

**Implementation Plan: Telehealth Model for Mental Health Crisis Management and Suicide
Prevention in Correctional Facilities**

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Introduction and Background

Incarcerated adults experience substantial and well-documented barriers to timely mental health care and effective suicide prevention. These barriers include chronic staffing shortages, limited access to psychiatric specialists, and a continued reliance on costly and high-risk off-site hospital transfers (Rosen et al., 2023; Novisky et al., 2025). Within medium- and maximum-security correctional facilities, the consequences of these systemic gaps are particularly severe. Individuals experiencing suicidal ideation or acute psychiatric decompensation are frequently transferred to community hospitals, a process that disrupts continuity of care, intensifies clinical symptoms, elevates security risks for both staff and patients, and further widens existing health disparities.

The correctional environment presents unique challenges to traditional models of psychiatric care delivery. Security protocols, restricted movement, limited on-site specialty resources, and the high prevalence of serious mental illness and suicide risk among justice-involved populations create a complex clinical and operational landscape (Winny & Rosen, 2023). Off-site transfers, while sometimes clinically necessary, impose significant financial and logistical burdens and may inadvertently contribute to poorer outcomes through delayed treatment, loss of institutional familiarity, and increased exposure to external stressors.

A growing body of evidence supports the use of telehealth as a viable strategy to improve access to mental health services in correctional and other safety-net settings (Edge et al., 2021; Tierney et al., 2023; Williams et al., 2024). Nurse-led models that incorporate remote Psychiatric-Mental Health Nurse Practitioner (PMHNP) support are particularly promising because they leverage the clinical expertise of advanced practice nurses while maintaining essential on-site nursing presence and security coordination. Such models align with national

standards for correctional health care that emphasize timely mental health assessment and robust suicide prevention practices (National Commission on Correctional Health Care [NCCHC], 2022).

This Implementation Plan outlines a 12-week nurse-led telehealth pilot designed to reduce off-site psychiatric hospital transfers for mental health crises in a medium- to maximum-security correctional facility housing approximately 1,200 individuals. The project addresses a clear gap in timely access to specialized psychiatric care and positions the PMHNP as a leader in delivering equitable, evidence-based mental health services to a vulnerable and underserved population.

Clinical Question

The clinical question guiding this project is: Can a nurse-led telehealth model with remote PMHNP support reduce off-site psychiatric hospital transfers by 30% during a 12-week implementation period in a correctional facility?

This question is designed to be specific, measurable, and directly linked to a clinically and operationally meaningful outcome (reduction in high-risk, high-cost off-site transfers) while remaining feasible within a defined pilot timeframe.

Purpose and SMART Goal

The overarching purpose of this project is to implement and evaluate a nurse-led telehealth model that improves timely access to psychiatric crisis care, reduces reliance on off-site hospital transfers, and strengthens suicide risk management within a correctional setting.

Primary SMART Goal

Reduce off-site psychiatric transfers for mental health crises by 30% within a 12-week pilot period.

Secondary Objectives

- Achieve $\geq 85\%$ referral completion and $\leq 10\%$ no-show rates for telehealth psychiatric encounters.
- Ensure crisis evaluation and PMHNP follow-up occur within ≤ 7 days of referral.
- Improve patient and staff satisfaction scores related to crisis response and strengthen documentation and completion of structured suicide risk assessments and safety plans.

Summary of Current Evidence

A robust and growing evidence base supports the use of telehealth for mental health service delivery in correctional and other underserved settings. Edge et al. (2021), in a systematic review of telehealth delivered in prisons, found that telehealth interventions were associated with improved access to care, reduced need for external transfers, and acceptable clinical outcomes across a range of physical and mental health conditions. These findings are particularly relevant to crisis-oriented psychiatric care, where delays in specialist evaluation can escalate acuity and increase the likelihood of off-site hospitalization.

Hewson et al. (2024) further examined interventions for managing chronic physical and mental health conditions in the prison population and concluded that structured, accessible models of care (including those supported by remote specialist input) can improve continuity and reduce acute care utilization. Williams et al. (2024) highlighted the potential of telehealth to enhance healthcare access among underserved and carceral populations, noting benefits including workforce expansion, reduced transportation burden, and more equitable service distribution.

Additional support for telehealth expansion in safety-net environments comes from Tierney et al. (2023), who documented substantial increases in telehealth use during and after the

COVID-19 pandemic and emphasized its ongoing utility for maintaining access when in-person specialty resources are limited. From a systems perspective, Rosen et al. (2023) underscored the critical impact of healthcare staffing shortages on care delivery in jails, reinforcing the rationale for models that extend specialist reach without requiring continuous on-site presence.

Collectively, this literature supports the premise that a nurse-led telehealth model with remote PMHNP involvement can reduce off-site transfers, improve the timeliness and quality of crisis response, and contribute to safer, more continuous mental health care within correctional facilities. The proposed project is further aligned with NCCHC (2022) standards that require timely mental health assessment and comprehensive suicide prevention practices.

Project Design and Intervention

This project will implement a 12-week nurse-led telehealth pilot focused on mental health crisis management and suicide prevention. The core intervention consists of structured, secure video encounters facilitated by on-site registered nurses and delivered by a remote PMHNP.

Intervention Workflow

When an incarcerated individual is identified as experiencing suicidal ideation, acute psychiatric decompensation, or other high-risk mental health symptoms, the on-site nursing team initiates a standardized referral process. The referral includes relevant clinical history, current risk assessment findings, medication information, and security considerations. A secure, HIPAA-compliant telehealth platform is then used to connect the patient with the remote PMHNP, with the on-site registered nurse present to facilitate the encounter, support technology use, assist with any immediate safety needs, and ensure clear communication of the treatment plan back to the facility care team.

During the telehealth encounter, the PMHNP conducts a comprehensive crisis evaluation, performs or updates a structured suicide risk assessment, provides psychopharmacologic recommendations or adjustments as appropriate, engages in brief supportive or problem-focused psychotherapy, and collaboratively develops or revises a safety plan. The resulting clinical recommendations are documented in the electronic health record and communicated to the on-site multidisciplinary team for implementation and follow-up.

Key Stakeholders

- On-site registered nurses: Facilitate referrals, support video encounters, implement nursing components of the care plan, and provide continuity between telehealth visits.
- Remote PMHNP: Provides clinical oversight, crisis evaluation, psychopharmacology, psychotherapy, and safety planning.
- Facility administration: Supports policy alignment, resource allocation, and integration into standard operations.
- Information technology personnel: Ensure platform reliability, connectivity, and technical troubleshooting.
- Security staff: Coordinate safe patient movement and presence during encounters while maintaining institutional security protocols.

Setting and Population

Practice Setting

The project will be conducted in a medium- to maximum-security correctional facility with a population of approximately 1,200 incarcerated individuals. The facility will use a secure telehealth platform that supports real-time video encounters and will have on-site registered nurse staffing to facilitate visits and support continuity of care.

Population and Eligibility

The target population includes incarcerated adults experiencing acute mental health crises, suicidal ideation, or other high-risk psychiatric conditions that would traditionally prompt consideration of off-site transfer. Inclusion criteria are the ability to participate meaningfully in a video-based clinical encounter and informed consent. Individuals who are acutely violent, medically unstable in a manner requiring immediate emergency department-level care, or unable to participate in a video format will be managed according to existing emergency protocols and will not be enrolled in the telehealth pathway for that episode of care.

Barriers, Facilitators, and Mitigation Strategies

Successful implementation of telehealth in correctional settings requires deliberate attention to both barriers and facilitators (Edge et al., 2021; Williams et al., 2024).

Identified Barriers

- Security protocols: Restrictions on movement, device access, and the physical presence of technology can limit the feasibility and frequency of video encounters.
- Technology reliability: Inconsistent connectivity, equipment failures, or limited technical support within the facility can disrupt scheduled visits and reduce clinician and patient confidence in the model.
- Staff training and workflow integration: On-site nursing and security staff must incorporate new referral and facilitation processes into already demanding workflows.
- Privacy and trust concerns: Incarcerated individuals may have legitimate concerns about confidentiality, recording, or the presence of security personnel during sensitive mental health discussions.

Facilitators

- Existing on-site nursing presence that can support technology use and care coordination.
- Administrative interest in reducing high-cost, high-risk transfers and improving institutional safety.
- Alignment with NCCHC standards and broader system goals related to timely mental health care and suicide prevention (NCCHC, 2022).
- Growing evidence base and post-pandemic familiarity with telehealth modalities among clinicians and institutions (Tierney et al., 2023).

Mitigation Strategies

Barriers will be addressed through early and sustained collaboration with security leadership to develop clear protocols for device use and patient movement; pre-implementation technology testing and rapid-response IT support; structured staff education and competency validation for referral and facilitation processes; and transparent communication with patients regarding the purpose, privacy protections, and voluntary nature of telehealth encounters. A secure, HIPAA-compliant platform will be used exclusively, and encounters will be conducted in a manner that balances clinical privacy with necessary security oversight.

Ethical Considerations

The incarcerated population is recognized as a vulnerable group with heightened risk for coercion, limited autonomy, and disparities in access to quality care (Novisky et al., 2025). Ethical implementation of this project therefore requires deliberate safeguards that go beyond standard clinical practice.

All telehealth encounters will occur on a secure, HIPAA-compliant platform. Informed consent will be obtained prior to participation, with clear explanation of the voluntary nature of

the service, the limits of confidentiality inherent in the correctional setting, and the right to decline telehealth in favor of existing care pathways without penalty. Protections against coercion will be emphasized in staff training and patient communication materials. Equity audits will be conducted periodically to monitor for differential access or outcomes related to race, ethnicity, housing unit, or other relevant factors. All project activities will adhere to professional nursing standards and the ethical expectations outlined in the AACN Essentials for professional nursing education (American Association of Colleges of Nursing, 2021).

Implementation Framework and Timeline

The project will be implemented using the Plan-Do-Study-Act (PDSA) cycle as a continuous quality improvement framework. This approach enables rapid learning, real-time adjustments, and progressive process refinement throughout the 12-week pilot.

Project Timeline

Phase	Timeframe	Key Activities
Planning	Weeks –2 to 0	Stakeholder engagement; protocol finalization; staff training
		and competency validation; technology testing and platform optimization; baseline data collection
Implementation	Weeks 1–12	Active telehealth pilot; real-time referral and encounter tracking; weekly PDSA huddles; ongoing barrier monitoring and rapid-cycle adjustments
Mid-point Review	Week 6	Formal data review; process and outcome assessment; targeted protocol or workflow revisions; stakeholder feedback integration

Phase	Timeframe	Key Activities
Final Evaluation	Week 12 + 2	Comprehensive outcome analysis; qualitative data synthesis; stakeholder debrief; sustainability recommendations and formal handoff planning

Staff training will occur during the planning phase and will include education on the referral process, technology facilitation, suicide risk communication, documentation expectations, and ethical considerations specific to the incarcerated population. Competency will be validated through return demonstration and brief knowledge checks prior to go-live.

Evaluation Plan

A mixed-methods evaluation design will be used to assess both process and outcome measures, providing a comprehensive understanding of the model's feasibility, effectiveness, and acceptability.

Quantitative Measures

- Primary outcome: Number and rate of off-site psychiatric hospital transfers (pre- vs. post-implementation comparison).
- Process measures: Time from referral to PMHNP evaluation; referral completion rate; no-show rate; completion rate of structured suicide risk assessments and safety plans.
- Data sources and timing: Electronic health record (EHR) transfer logs, referral tracking tools, and crisis metrics will be extracted at baseline, Week 6, and Week 12.

Qualitative Measures

Semi-structured interviews will be conducted with participating nursing staff, security personnel, and, where ethically and logistically appropriate, a sample of patients who received telehealth services. Interview guides will explore perceived feasibility, acceptability, impact on

crisis management, workflow effects, and suggestions for improvement. Thematic analysis will be used to identify key patterns and actionable insights.

Analysis Approach

Descriptive statistics will summarize process and outcome measures. Pre- and post-implementation transfer rates will be compared to assess progress toward the 30% reduction target. Qualitative data will undergo thematic analysis. Findings from both strands will be integrated during PDSA cycles to support continuous refinement of the model.

Anticipated Results

Based on findings from systematic reviews and related telehealth implementations in correctional and safety-net settings (Edge et al., 2021; Hewson et al., 2024; Williams et al., 2024), the pilot is expected to achieve the following outcomes:

- 30% reduction in off-site psychiatric hospital transfers
- Crisis evaluation and PMHNP follow-up completed within ≤ 7 days of referral
- $\geq 85\%$ referral completion rate with $\leq 10\%$ no-show rate
- Improved crisis resolution rates and higher patient and staff satisfaction scores
- Increased completion of structured suicide risk assessments and safety plans

Cost and Resource Considerations

Off-site psychiatric hospitalization and transfer costs represent a substantial financial burden for correctional facilities. When security escort, transportation, and hospital care are included, average costs range from approximately \$2,400 to more than \$5,000 per episode. In contrast, telehealth platform licensing, equipment, and staff training costs are considerably lower, estimated at roughly \$50–\$150 per inmate per month depending on scale and vendor arrangements.

A 30% reduction in transfers is projected to generate meaningful monthly savings while simultaneously improving clinical outcomes and institutional safety. Break-even is anticipated within three to six months through avoided hospitalizations and reduced security expenditures. These projections support both the pilot's short-term financial viability and its alignment with longer-term value-based care principles.

Sustainability and Future Recommendations

Sustainability Strategies

- Conduct quarterly performance audits led by the PMHNP and nursing leadership team to monitor transfer rates, process metrics, and fidelity to the model.
- Formally integrate the telehealth model into standard facility operating procedures, policy documents, and orientation materials for new nursing and security staff.

Expansion Opportunities

- Scale the model across additional correctional facilities within the system, adapting protocols as needed to local operational contexts.
- Engage in policy advocacy to support sustained telehealth funding and to advance full practice authority for PMHNPs in Nevada, thereby strengthening the long-term workforce and regulatory foundation for similar models (American Association of Colleges of Nursing, 2021).

Clinical Implications for Advanced Practice Nursing

This nurse-led telehealth model positions the PMHNP as a leader in addressing mental health disparities and suicide prevention within correctional settings. By reducing high-risk and costly off-site transfers, enabling more timely crisis intervention, and delivering integrated psychiatric care, the model advances equitable, evidence-based practice and strengthens the

contribution of advanced practice nursing to underserved and justice-involved populations (American Association of Colleges of Nursing, 2021; Williams et al., 2024).

Beyond the immediate clinical benefits, the project demonstrates PMHNPs' capacity to design, implement, and evaluate system-level interventions that improve access, safety, and quality of care. It also illustrates the value of interprofessional collaboration—linking nursing, psychiatry, security, administration, and information technology—in solving complex care delivery problems. These competencies align directly with the expectations of graduate nursing education and the evolving role of the PMHNP in population health and health systems leadership.

Conclusion

The nurse-led telehealth model with PMHNP oversight represents a feasible, evidence-based strategy to reduce off-site psychiatric transfers and strengthen suicide prevention in correctional facilities. Through timely crisis response, structured risk assessment, and coordinated mental health care, the approach mitigates critical disparities, enhances institutional safety, and supports improved reentry outcomes. By integrating advanced practice nursing expertise directly into the correctional setting, the model also helps address psychiatric workforce shortages and promotes more consistent, high-quality care for a vulnerable population.

This Implementation Plan provides a detailed roadmap for executing, evaluating, and sustaining the pilot. If successful, the model offers a scalable and replicable framework that elevates the PMHNP's contribution to innovative, equitable mental health delivery and has the potential to inform broader improvements in carceral health systems.

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