered nurse reported, "I perform assessments for risk of self-harm, ability to care for self (need general population housing or psychiatric housing) while the patient is incarcerated." While another registered nurse reported none, and another reported they used the Brief Jail Mental Health Screening tool. Psychiatric Evaluation Specialists were the most consistent saying that they do a biopsychosocial assessment without using a specific validated tool.

**Capital Transformation**. Capital transformation was related to large-scale organizational, governmental, and funding changes. The subthemes that emerged in this category were:

- the desire for implementation of solutions
- inadequate funding for community mental health services
- lack of insurance and limited coverage of mental health services
- the desire for policy reform

The first subtheme, the desire for implementation of solutions, encompassed extracts where participants report a need for organizational change. One participant said, "There are some really easy and obvious fixes, that sit on the dashboard. I think telling management to just try some wild ideas, give it a budget and try it."

The second subtheme was inadequate funding for community mental health services. This subtheme included extracts where participants remarked on issues or recommended changes in funding allocation. One participant, when discussing removing barriers to mental health care recommended,

"Increased federal and state funding for mental health." Another participant discussing barriers to mental health care said,

> "I would say jails and prisons themselves remove people from society and cause much more harm than they do good. They do not solve the social problems that crimes are a result of. Rather than providing facilities, programs or resources to rehabilitate or support people, money and policy supports jails and prisons."

The third subtheme was lack of insurance and limited coverage of mental health services. It was included in capital transformation because the reported problems with insurance related to national policies and issues with insurance coverage for mental health issues. One participant said, "There are not enough services covered by insurance or that are free to help support women's mental and physical health." Another participant, when discussing barriers to mental health care said, "It is also limited what is available to them. Most insurance companies do not cover Mental Health Services (if one even has insurance in the first place)."

The last subtheme was the desire for policy reform. A participant, when discussing removing barriers to continuity of mental health care recommended, "Policy reform re: homelessness and mental health crises through a race and social justice lens." Another participant recommended, "Move from a system of incarcerating people to putting money, time, and commitment into rehabilitative and supportive resources and programs."

**Trauma and Care**. The theme of trauma and care included two subthemes:

- cross gender housing in jail is non-therapeutic
- issues with safety in accessing community mental health resources

Due to limited psychiatric housing, women are often held in more restrictive housing that their level of custody dictates, and they are frequently housed in the same unit as men. One participant said,

> "The women's psychiatric area is unfortunately on the same unit as one where men are also housed, often men who are suicidal and/or who have major behavioral issues. While they do not directly interact, I think this can be very alarming for women, especially women with trauma histories related to men (which is most of our female patients!)."

Another participant said, "In an ideal world, female psychiatric housing would be totally away from male patients, so that it could be a more therapeutic space."

The second subtheme was issues with safety in accessing community mental health resources. Participants reported that women may not feel safe accessing community resources and that the safety risks around accessing care are poorly recognized. One participant said, "At times in the past I had women tell me that they were uncomfortable going to community mental health clinics due to how chaotic they sometimes felt and fears of running into past abusers." Another participant said,

> "I think similar to the jail, the community is a lot more concerning in terms of safety and support. The immediate resources around the jail are frightening and at the risk of sounding paternalistic, I would be worried to send a female friend or family member there. I think the risk of victimization, violence towards women is poorly recognized in mental health emergency care and outpatient services, as well as emergency supports."

**Enhancing Continuity of Mental Health Care**. This theme included the following subthemes related to enhancing the continuity of mental health care:

- easily accessible on demand services
- improved communication with community mental health providers and services
- warm handoffs

Easily accessible on-demand services referred to recommended walk-in and on-demand services to reduce barriers to continuity of mental health care. This theme related to a lack of intakes and long wait times in the community, a resourcing component. Participants recommended that mental health

services should be combined with housing and recommended walk-in intakes to reduce wait times to see a mental health provider in the community. One participant recommended, "Easy access to MH services such as a fully functioning walk-in intake process to prevent long wait times to access services." Another participant recommended,

> "Providing care the day a patient is released from custody. It is unrealistic to expect someone with a major mental illness to remember an appointment in the future, especially when their primary concern is finding a shelter bed, food, etc."

As the last participant remarked, easily accessible on-demand services are essential when considering additional barriers, which will be discussed under the next theme.

The second subtheme was improved communication with community mental health providers and services; mainly, participants wanted community mental health providers to connect with patients while they are still in jail. This is important when considering long wait times to see a psychiatric provider in the community and ensure medication continuation. One participant recommended, "It would be wonderful to see the community mental healthcare providers actually come inside the jail and provide continued care during their incarceration." Another participant said, "For patients without outpatient care, why can't they do a remote intake from the jail?"

The last subtheme was warm handoffs. A warm handoff is the "transfer of care between two health care team members, where the handoff occurs in front of the patient and family" (Agency for Healthcare Research and Quality [AHRQ], n.d.). When discussing removing barriers to the continuity of mental health care, participants recommended, "Warm handoff by community provider to physically meet the patient once released and help them navigate outpatient resources." Another participant recommended "Increased "warm handoff" efforts, including transportation and case management."

**Barriers to Continuity of Mental Health Care**. Barriers to continuity of mental health care included 1) housing instability, 2) lack of transportation, 3) lack of phone access, 4) substance use, 5)

lack of awareness of community mental health resources, 6) financial instability, 7) delays in community intake, 8) lack of available treatment services, and 9) acute mental illness. One participant stated,

> "I would estimate the majority (at least half) of our female inmates are homeless. They do not have phone numbers, addresses and other resources that they need to access community health. When someone is so underprivileged, basic human needs take the place of trying to take care of their mental health. Being in survival mode does not leave much room to take care of things such as Mental Health."

Participants also noted that return to substance use after jail release was a barrier. One participant said, "Another significant barrier is substance use - women report that while they are in the community, they use substances that prevent them from seeking help for their mental health." Participants also noted a lack of available treatment services. This included mental health services in general, services tailored to women, and substance use treatment services. A consequence of the lack of available treatment resources was delays in community intake, which was related to resources in the community. Another barrier was a lack of awareness of community mental health resources. Participants noted that they provide general mental health resource information to patients, while they also noted that the community mental health system could be disconnected and confusing.

Lastly, participants mentioned acute mental illness as a barrier. One participant questioned, "If you are really ill are you really going to schedule an appointment at outpatient, do an intake and wait a month plus at least for a provider?" This is important since other participants remarked on frequently working with acutely ill patients who cycle through the community back to jail. "Again, I'm sorry to report that I only see the folks that struggle or recidivate... I worry about female patients that are actively psychotic, actively using and victimized. We know some of our folks are very ill." Another participant used an analogy to describe how frequently they see acutely mentally ill individuals,

"I think of us as the ER that always sees kids with broken legs. How many healthy well-functioning are out there? Do the kids with broken legs ever get physical therapy? I don't know but here's another kid with a broken leg!"

**Uncategorized Themes**. There were uncategorized themes, including:

- providing general information on community mental health resources
- low engagement in community mental health services
- COVID impact
- recidivism

Some participants remarked that they provided general information on community mental health resources to women when discussing removing barriers to continuity of mental health care. Participants also estimated that there is low engagement in community mental health services among the women they work with, although participants reported this data is not tracked, so they are unsure of the actual frequency. Participants also noted that COVID had impacted the availability of community mental health services and walk-in intakes with community providers. Lastly, there were extracts related to recidivism. One participant said, “You see a handful of women who are in jail so frequently that they never really get to follow up--they are always here.”

***Quantitative Results of Select Qualitative Questions***

The frequency of mentions was determined for the following questions instead of coding this data.

- What community mental health services are you most frequently referring to or connecting women with?
- What type of mental health resources have women told you they have utilized in the past?

The most mentioned services participants connected women with were general information on community mental health resources for this question. The most mentioned resources women have used

in the past are community mental health clinics, the emergency department, shelters, and hospitalization or inpatients services. Data for these questions were included in Table 2 and Table 3, respectively.

**Table 2**

*What Community Mental Health Services are you Frequently Referring or Connecting Women with?*

| Community Mental Health Services | Frequency of Mentions |
|---|---|
| Designated Crisis Responder | 1 |
| Medication management | 1 |
| Case management | 1 |
| Mental health counseling | 1 |
| Group treatment | 1 |
| Substance use disorder treatment | 1 |
| Mental health treatment (not otherwise specified) | 1 |
| General information on community mental health resources | 3 |
| Valley Cities | 1 |
| Downtown Emergency Service Center | 1 |
| Sound Mental Health | 1 |
| Crisis/warm lines | 1 |
| Post-partum services | 1 |
| Inpatient/ITA | 1 |

*Note.* This table shows the community mental health resources that participants are referring or connecting women with.

**Table 3**

*What Type of Mental Health Resources have Women Utilized in the Past?*

| Mental Health Resources | Frequency of Mentions |
|---|---|
| **Intensive or Crisis Services** | |
| Downtown Emergency Service Center | 3 |
| Shelters | 4 |
| Jails | 1 |
| Emergency room | 4 |
| Program for Assertive Community Treatment | 1 |
| Crisis clinic | 1 |
| **Diversion Services** | |
| Law Enforcement Assisted Diversion | 1 |

| Case Management | |
|---|---|
| REACH | 1 |
| Case management | 1 |
| **Inpatient and outpatient Services** | |
| Hospitalization or inpatient services | 5 |
| Community mental health clinics | 6 |
| Valley Cities | 1 |
| Sound Mental Health | 2 |
| Navos | 1 |
| Outpatient care | 3 |
| Primary care clinics | 2 |
| Country Doctor | 1 |
| Private mental health resources | 2 |
| Sobering/ substance use disorder treatment | 3 |
| **Miscellaneous** | |
| Medications | 1 |
| Mobile vans | 1 |
| Drop-in services | 1 |
| Support groups | 1 |
| Mental health court | 1 |
| Counseling | 1 |
| Unsure or N/A | 2 |

*Note.* This table shows the mental health resources that women reported to participants that they have utilized in the past.

**Phase 2 Results**

Table 4 shows the results of the second survey. Before implementation, definitions for consensus were determined as previously described (see Figure 2). To limit the time commitment for participants, not all themes were evaluated for consensus. Some themes were not directly analyzed for consensus; instead, a derivative question was asked to clarify aspects of themes or theme importance.

**Table 4**

*Phase 2 – Results for Measurement of Consensus*

| Themes | Final Survey | | | | |
|---|---|---|---|---|---|
| | n | % | M | SD | CM |
| **Theme: access to mental health services within the jail** | | | | | |
| **Subtheme: “unladylike” vs. “silently languishing”** | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| In jail, women without overt expressions of mental illness are less likely to be referred for mental health services. | 20 | 55% | 2 | 1.17 | No |
| Women who act outside of perceived gender normal behavior are more likely to be referred for mental health issues within the jail. | 20 | 55% | 2 | 1.02 | No |
| **Subtheme: detriment of limited psychiatric housing for women.** | | | | | |
| Women with mental health issues are held in more restrictive housing than their level of custody dictates very often to always. * | 20 | 45% | 3 | 0.81 | No |
| In the jail, current limited psychiatric housing options for women negatively impact their access to mental health services within the jail. | 20 | 75% | 2 | 1.24 | Yes |
| **Subtheme: equal access to MH services – as evidenced by Kites** | | | | | |
| Men and women have equal access to mental health services within the jail. | 20 | 60% | 2 | 1.56 | No |
| Men and women have equal access to KITEs. | 20 | 90% | 1 | 0.68 | Yes |
| **Theme: jail-based communication** | | | | | |
| **Subtheme: internally siloed** | | | | | |
| There is a need for increased communication between teams within organization. | 20 | 90% | 2 | 0.83 | Yes |
| **Subtheme: unpredictability of release** | | | | | |
| *There is adequate notice before a release to be able to perform care coordination.* | 19 | 42% | 3 | 0.83 | No |
| **Subtheme: occurrence of in-house collaboration †** | | | | | |
| **Theme: interaction with community** | | | | | |
| **Subtheme: infrequently able to connect with outpatient MH provider prior to release** | | | | | |
| It is difficult to get in communication with outpatient mental health providers prior to release. | 18 | 55% | 2 | 0.69 | No |
| **Subtheme: disconnect from community organizations** | | | | | |
| *There is adequate collaboration between the organization and community mental health organizations for care coordination.* | 20 | 50% | 3.5 | 0.95 | No |
| **Subtheme: occurrence of collaboration with external providers and services †** | | | | | |
| **Theme: resourcing** | | | | | |
| **Subtheme: lack of intakes and long wait times in the community** | | | | | |
| The current availability of community psychiatric intake appointments is a barrier to the continuity of mental health care for women. | 20 | 75% | 1.5 | 0.95 | Yes |
| **Subtheme: insufficient staffing within the organization** | | | | | |
| *There is adequate staffing within the organization to meet patients' mental health care needs.* | 20 | 80% | 4 | 1.17 | Yes |
| **Subtheme: release planners – connectors to community** | | | | | |
| Within the organization, care coordination services are limited to a subset of patients due to staffing limitations. | 20 | 85% | 2 | 0.73 | Yes |
| **Theme: assessment and prioritization** | | | | | |
| **Subtheme: approaches to mental health assessment vary by staff †** | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| **Subtheme: desire to prioritize care** | | | | | |
| Prioritizing patients based on need at intake is very to extremely important for the organization to provide appropriate mental health care. * | 20 | 90% | 2 | 0.64 | Yes |
| **Subtheme: services limited to patients with high need** | | | | | |
| Within the organization, care coordination services are limited to a subset of patients due to staffing limitations. | 20 | 85% | 2 | 0.73 | Yes |
| **Theme: capital transformation** | | | | | |
| **Subtheme: desire for implementation of solutions †** | | | | | |
| **Subtheme: inadequate funding for mental health services** | | | | | |
| *There is adequate funding for mental health services in our community.* | 20 | 75% | 5 | 0.99 | Yes |
| **Subtheme: lack of insurance and limited coverage for mental health services** | | | | | |
| Inadequate insurance is a barrier to the continuity of mental health care for women. | 20 | 75% | 2 | 0.91 | Yes |
| **Subtheme: desire for policy reform †** | | | | | |
| **Theme: trauma and care** | | | | | |
| **Subtheme: cross gender housing in jail is non-therapeutic** | | | | | |
| Housing male and female patients together in the same unit makes women feel unsafe. | 20 | 95% | 1.5 | 0.75 | Yes |
| **Subtheme: issues with safety in accessing community mental health services †** | | | | | |
| **Theme: enhancing continuity of mental health care** | | | | | |
| **Subtheme: easily accessible on demand services †** | | | | | |
| **Subtheme: improved communication with community mental health providers & services †** | | | | | |
| **Subtheme: warm handoffs** | | | | | |
| Warm handoffs are very to extremely important to continuity of mental health care for women. | 19 | 89% | 1 | 0.69 | Yes |
| **Theme: barriers to continuity of mental health care** | | | | | |
| **Subtheme: delays in intakes** | | | | | |
| The current availability of community psychiatric intake appointments is a barrier to the continuity of mental health care for women. | 20 | 100% | 1 | 0.48 | Yes |
| Walk in intakes are very to extremely important to continuity of mental health care for women. * | 19 | 84% | 1 | 0.76 | Yes |
| Long wait times to be seen by a community mental health provider are a barrier to the continuity of mental health care for women. * | 20 | 95% | 1 | 0.59 | Yes |
| **Subtheme: housing instability** | | | | | |
| Housing is very to extremely important to continuity of mental health care for women. * | 20 | 100% | 1 | 0.48 | Yes |
| **Subtheme: lack of transportation** | | | | | |
| Transportation is very to extremely important to continuity of mental health care for women. * | 19 | 75% | 2 | 0.90 | Yes |
| **Subtheme: lack of phone access** | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Phone access is very to extremely important to continuity of mental health care for women. * | 19 | 75% | 1 | 1.07 | No |
| **Subtheme: substance use** | | | | | |
| Substance use is a barrier to the continuity of mental health care for women. | 20 | 95% | 1 | 0.52 | Yes |
| **Subtheme: lack of available treatment services** | | | | | |
| *There are adequate substance use treatment resources in our community.* * | 20 | 65% | 4 | 1.14 | No |
| **Subtheme: financial instability †** | | | | | |
| **Subtheme: acute mental illness** | | | | | |
| The patients I work with show symptoms of acute mental illness very often to always. * | 20 | 80% | 2 | 0.41 | Yes |
| **Theme: uncategorized** | | | | | |
| **Subtheme: low engagement in community mental health services †** | | | | | |
| **Subtheme: providing general information on community mental health resources** | | | | | |
| I understand what outpatient mental health resources are available to women leaving jail in our community. * | 20 | 40% | 3 | 1.29 | No |
| Providing general information on community mental health services improves the continuity of mental health care for women. * | 20 | 60% | 2 | 0.99 | No |
| **Subtheme: recidivism †** | | | | | |
| **Subtheme: COVID impact †** | | | | | |

*Note.* n = number of participants that responded; % = percentage of participants who agree with the theme; M = median; SD = standard deviation; CM = consensus met

* - Used for derivative questions.

† - Used for themes that were not directly evaluated in survey 2.

*Italics* – Used for themes that were evaluated with questions phrased in opposition.

## Discussion

The findings of this project demonstrate that all three projects' aims were met and provide support for making future recommendations.

The first aim was to determine what mental health services or policy changes are most needed to support mental health care continuity for women being released from jail. For instance, there was no consensus that there is equal access to mental health services within the jail. Further exploration is warranted to determine what is contributing to unequal access. One potential contributing factor is the

detriment of limited psychiatric housing for women. Participants agreed that limited psychiatric housing for women negatively impacts women's access to mental health services within the jail. People in psychiatric housing will have a care team and a higher frequency of mental health staff visits than people in non-psychiatric housing. In 2019 in one of the urban jails, 10% of the average daily population required psychiatric housing; however, an average of more than ten people per day were unable to be placed in psychiatric housing (Dailey et al., 2021). This may be due to the increased number of competency evaluation and restoration orders and the increasing demand for mental health services (Dailey et al., 2021). Another potential contributor is the idea that women who act outside of perceived gender normal behavior are more likely to be referred for mental health services, and women without overt expressions of mental illness are less likely to be referred for services. Neither of those concepts met consensus in survey two; however, 55% of participants agreed with those concepts, which warrants additional evaluation.

Another opportunity for organizational policy change is increased communication between teams within the organization. For instance, in the first survey, multiple psychiatric evaluation specialists mentioned psychiatric housing limitations for women, but registered nurses did not. Nurses may also be unaware of the Department of Adult and Juvenile Detention security classification system. In the jails under study, women in psychiatric housing are housed in more restrictive housing than their level of custody dictates often, which is a widely observed problem (TAC, 2014). In the second survey, most nurses reported that this issue only occurs sometimes. This shows that not all staff are aware of this issue, which is relevant to nurses since they are involved in recommending someone for psychiatric housing. However, knowing this information will not necessarily impact the nursing workflow.

Another subtheme related to housing that met consensus is that cross-gender housing in the jail is non-therapeutic. Again, there is limited psychiatric housing for women within the jail, which leads to men and women being housed in the same unit. This is another opportunity for policy change. It is

essential to acknowledge that the issue of housing limitation is complex and related to infrastructure and cost; limited availability of jail space for mental health treatment is a known organizational barrier within jails in Washington State (Washington State Health Care Authority [HCA], 2019).

Several questions within the themes of jail-based communication and interaction with the community did not meet consensus but bear discussion. The adequacy of release notice to be able to do care coordination did not meet consensus; although 42% of participants said adequate notice before a release occurs rarely, and 32% said it occurs sometimes. However, the one release planner who participated in survey two reported that adequate notice occurs often. In addition, there was no consensus on how difficult it is to communicate with outpatient mental health providers prior to release. However, the one release planner that participated reported it was extremely difficult. Similarly, there was no consensus on the adequacy of collaboration between the organization and community mental health organizations for care coordination. However, the participant release planner said there was inadequate collaboration with community mental health organizations for care coordination. These questions highlight aspects of the release planner's job role and show that additional information from release planners is needed.

Another potential area where there are policy implications is staffing. Before discussing staffing, it is essential to acknowledge the role of de-institutionalization and community mental health funding issues which have led to high volumes of people with mental health issues needing treatment within jails. According to a report by the Washington State Healthcare Authority, in 2019, $2,291,000 of the state general fund was allocated for mental health services for people in county or city jails and for facilitating connections with community mental health services in Washington (HCA, 2019). Despite this funding, these mental health service providers report barriers to providing mental health care in jails, including insufficient funding and a lack of qualified professionals to fill roles (HCA, 2019). Within the project organization, participants agreed that there is inadequate staffing to meet patients' mental

health care needs, and they agreed that care coordination services are limited to a subset of patients due to staffing limitations. Within the current system, the barriers to staffing and funding will continue to limit the provision of mental health services within jails.

Insurance and funding for community mental health services are on a related policy level. Participants agree there is inadequate funding for community mental health services and that inadequate insurance is a barrier to the continuity of mental health care for women. In Washington, Medicaid enrollment for people entering jail increased from 31% to 58% in 2014 (Henzel et al., 2016). However, 17% of Medicaid adults in the county of focus reported not seeking care due to cost (ACH, 2017). This is important since different costs may take priority, including housing and other basic needs, which were identified as barriers to the continuity of mental health care.

A theme related to policy is assessment and prioritization. In the first survey, participants had variable responses to what type of mental health assessment or assessment tool they use to determine what services women need after release. In compliance with the National Commission on Correctional Health Care at both urban jails, all individuals booked in jail are screened for health needs, including mental health and substance use disorder. However, assessments vary by staff in terms of understanding what mental health services someone may need upon release. Importantly, staff agreed that prioritizing patients based on need at intake is essential for the organization to provide appropriate mental health care. Potential opportunities for enhancing care include evaluation of current prioritization and assessment strategies. Lastly, staff expressed a desire for policy reform and implementation of solutions at an organizational level, although these were not directly explored in the second survey.

The project's second aim was to understand the most pressing barriers that impact women's abilities to obtain mental health services after release.

Long wait times in the community to see mental health providers and the current availability of community psychiatric intake appointments met consensus as barriers to the continuity of mental health care for women. Both of these relate to resourcing. In 2018 the county of focus was not designated as a mental health provider shortage area; however, among mental health organizations, 79% reported open job listings, and 80% reported staff turnover due to the high volume of patients and insufficient pay (ACH, 2017; Wiseman & Lofy, 2018). For instance, in 2016, 41% of total Medicaid claims in the county were for behavioral health, and six organizations accounted for 60% of Medicaid claims for outpatient behavioral health services (ACH, 2017).

Additional barriers from the first survey were explored as derivatives. Participants agree that housing and transportation are vital for the continuity of mental health care. Phone access did not meet consensus; however, more people rated phone access extremely important than transportation. Another potential barrier is issues with safety in accessing community mental health resources, which should be further explored.

The third aim of the project was to understand what community resources have helped promote continuity of mental health care after jail release.

Participants recommended services that could improve the continuity of mental health care for women. Easily accessible on-demand services were recommended but not further explored. Participants recommended "all in one" services, combined housing and mental health, walk-in intakes, and resources tailored to women, such as women's only shelters. Participants also recommended collaborative solutions such as having outpatient mental health providers do intakes while the person is in jail. Lastly, they agreed that warm handoffs are extremely important for the continuity of mental health care. Additional resources that have positively impacted women's ability to obtain community mental health services are peer connections, housing, and resources specifically for women, such as safe places and trauma resources.

When participants were asked what mental health resources women have utilized in the past, the most mentioned resources were shelters, emergency rooms, hospitalization or inpatient treatment, and community mental health clinics. This is consistent with the identified barrier of housing instability; emergency room utilization and hospitalization may reflect the number of women with SMI returning to the community and multifactorial issues with receiving and staying in mental health treatment in the community. When asked what community mental health services participants most frequently refer or connect women with, many expressed that this is not the central part of their job role but that they provide women with general information on community mental health resources. However, participants were divided on their understanding of community mental health resources and disagreed that providing general information on community mental health resources improves the continuity of mental health care for women.

**Limitations**

Several limitations exist, including limited release planner participation, limited definition of gender, use of the term adequate, low participation, time limitations, and low unique identifier recall. One of the study's limitations is that the work of connecting women with community mental health resources is the central role of release planners. This study focuses heavily on subjects pertaining to the release planner role; however, only one release planner participated in each survey. Another limitation is that substance use was identified as a barrier to mental health care continuity; however, substance use and diversion staff were excluded from this study. The organization does provide medication-assisted treatment (MAT), and substance use disorder specialists coordinate release plans, sometimes in conjunction with release planners in coordinated discharge. However, this study did not specifically focus on people's needs with co-occurring disorders. Another limitation is the limited definition of gender. Participants may have included in their response ideas related to non-gender binary and transgender people; research with this population is warranted to understand their unique mental

health care needs and barriers to mental health care continuity when encountering the justice system. Another limitation is the use of the term adequate. This term is open to interpretation and was utilized in several questions leaving staff to develop their measure of what adequate is. An additional limitation is the low participation rate for both surveys. When the surveys were administered, organizational staffing shortages and COVID-19-related impacts could have affected participation. Time was another limitation. Due to this, only two Delphi phases were completed, and to decrease the time burden on participants, not all survey one themes were analyzed in the second survey. Lastly, participants had limited unique identifier recall; only two participants could be matched with survey one participants. Therefore, data for participants that took both surveys were not presented separately.

## Conclusion

Women are disproportionately affected by the current system of incarcerating people with mental illnesses. They have co-occurring disorders, serious mental illness treatment needs, and unmet treatment needs while incarcerated, and they face numerous barriers to continuity of mental health treatment in the community. This project highlighted issues impacting mental health care within jails, barriers to care in the community, and opportunities for enhancing continuity of mental health care for women. Addressing these issues will require collaboration across community organizations and advocacy for community infrastructure and funding changes. Conducting a similar study among release planners and women with lived experience will increase understanding of needed community policy changes to support women leaving jail with mental health disorders.

## Practice Implications and Recommendations

Based on research results, community liaisons and advocacy are needed to address issues impacting the continuity of mental health care for women leaving jail. Liaisons can be leveraged to increase warm handoffs, establish improved walk-in and same-day intake systems, work together to minimize barriers, and implement solutions. Additional practice changes around identification and

screening for mental health disorders within the jail and discussion around how to ensure equal access to mental health services are warranted. In addition, advocacy is needed to address issues with funding for community mental health services and release planning services, expanded insurance coverage of mental health services, and increased community treatment options for women, including easily accessible services.

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## Appendix A.

**First Survey**

Please create a unique personal identifier that only you will know. Examples include make and model of your first car, first pet's name, favorite teacher, etc. Remember this identifier as you will need it again for the second survey.

_____________________________

What is your current job title?

______________________________

If you feel a question does not apply to your job role, please write not applicable. The following questions refer to women who are released from either of the two jails under study with at least one of the following mental health diagnoses: depression, anxiety, bipolar disorder, schizophrenia, or schizoaffective disorders.

1. Does your role involve connecting women with community mental health services?
    a. Yes
    b. No
2. What community mental health services or organizations are you most frequently referring or connecting women with?
3. Are there differences in male versus female appearing individuals being ability to access mental health services within the jail? Please describe.
4. What type of mental health assessment/assessment tool do you use to determine what services women need after release?
5. What cross-disciplinary communication about mental health needs occurs during the release planning process?
6. What percentage of women have an outpatient mental health provider who they have seen in the past 3-6 months?
7. If women have an outpatient mental health provide, how are you collaborating with that person before women's jail release?
8. What types of mental health resources have women told you they have utilized in the past?
9. Are there differences in ability to connect male versus female appearing individuals with community mental health services? Please describe.
10. What resources in our community positively impact women's ability to obtain community mental health services?
11. What community resources are needed to achieve better continuity of mental health care for women after release?
12. What barriers to receiving community mental health care do you observe or do women share with you? Consider including public policy barriers, community barriers, interpersonal barriers, and intrapersonal barriers.
13. What, in your opinion, could be done to reduce or remove the barriers you identified?
14. Is there anything else you think is important to share or comment on related to this topic?