

Understanding and Reducing Deaths in Custody

Case Study Report

Prepared for

Benjamin Adams, Program Manager
National Institute of Justice
Office of Justice Programs
U.S. Department of Justice

September 2024

RTI Project Number 0218273.000

Prepared by

Michael Planty
Duren Banks
Nicole Johnson
Zollie Saxon
Madison Fann
BeLinda Weimer
Kelsea Albertson
Melissia Larson
Michelle Casper
RTI International
3040 E. Cornwallis Road, PO Box 12194
Research Triangle Park, NC 27709
www.rti.org

Joe Russo
University of Denver
2199 S. University Blvd.
Denver, CO 80208

RTI INTERNATIONAL

Understanding and Reducing Deaths in Custody

Case Study Report

Prepared for

Benjamin Adams, Program Manager
National Institute of Justice
Office of Justice Programs
U.S. Department of Justice

Prepared by

Michael Planty
Duren Banks
Nicole Johnson
Zollie Saxon
Madison Fann
BeLinda Weimer
Kelsea Albertson
Melissia Larson
Michelle Casper
RTI International
3040 E. Cornwallis Road, PO Box 12194
Research Triangle Park, NC 27709

Joe Russo
University of Denver
2199 S. University Blvd.
Denver, CO 80208

September 2024

RTI INTERNATIONAL

This report is one in a series conducted for the National Institute of Justice (NIJ) Death in Custody Reporting Act (DCRA) Study under contract GS-00F-354CA.

Acknowledgments

This report is the result of an ongoing effort that has benefited from the assistance of many individuals. We would first like to thank study consultants Mr. Joseph Russo and Dr. John Shaffer for participating in site visits and interviews and contributing their expertise to improving the quality of this report.

Additionally, we would like to thank the staff of the National Institute of Justice (NIJ) who provided their attentive review and thoughtful feedback on this report. We would especially like to thank Benjamin Adams, who serves as the project monitor under Director Nancy La Vigne, for his continual guidance on this phase of the study and the study at large. Opinions or conclusions expressed in this paper are those of the authors and do not necessarily reflect the official position or policies of the U.S. Department of Justice. Any remaining errors or omissions within this report are the responsibility of the authors.

Finally, we would like to express our sincerest thanks to the many practitioners in the jails, prison systems, and law enforcement agencies who agreed to participate in the case studies, including Colorado Department of Corrections, Las Vegas Department of Public Safety, Pennsylvania Department of Corrections, Pitt County Sheriff's Office, Salt Lake City Police Department, Seattle Police Department, and Vermont Department of Corrections as well as one sheriff's office, one police department, and one prison system that wished to remain anonymous.

Table of Contents

RTI INTERNATIONAL

Tables

Executive Summary

Introduction

This report is part of the Death in Custody Reporting Act (DCRA) Study, which is designed to generate significant advances in the knowledge and understanding of deaths in custody and to develop recommendations that support efforts to prevent and reduce such deaths. The DCRA Study is conducted pursuant to the requirements set forth in the 2013 reauthorization of the DCRA (2013), which requires the Attorney General to conduct a study and submit a report to Congress to "(A) determine means by which such information can be used to reduce the number of such deaths, and (B) examine the relationship, if any, between the number of such deaths and the actions of management of such jails, prisons, and other specified facilities relating to such deaths" (see 34 U.S.C. § 60105 (f)(1)(A) & (B)).

All DCRA Study activities were conducted across three sectors in which adult and juvenile deaths in custody occur: law enforcement, jails, and state prisons. Each sector presents distinct causes and manners of death, and situational factors that demand different practices, policies, and solutions to reduce these deaths. This report describes results from the case study component of the DCRA Study. The goal of the case studies was to provide additional nuance and in-depth understanding to the findings from a national-level review of the prevalence and correlates of deaths in custody across the three sectors. The qualitative approach was designed to consider the importance of hearing directly from practitioners about their experiences and perspectives about the needs, challenges, and promising practices, programs, and policies that can prevent and reduce deaths in custody.

Methods

Site visits and interviews were conducted with 10 agencies across the three sectors from September 2023 through April 2024. A total of 89 interviews were conducted, including 22 interviews with law enforcement, 24 interviews with local jail personnel, and 43 interviews with state prison system staff. Practitioner roles varied by sector, but included command and agency leadership; medical, behavioral health and security staff; individuals responsible for policy, training, and quality assurance; and investigators, frontline supervisors, and custody staff. Interviews ranged from 45 to 90 minutes and all but one were audio-recorded with respondent consent. The interviews were transcribed, coded, and analyzed using NVivo 12 software.

The study team also collected and reviewed agency policies from each case study site that were relevant to the prevention or response to deaths in custody. For law enforcement, relevant agency policies included their use of force policies and death investigation policies. For prisons and jails, we reviewed policies related to common types of deaths in occurring in these settings and of practices that were raised by practitioners as beneficial. These included policies related to medical care provision, substance use and mental health screening and programs, and contraband detection.

Findings

Law Enforcement Arrest-Related Deaths

Across the interviews with law enforcement staff that participated in these case studies, common themes related to training, de-escalation, less-than-lethal tools and defensive tactics, medical first aid provisions, staffing, accountability, and the population served were identified.

- Respondents viewed clearly defined policies centered around de-escalation and a culture that supports de-escalation and training as critical. Delivering comprehensive, consistent, and scenario-based training was seen as important in preparing officers for different situations they may encounter in the real world. Trainings that teach verbal and physical de-escalation techniques, how to identify and respond to individuals of varied backgrounds or who may be in crisis, and first aid medical care as valuable parts of their curricula that can improve interactions with community members and lead to better outcomes were specifically mentioned.
- Respondents also viewed partnerships with social workers and other mental health professionals as force multipliers in connecting with individuals in crisis and resolving situations before they become critical.
- Strong accountability mechanisms, including early intervention systems, body-worn camera reviews, and oversight committees served an important role in holding officers accountable to policy and promoting continuous quality improvement of training and practice.
- Challenges identified by respondents included difficulties recruiting and training high-quality personnel who possess (or have the ability to develop) effective communication and other soft skills; engaging individuals experiencing homelessness or a mental health crisis or who are under the influence of substances; having adequate facilities and resources to provide the varied and consistent training to staff without compromising the ability to respond to calls for service; and ensuring that practice and training keep pace with the often frequent changes in law and agency policy.

All participating agencies have policies governing the use of force and on investigations of uses of force.

- Elements common to all three agency policies around use of force included the agency's principles related to use of force and an emphasis on "sanctity of life" or "preservation of life"; emphasis on de-escalation first and use of force as a last resort; guidance that force should stop once a situation is under control and on de-escalation tactics; levels and type of resistance officers may encounter; communication with persons of interest; directives on bystander intervention; authorized and unauthorized uses of force; guidance on provision of medical care; and required documentation, notification, and reporting requirements.
- All three agency policies included requirements for the investigation of nonfatal and fatal uses of force, including procedures to be followed by officers involved in the incident, parties who should be notified following the incident; relevant documentation to be

completed; investigative procedures and timelines to be followed; outcomes or results of the investigation; and requirements for annual internal reviews of use of force incidents.

Jails

Themes that emerged across the jail practitioner interviews included training, staffing, population served, suicide prevention, preventing intoxication deaths, medical care, and accountability.

- Jail practitioners discussed the immense value of consistent, realistic training in preparing jail staff for different situations or types of individuals they encounter. The types of trainings respondents mentioned that are especially beneficial include those related to the identification and awareness of individuals in mental health crisis or at risk of suicide; those that teach how to recognize signs of overdose or withdrawal; and those that teach more effective interactions between officers and persons of interest such as de-escalation and defensive tactics training.
- Respondents also discussed beneficial practices they engage in beyond training that helps prevent suicides, such as those that reduce the opportunity for self-harm (e.g., implementing suicide-resistant features in cells), robust identification and referral procedures, and ensuring officers conduct high-quality rounds.
- To prevent deaths related to intoxication, respondents noted that the jails also implement practices such as the use of detoxification cells and protocols, MAT, and screening for contraband to prevent drugs from entering the facility.
- The use of electronic health records was identified as a way to streamline classification and referrals and increase accountability.
- In the event that deaths or nonfatal critical incidents do occur in jails, respondents described formal investigations and incident reviews that often result in additional training on existing policy and practice.
- Practitioners also highlighted challenges they face that impact their ability to prevent and reduce deaths in custody, including difficulties with recruiting and retaining high-quality staff, and the growing mental health and behavioral health needs of the population in custody.

The document review identified similarities and difference regarding agency policies related to suicide prevention and the intake of intoxicated individuals.

- All agencies engaged in practices or had policies aimed at preventing suicide. Some common elements across the suicide prevention policies included protocols around intake and screening, processes related to mental health or medical referrals, procedures to place individuals under “suicide watch,” and guidance for staff on high-risk periods when individuals may be at a higher risk of suicide. Policy differences related to suicide prevention were mostly related to the level of detail included in the policy.
- Similarities in agency policy related to identifying and dealing with individuals suspected to be under the influence of substance or showing signs of withdrawal included calls for an initial screening at intake, requiring medical or clinical staff to be involved in the

screening process, and having individuals kept under close observation as dictated by medical staff. However, the specificity of the protocols varied by agency. For example, one or two but not all agencies included in their policies guidance around who should be notified about the individuals currently on detoxification protocol, how often medical staff should observe the individual, and how medical staff should administer medications.

Prisons

Interviews with respondents at state departments of corrections (DOCs) revealed several common themes and challenges, including staffing; facilities; providing medical care amid multiple challenges; improving response to emergencies; suicide prevention programs and practices; preventing intoxication deaths; and reviews and quality improvement.

- DOCs work to address staffing shortages through the use of agency or contract staff, recruitment and career development units, and incentives to compete with private companies.
- Challenges related to providing high-quality medical care included a lack of staff or resources and meeting the needs of an aging and sicker incarcerated population. Strategies to improve medical care included working to increase efficiencies in providing access to providers, tracking and monitoring healthcare delivery, providing preventive education to incarcerated persons on health and wellness, and implementing processes to help identify and improve practices.
- In addition to general medical care, DOC staff have also taken steps to improve response to emergency medical situations by implementing new policies, scenario-based training, and equipment.
- DOCs took specific steps to prevent suicide, including implementing screening and classification processes, implementing a variety of opportunity reduction measures, and working to improve mental health and wellness among incarcerated persons. Peer support/observer programs, therapeutic diversion units, high-quality/frequent rounds, housing practices, and improved environmental features were identified as key in preventing suicides.
- The DOC populations with substance use disorder are increasing resulting in challenges in preventing individuals from dying by intoxication or overdose. Key practices include reducing contraband through additional checks and using electronic mail services; treating substance use through MAT programs; and making overdose reversal drugs such as Narcan and related trainings readily available for staff.
- The DOCs noted that having robust review processes for deaths or critical incidents in place can help identify issues that can prevent similar incidents from happening in the future. However, the findings of these reviews may not always make it back to all relevant parties, and mechanisms to determine whether the findings are incorporated into practice, policy, or training are often missing.

The document review of DOC policies focused on those related to the use of telemedicine, peer support programs, and mail (as it relates to contraband interdiction).

- Two of the four DOCs had publicly available policies detailing their telemedicine program. Some of the common elements present in these policies include description of the responsible persons and staff who should be present during appointments and the documentation that is required; emphasis on continuity of care; and requirement that a patient's EHR is updated with appropriate documentation on the same day as the visit. The primary difference in agency policy related to the staff involved in appointments.
- Regarding peer programs related to mental health and suicide prevention, public-facing policies for the various programs were found at three of the four sites. Some of the common elements of these policies include requirements of an application process, training by staff before engaging in work, and documentation of activities and work performed. Differences in the level of detail provided across the sites was noted and included selection criteria, staff training and certification requirements, evaluation processes, program oversight structure, and reasons for dismissal from the program.
- Some common elements of the DOC mail policies included information on types of mail subject to search and review and guidance that legal or "restricted" mail has to be opened within the presence of the incarcerated person. There were differences in the procedures and level of detail provided in the policies, with only one or two agencies including protocols around photocopying mail; description of specific scanning technologies and when they could be used; and protocols around personal protection equipment that staff should wear when handling mail to prevent dangerous exposures to contraband.

Conclusions

Based on analysis of the 89 interviews we conducted, key themes emerged within each sector related to agencies' ability to achieve their missions and objectives while keeping the populations they serve—and their staff—safe and healthy. In addition, there were several cross-cutting themes that emerged consistently, including both challenges and facilitators in preventing or reducing deaths in custody.

- Some of the most consistent challenges across sectors include difficulties in recruiting and retaining high-quality staff and the negative impact staffing shortages have on daily operations and long-term preventive strategies. In addition, practitioners across sectors discussed a perceived increase in mental health, behavioral health, and physical health challenges among the justice-involved population, which adds further strain to their ability to deal with or care for individuals amid existing resource constraints.
- Common practices across sectors that may help prevent or reduce deaths in custody include having clear, easy-to-follow policies that are also readily accessible to staff when needed. Additionally, rigorous and consistent training tied to policy was touted by practitioners across sectors. Scenario-based trainings and trainings to enhance interpersonal and communication skills were specifically mentioned as beneficial in

preparing staff to respond effectively to critical incidents and communicating with community members and system-involved individuals. Practitioners also mentioned the value of interdisciplinary training for all staff, such as ensuring law enforcement and correctional officers are adequately trained in mental health and suicide awareness and that mental health practitioners are adequately trained in issues relating to security. Accountability mechanisms involving critical incident reviews and periodic assessments of relevant data were highlighted as beneficial in identifying gaps and recommending changes to policy, practice, or training for better future outcomes.

Although this report showcases the valuable perspectives of practitioners working in law enforcement, jails, and prison systems and provides important context to the challenges and successes they experience in working to keep their population well, the current study does not include other important perspectives that can provide added insight to these findings. Other perspectives include community members, impacted families, incarcerated individuals or other practitioners such as medical examiners. Although outside the scope of the current study, future work should incorporate interviews or focus groups with these other populations to provide additional context to the findings presented in this report. In addition to expanding the scope of data collection, the findings from the case studies revealed other opportunities for future studies, including research on the relative impacts of different trainings and training modalities that practitioners view as beneficial on deaths in custody; different oversight and accountability mechanisms and their impacts on deaths in custody over time; and the variety of programs, practices, and technologies used by criminal justice agencies to prevent or reduce deaths in custody.

1. Introduction

This report is part of the Death in Custody Reporting Act (DCRA) Study, which is designed to generate significant advances in the knowledge and understanding of deaths in custody and to develop recommendations that support efforts to prevent and reduce such deaths.[1] In the context of law enforcement, the scope of these deaths include "any person who is detained, under arrest, or is in the process of being arrested" during an interaction with law enforcement (i.e., arrest-related deaths), not only deaths occurring after an individual has been officially taken into custody. Furthermore, any individuals in custody of a jail or prison system who die are reportable under DCRA, even if the death did not occur within the confines of a detention facility (e.g., deaths occurring in transport or at the hospital). The DCRA Study is conducted pursuant to the requirements set forth in the 2014 reauthorization of the DCRA (2013), which requires the Attorney General to conduct a study and submit a report to Congress to "(A) determine means by which such information can be used to reduce the number of such deaths, and (B) examine the relationship, if any, between the number of such deaths and the actions of management of such jails, prisons, and other specified facilities relating to such deaths" (see 34 U.S.C. § 60105 (f)(1)(A) & (B)).

All DCRA Study activities are organized by the three main contexts in which deaths in custody occur: law enforcement, jails, and state prisons.[2] Each context presents distinct causes and manners of death, and situational factors that demand different practices, policies, and solutions to reduce these deaths. The scope of this effort is a mixed-methods design that included two phases: (1) a national-level review of the prevalence and correlates of deaths in custody within the three sectors[3] and (2) case studies with select law enforcement, jail, and prison systems. This report describes results from the case study component of the DCRA Study. RTI International conducted case studies with 10 law enforcement agencies, jails, and state prison systems across the United States. The goal of the case studies was to provide additional nuance and in-depth understanding to the findings outlined in the national-level review (Phase 1). The qualitative approach was designed to consider the importance of hearing directly from practitioners about their experiences and perspectives about the needs, challenges, and promising practices, programs, and policies that can prevent and reduce deaths in custody. It allows practitioners to speak candidly and drive the conversation to issues closest to their roles and responsibilities.

[1] The DCRA requires that states "report to the Attorney General information regarding the death of any person who is either; detained, under arrest, in the process of being arrested, en route to be incarcerated, or is incarcerated at a municipal or county jail, state prison, state-run boot camp prison, boot camp prison that is contracted out by the state, any state or local contract facility, or other local or state correctional facility (including any juvenile facility)" (BJA, 2022).

[2] This report focuses primarily on the programs, practices and policies that criminal justice practitioners engage in to prevent or reduce adult deaths in custody. Although the law enforcement agencies we spoke to can interact with adult and juveniles, the jail and prison systems we engaged with oversaw adult corrections.

[3] Understanding and Reducing Deaths in Custody: Interim Report, https://www.ojp.gov/pdffiles1/nij/309441.pdf

2. Methods

The study was designed to select up to 10 agencies across the three sectors. This limited sample was driven primarily by available resources and concerns about timeliness, knowing that selecting a larger, more representative sample would be cost-prohibitive. To the extent possible, we selected case study sites to present a diversity of agencies in terms of population size, region, and agency size.

2.1 Recruitment of Case Study Participants

2.1.1 Agency Selection

Practitioner interview recruitment started with our initial agency outreach. The goal was to identify and recruit 10 agencies (consisting of a mix of DOCs, jails, and law enforcement agencies) to participate in the case studies. RTI leveraged subject matter experts serving as consultants to this project to identify agencies currently engaging in or looking to engage in practices geared toward reducing or preventing deaths in custody. Agency outreach involved contacting agencies directly at the recommendation of the study consultants, representatives of professional organizations, or other knowledgeable individuals. In the initial contact and recruitment efforts, project staff described the study and data collection activities involved in the case study. Anticipating a certain level of nonresponse, the team reached out to a larger pool of 30 agencies. Some of the reasons cited by agencies that declined to participate included busy schedules or recent incidents that prevented their commitment to the study. If the agency agreed to participate, project staff worked with the agency to identify a point of contact who could assist with recruiting and scheduling relevant agency staff for an interview. We conducted in-person site visits with most agencies, except for one agency where it was not feasible due to agency staff scheduling concerns and staff interviews were conducted virtually. The site visits were conducted by two to four RTI project staff. The 10 agencies that ultimately agreed to participate in a case study for this project were diverse in several metrics, including size and geographic region (**Table 1**).

2.1.2 Practitioner Characteristics

The final qualitative interview sample consisted of 89 interviews conducted within 80 sessions across law enforcement, jail, and prison sectors. Collectively, we conducted 18 interview sessions across the three law enforcement agencies, 23 interview sessions across the three jail agencies, and 39 interview sessions across four state prison systems. Most interview sessions were conducted with a single interviewee, although some included multiple respondents.

Practitioner roles varied by each sector (**Tables 2** through **4**). For law enforcement, we interviewed command staff and other agency leaders; individuals in charge of policy, training, and investigations; front-line supervisors; and personnel tasked with investigating officer use of force and other critical incidents.

Table 1. Select Characteristics of Case Study Sites

	Case Study Sites									
	Law Enforcement			Jails			State Prison Systems			
	Site 1	Site 2	Site 3	Site 1	Site 2	Site 3	Site 1	Site 2	Site 3	Site 4
Size (No. Staff)	501–1k	501–1k	<100	501–1k	250–500	100–249	>10k	501–1k	>10k	5k–7.5k
Region	NW	West	NE	South	SE	West	SE	NE	NE	West
Incarcerated Population	–	–	–	501–1k	400–450	450–500	>25k	501–1k	>25k	15k–20k
Jurisdiction Size	>700k	100–250k	25–30k	>1m	150–175k	500–700k	–	–	–	–
No. Interviews	5	7	6	7	8	8	7	13	9	10

NW = northwest; NE = northeast; SE = southeast. Although two jails had law enforcement functions, staff interviews focused primarily on detention function. Jurisdiction size = population served.

Table 2. Law Enforcement Respondent Roles

Law Enforcement Roles	No. of Respondents
Officers/Investigators	2
Sergeant	4
Lieutenant	7
Captain	5
Administration*	4
Total	22

*Includes Deputy Chiefs, a Bureau Chief, and a Director of Internal Affairs. Total reflects 22 respondents interviewed across 18 meetings.

For jails, we interviewed individuals in leadership positions, those in charge of security, medical care and provision, classification, training, programming, and policy.

Table 3. Jail Respondent Roles

Jail Roles	No. of Respondents
Security/law enforcement	4
Investigations	1
Medical	3
Mental/behavioral health	2
Classification	2
Policy	3
Programming	1
Training	3
Administration*	5
Total	24

*Includes Chiefs, Deputy Chiefs, and a Commander. Total reflects 24 respondents interviewed across 23 meetings.

For prison systems, we also interviewed a range of individuals tasked with facility security and those in charge of providing medical and mental/behavioral healthcare (e.g., substance use disorder treatment) for incarcerated individuals. At the agency level, this included directors in charge of mental and behavioral health, medical care, training, policy, and accountability and quality assurance. We also interviewed staff at specific prison facilities, including superintendents, healthcare providers, and custody staff.

Table 4. Prison System Respondent Roles

Prison Roles	No. of Respondents
Security	5
Investigations	4
Medical	7
Mental/behavioral health	7
Operations	2
Policy	3
Training	4
Quality improvement	4
Data and reporting	1
Administration*	6
Total	43

*Includes a Commissioner, Secretary, Deputy Commissioner, and Superintendents. Total reflects 43 respondents interviewed across 39 meetings.

2.2 Conducting Semi-structured Interviews

Because we intentionally recruited practitioners from a wide range of roles and responsibilities, we created semi-structured interview guides to help guide the conversation toward different topics. We derived interview topics primarily from the literature review and secondary analysis conducted in Phase 1. The intent was to be sure we touched on all relevant topics but also allow the participant to drive the conversation toward topics they felt were most impactful and important to their role. We created two guides—one for law enforcement and one for jails and prisons. This was based primarily on their roles related to patrol and detention function, but we recognized that many sheriffs serve both functions and allowed for this overlap. Consultants with expertise and practitioner experience in either law enforcement or prison operations reviewed both guides.

Each interview was conducted with at least two members of the research team. Interviewees were asked to provide insights from their work experiences. The interview covered topics such as the respondents' experiences and perceptions of the common causes and correlates of deaths in custody within their agency and programs, policies, practices, and trainings their agency engages in to prevent or reduce different types of deaths in custody. Respondents were also asked to elaborate on challenges their agency faces, in addition to highlighting successes or best practices they engage in that are relevant to deaths in custody. Because of the variety of interview respondents' roles and responsibilities, not all questions in the semi-structured interview guide applied to each practitioner. Interviews ranged from 45 to 90 minutes. All interviews were audio-recorded with respondent consent except one interview in which the

respondent elected not to be recorded. In that case, the interview notes were analyzed instead. All interviews and site visits took place between September 2023 and April 2024.

2.3 Analysis of Qualitative Interview Data

Following each interview, the research team debriefed on major themes and issues that surfaced during the interviews. This allowed the team to adjust the protocol and interview guide. For all interviews, we considered information saturation at the individual, agency, and sector levels. Saturation is the point at which the information collected through interviews becomes repetitive and no new themes are identified. Although the number of agencies and the number of individuals interviewed were both limited by the project's design and funding levels, saturation was reached across each sector. Overall, similar themes and concepts were raised across the agencies within each sector, with only some unique differences emerging. Many of these differences were site-specific programs or initiatives the agency implemented such as a specific de-escalation training program or a peer support program. In addition to themes, quotations from practitioners for each theme were captured that offer personal insight and perspectives.

Six project team members transcribed and coded the qualitative interviews using NVivo 12 transcription and analysis software. Following each site visit, the audio recordings were transcribed and reviewed for accuracy. The six members of the study team then coded the cleaned transcriptions in NVivo using tags from a codebook. The codebook was created in stages. Similar to the separate interview guides, we produced two separate codebooks for law enforcement and corrections (jail and prison sectors) to capture the differences in function (patrol versus detention) and situations in which deaths in custody most frequently occur. These codebooks were developed prior to coding based on the interview guides and findings from Phase 1. After beginning the coding process, we adjusted the codebooks as needed when new codes emerged. The coding process involved sections of text tagged with short, descriptive codes or labels based on the discussion. This enabled coders to classify, sort, and analyze recordings into larger themes (e.g., staffing, training, medical). Beyond substantive codes, such as "staffing" or "death investigations," codes were also created to capture when practitioners were discussing "challenges" or "successes" related to different issues or practices they engaged in. These latter codes were applied through double-coding sections of the interview such that querying NVivo on text relating to "staffing" and "challenges" would yield interview sections about challenges related to staffing. To ensure the project team was aligned on the definitions of each code and how they would apply it to text, the task lead led an initial training that required each team member to code the same set of interviews separately. The coders then debriefed to discuss issues with code clarity, come to a mutual understanding of each code, and provide suggested revisions to the codebook. Based on the task lead's review of the coded output by the team members, there were no significant discrepancies among the coders on the application of specific codes. Following this initial training, each coder was assigned a series of interviews to code. The coding team met weekly to discuss questions that came up during the coding process and emerging themes. Once all interviews had been coded and common themes had been identified by the project team, the interview text associated with the codes corresponding to each theme were exported from NVivo and analyzed and organized into

the following discussion. Findings are organized by sector (i.e., law enforcement, jails, and prisons). As noted in Section 5, one prison case study site oversaw confinement of individuals incarcerated in both prison and jail. In this site, the findings from the qualitative interviews were included in the prison section only.

2.4 Document Review of Agency Policies

The study team also collected and reviewed agency policies from each case study site that were relevant to the prevention or response to deaths in custody. For law enforcement, relevant agency policies included their use of force policies and death investigation policies. For jails and state prison systems, we reviewed policies related to common types of deaths in occurring in these settings and of practices that were raised by practitioners as beneficial. These included policies related to medical care provision, substance use and mental health screening and programs, and contraband detection. We extracted relevant pieces of the policies for comparison across sites. Specifically, this first involved coding the type of policies each agency had in place. Then, two reviewers reviewed relevant policy text for similarities and differences across agencies[4] in key terms, populations affected by the policy, procedures, and requirements. Throughout our discussion of findings in the next sections, we discuss some of the differences and similarities in some policies as applicable.

[4] Policies were compared across relevant agencies within sector, so law enforcement agency policies were compared with each other, DOC policies were compared with each other, and jail policies were compared with each other.

3. Law Enforcement

As of 2018, there were an estimated 17,500 state and local law enforcement agencies in the United States. These agencies vary in their organizational structures, size, and responsibilities and include sheriff's offices, local police departments, state law enforcement agencies, Tribal agencies, and constables or marshals (Gardner & Scott, 2022). Between 2013 and 2016, the count of arrest-related deaths increased, but most law enforcement agencies in the United States had no arrest-related deaths (RTI International, 2024). The most prevalent manner of arrest-related deaths is an officer-involved shooting, followed by vehicle-related death and less-than-lethal weapon use. The prevalence of arrest-related deaths varies across different demographic populations and agency characteristics. To understand practitioner perspectives around the prevention or reduction of arrest-related deaths, we conducted 22 interviews over 18 sessions with a range of staff at three law enforcement agencies of varying sizes and in different regions of the United States. Although the agencies differed in size, location, and issues they face in their communities, several themes that were common to all three agencies emerged from our conversations. The following section describes these seven common themes: training, de-escalation, less-than-lethal tools and defensive tactics, medical first aid provision, staffing, accountability, and population served.

3.1 Theme 1: Training

Respondents across all agencies discussed the importance of training in ensuring officers were well-equipped to manage a variety of critical scenarios in the field. They discussed several key issues related to training, including comprehensive training and scenario-based exercises. Additionally, respondents stated that having the proper resources and access to state-of-the-art facilities was critical to successful training programs and participation. Overall, the three agencies were aligned on the need and perceived value of providing high-end comprehensive and applied training to prevent excessive uses of force or officer-involved deaths.

Comprehensive Training that Teaches Frequently Needed Skills

Respondents in leadership positions within their agency suggested their respective agencies sought to provide a well-rounded training curriculum to their personnel, explicitly mentioning trainings with a focus on de-escalation, mental health, and use of less-than-lethal tools. For instance, leadership discussed incorporating crisis response training into their annual requirements and integrating crisis response components into other trainings as an important part of ensuring officers know how to respond to someone in mental health crisis. Other agency supervisors and line staff also noted the value of a diverse training curriculum, emphasizing de-escalation and communication skills training, defensive tactics, and bystander intervention training as important in preventing excess use of force or deaths. A common perspective that emerged was that training should reflect the skills most needed in everyday police work. Skills such as verbal de-escalation or communication skills and defensive tactics were seen as frequently used in the field but not as frequently trained as firearms skills. For example, a patrol

officer in one agency described how he was working on getting the agency to implement a Brazilian jiu-jitsu–based defensive tactics training program because he saw this as a gap.

> "So for police, you're mandated twice a year to qualify shooting, right? Which that's important. You need to know how to shoot just in case you're involved in that type of incident. But there is no mandate for defensive tactics, which you're more likely to get into a physical confrontation with someone than a shooting incident with someone."—Respondent 67, Officer/Investigator

A review of agency policies showed that all three agencies required their officers to complete similar basic and in-service trainings on firearms, less-than-lethal weapons and defensive tactics, use of force and de-escalation, mental health, emergency medical response, and incident reviews.

Scenario-Based Training

In addition to the value of a comprehensive training curriculum that focuses on everyday skills, respondents also noted certain modalities of training as more conducive to retaining and translating these skills to the field—particularly scenario-based trainings where officers are able to actively apply skills they have learned to realistic real-world situations. These interactive, immersive training exercises were viewed as more useful than written, computer-based, or classroom-based trainings. All agencies implemented scenario-based training in some form. One Captain described how his agency incorporated mandated crisis response training into existing scenario-based training rather than relying on PowerPoint presentations to teach officers how to recognize different forms of mental illness and how to respond to these cues.

> "I'm not a fan of PowerPoint or you know, the learnings are fine for certain things, but when you're talking about actually being able to learn to use a skill, I don't think it's as effective…so to have another course where you're going to tell me about different forms of mental illness and how they might manifest themselves and how you might interact with them. It's informative, but it's not skill based. And so, we decided to integrate that into all of our scenarios…most of them have a CIT [crisis intervention training] component, where they're supposed to use the skills that they've been taught."—Respondent 9, Captain

Respondents believed that situating skills training within real-world situations allowed officers to contextualize and apply the skills as they learned them, as opposed to a more passive learning approach. A Deputy Chief in another agency noted a similar approach their agency takes to developing scenarios to train rather than relying on written materials.

> "We're constantly sending people out for specialized training, training our own officers to then train within our department, and then pretty much coming up with reality-based scenarios that we put our officers through, not just 'here, read this article,' like this is what happened, and we try to do it from every angle."—Respondent 68, Deputy Chief

Respondents in other agency roles echoed the utility of scenario-based training. For example, personnel in charge of policy development noted that scenario-based training was helpful in ensuring officers better understand the nuances of different policies and how they should be

applied in practice. Additionally, personnel in charge of training said that ongoing, scenario-based trainings were critical for building officer confidence, proficiency, and adaptability and enhancing decision-making capabilities under pressure.

Respondents in all three agencies noted specific technologies as facilitating the delivery of scenario-based trainings. Respondents discussed using real incidents, particularly from body camera footage, in developing training scenarios. In one agency, officers review video footage of incidents occurring with other departments or within their own department and discuss what, if anything, could have been done differently to produce better outcomes. In addition to body-worn camera footage, two agencies had integrated virtual reality (VR) into their training as a mechanism to enhance skills development and increase retention. One Captain who was initially skeptical of VR's ability to train "skill-based" techniques noted that "one of the things that sold me on [it] is that you actually retain [information]." (Respondent 9). Another officer who was in charge of training in a different department discussed that although he did not think that VR training translates perfectly to real life, there is value in the tool to help younger officers practice their communication and decision-making skills in a controlled environment before facing real situations.

> "VR is a good tool…to bring [younger officers] in a controlled environment and start to really like, 'Okay, it's not a real person but let's practice on how you communicate. What are you seeing? What would you do? You see something like that, how could you overcome that? What contingency should there be?' I think it's really good for that."—Respondent 16.2, Lieutenant

Similar to stressing the importance of scenario-based training, other opportunities to gain experience and exposure to different aspects of policing were described as important in developing the necessary skills for the job. Unfortunately, the COVID-19 pandemic stunted some of the exposure that new recruits have historically received during field training. In at least one agency we interviewed, many policing activities that bring officers in contact with people (including vehicle and pedestrian stops) were scaled back to mitigate the spread of the virus. Therefore, recruits who were trained during this period did not engage in these and other activities that involved interfacing with the public as normal. The agency reported difficulties with newer recruits adapting to standard policing activities as social distancing rules loosened. Partly as a response to this challenge, this agency decided to increase their required field training hours from 500 to 800 hours. This shift was designed to prepare new recruits more fully by giving them more time to gain supervised experience, develop core skills, and become more comfortable before going into the field on their own. A Captain in the department described their field training approach as phased, where new recruits are gradually given more responsibility and autonomy.

> "Phase one is basically you're sitting in the passenger seat and you're watching everything for several months…then we start giving you more things when you're under intense supervision. And then the last phase is where...you're still being supervised but we're not really giving you the answers anymore."—Respondent 65, Captain

In addition to the extensive field training new recruits receive, the agency also requires their recruits to gain exposure to different units within or external to the police department, such as dispatchers, who they will work with on a daily basis as they respond to calls for service. Exposing recruits to the work of radio dispatchers was viewed as a valuable way to understand what questions they need to ask to better understand and tailor their response to situations appropriately.

> "When they come out of the academy, we send them over to the central communications....They do eight hours of training over there to find out how their process works for them. That kind of gives them one side of the information that they're getting…it kind of works to respect what [dispatchers] do, but also to respect that they have a lot going on over there. And we can't just rely on what's being said, and they need to actually ask more questions"—Respondent 69, Lieutenant

Trainings Highlighted by Law Enforcement Practitioners

Law enforcement respondents across multiple ranks described **scenario-based trainings** that teach skills in the following topics as especially valuable in preventing arrest-related deaths:

- De-escalation
- Communication
- Mental health awareness
- Defensive tactics

Resources and Support for Training

Respondents from across the three agencies discussed the importance of having necessary resources and supports available for training. The agency leaders we interviewed noted that staffing and resource constraints posed the primary challenge in training staff rather than leadership will or agency culture. One Deputy Chief described the value of training in their department as percolating from the top down, noting "our Chief is extremely supportive, and he has instilled upon our command staff how important [training] is. And yes, there is 100% support. If we can get it done, we're getting it done." (Respondent 68). In agencies where there is adequate support from leadership, the limiting factor is ensuring there is enough coverage on the street. A Deputy Chief at another department echoed this challenge of balancing the desire to ensure staff receive consistent training while maintaining appropriate staff on the street.

> "I think people expect an amount of training that agencies…simply cannot provide because of staffing levels. Even if we were fully staffed, most agencies in America, at least in my experience, are staffed at a level just to be able to keep up with calls for service, and even that's a little bit of a stretch…if the United States is serious about increasing officer training, they need to heavily invest in staffing for agencies to be able to pull people off the line on a regular and consistent basis and not have [a] negative influence on their core duties at the same time."—Respondent 13, Deputy Chief

Other respondents also described how staffing and resource constraints pose issues when agencies are required to retrain officers. For example, one Sergeant in charge of policy at their agency described how they have to retrain new recruits on their agency's policy, as the training

at the State Academy is viewed as being at odds with that of the police department. Retraining new recruits ultimately added to resource constraints.

Apart from constraints posed by staffing levels, having high-quality facilities in which to train was described as beneficial and possibly incentivizing to agency staff. Multiple respondents in one agency described their training facility as in need of updating, which they felt was a reason some officers were reluctant to work out or train in the facility. As one Captain noted, “If you see our facilities, they are in dire need of a lot of either TLC or a total makeover.” They further surmised that “some officers who are reluctant to train in defensive tactics or ground fighting may be less reluctant if the facilities had nice bathrooms and the mats were really nice and fresh and the equipment was good” (Respondent 15).

Respondents across the three agencies agreed that training was a vital part of preventing excessive use of force or death. In particular, ensuring staff have consistent training between the academy and the agency, adequate field training, and comprehensive and routine scenario-based training for various encounters they could face may improve their confidence and ability to navigate different scenarios and reduce their likelihood of using excessive or lethal force.

3.2 Theme 2: De-escalation

Across all agencies, respondents described de-escalation as an overarching goal of use of force policies and training and, ultimately, officer interactions with the communities they serve. Law enforcement personnel consistently cited the value of clear de-escalation policies and training on using de-escalation principles and skills to prevent excessive uses of force or deaths. Some respondents described de-escalation as part of their agency’s culture and at the core of their deployment model. Indeed, all agencies participating in these case studies emphasized de-escalation within their use of force policies.

De-Escalation Defined

De-escalation is defined as slowing situations down to allow for more time, more space, and more resources (e.g., officers) to address situations where a strong danger element is not immediately present.

These are situations when an officer may have encountered an agitated person or one in crisis and does not force an immediate reaction or response from the individual.

See more information here: National Consensus Policy and Discussion Paper on Use of Force

Respondents and their respective agencies’ use of force policies highlighted aspects of de-escalation, including “slowing down” the response to incidents, allowing for “more space” between officers and persons of interest, and providing time for “more resources” (e.g., more officers or mental health professionals) to respond to the incident. Agency leaders who were asked how they try to prevent officer-involved deaths spoke about the value of “taking a step back” in volatile situations, coupled with training on how to identify cues of mental illness or medical distress.

> "There's a lot of different things that could be going on at the same time. They could have some mental health issues that they're dealing with. So, we teach our officers to try to step back, assess the situation, and that's also what we incorporate in our training."—Respondent 68, Deputy Chief

> "Started teaching people different forms of de-escalation, because everybody thinks it's verbal, but slowing things down, getting more resources to the scene. And that was something that I felt was really novel is the idea of slowing something down, so that you have time to engage in communication, have time to get additional people there, maybe CNT [Crisis Negotiation Team], now we have MHPs [Mental Health Professionals] that may respond."—Respondent 9, Captain

Respondents spoke about specific trainings they receive that teach or promote de-escalation tactics. Officers in all three agencies are required by policy to intervene in excessive uses of force by other officers. One officer spoke of his experiences using bystander intervention training, which teaches law enforcement officers how to effectively intervene in interactions between other officers and persons of interest, in the field when he sees other officers becoming too heated.

> "So, I've had it multiple times where an officer is yelling at an individual and I had to step in front of him…it gives them a chance to cool down...if we see somebody is getting too heated like [with] a suspect…or we think it might escalate to a certain point, we just prefer them to go over there, 'I got it.' And we just handle the situation."—Respondent 67, Officer/Investigator

Trainings that Incorporate De-escalation Tactics

Practitioners discussed several trainings designed to teach de-escalation skills and tactics or that incorporate elements of de-escalation into the training. Some examples include the following:

- Integrating Communication Assessment and Tactics (ICAT)
- Crisis Response and Intervention training
- Bystander intervention trainings (e.g., Active Bystander in Law Enforcement [ABLE] training, Ethical Policing is Courageous [EPIC] training, and Ethical Protector training)

Despite the generally positive perception of these trainings, some respondents noted initial challenges with officer buy-in to new ways of doing things, which can ultimately complicate an agency's de-escalation goals until there is sufficient buy-in from supervisors and front-line officers.

> "At first it was a lot of the challenges where people [were] not taking it seriously. You know, the old boy mentality like, 'you can't tell me what to do.' Cops don't like change. So any time you tell them to stop doing something that they've been used to doing for 15 years, and they change it around, that was a huge challenge. But now it's more at this point… it's not going away, so it's better to just accept it and embrace it. And it's better in the long run."—Respondent 70, Sergeant

Improving Communication, Soft Skills, and Cultural Competency

Multiple respondents mentioned ensuring that officers are equipped with communication skills (e.g., verbal de-escalation skills or "verbal judo," which is using effective and engaging verbal techniques to persuade another to comply), along with an ability to communicate with individuals from diverse backgrounds effectively.

Respondents from one agency described using verbal persuasion and Listen and Explain with Equity and Dignity (LEED) techniques to resolve incidents without resorting to force.

> "So, we look at verbal persuasion, LEED techniques, time, distance, and shielding…If we know where you are, and you are not threatening anybody else, do we have to rush it? No, we can take 15 minutes and discuss it."—Respondent 8, Lieutenant

Listen and Explain with Equity and Dignity Defined

LEED represents the four pillars of procedurally just policing. LEED includes techniques, such as verbal persuasion, that focus on gaining voluntary compliance, and are designed to help resolve incidents without resorting to force.

For more information see https://www.ojp.gov/pdffiles1/nij/248654.pdf

Multiple respondents noted the need for effective communication skills among younger officers. Some respondents described younger officers as having challenges with communicating effectively. The examples provided by respondents included officers not making eye contact with persons, speaking in a disrespectful tone, or repeating commands rather than explaining requests. Many respondents suggested that this perceived shortcoming could lead to more friction between younger officers and the persons with whom they interact, which could also lead to poorer outcomes. For example, one Sergeant described how social skills and immaturity among officers are among the biggest challenges he sees related to de-escalation.

> **"**A lot of our problems are with maturity. And another part is that I'm also on our force review board, so I see a lot of these things with our newer officers…I see it as officers not having the ability to communicate. They have no ability to, like when I'm speaking to you, I'm making eye contact. They don't get it.…They'll look straight at the ground, they'll stare off, they don't realize that sometimes that can irritate a person that's in crisis, that they want attention, they're feeling like, hey, you're just freaking ignoring me and just doing your own thing. Just going through the motions."—Respondent 10, Sergeant

Another respondent noted a similar challenge with training younger officers in soft skills.

> "There's a different learning curve at this point with the younger generation coming up. I've noticed and it has a lot to do with social interaction... Not that they don't have them [skills] at all, it's just different for them to get comfortable, knowing what they [have to] say and how to get the information and then being in charge when they have to."—Respondent 70, Sergeant

Beyond generally improving communication skills among younger officers, increasing officer awareness and exposure to the diverse cultures within their communities was viewed as a way to improve interactions with people of different backgrounds. Officers specifically cited the value of working within a jail or prison to develop communication skills, diversifying the police force, and implementing a community awareness training to create more cultural awareness.

> "We bring in recruits 45 days early, before they start the academy, and we put them through community awareness type curriculum. It's community centered. People from the community come in and give their perspective…The goal is to help [recruits] to see people as people and to understand that people have different perspectives based on their experiences and how they interact with them."—Respondent 9, Captain

Clarity of Policy

Respondents in policy development roles mentioned the importance of clarity relates to de-escalation policy, including step-by-step guidance that emphasize the aspects of de-escalation that can make it simpler for officers to follow.

> "We really spell it out in what we want from our officers in terms of de-escalation…just because you're saying, 'hey, drop your gun, hey, drop the gun', that's not de-escalation. We identify in our policies problems where officers are speaking over each other. We put all of that basically step by step in our policy to illustrate that not only is it verbal, but we also use time, distance, shielding."—Respondent 10, Sergeant

The same respondent also noted that the way their policies are organized carries through to their training and makes it easy to follow for officers, which could in turn make it easier for them to understand and adhere to policy.

In sum, all agencies we spoke to prioritized de-escalation training and principles and ultimately believed there is value in slowing down, taking a step back, and assessing the situation when possible to avoid excessive or lethal use of force. Some respondents in leadership positions acknowledged that de-escalation was not a panacea, nor was it possible in every situation, with one Deputy Chief noting that "some people simply will not be de-escalated and sometimes force is needed to protect not only the officer or innocent people or even the individual and sometimes that has negative outcomes. It's just the reality of use of force" (Respondent 13). As another Deputy Chief put it, "you're not going to win in every situation. Unfortunately, sometimes there will be an in-custody death. But if you can prevent it by not just jumping the gun and just tackling somebody right away when you can try to evaluate the whole situation before that, it's important" (Respondent 68).

3.3 Theme 3: Less-Than-Lethal Tools and Defensive Tactics

Less-Than-Lethal Tools

The agencies we spoke to equip their officers with similar tools designed to administer less-than-lethal (LTL) force, including conducted energy devices (CEDs), oleoresin capsicum (OC) spray, and batons. Two of the larger agencies we spoke to also use 40 mm less-lethal

launchers and beanbag shotguns. When circumstances allow for it and it was deemed necessary (e.g., coming to a scene with an agitated individual holding a knife or other weapon), tools that provided officers with the ability to keep more distance between themselves and the persons with whom they were interacting were viewed more favorably.

CEDs

Most respondents agreed that the CEDs, also known commonly by the brand name TASER®, were the most frequently used LTL tool after efforts to de-escalate a situation have failed. Some respondents revealed that their agency had recently purchased the TASER 10, which they perceived would be helpful in certain cases where they needed such distance to defuse a situation because of its longer reach and multiple contact probes.

> "We recognize that the more distance we can get in some situations, the less likely we're going to have to use heavier force on individual. And so that was one of the things we looked at and we went to the Taser 10…It's a less lethal weapon that in some cases can help us, especially where we need that distance, but still engage someone, you know, if they're either suicidal or homicidal or whatever the situation is."—Respondent 17, Lieutenant

However, multiple respondents noted the unreliability of CEDs and cited a success rate of somewhere between 30%–60%. One reason provided for this unreliability is the heavy winter jackets or thick layers that people wear in colder climates, making it difficult for CEDs to make direct contact.

> "Saying you have to get 12 feet away from a person with a knife to do anything…that's too close because they can attack and kill you before you can do anything. And a [CED] is 50%...41 to 51% is what we averaged over the years. So, you're letting somebody get close enough to stab you, with a tool that only works half the time. That's not really a good situation."—Respondent 9, Captain

> **"**The [CEDs] are changing so quickly and the technology is changing so quickly that it's hard for me to even say that is a reliable piece of equipment…if I had to guess, maybe a 50% success rate. We're in [City], it's cold, its winter, everyone's wearing winter jackets. So, the [CED] is rendered useless pretty much."—Respondent 15, Captain

In light of the variable success rate, respondents claimed that officers, particularly newer officers, tended to over-rely on these tools.

> "I've seen it more with newer officers…they really rely on [Tasers] more so than, because like in training, you shoot someone with a Taser, they go down. So, when you shoot someone with a Taser and they don't go down, [officers] don't know how to react to that…So, it's getting them in positions where they're trusting the less-lethal more than they probably should."—Respondent 14.2, Sergeant

Baton

Baton use was consistently rare across all agencies according to respondents. Respondents cited agency culture, a perceived lack of utility, and negative public perception as possible reasons for their lack of use.

> "I'm also not a fan of batons. I just have not had much success using them. And in reviewing force, I haven't seen where they've been successful. Especially the expandable batons."—Respondent 9, Captain

> "[Force using expandable batons] always looks terrible. Always."—Respondent 15, Captain

OC Spray

Officers also mentioned the infrequent use of OC, or pepper spray, given the collateral and lasting impact on officers who are deploying it.

> "It's used, but it's not used a whole lot. It gets really messy. I always get sprayed. 100 percent of the time…it's used but it's not frequent."—Respondent 9, Captain

> "We obviously offer it as a tool. Our officers use it. They can have it on them. I think the trend just over the years, I've been here 18 years, when I was in a patrol operational setting, I never used my pepper spray. I've used Taser a few times, but just choosing tools, you kind of go away from the pepper spray."—Respondent 17, Lieutenant

40 mm Less-Lethal Launcher and Beanbag Shotguns

Respondents in two of the larger agencies we spoke to mentioned 40 mm less-lethal launchers and beanbag shotguns as additional tools they use. The ability to reach individuals from a greater distance than, for example, a CED, was cited as a major benefit to these tools in terms of officer safety and dealing with threatening or suicidal persons. Respondents viewed the 40 mm weapon as less physically damaging to individuals than CEDs while simultaneously being more effective. According to one agency's policy, there is specific guidance outlined on where officers should target on a person's body.

> "I think that our 40-millimeter program is exceptional right now. I think that ability to reach out and touch somebody from 40, 50 yards away is incredible. You're less likely to put officers at risk of getting stabbed or anything happening to them with that ability to reach out as compared to 14, 15 feet max with a Taser."—Respondent 11, Sergeant

> **"**We have a 40-millimeter round which has been pretty effective when it comes to distance with suicidal subjects. We've had a lot of success with that and as well as our less lethal shotguns."—Respondent 15, Captain

One agency took additional precautions to minimize the chance that officers mistakenly use a lethal shotgun in place of a less lethal (beanbag) shotgun. These precautions included ceasing to issue lethal shotguns to officers, outfitting the less-lethal shotgun with orange features, and putting in place a "rigorous loading method to ensure [officers] are not loading live rounds."

(Respondent 13). Of course, as with any LTL, the use of the 40-millimeter must be guided by careful policies and practice and in consideration of other solutions based on the circumstances.

Defensive Tactics Training

A key challenge that emerged across agencies was a lack of confidence among both newer and veteran officers in engaging in hand-to-hand interactions, which results in officers reaching for their LTL or lethal tools more quickly. All agencies noted that better defensive tactics and de-escalation training and the corresponding confidence training brings can prevent an overreliance on LTL and lethal tools. Defensive tactics training was discussed by personnel at multiple ranks as being critical to improving officer–individual interactions through multiple mechanisms. These include building the actual skills to engage in hands-on encounters successfully and building sufficient confidence in officer capacity to engage in a physical altercation with a person in the first place. Respondents perceived that equipping officers with comprehensive and consistent defensive tactics training coupled with de-escalation training can contribute to safer outcomes for both law enforcement personnel and the individuals with whom they are engaging. One supervisor stated that with such training, "there is less fear with handling people in the street, [officers are] not as quick to go to tools on the belt because they're more confident with their skillset" (Respondent 15).

> "Some of the more frightening things that I see as a division commander are older officers who feel that they just don't have that edge anymore when it comes to…hand to hand, defensive tactics, the strength, the ability, the agility, the mobility. And they're quick to go to their tools because of fear that they just can't…go hands on or de-escalate without going to a deadly force…we can only get that confidence through training and having the best facilities to train; that way we know that we have the capability and the skills to handle a situation before going to our tools."—Respondent 15, Captain

> "We used to go a lot more hands on with people. You learned how to grapple with people and wrestle with people and get cuffs on them. Now it's more people will stand back, and they'll shoot them with a Taser, or they'll spray them with OC aerosol...I just see a lot more dependence on these items which has gotten officers probably injured where they wouldn't have had to if they were better equipped [with defensive skills]."—Respondent 14.2, Sergeant

Another respondent also mentioned the confidence that defensive tactics training can build in officers, some of whom have never been in physical altercations.

> "It does build your confidence a little bit because some of the people we hire have never been into a physical altercation. When they first get into that physical altercation and sometimes are quick to go to a tool, sometimes you find that an individual may be able to handle it with their hands. So, it builds confidence…It does reduce the injury."—Respondent 19, Lieutenant

Another respondent described additional benefits of defensive tactics training, including compensating for the unreliability of LTL tools (e.g., inability of CEDs to penetrate winter coats) and improved public perception of the interaction.

> "If I use a Taser on a guy that's wearing a parka, there's no point in using your Taser. It's not going to penetrate the parka. A baton might not do anything to him. So let me do a double leg take down, put them on the ground and just put him in a compliant hold. I'm not causing serious bodily injury or have to get decontaminated from OC spray. I don't have to worry about any broken bones with the baton or how it looks…"—Respondent 67, Officer/Investigator

Respondents mentioned some challenges when it came to delivering defensive tactics training to officers, including limited training hours dedicated to defensive tactics and incentivizing officers to train when the training was not mandated. One law enforcement supervisor mentioned newer and well-equipped facilities may incentivize more officers to take advantage of defensive tactics or ground fighting training: "I think when you have the top line facilities you get people in the door more easily than we do right now, where it's like, 'oh, it's cold and musty and [I] don't really feel like going'" (Respondent 15). When it comes to guidance on using defensive tactics or LTL weapons, every agency's policies outlined the circumstances where use of the technique or tool was permitted and emphasized de-escalation and the use of force as a last resort. Agency policies differed on the varying degrees of specificity of their prohibited uses of tools and techniques. For example, two of the agencies explicitly prohibited specific restraints in all circumstances whereas one agency was less prescriptive and specific about its prohibited practices.

In sum, LTL tools and defensive tactics provide officers with additional ways of resolving situations and bringing individuals into compliance when verbal de-escalation techniques fail while also greatly limiting the likelihood for death. For LTL tools, it was clear that law enforcement officers value tools that allow for more distance between themselves and individuals of interest, such as CEDs and 40 mm less-lethal launchers. However, LTL are not always effective or appropriate based on the circumstances. For example, CEDs are perceived as less effective in certain situations like colder weather when the person is wearing multiple layers of clothing or when a person is experiencing extreme physical crisis and simply doesn't respond to the electroshock. Additionally, the possibility of serious injury or death exists whenever these weapons are used. Defensive tactics training was also viewed favorably by respondents because it teaches skills that allow officers to control encounters without resorting to LTL tools or in the case that LTL tools fail. Providing adequate training hours and resources dedicated to defensive tactics was seen as an important need.

3.4 Theme 4: Medical First Aid Provision

Respondents tended to agree that law enforcement should be equipped, through training and proper equipment, to provide first aid to individuals while waiting for emergency medical care to arrive on scene. Whether law enforcement in these jurisdictions must provide medical attention to individuals is described in agency policy and, in some cases, law. Although the ability to provide medical care was viewed positively, respondents suggested there is a balance that must sometimes be struck between providing first aid and controlling a threat. Some of the equipment respondents specifically mentioned were first aid kits, chest seals, tourniquets,

automated external defibrillators (AEDs), and naloxone spray (brand name Narcan).[5] Despite the range in jurisdiction size, respondents from every agency mentioned specific trainings they implement related to medical care and trauma, including a trauma care (i.e., law enforcement casualty care, or tactical casualty care) course and naloxone training. One respondent we spoke to suggested that law enforcement has historically relied on the knowledge that the fire department or emergency medical technician (EMT) will provide medical treatment and thus did not place a heavy emphasis on medical training for officers. However, they felt this trend was reversing.

> "I think we've done, as far as law enforcement in general, a really poor job of training our officers, even basic first aid...I think we've done a really good job lately…the union actually bought everybody tourniquets. And for the officers, now you notice the officers are putting them on the suspects, which I think the department's now looking that way."—Respondent 14, Lieutenant

Evidence of this trend was apparent in another agency we interviewed, as one respondent described the quality of his agency's casualty care training as "one of the best in the country" (Respondent 9). All officers in his agency are trained in basic trauma care, with some portion of their officers trained "to the level of a firefighter" in responding to injuries.

> "We give first aid on scene…We have a great law enforcement casualty care course. We have 40 now that are trained…completely outfitted to the level of any firefighter…and can respond to most injuries. And then we're expanding that program and all of our officers attend a portion of it. So, they're all trained in basic trauma care. We've issued them all tourniquets. We have these first aid kits in the cars. We're looking to get AEDs back in there. Everybody's been issued and trained. In fact, we just retrained this year on Naloxone."—Respondent 9, Captain

Some respondents described success stories where individuals who had been shot by police had survived because of the medical training that officers received.

> "I have been involved in two OISs [officer-involved shootings] as an investigator where I'm absolutely certain that the subject was saved by the lifesaving efforts of the officers on scene. That was the application of our curriculum."—Respondent 8, Lieutenant

Although not traditionally viewed as part of their duties, there is a broader movement toward law enforcement providing first aid to individuals at the scene of critical incidents while waiting on EMTs to arrive, with at least one jurisdiction in this case study requiring this by law. All agencies we spoke to implement trainings around trauma care and provide officers with equipment that can be used to stabilize injuries. Officers viewed these trainings as valuable in light of the potential lifesaving effects of an immediate emergency medical response when seconds often count.

[5] Chest seals are commonly used to seal bullet (or other) wounds to prevent airflow into the chest cavity. AEDs are portable devices that are used to treat someone who has gone into cardiac arrest. Narcan is the brand name for Naloxone spray used to reverse opioid overdose.

3.5 Theme 5: Staffing

All the agencies we interviewed reported that staffing was an issue. Respondents cited the lack of soft skills; inability to train appropriately because of understaffing, media, and culture; and the decline in the lateral recruiting pool as issues impacting staffing.

New Recruits Lacking Communication and Other Soft Skills

Two of the three agencies cited a lack of communication and other soft skills in new, younger recruits. Several respondents believed the new generation of officers have less life experience and are more immature than previous generations. Respondents thought these deficiencies impacted community engagement and officer conduct in the field.

> "A lot of our problems are with maturity…Soft skills are just lacking. I don't know how to bring that back. It's just lack of experience."—Respondent 10, Sergeant

> "Some of the newer officers coming in, younger, a lot of texting, not a lot of personal contact with people. So, we have noticed that. And that is one of the things that we are trying to identify as, I'm not saying necessarily a deficiency, because it's not their fault that it's the world of technology…This is a very difficult job. You're going to get people screaming at you…. We have a lot of sensitivity…you guys need to put your phones down, talk to each other, to listen to stories, because that's where you get the experience from."—Respondent 68, Deputy Chief

Difficulty in Recruiting and Retention

A few respondents mentioned reasons for the difficulty in recruiting and retaining high-quality officers. One respondent cited staff burnout from the COVID-19 pandemic and co-occurring protests as partially contributing to many experienced officers leaving the agency in 2020. Both low public sentiment and agency culture were mentioned as affecting the ability to hire and retain staff.

> "[There is] a lot less interest in the job because the way police are looked at and there's a lot less respect… It has affected recruiting. They don't look at officers the same way they used to."—Respondent 10, Sergeant

In addition, one agency mentioned the reliance on the lateral hire pool (i.e., hiring from other agencies), a traditional source used to attract potentially high quality, proven candidates. Currently it was not perceived as good of a recruitment tool as it used to be due to shortages existing in other agencies further limiting the ability to fully staff the agency. There is also the need to be cautious about the motivation of lateral candidates wanting to change agencies as there could be disciplinary issues driving their decision.

> "Yeah, we used to have a lot of success with that. We don't anymore. And so, there were a lot of things said and done in 2020 and 2021 that has essentially dried up our lateral pool."—Respondent 13, Deputy Chief

> "There are some definite challenges to lateral hires. The first question that comes to my mind is why are they leaving their parent agency, right? Is it because they're trying to avoid some discipline or whatever. You have to ask those

questions. And in some cases, we found that's the truth."—Respondent 13.2, Bureau Chief

"One of our challenges with the laterals is the fact that we're all fishing out of the same pond, a lateral comes and goes."—Respondent 16, Captain

Training affected by understaffing

The difficulty in recruiting also affected the level of training. One agency noted that because they are so understaffed and need to hire quickly, they do not get to train the officers as extensively as they would like because there are not enough staff members to cover the field. Even when lateral hires are made, respondents noted retraining lateral hires from other jurisdictions on departmental policies and procedures and getting them familiar with the agency culture as a significant challenge, given the pressing need for officers on the street. As one Lieutenant noted, "they know how to be cops, but they don't know how to be cops for us, right?" (Respondent 16.2).

"We are well above the minimum standards that the State Academy provides. We invest a lot of time and a lot of energy in making sure that our officers have the best training that we can possibly provide them. However, we have a hard time projecting that into the field, because we just don't have the staffing."—Respondent 13.2, Bureau Chief

"We need officers, and we found [that] a way to streamline that was to hire laterals from other agencies…we are trying to get these officers out in the street and they might be laterals that either come from agencies that have different policies or some bad habits. And so, when we try to pump these officers out into the streets as fast as we are, there's a gap...we need to make sure that they are up to speed on our policies and maybe we need to slow it down just a hair to get them to where they know our policies and trained in our policies."—Respondent 15, Captain

Common Staffing Challenges Highlighted by Law Enforcement

- Younger, inexperienced officers with poor communication skills
- Recruitment difficulties and attrition caused by staff burnout & poor public sentiment of policing
- Limited or reduced training for new officers because of understaffing & limited budgets

Respondents reported staffing as a challenge of varying degrees in all agencies. Respondents noted that recruiting and retaining high-quality officers was made difficult by poor public sentiment around policing as a profession and, in some agencies, a lack of support shown by agency leaders. These challenges result in agencies being understaffed for their workload, which further results in difficulties training staff adequately while maintaining coverage in the field. Difficulties with recruitment and retention also translate to lowering standards for new recruits. This can ultimately compound the need for more time to train new recruits sufficiently, including lateral hires, on the agency policies, practices, and communication skills necessary to be successful at the job. Ultimately, recruiting lower-quality staff who receive less training may contribute to more use of force cases and arrest-related deaths.

3.6 Theme 6: Accountability

Respondents indicated their agencies had implemented a variety of policies and practices to ensure accountability. Accountability here refers to addressing misconduct and ensuring staff follow agency policy and procedure. Clearly written policies connected to rigorous training—as well as mechanisms to identify staff not following policy, front-line leadership, body-worn cameras, appropriate investigator experience and training, and independent oversight—were central to the theme of accountability.

Clearly Written Policies Connected to Rigorous Training

Interviews revealed that each agency worked to provide clear policy guidance on use of force, how investigations into incidents would be conducted, who would lead the investigations, and the timeframe allowed for completion. Policies served as the basis of agency trainings and as policies were updated, so were trainings. Problems surfaced when policies were too abstract, not clearly defined, when there were too many policies, or when policies were constantly changing. These situations made it difficult to operationalize behaviors into effective training exercises.

> "Because we are starting off with de-escalation and how we get into force here, our force policies are broken up like our use of force tools are. Every aspect of force an officer is going to get into, we define it in policy. And the way that's set up, it also formulates how we train, it formulates how we dispatch, it formulates basically everything that we do. I think that's where a lot of agencies are lacking, where they have these complex manuals that you read, it makes no sense to me."—Respondent 10, Sergeant

Accountability Measures Noted by Law Enforcement

- Clear policies connected to rigorous training
- Use of force investigation to influence training and policy development
- Responsive and fair disciplinary system
- First-line supervisors holding officers accountable
- Use of officer early intervention systems
- Use of body-worn cameras

A range of staff from within and outside the agencies play a key role in the development and revision of policies to make them functional and provide accountability.

> "There usually would be a representative from our Office of the Inspector General there as well. To handle, if it looks like an obvious, let's say we have a policy issue that's causing the officer to get into that interaction that causes the injury. Sometimes they would note it. They would communicate with our office. Hey, we need to make a policy suggestion. Sometimes it makes sense, sometimes it really doesn't."—Respondent 10, Sergeant

> "Nobody really knew about the state code that was coming. I asked some of the chiefs and they're like, well, we've got our attorneys working on it. And I'll be honest, I don't want to work under protocol written by attorneys because it will not be a functional working protocol. So, we just hashed out a protocol …You know, it wasn't perfect. No, it's been tweaked here and there. But the goal was to make it functional for a good, solid investigation…we want evidence-based

> investigations. We want facts. We don't want opinions. And so, we tried to write it that way."—Respondent 14, Lieutenant

Several respondents believed their agencies were doing a good job with their policies and ensuring accountability. A Deputy Chief said he thought his agency was "marching towards the right direction, and I think we're getting better all the time. We're learning from mistakes across the nation or within our own organization and I think we're adjusting our policies and we're adjusting our training, which I think is more important than this, than policies" (Respondent 13). A Sergeant from another agency stated that "I think we investigate our own boards more thoroughly…I think we're in the top three that really monitors our performance, misconduct, our policies. We're constantly fine tuning and working in that area" (Respondent 10).

Use of Force Investigations Leading to Policy and Training Changes

All three law enforcement agencies outlined policies and protocols on investigations into or reviews of use of force and deaths in custody. Respondents noted that part of their investigation process was identifying policies, practices, and trainings that needed to be improved based on incidents and findings. This feedback loop was critical to also offering an opportunity to affirm when proper policies were followed and officers behaved responsibly and appropriately.

> "If the officer uses force, or in the case of an in-custody death, we look at it all the way through and look for things that we can improve on, because we're always looking for ways to do things better. When we do look for misconduct, we look for criminal conduct, but we're also just looking for things that we can train on or improve on….There are times that you look through and you find something completely unrelated that's like, wow, we should do this differently, we should respond differently."—Respondent 9, Captain

Mechanisms to Identify Failure to Follow Policy and Training

Measures to identify officers who are not following policy and training and disciplining them is important, as noted by respondents across the three agencies. One agency had an early intervention system in place to look for patterns in conduct that may need attention.

> "So, when we have an issue, and this is something that happens with our EIS [early intervention system] that we have in place. …They have an algorithm that they look at. …Maybe there could potentially…be a substance abuse issue. There could be a domestic situation going on. So, they have a system doing that. And when we see on the board,…we've seen this three times from the same guy over the period of six months, then we start acting."—Respondent 8, Lieutenant

Another agency identified a more informal process of understanding staff competencies and identifying strengths and weaknesses that may require training.

> "Number one, we know the personalities and the strengths and weaknesses pretty much of [all] our officers. And again, just like some doctors have better bedside manners than others, you're going to have some cops with a better bedside manner essentially than others. So, we try to identify who will be the best to send to the train the trainer schools to come back and train. And we also

> evaluate our officers for their strengths and weaknesses, and then we send them to classes."—Respondent 68, Deputy Chief

One respondent indicated that their agency saw identifying officers not following policy or training as the first step that needed to be followed by additional training or discipline to instill accountability.

> "Of course, you get the oddballs out there that will not follow policy, will not follow training, and you can't avoid it. You have some people that go out on that limb, but again, our discipline aspect, or [how] we catch misconduct, is robust. So that one incident, where in [CITY], where it happens all the time, that misconduct will flourish…Here, it'll be caught right away, and generally you're not going to have that outlier officer lasting in the agency."—Respondent 10, Sergeant

First-line Supervisors

Law enforcement agencies identified first-line supervisors as critical for holding their officers accountable by ensuring they understand the policies and regulations related to the discharge of their duties and initiating discipline or retraining or other processes when issues are identified. First-line supervisors see officers daily in the field and are in a position to identify issues earlier than other supervisors.

> "My role as a sergeant of patrol is [to] basically keep my people under control, making sure that they know the rules and regulations. What the AG [Attorney General] guidelines say and what we can and can't do. That's basically my role as front line supervisor to make sure that…I have given them enough instruction to know what they can and can't do"—Respondent 70, Sergeant

> "They're not the person's best friend. They're holding people accountable. They are calling them where they need to, but then we also have the ones who are just kind of like, they don't want to be the bad guy…That's a culture here we're trying to fix in terms of like, it is a supervisory role that is your job as the first line supervisors to…holding our individuals accountable."—Respondent 15, Captain

Body-Worn Cameras

All three law enforcement agencies used body-worn cameras, which may help promote accountability (Chapman, 2019). Respondents indicated that their agencies had policies or ordinances regarding how and when the cameras were to be used, who can review the footage, and how soon the footage has to be released to the public.

> "All body cameras stay recording unless the AG, the assistant prosecutor tells us that we're allowed…if the officer or officers are injured, they can turn it off. If they're getting treatment or evaluated, either by the ambulance or hospital. Other than that, we are recording….Once they're turned off, they have to be labeled properly…The actual camera itself is immediately locked and the Prosecutor's office are the only ones that can review it."—Respondent 69, Lieutenant

Of course, camera footage was part of the policies and protocols for conducting use of force or incident reviews. Camera footage is often the first thing to be reviewed, and respondents considered this footage when discussing whether policy or training changes were needed.[6]

> "Body camera's a big thing. They'll watch that right up front…we watch the video usually that night and that's already starting. Ooh, we need to look at that and why did he do it that way or why did she do it that way? Do we need to change something? Training will be involved with that pretty quick. So, yeah, we do look at how can we stop this from happening the next time."—Respondent 14, Lieutenant

In addition to being central to investigations, one agency used cameras for real-time reviews when possible and conducted audits to make sure the cameras were on.

> "In real time. If I'm sitting there and I hear like an active family fight I can be like ooh that doesn't sound good what the guy is doing. I can remotely [access] their cameras from anywhere. You can do it from another state. . .And then we have an audit squad that goes in and they just pull random case numbers and confirm my case number. It's got a body camera attached to it."—Respondent 19, Lieutenant

Although agencies have body-worn cameras, one respondent thought their agency and supervisors could use the technology to monitor officer behavior better. A Deputy Chief in one police department thought that body-worn camera footage was a better tool to identify issues than their department's early warning system.

> "I can only speak to our early intervention system. I'm sure there's other agencies that do it better. I have not seen a considerable benefit from having it…I think what we get more bang for our buck on are random body worn camera video audits. I think we get more bang for our buck on that when it comes to accountability and checking in on people, if you will."—Respondent 13, Deputy Chief

Finally, a police department Captain who had promoted out of internal affairs noted that camera footage also shows the good work of officers but often is cut off and does not show the full picture when released to the public, which impacts the level of accountability in the public's eyes.

> "I was always reviewing body worn cameras. And they really were the defining factor that would have been harder to demonstrate the good work that police officers are doing….It's unfortunate a lot of our body worn camera [footage]…that's released with state law here within 10 days, usually is cut off before the life saving measures by the officers are started...That's an unfortunate thing because the public needs to know the efforts that the officers are doing to not kill somebody is to stop a threat. And then once that threat [is] stopped, we're doing everything we can to keep that person alive."—Respondent 15, Captain

[6] Although there is a policy question around whether officers should be allowed to view body-worn camera footage prior to preparing a report or statement (e.g., Farber, 2024), respondents from all sites we interviewed discussed the review of body camera footage in incident reviews in general as useful for informing policy and training.

Reporting and Transparency

Police transparency on issues such as use of force and officer-involved shootings is critical for building public trust. One way to be transparent is for agencies to provide data to the public on these incidents. All three law enforcement agencies provided the public with data on use of force. One law enforcement agency provides public use of force and officer-involved shooting dashboards, and another publishes annual reports with use of force data. The third law enforcement agency is required to report data to the State Attorney General's Office, which provides a use of force dashboard. The data included in the dashboards is summarized in Table 5. The dashboards provide a more nuanced breakdown of use of force and officer-involved shooting data, allowing users to select data by year, location, and statistics by individual of interest and officer.

Table 5. Information Reported in Public-Facing Dashboards

Use of Force Dashboard	
Agency and Officer Elements	**Subject Elements**
▪ Number and percentage of incidents ▪ Number of incidents by precinct/agency/officer ▪ Number of events by type ▪ Trends by year ▪ Use of force types by days of week and hours of the day ▪ Number of officers ▪ Type of officer force ▪ Number of officers injured ▪ Officer injury type ▪ Type of treatment officer received	▪ Number of subjects ▪ Demographics (age, gender, race/ethnicity) ▪ Actions and type of resistance ▪ Perceived condition/impairment of subject (e.g., under influence of alcohol or drugs, mental health issue) ▪ Number injured ▪ Injury type ▪ Arrest status ▪ Reasons subject not arrested ▪ Type of treatment received ▪ Hospital treatment

Agencies also achieved accountability by implementing independent oversight and monitoring of use of force investigations. Independent or outside agency leads or members in an investigation reduce the appearance of covering up the findings and is seen by respondents as a way of increasing the likelihood of accountability.

> "It's very somewhat transparent. We can't release everything, but it opens it up to we're not trying to cover up things. You not only have us investigating out there and a couple of other agencies helping us, you also have direct oversight by the DA's office investigator. Their chief will show up and there are a couple of investigators and they'll just shadow. So, you have that independent oversight from right off the bat."—Respondent 14, Lieutenant

Agency processes and tools for creating robust accountability systems are critical to determining whether policies and practices are being followed and to serve as a critical feedback loop for improving policies and training when needed. Effective first-line supervisors, processes in place to review body-worn camera footage (for investigations and routine

assessments), and independent monitors can help identify critical gaps and opportunities to improve policies and practices in an effort to reduce arrest-related deaths. Tracking and reporting incidents and their characteristics to the public can also help to promote transparency and strengthen public trust in the agency.

3.7 Theme 7: Population Served

All three agencies, although differing in size, urbanicity, and region, deal with populations that present unique challenges when responding to calls. Similar to many other agencies across the United States, respondents spoke of the challenges related to identifying and interacting with individuals with mental illness or in mental health crisis, individuals with substance use disorder or under the influence of substances during police encounters, and persons with a disability. All agencies interviewed were actively dealing with homeless populations that had co-occurring mental health and substance use disorders. Respondents also described some of the programs and practices that they engage in to help facilitate better interactions with these populations and mitigate the possibility of these encounters ending negatively.

Challenges of Engaging Individuals with Mental Illness, Disabilities, and Substance Use

Respondents repeatedly described a perceived increase in drug use factoring into their interactions and how drug use renders many of the de-escalation tools (especially verbal tools) officers are taught through training useless. Multiple respondents described the difficulties of engaging someone under the influence of drugs, citing a lack of comprehension and rationality on the part of the individual and violent behavior as posing particular challenges to securing an individual and routing them to needed services. One Sergeant described how certain substances can make individuals more violent, which makes it difficult to get them into custody and subsequently into treatment.

> "It's a tricky thing because we have to kind of contact them when they're in that kind of a state and being violent because we're saving them from other people. You have to get the force in because you have to get them into custody, get them into medical as quickly as possible because they're on a clock."—Respondent 10, Sergeant

Another respondent added increased physical strength as another challenge with individuals who are under the influence of some substances, which means responding officers have to apply more force when they "normally wouldn't" (Respondent 69). Echoing this, another respondent from the same agency noted that "Most of our use of force comes [from] drugs and alcohol" (Respondent 66). Although engaging individuals with mental illness posed similar challenges, at least one respondent discussed how de-escalation with individuals under the influence of substances was an even greater challenge.

> "I can say as much as I want to rationally tell you, 'Please, I'm not going to hurt you. Please just sit down. Stay right there. I'll even keep this distance from you....' They're not understanding that. There's no rational component when you're dealing with someone who is under the influence of something, which makes it very difficult….It's one thing when you recognize that they actually are

> under some kind of mental illness or stress where it's not involving [substances]. Then the de-escalation and the calming techniques and the distance, we have all the time in the world sometimes as long as they don't have a weapon. We can talk then, but not when you're mixing things or when you're just dealing with somebody that is under the influence."—Respondent 68, Deputy Chief

The three agencies we interviewed had policies or practices in place intended to divert individuals with substance use disorder into services. In addition, with the increase in overdoses seen in jurisdictions across the country, all agencies required their officers to carry Narcan, which was viewed by respondents as beneficial. Again, some challenges that respondents described with these practices included the limited resources available to treat individuals who should, by law or policy, be diverted into treatment and a challenge with getting individuals to accept treatment voluntarily.

> "Our policy requires that you connect them with services, which are all external to the department. We have LEAD (Law Enforcement Assisted Diversion), we have the crisis resource facility that we can take them to if they have beds available. And then if LEAD will take them, they will take them for diversion. [We] have involuntary treatment. So, if they meet the criteria for an ITA [Involuntary Treatment Act], we can take them up to the hospital. They'll evaluate them. If they have beds for them, they'll keep them….The reality is there aren't enough resources....And I think that's mostly what officers get frustrated with. You're mandating them to do something that they can't possibly comply with."—Respondent 9, Captain

At least one respondent described having to keep up with new challenges that might be emerging with the populations they serve, particularly in the aftermath of the COVID-19 pandemic. Respondent 68 noted, "there's been new things just coming out after the pandemic, that people are struggling because they were in their houses and isolated for so long. That's something completely different that we need to learn about."

Alternative Response and Co-Responder Models

All agencies we spoke to have some form of alternative response model in place, though they varied slightly across the agencies. The agencies specifically deploy co-responder models that pair social workers or mental health professionals with specially trained officers, most often and at minimum trained in CIT. In one of the agencies, the co-responder program they implement is referred to as their Crisis Response Team (CRT), which works during the daytime 7 days a week, keeping records of individuals they have encountered who may require additional planning or special approach by patrol officers. The CRT is also available to provide additional information to officers responding to situations to facilitate de-escalation.

> "[CRT] is going to also contact the other officers via radio [and] say, 'hey, wait, hold off until we get up there.'…You might be dealing with somebody who is exceptionally dangerous. They will be triggered by three officers, where they won't be triggered by one….So, you might have the other two officers out of sight around the corner, but [CRT] is providing that information so that we're able to de-escalate that situation."—Respondent 8, Lieutenant

Co-Response Models

One agency partnered with Volunteers of America. The co-response program placed mental health professionals in ride-alongs with officers 1 day a week. The agency could also bring a tablet to these calls that let them connect individuals with medical providers in real time on scene. These resources make things "a little easier to get the person pointed in the right direction for the type of care they need."—Respondent 66, Officer/Investigator

Respondents from another agency echoed the value of embedded social workers in de-escalating potentially volatile situations.

> "Part of that de-escalation is our social workers…We find that to be a good de-escalation tool because sometimes people don't necessarily want to talk to the officer, but they're willing to talk to that social worker…. And so, we've used that a lot to our advantage is the social workers. We do have CIT they're actually housed in the same building, CIT and social workers; they work very closely. So when a CIT officer gets a mental health case or something where you know, there's some kind of criminal charges pending or that's why the CIT officers involved, then they can bring in that social worker to see if there's a different avenue they can approach where they can actually get an actual treatment or get back on medications."—Respondent 17.2, Sergeant

Respondents also noted several challenges related to alternative responses, such as ensuring compliance with federal and state laws that regulated individual privacy and health records.

> "They have very strict privacy laws, but yet you're embedding [social workers] within a public sector agency that has essentially freedom of information and access. So, navigating those two worlds was actually probably the biggest challenge we had when we initially had them trying to make it so that they could still maintain patient confidentiality, but still have the cop there who has a body camera that's videotaping."—Respondent 17.2, Sergeant

Another challenge respondents raised concerned with mental health professionals and their perceived safety when responding to certain calls.

> "While everybody in the entire world wants to say, oh, we're going to pair up a mental health person with a cop, mental health people do not want to come out…if they don't have a gun, they don't have a vest. They're not safe, they are afraid. So, while it's nice in theory for everyone to say, hey, just send the mental health person, they're not going to go by themselves…So, we bring them out when it's a safe situation."—Respondent 68, Deputy Chief

> "Now we have MHPs [Mental Health Professionals] that may respond, although I don't think they're actually going to until it's more stable, so if we were in a violent confrontation, they're not coming. I mean, they made that clear."—Respondent 9, Captain

Finally, some respondents mentioned challenges with getting individuals to accept or seek treatment. One Sergeant described the following:

> "We try to let them know that we're not a threat to them and that we're there to help them, not to hurt them. And then we kind of try to take a step back, if we can get Volunteers from America there, that's great. But if they're not willing to accept the help, can't really force them. [If] they say that they're going to harm themselves or someone else…we can basically make them go to crisis and see somebody. Unwillingly if we have to. Which then that brings in force, which we don't want to do. So even if we have the means to make them go, we still try to get them to willingly go. We try to bring our ambulance crew in, they try to convince them that it's better, but obviously only if it's safe."—Respondent 70, Sergeant

All three agencies we spoke to include their response to special populations in policy, and all received trainings dedicated to identifying signs of mental health, disabilities, or substance use issues and de-escalating situations with such individuals. One Sergeant in charge of policy described how frequent interactions with special populations (e.g., homeless individuals) led to the development of policies and procedures specific to these populations.

> "We have policies and procedures that actually are very specific to mental health related processes and situations and scenarios. We also have homeless related things that specifically relate to them when it comes to like trespassing, when it comes to littering and stuff like that. So, we have certain stuff just because we've interacted with them so much that we've had to make a policy about those types of things. So, we do have a lot of that structure in our policy procedure manuals."—Respondent 17.2, Sergeant

As noted in section 3.1.1, some of the trainings relevant to use of force, de-escalation, and interacting with special populations that respondents mentioned include CIT, mental health first aid, and autism awareness and sensory-inclusive training. Although all respondents saw the value in such trainings, at least one Lieutenant in charge of training mentioned that their agency could do a better job at assessing officers' ability to apply the lessons learned, noting "where I think we could do better is the…verification that the training was received…and you know how to apply it" (Respondent 16.2).

All agencies described numerous policies and practices they engage in that attempt to divert individuals to needed services and de-escalate situations involving someone in mental distress or under the influence of substances. Respondents viewed some of these practices favorably, including training on recognizing signs of mental illness, autism awareness, and signs of overdose and using alternative responses, including co-responding with social workers and telehealth in the field. However, respondents also described multiple challenges, including

limited resources available to meet demand and the lack of will on the part of individuals to engage in treatment.

3.8 Findings from Document Review of Use of Force Policies

As noted previously, all three agencies have policies governing the use of force, including lethal force. Although the structures of these policies differ, they invariably provide detailed guidance around the agency's principles regarding use of force, as well as the use, documentation and reporting requirements, and investigations of force. We compared the general content of each use of force policies to assess commonalities and divergences across agencies. In addition, we compared the content of the policies to the National Consensus Policy on Use of Force, a model use of force policy put forth by 11 professional law enforcement leadership associations.

Common Elements in Use of Force Policy

Despite differences in level of detail, elements common to all three agency policies around use of force included the following:

- The agency's principles related to use of force
- Emphasis on "sanctity of life" or "preservation of life"
- Emphasis on de-escalation first and use of force as a last resort
- Guidance that force should be ceased once a situation is under control
- Guidance on de-escalation tactics (slowing down response, putting distance and shielding/cover between officer and individuals of interest)
- Levels and type of resistance officers may encounter
- Emphasis on communication with individuals of interest with the goal of obtaining voluntary compliance
- Directives on bystander intervention
- Specific communication tactics and considerations (e.g., language barriers, mental illness)
- Authorized and unauthorized uses of force, including when discharging a firearm is prohibited (e.g., firing from or at a moving vehicle in most circumstances, at individual threatening self-harm)
- Guidance on provision of medical care
- Required documentation, notification, and reporting requirements

Some elements that were specific to one or two agencies, but not all, include the following:

- Officer decision-making model
- Specific communication strategies when multiple officer(s) involved
- Contingency communication strategies when initial attempts fail
- Detailed guidance around the use of various weapons or tools (including scenarios in which the weapons or tools are (un)authorized, the distance at which tools should be used, and body parts that should be avoided)

A comparison of the elements of the Consensus Policy with the three agency policies revealed very similar content. As expected, the agency policies provided more specific direction around required procedures, including around the use of less-lethal force, deadly force, and de-escalation, with the exception of training. In the Consensus Policy, training on the policy and relevant statutes is required at least annually, as is regular training designed to provide techniques on de-escalation, simulate shooting situations and conditions, and enhance officer discretion and judgment in using less-lethal and deadly force. Requirements for training on the use of force policy was located in two of the agency use of force policies we reviewed (annually in one agency, semiannually in the other). However, none of the agencies included requirements for trainings that simulate actual shooting situations and conditions in their policies, though in conversation it became clear that scenario-based trainings were conducted in practice.

Investigations and Reviews

All three agency policies included requirements for the investigation of nonfatal and fatal uses of force.[7] These requirements included the following:

- Procedures to be followed by officer(s) involved in the incident
- Parties who should be notified following the incident
- Relevant documentation to be completed
- Procedures and timelines to be followed by investigating party
- Outcomes or results of the investigation

In addition to individual investigations, the three agencies also require in their policies that all documented use of force incidents should be analyzed annually for potential trends or areas of concern. The scope of this annual review varied somewhat across agencies. In one agency, details on what the analysis entails were not included. The typical activities involved in annual use of force reviews include an assessment of the following:

- Use of force incident reports (including date/time, type of encounter, demographics of persons of interest, injuries to individuals/officers)
- Video footage (body-worn camera, mobile video recorder)
- Complaints received

These reviews typically result in recommendations by agency leadership for additional training, equipment needs, or policy revisions as necessary.

3.9 Summary

Arrest-related deaths remain a critical national issue. Understanding in more depth what some law enforcement agencies are doing to mitigate such deaths and the challenges they face contributes to the knowledgebase of how we may prevent or reduce arrest-related deaths at a

[7] Because the Consensus Policy does not include the investigation of use of force within its scope, we do not compare the agency policies to the Consensus Policy on this aspect.

national scale. In these case studies, we interviewed multiple law enforcement personnel at three separate agencies in a range of roles and responsibilities. Seven key themes emerged from those interviews. As noted at the outset of section 3.1, the agencies involved in these case studies are diverse yet share many of the same priorities, concerns, and challenges with preventing and reducing excessive force or death. At a fundamental level, respondents viewed clearly defined policies centered around de-escalation and a culture that supports de-escalation and training as critical. Additionally, delivering comprehensive, consistent, and scenario-based training was seen as important in preparing officers for different situations they may encounter in the real world. In particular, respondents mentioned trainings that teach verbal and physical de-escalation techniques, how to identify and respond to individuals of varied backgrounds or who may be in crisis, and first aid medical care as valuable parts of their curricula that can improve interactions with community members and lead to better outcomes. Respondents also viewed partnerships with social workers and other mental health professionals as force multipliers in connecting with individuals in crisis and resolving situations before they become critical. Strong accountability mechanisms, including early intervention systems, body-worn camera reviews, and oversight committees can serve an important role in holding officers accountable to policy and promoting continuous quality improvement of training and practice.

Common challenges also emerged, including difficulties recruiting and training high-quality personnel who possess (or have the ability to develop) effective communication and other soft skills; engaging individuals experiencing homelessness or a mental health crisis or who are under the influence of substances; having adequate facilities and resources to provide the varied and consistent training to staff without compromising the ability to respond to calls for service; and ensuring that practice and training keep pace with the often frequent changes in law and agency policy.

4. Jails

As of 2019, there were 2,850 jail jurisdictions operating 3,116 public and private jail facilities. In 2019, 1,200 individuals died while in the custody of local jails—a 5% increase from 2018 (1,138 deaths) and a 33% increase from 2000 (903 deaths). The predominant manner of jail deaths was illness, followed by suicide and intoxication. In contrast to illness and suicide mortality rate, which have remained relatively stable over time, the alcohol/drug intoxication rate has more than quadrupled from 2000 to 2019, with most of the increase occurring in the last 7 years of the study period. The prevalence of jail deaths varies by demographic population and facility characteristics.[8] To understand the policies, programs, and practices associated with preventing or reducing jail deaths, we conducted 24 interviews with a range of staff at two sheriff's offices and a public safety agency that varied in size, region, and other factors. The three agencies had both patrol and detention functions; however, our focus was primarily on the correctional staff and issues related to deaths occurring in custody. Themes that were common to all three sites emerged from our conversations: training, staffing, population served, suicide prevention, preventing intoxication deaths, medical care, and accountability. We also reviewed select policies relating to practices that respondents discussed as beneficial in preventing or reducing deaths in jail custody.

4.1 Theme 1: Training

High-quality training that is realistic and applicable to common scenarios is vital to ensuring jail staff are prepared to prevent a variety of types of deaths in custody. Respondents discussed the importance of effective training for both detention and medical staff in preventing deaths in jails. All agencies we interviewed have extensive training opportunities for new recruits and existing staff. As new recruits, detention staff attend several trainings, in some cases beginning with pre-academy trainings on fundamental topics such as firearm safety and the agency code of conduct, as well as basic correctional officer training at a Training Academy, and supervised field training. All agencies also require in-service

Trainings Highlighted by Jail Staff as Valuable

- Identification and awareness of mental health crisis or suicide prevention (e.g., CIT, mental health first aid)
- Awareness of officer's own mental health
- Implicit bias and cultural awareness
- Recognizing signs of overdose and administering Naloxone
- Responding to medical emergencies (e.g., CPR, first aid)
- Improving interpersonal communication
- De-escalation
- Defensive tactics
- Use of force
- Use of different restraint tools

[8] See "Understanding and Reducing Deaths in Custody: Interim Report," https://www.ojp.gov/pdffiles1/nij/309441.pdf

training to be completed annually, often including a base set of trainings to be taken within an allotted amount of hours.

Jail practitioners highlighted several trainings they viewed as valuable. In some cases, existing trainings that may have been designed with patrol officers in mind, such as for de-escalation, were adapted by detention staff for the jail setting. Beyond specific training courses, agencies are also regularly required to conduct practice drills designed to simulate a real-life emergency situation. These drills are intended to prepare detention officers to respond efficiently and appropriately in a wide variety of scenarios. Although training was seen as vital to prevent and reduce deaths in custody, respondents spoke of various challenges they encounter in ensuring their staff are adequately trained.

Training Delivery

How an agency delivers training to its officers can have an impact on how well-received the training is and how well the concepts are retained. Agencies delivered their trainings in a variety of formats, including in person through formal classroom-type trainings, in scenario-based trainings, through videos, and online classes. For example, one agency discussed how their use of technology allowed them to provide officers with more access to training online while being cognizant of cost.

> "Actually, we got a platform to where there's [an] officer training portal that is tied to it….And they get access to it all the time while they're at work. There's a lot of ways that we're looking at innovation of training."—Respondent 41, Chief

Respondents noted scenario-based trainings that mimicked real-life scenarios and were more hands-on as particularly useful in helping to prepare officers, including new recruits, to encounter similar situations in the course of their work and test skills learned through classes.

> "Now it's changed over the years where it's more hands on instead of repetitive stuff that we do… Inside of jail now we're having scenarios like where maybe in your career you haven't dealt with it…The hope is that you learn something from it….I think it's beneficial."—Respondent 60, Policy Officer

> "They [recruits] come to us for two weeks before they get to a detention center. And one of the scenarios, we do reality-based suicide attempts. So we set it up to where we have a mannequin hanging from a sheet. We don't tell them anything other than, I know this is your first day at job by yourself, you do a count. They come across the cell. We have checklists which are, 'did you notify your supervisor? You probably need to notify medical; you've given out the right unit? And have already taken notes? Like what is your protocol?'"—Respondent 59, Sergeant

Multiple respondents discussed repetition in training as important for retaining skills. For example, a lieutenant in charge of training described how agencies requiring officers to train on skills such as firearms or defensive tactics for 4 hours each year are not going to retain the information they learned through the training and that repetition is what allows staff to fully connect with the material. This perspective was echoed by a Captain in charge of policy, who

described an example where they needed “continual hands-on training” on a new body scanner they had started using (Respondent 44).

Another respondent also talked about the utility of peers delivering training around mental health awareness. For example, rather than send a mental health clinician to become certified as a mental health first aid instructor, the jail had two officers become certified instructors to provide credibility and gain buy-in from other correctional staff. This was viewed as beneficial to their ability to certify everyone in the jail in mental health first aid training.

> “If you have an officer standing here telling you this is why we're doing this and this is what we need, it is kind of like having a peer support specialist talk to someone, you know, basically they're going to take it and receive it better. So when it came to training that, I think that was a real big deal for us because we literally certified everyone in jail.”—Respondent 40, Programs Coordinator

Dedicated division to support training

Given the importance of training, one respondent believed that agencies should have their own divisions dedicated to training and staffed with in-house certified instructors. The value of an agency having its own training division includes being able to provide training to staff at any time without the need to send them out to external classes and being able to provide training tailored to the state and local laws and agency policy.

> “If you want something that's going to improve an agency, you have to have a legitimate true training division. And that training division does all of the agency's training….There's so much training to be completed....You never have to send people out to a course. You never have to make sure they get online. And they bring them in. They have classroom settings, and they do real world training. And your training is meeting your standards.”—Respondent 24, Lieutenant

However, one Chief described the benefit of sending his staff to external training, including motivating and inspiring his staff.

> “So it's not just one or two trainings because the more training you get staff into the more involved they get…Because they co-mingle with other county governmental employees, which sparks and piques their interest…But if you don't do any of that, they just think this same old mundane practice of going, I guess I'll go to work tomorrow and do x y and z. So we find ways to motivate them and encourage them.”—Respondent 41, Chief

Changing culture of training

One agency discussed how they revised their training program in response to staff turnover. Specifically, agency leadership realized they were losing new recruits because of fear or apprehension. Recognizing this, the agency began training field training officers (FTOs) to be transparent with recruits about the nature of the job, while simultaneously encouraging a more open and supportive culture.

> “I said, that [apprehension is] all normal. Just don't quit. Don't give up. And if you have problems, reach out to us…And we were intentional about sending that

> message to them and we quit losing them. And then working with the FTOs…having this attitude like 'you better get used to it because it gets worse' and all that. That's not healthy. You know, they're part of the culture problem. And so we addressed that with the staff."—Respondent 20, Assistant Chief

Making a practice of cross-training detention staff and treatment staff may also help staff understand their mutual missions. In one agency, the nursing provider shared they were excited to be able to sit in on a de-escalation training geared towards detention and planned to share the information learned with their staff. In another agency, the programming coordinator discussed how they would like to see more training for officers and staff, particularly training that would allow social workers to understand from the security standpoint of why they do certain things. Another respondent noted it would be similarly beneficial for detention officers to learn more about engaging with individuals with mental health disorders.

> "All she understands is the treatment side but doesn't understand the officer's side. So for her, it's like, I want you to get that training. I want you to understand that so you know why they say or why they act or why they react the way they do. I would like the officers to understand more the treatment side of it and the treatment side to understand the security side of it."—Respondent 40, Programs Coordinator

> "I do think that there should be maybe some education on how to communicate effectively with these patients, you know, that are mentally ill."—Respondent 45, Mental Health Coordinator

Integrated Communications Assessment and Tactics Training

ICAT training was developed by the Police Executive Research Forum (PERF) to help officers interact with individuals who may be in crisis or acting erratically but who do not have a weapon. The training focuses on "decision-making, crisis recognition and response, tactical communications and negotiations, and operational safety tactics."

One agency in this study was in the process of implementing ICAT training within their jail to better equip their detention officers with de-escalation techniques and reduce unnecessary use of force. This would make the agency one of the few that have implemented the ICAT program within the jail setting.

See more at https://www.policeforum.org/about-icat.

Trainings Discussed by Respondents

De-escalation training

De-escalation training, including trainings that teach communication skills, were repeatedly mentioned as important to detention officers. Many de-escalation curricula have been designed with general law enforcement in mind; however, one individual in charge of training at his agency discussed how he had modified an existing de-escalation course for the jail environment so the scenarios more accurately mimicked what detention officers faced in real life.

> "And so the course that I implemented here is an eight hour block where they are taught different styles of effective communication…the second portion of the class is all scenario based. I've worked towards changing it [the training] solely for the jail to find out exactly what the jail responds to, violent subjects inside cells, what their policies are, suicidal subjects. So that the jailers are going to those scenarios and learn to communicate effectively that way versus trying to do a patrol de-escalation."—Respondent 24, Lieutenant

Some of the scenarios used in the training include situations where an individual has a mental disability, is suicidal, or is experiencing emotional distress. The goal is to have the officers use communication skills to de-escalate the situation. They also use real scenarios of incidents where an officer could have done something better, lending credibility to the scenario.

> "Try to communicate with them effectively and keep them calm…there's always the one [scenario] where communication is not effective to [help them] understand that [not] everything can be resolved by words."—Respondent 24, Lieutenant

Ensuring the right people are targeted with the right trainings is also important. In one agency, special units, such as a detention response team that responds to critical incidents, received more specialized training intended to make them experts in use of force and de-escalation. Having these highly trained teams respond to certain scenarios, such as a cell extraction, may produce better outcomes for all involved. Providing additional trainings to those who need it was also discussed by one Chief, who took this approach to train the new, younger generation of employees in effective communication skills.

> "And in this new generation, they're not used to talking. So, in order to get them to talk, we got to invest and just train them. Keep throwing training at them until it sticks."—Respondent 41, Chief

Defensive tactics

Respondents also repeatedly discussed defensive tactics training as something sites implemented to better equip their officers to engage in physical encounters with incarcerated individuals. A lieutenant in charge of policy at one sheriff's office described how his goal had been to get enough certified instructors on both the patrol and detention sides so that the trainings could be tailored to those different contexts. The agency teaches tactics grounded in different styles—including some elements of Brazilian jiu-jitsu and Krav Maga[9]—that are customized to fit agency policy. Another respondent similarly praised the tailored defensive tactics program for not only giving officers the skills and confidence to apply the techniques but also in changing the culture around defensive tactics.

> "They should be teaching different tactics for a patrol than they are for jail. And we [have] since done that….Our goal is, as we go to these courses, we minus out what we think isn't effective…what is not allowed, and what would be perceived as aggressive."—Respondent 24, Lieutenant

> "They've done a fantastic job of building a program where they combine several different disciplines into what are the effective tactics that we want to teach

[9] Brazilian Jiu-Jitsu is a martial art based on ground fighting, grappling, and submission holds whereas Krav Maga is a combat and defense martial art that also incorporates ground fighting techniques in addition to striking techniques (e.g., from boxing).

> them…That they can understand and deploy without having too much thought behind it…They took it a step further and built a manual with instructions on how to do these things. And even further than that, they built in how to correctly report things…So it gives them [officers] the confidence in knowing you're allowed to do this when you need to, stop when you have to stop, don't be afraid to report it because it's okay. There's a big culture change and all those things kind of blending together are really helping to reduce the incidence."—Respondent 26, Commander

Mental and behavioral health training

Respondents also mentioned trainings geared toward mental health awareness and suicide prevention and training on how to recognize signs of detoxification. Jail respondents in all agencies receive these trainings during their initial basic training and regularly during their annual in-service training. The mental health–related trainings that were mentioned specifically included CIT, mental health first aid, and suicide awareness trainings for both detention officers and incarcerated individuals. An officer from one agency also discussed a reality-based training designed to simulate an individual experiencing the symptoms of schizophrenia, which they believe develops more empathy and understanding among officers when dealing with this population. Beyond the more formal trainings that agencies engaged in, they also implement more informal trainings. For example, a nurse in one agency sends out a monthly email that informs corrections officers on topics such as recognizing the signs of someone who is in detoxification. Coupled with consistent, reality-based trainings, these types of reminders and information sharing may reinforce what officers have learned through more formal trainings.

In summary, every agency we interviewed underscored the importance of training. Specifically, respondents discussed delivering high-quality, relevant, and scenario-based training to officers as a vital piece of ensuring officers are prepared to deal with different situations they encounter in the jail and to prevent negative outcomes. Beyond specific trainings that respondents noted as beneficial (e.g., de-escalation, defensive tactics, suicide awareness trainings), certain aspects of training delivery were also mentioned as improving retention and buy-in from officers, including leveraging online resources and peers as trainers to enhance credibility. Agency respondents also discussed the value of in-house training divisions and tailoring existing trainings to apply to the jail context and the agency's policies.

4.2 Theme 2: Staffing

Recruitment and Retention

Correctional officer staffing is a perpetual problem in jails across the country, one that can directly and indirectly impact operations and deaths in custody. Recruitment and retention efforts are hindered by a variety of factors such as low public opinion of correctional work, challenging work, harsh conditions, high-stress environment, mandatory overtime, and inadequate compensation relative to the responsibilities.

The agencies we visited were, for various reasons, experiencing relatively low levels of correctional officer vacancies, at least in terms of funded positions, which may distinguish them

from many other agencies across the country that are experiencing low staffing levels. It is possible that the agencies in this study understate certain staffing challenges experienced by agencies with significant and chronic staffing needs. That said, all noted the significant efforts required to get to that condition and, more importantly, maintain that progress moving forward. Respondents cited several contributing factors to their success, including creating a healthy culture, addressing staff mental health needs (e.g., stress, trauma), investing in staff training, and achieving pay parity with the law enforcement side of operations or neighboring jurisdictions.

> "More staff and pay parity? We have to get rid of this black cloud over corrections. And the only way to do that is to professionalize it more...I think there needs to be more public knowledge of what goes on in the jail. There's no glory for the correctional officer. It's a thankless job."—Respondent 20, Assistant Chief

One agency was able to achieve full staffing, in part, through an incentive program that rewarded officers for referrals that led to applications and new hires.

> "That's probably the thing that contributed to getting us out of the hole more than anything. I said, if you get somebody referred, then I will exempt you from overtime for a month and I'll let you pick your post for a month."—Respondent 20, Assistant Chief

> "Our chief basically encouraged everybody to make it everybody's problem that we don't have enough staff. If everybody referred one person, we wouldn't have a staffing issue. Everybody knows somebody, right? And they incentivized it with doing things that are tangible for them here and quickly."—Respondent 26, Commander

The same agency emphasized the importance of celebrating staff and treating them as professionals (e.g., eliminating searches when they report for work and allowing use of cell phones in the jail) in recruitment and retention efforts.

> "More regulation, more responsibilities, more stress. And then on top of that, we search them before they go to work, we disconnect them from their phones, and we treat them almost like an inmate themselves. And then we wonder why we have so many openings in a jail. It's really quite terrible if you think about it from a recruiting aspect. We don't do those things. We don't search my staff and I let them have their phones. And this really, really helped."—Respondent 20, Assistant Chief

Common Challenges Related to Staffing

Understaffing was described as negatively impacting many aspects of jail operations, including security and delivery of healthcare, but practitioners described numerous barriers to recruitment and retention:

- Disparity in pay relative to law enforcement officers
- Low public opinion
- High-stress, challenging work environment

Although respondents reported recent success in recruitment and retention, they acknowledged that it can be fleeting as they have experienced ebbs and flows in past years. Furthermore,

while vacancy rates may be relatively low, respondents routinely articulated the need for more correctional officer positions.

For example, some jurisdictions have established officer-to-incarcerated individual ratios that try to account for several factors, including housing unit population and facility design. Agencies are typically funded to fill positions to maintain these ratios, and respondents indicated that there is always pressure to operate as leanly as possible. Several respondents perceived dissonance between these staffing level standards and what is actually needed to operate the jail safely. They asserted that the established ratios are outdated and insufficient, largely because of the changing nature of the jail population, which is increasingly held on violent or felony charges; in poor health; and suffering from substance use disorders, mental illness, and homelessness (e.g., James & Glaze, 2006; Couloute, 2018; Zeng, 2023; Dalbir et al, 2024). Furthermore, focusing on formulaic ratios can be misleading because not all officers are actively monitoring incarcerated individuals during their shift; they may perform a variety of duties. For example, respondents noted that the number of hospital transports are increasing because of medical issues, which takes staff away from the jail. Ultimately, respondents believed that the demands on staff are too great, and the increased workload and stress can negatively impact performance and key outcomes. Although officers are doing their best under difficult circumstances, more staff are needed to properly monitor and care for the population.

> “I think we get so busy and we're trying to do so many things at once. And then sometimes you have one officer in that unit and two related messages and all these things. Yeah, I don't think it's a lack of care at all. I just think we're busy.”—Respondent 63, Classification Officer

> “One person to manage all those people, of course, they're going to miss things. Of course, we're forcing them into taking shortcuts. We're forcing them into maybe being late on the rounds or forgetting they left a towel in the cell or something like that. We're asking too much of the modern correctional officer….What is needed is more eyes on more humans, especially considering the ratios haven't changed. But the inmates have.”—Respondent 20, Assistant Chief

Issues with New Recruits

Respondents noted that new recruits, particularly those from younger generations, are less prepared to work with the incarcerated population than previous generations. They noted that new recruits often lack relevant life experience and communication skills; they have difficulty handling confrontation. Although these deficiencies can generally impede effective performance as a correctional officer, they are more problematic given the increasing prevalence of mental illness in the incarcerated population, a group that is better managed by staff with higher levels of sensitivity and social skills than most new recruits possess. Respondents believed that, while challenging, recruiting staff better suited and prepared to work with those experiencing mental illness would have an impact on deaths in custody.

> “What I'm seeing these days more and more is the lack of social skills. Some of [the new recruits] lack social skills and some can absolutely not deal with

> confrontation. And they, oddly enough, are the ones that get amped up and escalate things because they don't know how to deal with the confrontation."—Respondent 25, Lieutenant

Medical staffing issues

Several respondents reported that medical staff were overworked and articulated the need for greater capacity, particularly in nursing. In some cases, funded positions were vacant due to high levels of turnover. In other cases, respondents noted that although they were technically fully staffed, there was a need to add positions to the provider's contract or county budget, depending on how medical service is provided in that jurisdiction, to meet demand. Some respondents noted that these deficiencies leave gaps in medical staffing patterns. Ideally, doctors or licensed practical nurse (LPN) would be available on site more often, particularly during night shifts.

> "So right now, we have our psychiatrist who does telehealth twice a week. She is very involved. She has a very good rapport with the patients. It makes a huge difference. She's able to reach some of the ones that sometimes are unreachable. She's here two days a month and then she sees them face to face. And it makes a huge difference. And I'm advocating for her an additional day because she makes such a big difference."—Respondent 42, Health Services Administrator

"I would say probably a doctor on night shift. And a nurse practitioner on night shift…sometimes it'd be better to have somebody in house, because then we're not waiting for them [doctor] to call us back, and there's no gap."—Respondent 42, Health Services Administrator

Additionally, correctional officer staffing issues can also impact medical service delivery. Some respondents reported that officers are required to escort medical staff into housing units to see individuals. Agencies may dedicate an officer to this purpose; however, they are not always available. In these cases, medical staff must wait until the housing unit officers can take time from their other duties to escort them in, which can delay treatment.

Collaboration Between Custody and Medical Staff

Given the increasing prevalence of medical and behavioral health issues among incarcerated individuals, it is not surprising that respondents noted the importance of a positive and collaborative relationship between detention administration/custody staff and medical staff. As one example, a jail administrator moved the lead psychologist's office next to his, in part, because of how often they meet but also as an acknowledgment of the importance of the role in support of overall jail operations.

> "I have a really good relationship with the chief and captains. We work very well together…Everybody wants to do the best thing for these patients."—Respondent 42, Health Services Administrator

That said, respondents noted that tension is not uncommon between custody and medical staff (particularly contractors), given their differing focus and priorities; however, these issues must be worked through to produce the best outcomes.

> "I feel like here we're very lucky because…the last seven years we've [medical staff] had a really good rapport with detention. I've been to sites where that's not the case. There's not good rapport between the two, and I see where it can definitely make both sides jobs much harder….We are contract workers so they're our customer, so we're really going to do what we can to keep them happy, but yet still do our job and vice versa."—Respondent 22, Director of Nursing

Staffing has been a significant challenge that jails have had to navigate. Respondents spoke of multiple challenges related to staffing, including with recruiting and retaining high-quality staff, misalignment between medical and detention staff priorities, and impacts on operations and service delivery. All agencies are actively leveraging limited resources to provide services, and in some cases have found innovative ways to recruit new staff, such as through a staff referral program.

4.3 Theme 3: Population Served

Addressing both mental health and substance use disorder among incarcerated persons are top concerns in preventing or mitigating deaths in custody. Respondents described that although technology and programming have been beneficial to serving the unique needs of this population, jails are not equipped as hospitals and many incarcerated persons have experienced years of unmanaged health. Despite this, respondents felt they were making a concerted effort with limited resources. In describing the change of the correctional population over the years, respondents focused on individuals entering the facility with underlying mental health conditions and active substance use disorder. The physical and behavioral health conditions were seen as a reflection of limited external community-based resources.

> "Our patients are sicker. We're dealing with a lot more mental health, medical [issues]. More than we were even 3 or 4 years ago."—Respondent 22, Director of Nursing

> "…years ago, someone come in the pipe meth, heroin, an alcoholic. We didn't worry about dying and getting the medicine. You know? They were bad. They were rough for a week, but we didn't worry about it. Now, when they come in, we're concerned."—Respondent 61, Sergeant

Mental Health Among Incarcerated Persons

When asked about the needs of the population they serve, respondents indicated 65%–85% of the incarcerated population had an underlying mental health issue. Respondents described the formalized protocols related to mitigating and preventing mental health crisis as paramount. All the jails we interviewed discussed the mental health screening process occurring during booking and intake and throughout an individual's stay in detail. Respondents described the criteria and practices for placing and removing individuals on varying levels of mental health and suicide watch as well as which particular staff had the authority to make these decisions. The presence of clear protocols and directives appeared to assist respondents in ensuring individuals were subject to appropriate supervision levels.

> "Screening for mental health and substance use occurs at multiple points: intake/booking, medical intake, and at varying levels during the stay dependent on how someone is classified."—Respondent 21, Psychologist

In one facility, respondents expressed concern over an increase in assaults on officers by the mentally ill population. This was described as largely unintentional and more reflective of an individual's confusion and inability to integrate into general population, in those cases in which they did not classify for placement a special unit.

Although jails have implemented mental health screens, assessments, and medical treatment, respondents noted gaps in the type of counseling opportunities provided. Both staffing and space were noted as barriers to providing appropriate levels of counseling; whether individual or group. The ability to conduct more counseling was seen as a preventive measure to escalating mental health crisis and a way to reduce sick call visits.

> "I do think that there would be a decrease in the amount of patients that we see every week, every month, if we did allow a group. Even if we didn't do individual. [counseling]…realistically speaking, we're not going to be able to do individual because there isn't always that many people. But if we allowed a group maybe three times a week."—Respondent 45, Mental Health Coordinator

Substance Use Disorder Among the Population

Staff frequently mentioned the prevalence of substance use disorder and the need for detoxification protocols. Respondents indicated a recent change in increased awareness and introduction of policy and practices in caring for this population that has helped staff's ability to manage the population. This reflects the national opioid crisis, especially in vulnerable populations, and the responses created both in the community and in jails.

Among all jail sites, there was an appreciation for standardized protocols that not only reduce incarcerated individual management issues but are also reflective a more humanizing approach to medical care. Respondents described a historical environment that lacked adherence to medical protocols for individuals experiencing withdrawal from substances. Staff describe a setting in which these individuals were at the hands of jail medical staff philosophy and jail policy, which dictated the level of care they would receive to manage the symptoms. For example, there was concern when jail medical staff, specifically physicians approved for prescribing, refused medications to individuals when they felt they were "faking it" (Respondent 21). This created a situation in which the resulting medical issues and behavior then became a management challenge for officers. Conversely, respondents mentioned doctors who brought an "everyone gets medicated" philosophy, which respondents stated increased the risk of overdose on the block.

Respondents were keenly aware that today's illicit street drugs represented the substance use related medical challenges they would see inside the jail. The change in the street drug market, specifically the introduction of fentanyl and subsequent higher levels of contaminated drugs, have required them to adapt their medical care response from the moment the individual enters the facility. Several respondents expressed that the severity of substance use disorder was

heightened after COVID-19. The ever-changing drug market was expressed as a concern for overdose risk because of higher potency and the lack of knowledge of what incarcerated individuals may have ingested prior to entering the facility.

> "I've seen recently more fentanyl than before, which is scary for us. It's absolutely terrifying because when they come in…they're in such a bad state when we get them that in my opinion, it's a miracle that we keep as many as we do alive."—Respondent 61, Sergeant

Responding to the Population of Returning Individuals

Respondents described the jails as an environment that could exacerbate behavioral health conditions for many, despite serving as a respite for others. There was an awareness that if jails provided either internal or external resources, they could not only mitigate mental health issues but could also impact one's health. Respondents discussed "frequent flyers", individuals who cycle in and out of the facility, as individuals impacted by their behavioral health conditions or lack safe and secure resources within the community that would serve as protective factors to criminal justice involvement. This presented an opportunity to engage with them differently in the hopes of addressing issues that would reduce reentry into the facility.

> "I do definitely see a lot of repeat offenders, especially with the homeless population. Sometimes their hands are kind of tied behind their back. It's just like a vicious cycle of in, out, in, and out."—Respondent 63, Classification Officer

> "If there's somebody that is one of our 'frequent flyers' that are coming in every other week for a trespass charge because they have mental health issue and they don't have anywhere to live, and nobody wants them to stay with them, we might start looking into community-based services, you know, pathways, or reaching out to other community organizations to have long term care or inpatient care."—Respondent 40, Programs Coordinator

In one particular jail operating in an area with a highly transient population a respondent estimated the homeless population in the jail at "about a third" (Respondent 63). During the summer when the temperature peaks, there is an influx of unsheltered individuals entering the facility, requiring the jail to adapt. Respondents noted the constant churn of individuals was a barrier to providing meaningful treatment inside the facility and setting up discharge planning that connected incarcerated individuals to supportive services.

Respondents stated that in mitigating and preventing injury and death in custody, it was important to pay attention and recognize changes in behavior. This included changes in dietary intake, conversations with staff and others, and self-isolating behaviors. Observation of individuals during the intake process was described as important to identify behavior changes later on, especially with those screened for mental health or active detoxification. The increased attention to observing and responding to changes among incarcerated individuals was a role both custodial and non-custodial staff felt responsible for and described their responsibility to act on these changes. Respondents described how staff work together, especially when supportive positions such as jail navigators, social workers, and other non-medical professionals were employed by the jail, demonstrating a continuum of care.

> "The case manager will go down and talk to them. They may need a place to stay when they get out, so the jail navigator will get on that. Or they may say, I haven't seen my kids. The case manager will report that to the social worker and say, this person needs social services, they need food stamps, they need to see their kids when they get out, and the social worker will start working on that…so the case manager is kind of that centralized hub that dictates the next move for a person."—Respondent 40, Programs Coordinator

Alternatives to Incarceration for Mental Health Population

Respondents mentioned the overuse of jail for individuals with an underlying mental health condition. Related to this view, one command-level staff member held the conviction that "you don't die in custody if you're not in custody" (Respondent 21). Respondents felt that the nexus between mental health and criminal activity was clear and that jails are serving as de facto mental health facilities because of an overreliance on hospitals and jails resulting from stigma of mental health.

> "It's just sad that you're schizophrenic and talking to yourself at the racetrack, at the gas station, and they arrest you and you're incompetent to stand trial. You're going to stay here 180 days until you time out because you're never going to [state hospital] because that's a 450-day wait."—Respondent 21, Psychologist

> "We're trying to stabilize them and make the best of the situation we have when they're here. And I'll always go back to 'they shouldn't be here to begin with'. In most cases, they should have been diverted."—Respondent 26, Commander

Consistent with these sentiments from respondents, they also discussed the value of jail-based programming to address behavioral health conditions.

Jail Programming to Address and Mitigate Behavioral Health and Mental Health Issues

A philosophy of improving the lives of incarcerated individuals, to "leave them better than we found them," was a common theme among the jails. Respondents frequently mentioned programming within each of the jails as a positive way in which they were mitigating and preventing deaths in custody. Recognizing the needs of the population, specifically behavioral health and the role of co-occurring disorders, each had a variety of programming that supported incarcerated individuals' access to supportive services that could include vocational, educational, faith-based, and behavioral health services. Reasons for programming included keeping individuals engaged in activities to minimize management issues, preparing individuals for reentry, and addressing issues believed to contribute to recidivism such as social detriments to health related to poverty and behavioral health. One respondent noted that programs serve a purpose both in and outside of the facility, articulating that staff "are not necessarily helping just prevent deaths while they're here…they're helping for when they leave because they're connecting them with resources that they may not have had there, connecting them with programs and housing" (Respondent 44).

> "There's housing units for folks with addiction, general addictions...In that housing unit, they do learn certain things, certain skills. People come in with

> parenting classes, the anger management classes, all of that. We have people from [UNIVERSITY] that come in that have psychosocial groups and psychoeducational groups."—Respondent 40, Programs Coordinator

> "I'll give them handouts if they're accepting of handouts…We'll talk about stress management. What they can do to help their stress, what they shouldn't do to make their stress any worse. I'll give them puzzles, little things that they can read, the handouts, anything that is related to mental health. We definitely give them cognitive behavioral therapy (CBT) skills and techniques."—Respondent 45, Mental Health Coordinator

> In preparing individuals for reentry into the community, and in the hopes of reducing recidivism for individuals for these populations, one jail discussed the role of their jail navigator. The role of this position is to conduct follow-ups with individuals with mental health conditions who have been in the facility for an extended time. It is recognized that this individual will need mental health services upon exit and support navigating the resources. The lack of mental health facility beds, and wait time, was noted as a concern. Serving as the bridge between the inside and outside, the position will contact external service-based agencies. Once the individual exits the facility, it is then the role of a case manager to conduct follow-ups at 6- and 12-month intervals "just to make sure they're good, if they have any needs, or if there's anything we can help them with or try to help them again....housing, transportation, employment"(Respondent 40).

Respondents mentioned the use of technology as a preventive measure for mental health crises. Respondents articulated the jail environment can be seen as depressing and isolating. However, as COVID-19 changed the visitation policy, jails were able to pivot to the expanded use of technology for video visitation. After COVID-19, the continued availability of this technology has allowed incarcerated individuals to connect with their loved ones more frequently, which was recognized as having a healthy impact on one's mental health. Respondents also noted this had a positive impact for children who could connect with a parent nightly as opposed to being exposed to jail visitation and seeing a parent in a carceral setting.

One respondent described what it was like for incarcerated individuals to use this technology to mitigate the loss of connection to family and to visually connect with familiar scenery.

> "So my mom lives in [CITY]…I committed a crime here in [COUNTY]. Well, guess what? My mom can't afford to come to [COUNTY]. But she can pay a couple of dollars, and I can see her in her kitchen on [video visitation]. That helps deter me from going stir crazy from not being able to see my mom. One of the coolest technologies ever invented for jails…tablets and their video visitation system."—Respondent 41, Chief

Shift in Jail Staff Perspectives on Addressing the Needs of the Incarcerated Population

The respondents demonstrated a keen understanding and empathy for the vulnerable populations housed in the facilities. These populations included those experiencing behavioral health issues, homelessness, and charges that put them at risk for victimization by other

inmates. In one particular jail, they ended the practice of posting face sheets that contained an incarcerated person's images and charges.

> "Our goal, and I tell all of my staff, you've got 24 to 48 hours to address somebody that comes in with a mental health or substance use issue. And whatever that looks like is based on the individual, because it's all individualized….If they have an opioid use disorder, we are going to try to get them to MOUD treatment and MAT treatment."—Respondent 40, Programs Coordinator

> "A guy back here, his wife died and then his grandmother died…they did a search of the unit he was in and found what would be considered contraband. It was [his wedding] ring…so they went back and put it on his bunk and let him keep it. It's things like that, you don't know what would have happened if it was thrown away….So I think things like that is how we're preventing a lot of the issues from happening."—Respondent 40, Programs Coordinator

Although there was strong support for programming that positively impacts the health and well-being of incarcerated individuals, respondents noted that the needs and priorities of protecting and managing the changing jail population would also require continual training and evaluation of staffing levels and responses.

> "Most people [new staff] have no idea…about the homeless population, drug abuse or the mental health that we have. So [it's] definitely a culture shock the first couple of years. It was for me."—Respondent 61, Sergeant

Similar to other agencies across the country, the practitioners we interviewed faced numerous challenges with the population of individuals entering and re-entering their facilities. Mental health and substance use disorders as well as being unhoused were common characteristics of the population served by the jails, and many of these challenges were viewed as increasing in recent years. Respondents described ways that their agencies have had to adjust to meet the complex needs of this population, including through expanding staff training and programming while being mindful of the toll on staffing levels and availability.

4.4 Theme 4: Suicide Prevention

Suicide has historically been a leading cause of death in jail custody. Despite efforts to better understand the phenomenon and identify and mitigate the risk factors of suicide, these deaths persist. The efforts of jail staff to prevent suicides and preserve life are less visible to the public than suicides that are successful.

> "Here we're actually pretty good at preventing suicide. Although they do happen. We've had one over the last year, but we've prevented like 58 active attempts where we've cut them down."—Respondent 20, Assistant Chief

Several respondents discussed the challenges associated with the growing number of incarcerated individuals with serious mental illnesses and noted that jails were simply not designed, or properly staffed, to provide the requisite level of care. Some respondents cited the lack of resources to address behavioral health needs in the community—before individuals

become justice-involved—as a critical factor. They expressed concern that in many cases, mental illness has become criminalized and jails have been turned into "dumping grounds." Others supported the establishment of county-run diversion centers, which could better serve this population compared with jail, without compromising public safety.

> "We are the de facto modern mental health institution. I think it's quite terrible here because there's no real resources, you know, for the uninsured. For the layperson, there's no county hospital. The local mental health authority doesn't have beds."—Respondent 20, Assistant Chief

> "I would say quit arresting people that really basically need mental and substance abuse treatment to start out with. There should be a real true robust diversion program in this county."—Respondent 21, Psychologist

One agency reported that the situation is exasperated by staffing shortages in state hospitals, which limits their capacity to treat incarcerated individuals deemed incompetent to stand trial. As a result, these individuals are sometimes held in jail for years before transfer to the hospital so the trial competency restoration process can begin.

> "We had one guy die this year waiting on a state hospital….They can't staff the state hospitals and so they can't even use all of the little amount of beds they do have. So our inmates wait. If you're on a low-level charge, you wait 450 days to go to the state hospital. If you're on a first-degree felony assault, murder, that's 860 days to go to the hospital."—Respondent 21, Psychologist

Screening

All agencies we visited screen individuals booked into their jails for mental health issues, including suicide risk, using various instruments (e.g., Columbia Suicide Severity Rating Scale). Furthermore, some agencies reported that they will refuse to accept an individual from an arresting officer if they determine the individual to be "unfit for confinement." In these cases, the arresting officer must take the individual to a local hospital to be treated and cleared before admission to the jail.

> "So the question on your standard arrest forms, it'll say, basically, do you believe this person to be mentally ill?...I think we're still the only jail in [STATE] that will deny acceptance for psych issues. We forced them [arresting officer] into taking them to hospital. And then we took that generic question and we elaborated on it. So, we'll use that to determine whether or not

Columbia Suicide Severity Rating Scale (C-SSRS)

The C-SSRS is a screener that assesses suicide risk through a series of brief, simple questions around the following:

- Whether individuals have thought about suicide and when
- The actions they have taken to prepare for suicide
- Whether they have ever attempted or started to attempt suicide

See more information here:

https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/about-the-scale/

> this person is fit for confinement or if we need them to go to the hospital to get fit for confinement."—Respondent 20, Assistant Chief

> "If any time a patrol deputy or officer is out on scene and they have somebody who's a suicide subject, they're already taken to a mental health facility. We don't take them to the jail...If we don't have that information prior to arresting them and taking them, we do what's called an EIMI [Early Indicator of Mental Illness]. It is an indicator of mental illnesses."—Respondent 24, Lieutenant

As part of the screening process, some agencies reported that they access and review external databases to determine if incarcerated individuals had previously sought mental health treatment. One system described, managed by the state, captures information from public/state-funded mental health facilities and providers in that state. Another system, managed by the contracted medical service provider, allows their staff to track services delivered to the individual across the correctional facilities in which they operate (e.g. across counties, states). Although information sharing gaps persist, the respondents reported that these systems can provide important insights and help ensure that individuals who were on medications prior to admission can continue without unnecessary delay.

Respondents reported various protocols for determining the frequency of contact with behavioral health staff; the level of watch needed, if any (e.g., mental health watch, suicide watch); the tiers within each level allowing for a step-up or step-down, as needed; and the authority required to make these decisions.

Preventing Suicide Attempts

Although screening for suicidal ideation and intention is critical, particularly closer to intake, respondents acknowledged that suicide is very often an impulsive decision; therefore screening, although important, is not enough. Indeed, it is not uncommon for incarcerated individuals with no previous indication of a behavioral health issue and held in general population to die by suicide. Respondents routinely stressed the importance of learning from previous incidents, including near misses, and developing strategies to reduce access to means of suicide.

> "I believe as a clinician, you're not going to screen your way out of suicide…you can't go around and ask a thousand people every two hours are you going to kill yourself. But we can do things here to mitigate access to means. So that's our big focus."—Respondent 21, Psychologist

One agency discussed several issues with the physical design of the facility they have had to address to prevent suicides attempts. For example, in response to individuals throwing themselves from the second tier of housing units, they have started installing metal mesh material as a to eliminate this risk.

> "You go to the second tier. The second floor. Well, now you see there's cage material in orientation. And in the chute, we put up some wire mesh to keep people from swan diving off the second floor, which has only been a trend like in the last few years."—Respondent 20, Assistant Chief

Somewhat relatedly, the facility simply does not have enough specialized housing units or cells to accommodate the increasing number of individuals with mental illnesses or at risk of suicide. As a result, these individuals are often housed in settings meant for general population. Respondents noted several modifications they have had to make to reduce suicide attempts, including retrofitting light fixtures and handrails to prevent hanging and covering electrical outlets to prevent electrocution or fire-starting.

> "There are handrails. We're getting the lights changed in the infirmary [so] that [they] don't stick out....And so you can wrap around that. We do have to have some cells remain with some good handicap rails, so we're in negotiations on what we do with that. We had him [chief] get covers for outlets."—Respondent 21, Psychologist

The agency also described a dilemma in that state standards, which mandate a sprinkler head be located in each cell for fire suppression; however, the heads pose risks both as a potential ligature point as well as a source of metal that could be used to self-harm. The same agency noted conflicting guidelines between state standards versus best practice with respect to housing suicidal individuals. In this case, the standards call for isolation whereas best practice, and the agency's philosophy, is not to isolate the inmate.

> "I'm teaching this material [state standards] in here. And one of the things is it talks about types of cells used for suicidal inmates. And there on the state material, it says separation cells, single cells and violence cells. And all three of those goes against our philosophy on what you should do with suicidal inmates. And that is put them in a double cell with somebody else."—Respondent 25, Lieutenant

Opportunity Reduction Measures for Suicide Prevention

Jail practitioners described multiple ways they try to mitigate access to means and opportunity for self-harm, including:

- Installing suicide-resistant features in cells (e.g., recess lighting, covers for electrical outlets)
- Removing/modifying features that could be used as ligature tie-offs (handrails, sprinkler heads)
- Installing cages/metal mesh material in upper tier units
- Housing individuals in double cells
- Standardizing and minimizing property individuals can bring into special housing units
- Implementing technologies that improve observation (electronic rounds tracking systems, cameras, health monitors)
- Training detention officers to conduct high-quality rounds

Respondents discussed several challenges associated with the types of items incarcerated individuals on mental health/suicide watch should not have access to. Agencies typically make this determination in consultation with medical staff; however, the list of items can vary based on factors such as the levels of watch and the inmate's previous self-harm behaviors (e.g., eating pencils). Therefore, it can be difficult for correctional officers to maintain awareness of each person's individual circumstances and to vigilantly monitor whether they possess banned items. To improve effectiveness, some

agencies have both significantly reduced the items these individuals can possess and standardized the items so that officers can immediately identify a banned item.

> "We standardized and reduced the amount of property allowed in the special housing units in order to reduce the means for suicide…we agreed on a very small list of things that they could have…And it's not ideal in every way, but it at least standardizes it to where the officers don't put a lot of thought into it. You can walk by a cell and notice that [an item] doesn't belong there….But if every cell they go to has different allowances, it's just unmanageable."—Respondent 26, Commander

Several respondents noted how difficult it can be to prevent a determined individual from a suicide attempt.

> "As I've said I've been doing this long enough and written enough incident reports as a peace officer of suicide attempts. I know the ones that are seeking attention and I know the ones that are truly determined. Those that are truly determined, they're going to find a way to do something when somebody is not watching them. Short of putting them in a glass cell with nothing in there, I don't know that you're going to stop every attempt."—Respondent 25, Lieutenant

The agencies we visited all emphasized the importance of situational awareness, primarily in the form of correctional officer rounds, in preventing suicides; however, each reported different policies regarding how often officers must check on individuals to assess their condition (e.g., every 15, 30, 60 minutes) and the condition of their cell (e.g., excess property, material blocking the window). The frequency varied based on factors such as the agency, relevant state standards, and the level of watch, if any, deemed appropriate by medical staff (e.g., suicide watch, mental health watch). During one visit, we observed individuals under constant observation.

Respondents stressed the importance of adhering to policy, both in terms of the frequency requirements but also the need for officers to conduct "quality" versus cursory checks.

> "I just think not getting in the routine of just doing a tour, but actually checking to see what's going on and not just walking down and back and calling that a tour. I think that's important as well. I think we have good plans in place. I just think we need to be a little bit better at following what we're supposed to be doing."—Respondent 63, Classification Officer

> "The most important part of the officer's job is self-checks and supervisor rounds and visually making sure that someone is breathing and alive."—Respondent 47, Lieutenant

Respondents discussed different strategies to ensure that officers are properly conducting their rounds. One agency described how managers (e.g., sergeants and lieutenants) will periodically review video footage to assess whether officers are conducting "quality" rounds. As one chief noted, it is important to "inspect what we expect, so that we yield the proper result" (Respondent 41).

> "As the officer's walking by making rounds, either he's paying attention, looking in those windows, or he's not. The lieutenant can visually check on every one of his personnel and do a quarterly check to see if they're making their rounds properly. So that's another way we ensure that proper supervisory rounds are being made. It's not just about making rounds to hit buttons. Is it a quality round, right? The more we do that, the officer becomes conscious like, I don't know when the lieutenant is going to pull mine up."—Respondent 41, Chief

Another approach leverages round management technology consisting of a handheld computer carried by the correctional officer and RFID tags located outside cells. Basic systems timestamp the officer's presence during rounds, whereas advanced systems also allow officers to record notations documenting the incarcerated person's condition (e.g., not eating, not sleeping, poor hygiene) so mental health staff can follow up.

> "We upgraded our rounds tracking system…the system helps us be more intentional about the rounds. It's not just looking at a face and scanning a tag, which becomes very routine and sometimes breeds complacency. You're looking at every individual now and you've got something to report their behavior."—Respondent 26, Commander

Key to effectively performing rounds is knowing what to look for. Respondents reported that correctional officers are trained to, and routinely, make mental health referrals for individuals they believe are in distress. Although some training is available, several respondents discussed the need for more consistent training and resources in topics such as mental health first aid, suicide awareness, signs of depression, de-escalation techniques, communicating with people suffering from mental illnesses, and crisis intervention. Furthermore, refreshers on mental health watch and suicide watch protocols and what things incarcerated individuals can and cannot have access to would be beneficial.

> "The more urgent it is, the more immediate we're going to get them that help. So, if it's just an observation that may mean nothing, but I want to make note of it, I'll use that Guardian system. If it is a little bit more notable, I think somebody needs to see this person, then I'll do the mental health referral."—Respondent 26, Commander

Relatedly, respondents noted that direct observation versus linear design jails allow officers to have greater situational awareness of incarcerated individuals; however, regardless of the design, suicide prevention efforts would be enhanced by the presence of more cameras to reduce the number of blind spots.

> "It is hard to do with a linear jail like we have, you know, we're three quarters of a mile from booking all the way down the block, so it's hard to do…But I think jails across the U.S. who are looking at designing their facilities, they need to design it with direct supervision [in mind]."—Respondent 46, Captain

Agencies also reported interest in emerging technologies or approaches that would aid suicide prevention efforts. For example, respondents noted that they were exploring new vital signs monitoring technology, which leverage sensors to identify and alert staff if a monitored

incarcerated individual's vital signs (e.g., pulse rate, respiration rate, body temperature) indicate distress.

Several respondents discussed the important role that incarcerated individuals' communication tablets are playing in suicide prevention efforts. For example, the tablets help reduce idleness and facilitate communication with friends and family; keyword monitoring of communications can identify suicidal thoughts and can also be used to deliver mental health counseling. One respondent reported that access to tele-psychiatric services delivered via tablet increased mental health visits by 30% because the improved efficiency allows staff to see more individuals.

> "We implemented systems where inmates could get mental health counseling over tablets and over Zoom and things like that…So it allows medical staff to extend themselves out further and reach a greater number of inmates."—Respondent 26, Commander

Responding to Suicide Attempts

Respondents noted policy changes that have helped staff respond and potentially interrupt suicide attempts. For example, two of the agencies visited are now providing all officers with EMT shears to be worn on their duty belt. Direct access to these shears allows officers to more quickly cut down individuals who are attempting suicide by hanging; previously, these or similar, tools were typically issued only to a supervisor or kept in a central location (e.g., command center), which delayed response time.

> "We bought 350 [rescue shears] and got them issued out. So now as everybody gets hired in and they get their uniform, they get a pair of rescue shears."—Respondent 25, Lieutenant

Other helpful strategies mentioned include deploying automated CPR machines, locating medical stations near housing clusters as opposed to a central location, and conducting regular drills. One respondent reported that the simple step of better training and communication between correctional officers and medical staff resulted in more accurate use of radio call codes which allows medical staff to bring the right equipment to an incident saving precious time.

> "We recognized a problem when officers were calling out certain situations and they [medical staff] were not showing up with the proper equipment. So, we partnered with medical…They just kind of educated us on the terminology, like 'code blue' and 'man down'. [We] put that on paper with them and pushed that out to correctional staff so they can properly call out for something."—Respondent 59, Sergeant

In summary, suicide remains a critical issue in jails. In response, jails implement a variety of programs and practices to prevent suicides. Every jail we interviewed administers suicide prevention trainings for staff that are designed to help identify when someone is in mental health crisis or at risk of suicide, in addition to administering screening tools at intake to classify individuals based on their needs and status. Jails we interviewed also implement programs aimed at improving incarcerated persons' mental health status and practices that reduce the

opportunity for self-harm, including suicide-resistant smocks or features in cells or special holding cells that require closer observation. Additionally, jail practitioners discussed the added value of different technologies, including electronic rounds tracking systems that can help ensure staff conduct high-quality rounds at a frequency dictated by policy and tablets that can help facilitate mental health counseling and connect individuals with their families. Beyond measures that mitigate the risk of individuals engaging in suicide behaviors to begin with, practitioners also take steps to improve their response to suicide attempts through ensuring staff are properly equipped (e.g., with rescue shears) and trained.

4.5 Theme 5: Preventing Intoxication Deaths

Screening for Substance Use Disorder

Screening for substance use disorder was established within each jail, and respondents indicated an increased focus on using other indicators and not just inmate self-report to identify potential overdose risks. All the jails described a system of screening that occurs initially at intake to identify mental health, substance use, suicidal history or present feelings of ideation, and recent hospitalization. One respondent noted that there is an understanding that the sooner they know this information the more they can get ahead of it (Respondent 22). Asking arresting officers what transpired on the call for service and up to the point of arriving at the jail was also noted as important in learning an inmate's current status.

> "It requires them to ask the arresting officer specific questions about what they might have said or done before they ever got to that point. We require that of them before we will even take the inmate in. And that could be anything medically related, mental health issues that might have been obvious at the time, or suicidal tendencies."—Respondent 26, Commander

One particular jail had an EMT staff member staged in the intake/booking area whose responsibility was to ask basic medical screening questions to identify any immediate needs and whether the individual was deemed "fit" for confinement, versus being sent to the hospital. This position considered the charges and whether the potential for drug intoxication or smuggling drugs existed. Positive indicators would trigger immediately placing the individual on a detoxification protocol. An individual's history of detoxification or other identifying factors could also trigger an automatic detoxification protocol.

> "Before, a nurse would come up, ask like five basic questions and that would be it…But now they [EMT] do a whole pre-booking assessment before we take somebody. They're going to ask like 45 questions at this point."—Respondent 61, Sergeant

> "Every single person that goes on detox gets referred to mental health…Because a lot of times, anxiety and suicidal ideation and that kind of thing just this statistically goes along with detox and substance abuse and use."—Respondent 22, Director of Nursing

One respondent described the comprehensive screening process that recognized the heightened risk of overdose. In this facility, a full clinical assessment is completed within 48

hours for an individual experiencing substance use disorder. This differs from mental health screenings where everyone at intake gets a mental health screening but may not get a full mental health assessment. Similarly, because some incarcerated individuals fail to disclose their substance use, one jail employs detoxification monitoring nurses. In recognition of a cross-contaminated drug supply, everyone screened for substance use is monitored for opiates.

> "That's our first point of contact. I always tell the nurses that being in booking is one of the most important jobs because you have to get all this information out of people that have just been arrested and they don't want to be forthcoming and they're inebriated and or they're high on something or they're just angry and pissed off or their mental health.."—Respondent 42, Health Services Administrator

> "Recognizing that MH [mental health] is a part of detoxing: every single person that goes on detox gets referred to mental health…. Just statistically, anyone detoxing is at higher risk of certain things. Because a lot of times like anxiety and suicidal ideation and that kind of thing just this statistically goes along with detox and substance abuse and use."—Respondent 22, Director of Nursing

Respondents mentioned that education on recognizing overdoses is important and was key in one incident to saving a life. In this incidence, they were called to respond to an overdose in a cell occupied by two incarcerated individuals. As the individuals were separated and one was being revived, an officer checked on the second individual who had been moved to a separate room and discovered that he was also overdosing. Both were revived. One respondent indicated that this education was equally important in recognizing who needed to be on a detoxification protocol, stating that it is easy to take someone off of the protocol, so being able to recognize the signs of an impending overdose and putting someone on a detoxification protocol was critical (Respondent 62).

Detoxification Protocols and Cells

Respondents described the absence of well-managed detoxification protocols as a major concern, in addition to the lack of space for housing groups of individuals experiencing withdrawal from substances. Respondents recognized that these individuals need specialized care, and the absence of such spaces will create more medical issues. Lack of space and attempts to repurpose existing areas were mentioned as barriers to addressing the lack of placement for individuals in withdrawal appropriately. A respondent from one agency touted the benefits to having multiple people housed in detoxification cells, as other people in the cell can serve as unofficial observers who can alert staff when someone is in medical distress. This contradicts another agency's policy on housing individuals in special holding cells (e.g., detoxification cells) on a single-person basis to the extent possible.

> "The issues that we're seeing with the detox rooms, you have 3 or 4 inmates in the detox room that are all detoxing the same time. In my opinion, it a little bit defeats the purpose of a detox room if all of them are kind of out of it...I have noticed before we had the detox rooms, you had those general housing inmates mixed with the detox that could be like 'Hey CO, you have somebody in here seizing.' So, I do think that the detox room was a good idea, but I don't think the

> full plan of it is going the way that we expected."—Respondent 63, Classification Officer

> "I prefer more like a buddy system...It's a hard thing to do, especially if you're in a sane mindset…you could be by yourself… going through withdrawal and you're probably scared. It's not good to be by yourself. So, I would definitely say two or more in the cell together."—Respondent 61, Sergeant

Naloxone

As drug intoxication trends has changed, the jail response has changed. The presence of naloxone, a lifesaving opioid reversal medication, was noted by respondents in all sites and was viewed as necessary medical intervention, much like an AED.

> "Thank God for Narcan because we would have had several deaths in this facility if it was not for Narcan. This region is heavily known for drug and drug use."—Respondent 41, Chief

Each jail articulated where this type of emergency response equipment was located for immediate response, with one jail indicating they wished they had naloxone for officer response. Respondents who discussed naloxone understood the emergency nature of administration and its ability to save a life. One jail mentioned the use of more protective equipment by officers when responding to overdoses, which could involve an unknown substance, inside the jail. Respondents articulated that incarcerated individuals do get creative in creating intoxicating substances, and therefore, appropriate medical responses can be challenging.

Medication-Assisted Treatment

Jails across the country have been implementing medication-assisted treatment (MAT), which includes administering Medications for Opioid Use Disorder (MOUD) programming and protocols at a rapid pace over the last decade. In our interviews, staff support for MOUD maintenance was commonly mentioned for its ability to prevent overdose deaths, to minimize negative behaviors experienced during withdrawal and dependence, and to respond to health conditions related to opioid use disorder. One respondent we interviewed also attributed MAT to mitigating mental health issues.

> "The whole MAT thing seems to have helped a lot because you don't have them going through the same depression and withdrawal symptoms"—Respondent 25, Lieutenant

Medications for Opioid Use Disorder

MOUD include various medications (e.g., Suboxone, Buprenorphine, Methadone). Although maintenance of existing MOUD is required by the Americans with Disabilities Act, the practice of inducing MOUD while incarcerated takes significant planning and resources.

Challenges raised in interviews with jail practitioners include the following:

- Planning discharge to ensure access community-based services
- Available space for implementation
- Dedicated staff to implement the program

Benefits raised include the following:

- Preventing overdose
- Improving health and mental health status

See more information on MOUD here: https://archive.ada.gov/opioid_guidance.pdf.

Despite practitioners' views on the benefits to inmate health from both the maintenance and induction of MOUD, respondents mentioned several challenges centered around capacity to provide MOUD. For one jail, the need for appropriate discharge planning was identified as a barrier.

> "The immediate thing holding us back is the discharge planning. The reason I only do the maintenance, [as opposed to] the continuation is, I know you know where to go to get the stuff when you leave. If I start you here and send you out now, you're at a great risk for overdose."—Respondent 21, Psychologist

Another jail was able to overcome this challenge with the use of specialized support staff to pave the way for a continuum of care upon exit.

> "Once we get them here, the court clinician and the peer support specialist essentially do an intake process for them while they are here so then when they leave, it's an easy transition. They just go in for court and they're already pretty much enrolled."—Respondent 40, Programs Coordinator

Practitioners also mentioned other resources, such as space and staff, as challenges in fully implementing MOUD. Many jails around the country have been able to house populations with SUD together to fully engage in treatment modalities, such as support groups and counseling. However, another jail recognized that the use of MOUD should not be reserved only for those accepted into a dedicated housing unit and allows individuals in general population to use

MOUD. Additionally, one jail was able to have a dedicated corrections officer attached to MOUD activities, which enabled the protocol to be carried out without delay, while another jail described medical staff having to wait on an escort by detention staff to visit individual housing cells to deliver health services.

Technologies Screening for Contraband

The implementation of a body scanner was seen as a preventive technology to prevent drugs from entering the facility. However, there was concern as to the quickness in which the technology would become outdated. There was also concern as to the limited amount of training provided either by the vendor or unavailable because of budget constraints. Additionally, staff raised concerns about the physical features of the body scanner being tight and dark for larger inmates and those in crisis who may be uncomfortable or concerned about being inside the device.

Adapting Medical Staffing to Reduce Risk of Overdose

Although the sites engaged in screening, treatment, and programming to address substance use disorder and reduce the risk of overdose deaths, changes in staffing roles also presented an opportunity to mitigate deaths in custody. The ability to fully address a continuum of care was dependent on jail medical staffing and budget, but creative ways to reallocate staff based on need were identified.

> "We also now have our RNs in the detox role too…we took the detox monitoring aide to help lighten the load for the LPNs because they were overloaded with everything going on…We've had a significant decrease in hospitalizations and people having to go out to the hospitals for detoxing…so things are being caught at a much quicker stage rather than waiting till it's moderate to severe when they need hospitalization or need to be sent out for treatment."—Respondent 22, Director of Nursing

As the jails have implemented programming and more specialized medical staffing, respondents noted challenges. Nurses seeking to check on incarcerated individuals and provide services would need to wait for officers to escort them. Respondents noted they felt dismissed, and it was unclear whether this was a lack of officer buy-in or understaffing of officers. One jail felt so strongly that medical schedules be consistent that they dedicated one officer solely for escorting the MAT nurse to individual cells.

All jails we spoke to implement a variety of practices designed to identify and treat incarcerated individuals with substance use disorder. Beneficial practices discussed include the use of intake screening tools, detoxification cells and protocols, and MAT. Technology that screens for contraband entering the jail (i.e., a body scanner) was also discussed by practitioners, though there were several concerns raised, including the lack of training staff receive to operate the technology. As with many other aspects of jail operations, staffing levels and resources often impact the delivery of care necessary to prevent or reduce intoxication deaths. However, the agencies we interviewed are finding innovative ways to address these issues, such as reallocating or dedicating certain staff based on need.

4.6 Theme 6: Medical Care

Electronic Health Records

The automation of internal record management systems has extended to ensuring electronic health records are updated. Respondents described the nature of the jail setting in which individuals needing care depend on jail staff because they themselves cannot call a doctor's office or knock on medical's door. The use of referral systems and electronic records was commonly referred to as creating accountability and ease for an incarcerated individual's medical care. One respondent described that "electronic records really emphasize not losing people" (Respondent 21). The variation of use depended on the technology platform, with some automatically sending referrals based off intake screening responses to systems used to schedule follow-up appointments. Respondents described the use of electronic records at booking to assess immediate and expected needs and their use as referral systems once the inmate was classified and established within the facility. Multiple respondents pointed out that staff should always be reviewing electronic records of past history within the facility from a prevention standpoint, identifying behavior patterns and how prior care could dictate current care.

> "You can categorize folks and it automatically creates follow up for hypertension, seizures, diabetes, pregnancy, there's multiple layers and layers of automation that we've sort of programmed into the electronic record so that you almost literally can't make a mistake booking people in."—Respondent 21, Psychologist

One jail described their process in which the magistrate is flagged to support access to medical records if an incarcerated individual is not forthcoming or a poor historian of their own medical knowledge. Access to a statewide database that provides historical information if an individual has been seen at a state-funded community mental health facility was also mentioned. An identified gap was the lack of a statewide database that allows jails to record suicide attempts, a source of information sharing that could inform subsequent jails of prior attempts made by an individual.

The role of officers in recognizing and responding to incarcerated individual medical needs was described and varied across the sites as far as technology and process. At one jail, medical staff spoke about officers being able to refer individual to mental health service using a fillable form, but once they learned more about the mental health needs and terms, they could enter a report into the electronic record system for mental health referrals.

Respondents discussed other means of flagging suspicious behaviors that would indicate a potential mental health crisis. Individual medical needs were also assessed through observations made by jail staff who listen to jail calls. If an incarcerated individual's conversation indicated a possible mental health crisis, staff would communicate this to the appropriate personnel. This knowledge gathering also occurred from reports from other incarcerated individuals. Respondents discussed the likelihood other incarcerated persons would notice behavior changes, including extreme mood changes, isolation, and agitation, and would request officers to handle the situation.

Jail Infirmary

Respondents mentioned the lack of space to care for the increased population of those experiencing mental health concerns and for those in detoxification as a pressing issue. The closed physical nature of a jail structure limits the ability to adapt space to house individuals in need of behavioral health or general medical concerns appropriately.

> "Our small infirmary that was built for medically sick people is overrun with mentally ill. And that's spread into our special housing units, which are made for disciplinary issues and administrative separation, which are primarily filled now, both of them, with mentally ill."—Respondent 26, Commander

Addressing medical needs among the incarcerated population is another challenge for jail staff because these needs are often co-occurring with other mental or behavioral health concerns. Jail staffed discussed their use of electronic health records as a way to screen and refer individuals for any health-related concerns. Automated systems that trigger referrals based on answers to intake screeners were especially noted as a way to keep things from falling through the cracks and therefore increase accountability. Some gaps that jail staff discussed related to their ability to provide medical care include information siloes, particularly access to external databases around mental health history and a lack of space for medical care, given an increase in individuals with mental health concerns.

4.7 Theme 7: Accountability

4.7.1 Incident and Death Response and Investigations

In general, the agencies we visited all reported similar processes regarding response and investigations around serious health incidents and deaths in custody, although there are variations. In responding to emergency incidents, correctional officers and medical staff engage in life-preserving efforts. In the case of a death, there are common elements involved in the investigation process. In many cases, the investigation would be conducted by an external entity, though some respondents indicated that deaths due to natural causes were not necessarily investigated by external entities. Agencies may support these investigations as needed, but all gather information for their internal critical incident review process.

Typical Elements of Death Investigations in Jails

- Preservation of crime scene (in the event of an unnatural death)
- Notification of appropriate internal parties (e.g., chain of command)
- Gathering documentation (e.g., physical evidence, photographs, video footage, medical records, logs, documentation of rounds)
- Notification of external agencies, as required (e.g., jail commission, state Attorney General)
- External agency conducts investigation (e.g., state or other law enforcement agency, state jail inspector)
- Medical examiner or coroner determines cause of death
- Internal critical incident review

The critical incident review process is typically multidisciplinary and, depending on the nature of the incident, could include correctional officers and supervisors on duty at the time of the incident, medical staff, administration, policy, and training staff. Internal affairs could be involved in use of force cases; however, these are rare in jails. The process focuses on root cause analysis and evaluation of precursors/contributors to the incident and the response. The review also evaluates whether staff acted in accordance with policy and training and identifies opportunities for improvements that would reduce the chance of future incidents.

> "In the times that we have had deaths…or near misses let's say. You go back and look at what happened…What could we do different. So usually there's a tweak, but as time goes on, you just get fewer things you can actually [change]."—Respondent 21, Psychologist

> "We do critical incident reviews... We'll watch video and see how we did, and then we'll just go over what can we do better? Self-reflection is the best thing in the world, right? This is what we could have done better and this is what we do well and how we do it next time."—Respondent 61, Sergeant

4.7.2 Policy Changes

The respondents noted that in most cases, critical incident reviews following a death or near miss did not prompt major changes but rather reinforced the importance of vigilant adherence to existing policies and procedures in accordance with the training provided.

> "Inspect what you expect. Reinforce training. Have those supervisors that are responsible for the oversight or proper management of rounds inspect those rounds, watch those videos tied directly to those individuals. Make it part of a common practice that the head supervisor that is responsible for the team on the floor inspect the rounds of those individuals that they serve…We've got to hold officers accountable."—Respondent 41, Chief

That said, some agencies did report substantive changes as a result of a death in custody or near miss. For example, one agency replaced restraint chairs with a wrap system to reduce the chance of medical complications.

> "We had the one controversial death, and then quickly after that discontinued the use of restraint beds...we switched our restraint chair to one that's just so easy to use. It might not be quite as secure. But it at least holds them still to where they have a chance to calm down, where we're not going to fight them in that position. And it's just better all the way around when we don't have to fight them into a restraint system. So that was one of the biggest things that we did, switching our restraint systems to things that were easier for the staff to use…and safer for the inmates."—Respondent 26, Commander

Another agency discussed changes in the items provided to suicidal individuals (e.g., suicide-resistant clothes, mattresses and covers) and strict control of towels and razors.

> "This inmate hung himself. That's a major change. He was able to cut a strip out of the mattress. Which is a little bit stronger than a fabric. He was able to tie around it around the windowsill…I do not believe during that time we had [anti-

>]suicide mattresses and covers. We have those now. I can't say if it was a result of that, but I know that is something that we changed."—Respondent 46, Captain

Other changes of note appear to have been more organic, based on general trends or acquisition of new technology. For example, respondents noted that video visitation and digitized mail systems have successfully reduced the introduction of contraband drugs into jails. Similarly, some agencies have deployed full-body scanners in booking areas to detect drugs within a person's body cavities and Narcan is now commonly used to revive persons who are overdosing.

When an emergency medical situation occurs in jail, corrections officers and medical staff work together to administer first aid. Our discussions with practitioners revealed that deaths or other critical incidents (such as suicide attempts) are regularly investigated and reviewed in jails to understand how the incidents occurred and what (if anything) could be done in the future to prevent a similar event from occurring. In some cases, these reviews result in a change to policy, practice or tools used by the agency. More commonly, respondents spoke about the outcomes of reviews as reinforcing existing policies and training. The importance of maintaining accountability and oversight of staff to ensure they are adhering to training and policy was further emphasized as a mechanism to preventing deaths in custody.

4.8 Findings from Document Review of Select Jail Policies

Given the prevalence of intoxication and suicide deaths in jails, we focused our document review on agency policies related to the intake of intoxicated individuals and suicide prevention policies.

Common Elements in Suicide Prevention Policies

We reviewed the agency documents for suicide prevention policies. All agencies engaged in practices or had policies aimed at preventing suicide. There were some similarities and differences among agencies in their suicide prevention policies; differences were mostly related to the level of detail included in the policy. Some common elements of suicide prevention policies include the following:

- Protocols around intake and screening to assess individuals' mental health status and current suicidal ideation and classification
- Processes related to mental health or medical referrals
- Procedures to place individuals under "suicide watch"
- Guidance for staff on high-risk periods when individuals may be at higher risk of suicide (e.g., when first admitted to jail, after receiving distressing news)

Suicide watch is a form of very close observation used for individuals deemed at risk of suicide (though the levels of risk vary). All agencies had policies around suicide watch. Some of the common elements within these policies include the following:

- Protocols for placing and removing individuals from suicide watch
- Guidance around staff roles and responsibilities

- Definitions of levels of risk for suicide
- Definitions of levels of supervision (e.g., 15-, 30-minute, constant observation)
- Prohibited items in suicide watch cells
- Protocols for how individuals must be dressed (e.g., in safety smock) and transported within the facility
- Protocols for medical and mental health evaluations (e.g., assessed within 12 hours and seen by nurses daily)
- Documentation required for incidents involving individuals on suicide watch

Common Elements in Policies Related to Intoxication

The document review revealed some similarities in agency policy around identifying and dealing with individuals who were suspected to be under the influence of substances or showing signs of withdrawal. Some of these common elements include protocols that:

- Call for an initial screening at intake
- Require medical or clinical staff to be involved in the screening process
- Require individuals to be kept under close observation at a frequency dictated by medical staff

However, the specificity of the protocols varied by agency. Elements included in one or two but not all agencies are as follows:

- Guidance around who should be notified about the individuals currently on detoxification protocol
- Guidance on how often medical staff should observe the individual
- Guidance on how medical staff should administer medications
- Procedures in the event an individual refuses medication
- A table summarizing appropriate monitoring tools, frequency, and duration of administration
- A cross-walk of medications associated with withdrawals from specific substances

Ultimately, having structured, clear policy on screening, interacting with, and monitoring individuals at risk for suicide and overdose is critical for ensuring staff are able to easily follow and be accountable to these important policies.

4.9 Summary

As short-term confinement facilities, jails across the nation experience a constant and rapid churn of individuals under their supervision. Often, and increasingly so, these individuals have significant mental health, substance use, or medical-related needs (Maruschak et al., 2023). Some may be lacking in basic needs such as stable housing (Augustine & Kushel, 2022). In many cases, individuals may be experiencing several of these issues simultaneously (e.g., Dalbir et al., 2024). These significant issues can pose challenges for jail practitioners, including detention and medical staff who are charged with maintaining security within the facility and caring for individuals. Critically, jail staff are also charged with preventing in-custody deaths,

which could include deaths related to medical issues, suicide, and intoxication or overdose among individuals in custody.

To better understand some of the challenges faced by jail staff in preventing or reducing deaths in jail and the policies, programs, and practices that agencies are engaging in that may help reduce deaths in custody, we conducted case studies with three diverse agencies operating jail facilities. Through these case studies, we interviewed jail personnel holding various roles and responsibilities, which resulted in seven themes that emerged from these conversations. Jail practitioners discussed the immense value of consistent, realistic training in preparing jail staff for different situations or types of individuals they encounter. Practitioners mentioned different types of trainings that are especially beneficial, including those related to the identification and awareness of individuals in mental health crisis or at risk of suicide; those that teach how to recognize signs of overdose or withdrawal; and those that teach more effective interactions between officers and individuals, including de-escalation and defensive tactics training. Respondents also discussed beneficial practices they engage in beyond training that helps prevent suicides, such as those that reduce the opportunity for self-harm (e.g., implementing suicide-resistant features in cells), robust identification and referral procedures, and ensuring officers conduct high-quality rounds. To prevent deaths related to intoxication, jails also implement practices such as the use of detoxification cells and protocols, MAT, and screening for contraband to prevent drugs from entering the facility. Respondents also mentioned the use of electronic health records as a way to streamline classification and referrals and increase accountability. In the event that deaths or nonfatal critical incidents do occur in jails, respondents described formal investigations and incident reviews that often result in additional training on existing policy and practice. Practitioners also highlighted challenges they face that impact their ability to prevent and reduce deaths in custody. In particular, these challenges included difficulties with recruiting and retaining high-quality staff, and the growing mental health and behavioral health needs of the population in custody.

5. Prisons

In 2019, there were 1,155 state-operated prisons and another 411 run privately facilities. The total number of individuals held in state prisons increased from 1.2 million in 2001 to a high of 1.3 million in 2008 before declining back to 1.2 million in 2019. Additionally, over time, more individuals were serving longer sentences and more individuals 55 years old or older were sentenced to prison. In 2019, 54% of all prison facilities reported one or more deaths. The predominant manner of death in state prisons is natural death caused by illness, followed by suicide and intoxication. State prison deaths caused by suicide, drug or alcohol intoxication, and homicide have increased significantly over time, and most of the increase has occurred during the past 5–6 years. The prevalence of deaths occurring in prison varies by demographic population and agency characteristics.[10] To understand the policies, practices, and programs related to prison deaths, we conducted 43 interviews with a range of staff at four state DOCs that vary in size, region, and other factors. At one of the sites, the DOC oversees both the jail and prison system in the state, meaning that individuals sentenced to both jail and prison are housed in the same institutions and subject to the same policies, practices, and programs.[11] DOC staff within three of the four sites are also represented by a labor union. Medical care, including care provided by nurses and other healthcare professionals, is provided entirely by contract staff in one of the sites, while the other three sites employ a mix of internal and contract personnel. These differences resulted in some variation in the perceived challenges experienced by the sites. However, several themes that were common to all four sites emerged from our conversations. The following section describes these themes: staffing; facility environment; providing medical care amid multiple challenges; improving response to emergencies; suicide prevention programs and practices; preventing intoxication deaths; and reviews and quality improvement. Differences and similarities in agency policies are also discussed for select practices that were important to preventing or reducing deaths in custody.

5.1 Theme 1: Staffing

All DOCs we visited reported that staffing was an issue, though vacancy rates had improved since the COVID-19 pandemic began impacting prison operations in 2020. The need for staff to work more hours because of understaffing, the difficulty in competing with private sector pay and schedules for medical personnel, the culture inside prisons, and a generational change in perspective regarding working in prisons have impacted staffing. Understaffing resulted in an inability to keep staff trained and impacted the provision of services.

Difficulty Recruiting and Retaining Staff

All four DOCs indicated that the recruitment and retention of staff across all roles is an ongoing challenge for their agencies. Vacancies made it necessary for staff to work more hours, including mandatory overtime, and take on additional responsibilities which impacts retention, quality of work, staff wellness, and general morale. Respondents referred to “mission fatigue”

[10] See “Understanding and Reducing Deaths in Custody: Interim Report,” https://www.ojp.gov/pdffiles1/nij/309441.pdf
[11] All responses from this site were included in the Prison section of this report.

that results from being understaffed but still being required to implement new initiatives and the complacency that settles in when working long days. Furthermore, the loss of experienced staff made it difficult to ensure teams had a good mix of new and more experienced staff working across shifts.

> "You always worry about staff efficiency…We're trying to get [the vacancy rate] down to 10%. But still, you still have people doing 16-hour shifts and at that point efficiency goes down."—Respondent 29, Operations Manager

The shortage of nursing staff was consistently identified as an issue. This is particularly difficult because of the aging prison population and the need for more medical care. In terms of medical care provision, one respondent referred to the DOC as a "nurse-driven agency," which highlights how shortages in nursing staff can have severe implications for DOCs. Although travel nurses and agency nurses who work for a third party were often used to fill the gap, they do not completely fill the gap.

> "We've had to rely on a lot of agency nurses, especially through Covid. And when you bring in agency staff, basically what you're trying to do is fill a void, right? They get a half an hour training by policy…and then you're sent to work in the field and partner up with somebody else who's just as busy as you are."—Respondent 48, Nurse Supervisor

> "We can't do 24-hour nursing staffing if there's not enough staff. If there's only nurses until 11 at night, between 11 and 7 in the morning there's no healthcare personnel in the facility. So sometimes when we have…a death, I'm like, why is there no note at all? And then you find out, oh, there's no nursing."—Respondent 3, Quality Improvement Specialist

Common Challenges Related to Hiring Medical Staff

DOCs face significant challenges in attracting and hiring nurses and other medical staff, which in turn impacts healthcare delivery. Challenges highlighted by DOC staff include the following:

- Disparity in pay relative to private agencies
- Inability to offer telework or schedule flexibility
- High-stress, challenging work environment
- Location of facilities (e.g., rural)

DOC staff believed that the difficulty recruiting nurses and other providers is because there are "better opportunities" for them outside the DOC related to pay, work schedules, telework, and location.

> "I try to get candidates to see the larger package that if you look at your benefits and you're eyeing your retirement, we're actually paying you more…We're trying to get creative on how we can offer our nurses the same types of flexibility so that we can compete."—Respondent 74, Health Administrator

> "Our department heads are doctoral level psychologists….And I'll tell you, it has to do with pay. They are getting 30 or 40% more than what the [state] pays them. And because we work in a prison system…they can't work from home…they tell me those are the two biggest things: pay and can't telework."—Respondent 51, Director of Psychology

In addition, the culture of working in a prison can be very difficult compared with hospitals and other health facilities.

> "When you have contract medical providers who aren't as familiar with our policies, trying to recruit and retain staff can be difficult. Culture inside a correctional facility is very different...It's scary to some."—Respondent 49, Chief of Quality Improvement

To address the staffing issues, respondents reported that their DOCs have established teams, offices or departments solely focused on hiring, implemented career development guidance to allow staff to advance, implemented staff wellness programs, revised scheduling to give staff breaks and more time away from the facilities, and began offering sign-on and retention bonuses and increasing salaries. Some DOCs are working with local colleges, universities, and trade schools to identify candidates to hire.

> "We weren't really doing anything to support a staff member through their career…So we built out an entire division, the Office of Professional Standards and Compliance…They centralized a lot of our recruitment, which helped drive recruitment up. They put staff experience supervisors in all of our facilities. Their job is just monitoring morale, support, mentor younger staff, those types of care and feeding things."—Respondent 30, Commissioner

To increase the hiring pool, one DOC recently lowered the minimum age requirement for correctional officers from 21 to 18. However, respondents perceived that younger recruits with less work and general life experience sometimes lack the necessary communication skills to do the job effectively.

> "We're so short staffed…and to alleviate the pressure on [existing staff], we're hiring more quantity over quality…Communication's huge in our line of work. You have to learn how to communicate back and forth."—Respondent 55.2, Major

Impacts on Provision of Services

Staffing consistently came up in conversation as a significant barrier to providing services and implementing programs because often, the same staff are working across different programs and initiatives.[12] Healthcare staff can't spend as much time with patients and are unable to focus on prevention or provide the level of education they would like. Services like transportation must be reduced, and in some cases, units had to be closed and incarcerated persons consolidated to ensure the appropriate level of security.

> "Do we have enough staff to meet the constitutional minimums? Yeah. The issue when you only hit the minimums is the lack of prevention. You then have things that are lower-level issues that could have been fine, that then rise to the point of being serious issues. And so, you're never able to get ahead."—Respondent 1, Director of Behavioral Health

[12] In the Supreme Court case *Brown v. Plata*, overcrowding in California prisons was determined to directly impact the quality of medical and mental health care for incarcerated individuals.

> "It's not just, do we have a van available? But do you have transport teams, and right now with the way staffing is we just don't have staff to do that. So, we're falling behind."—Respondent 52, Chief of Clinical Services

Training

Respondents noted that staff training is important for the well-being of both staff and incarcerated persons; however, resources and staffing challenges impacted DOCs' ability to provide training. This includes training for new corrections officers and in-service and continuing education training for existing staff. One DOC respondent felt that there is resistance from prison leadership to send correctional officers to training because of staff vacancies and the need to balance security and services. As this respondent noted, "the issue that we really have is prisons allowing their correctional officers to attend these trainings" (Respondent 5.2). Relatedly, a lack of training staff was identified as a barrier. Training specialists who were required to take on other duties beyond training further impacted their ability to train adequate numbers of staff.

> "The training specialists have a lot of other duties than just training as well within the facility... I think they should be concentrating specifically and solely on training and not being pulled in so many different directions."—Respondent 5, Director of Training

One administrator noted that low recruitment was impacting their ability to get people trained in a reasonable time frame. This often meant that recruits were put on the job before they received their formal training until there was a large enough cohort to fill a class.

> "Because of the staffing shortages, we're not getting as many people as we should out…we don't hire enough to fill a class. So, what keeps happening is it takes a long time for an officer to go to train. Sometimes it's taken four to six months."—Respondent 6, Deputy Commissioner

Impacts of Staff Shortages on Training

Although the DOCs saw value in and wanted to do more training, **staffing shortages** posed a significant barrier because of the impacts on shift coverage and lack of trainers. These challenges were exacerbated by the COVID-19 pandemic.

The COVID-19 pandemic was repeatedly mentioned as impacting staff training. Because COVID-19 significantly affected prison operations and resulted in increasing vacancy rates, training often fell by the wayside or was impossible to keep up. A Mental Health and Substance Use Director said that COVID-19 "had a huge impact on people being able to do training because they were just working endlessly" (Respondent 28). A Commissioner said that because of COVID-19, their agency had "curtailed core competency training, so people weren't keeping up the training because we had so few staff" (Respondent 30). A Training Director also noted that during COVID-19, it was difficult to train because of staffing shortages. However, many respondents seemed optimistic that their agencies were catching up with the backlogs, with one Training Director stating, "we're going to get back to where it was" (Respondent 31).

Having adequate staffing is vital to the DOCs' mission. However, recruitment and retention of high-quality staff has remained a persistent challenge for the DOCs we interviewed, similar to many of their peers across the country. Staffing vacancies touch on every aspect of DOC operations, from security to medical care provision. Similarly, vacancies in one area (e.g., custody) can have direct impacts on their ability to provide medical care, and vice versa. Agencies we spoke to are doing several things to offset the challenges brought on by staff vacancies, including seeking agency or contract staff, creating new units dedicated to staff recruitment and career development, and using incentives (such as competitive retirement packages) to compete with private companies.

5.2 Theme 2: Facility Environment

DOCs are continuously updating facilities to make them safer and more secure, prevent suicides, and allow for better monitoring. However, some respondents mentioned the old age of many of their facilities, which eventually impacted the staff and ability to keep incarcerated persons well. They felt some facilities or units needed updates, which DOCs often lacked the resources to provide. Air conditioning, more open layouts, and suicide-resistant features were mentioned as beneficial in reducing deaths in custody.

> "There is a unit that I have that doesn't have call bells."—Respondent 56, Corrections Classification and Treatment Manager

> "You mentioned air conditioning, that's a good one...I do think that when possible, even if you're in dormitory settings, I think to have not so many offenders in the dorm can be helpful, not only for COVID, but just for general welfare."—Respondent 2, Chief Medical Officer

> "It's the physical spaces people are in, especially ligature risks."—Respondent 37.2, Quality Improvement Specialist

Space was an issue at some DOCs and was seen as insufficient to provide the needed care or allow for spreading the population out for safety and security.

> "We need more physical space for health care operations… you need to have a system that actually has space for wellness.…We know what the dimensions of wellness are and what can we do inside of the correctional facility to allow more space for those things to actually occur and even possibly flourish." – Respondent 27.2, Mental Health and Substance Use Director

Having adequate facilities are vital to the DOCs' mission. Ensuring facilities and features are updated to be able to provide healthy environments for staff and incarcerated persons is also a priority for the DOCs we spoke to, though often difficult to realize due to limitations in budget.

5.3 Theme 3: Providing Medical Care Amid Multiple Challenges

Consistent with national trends, the most prevalent deaths occurring within the DOCs we spoke to were natural or medical-related deaths. DOCs faced various challenges in their ability to provide comprehensive, timely, and high-quality medical care to individuals incarcerated in

prison. Some of the common challenges that were raised included issues introduced by the complex needs of the population and staff shortages. Respondents discussed some of the practices they engage in to offset these challenges, including hiring in-house specialists, using telemedicine, providing training, implementing peer support programs, and using electronic health records to track and monitor services.

Population Served

The characteristics and needs of the incarcerated population were discussed by respondents at all sites as impacting the provision of medical care. Topics including the aging prison population, increasing mental and behavioral health challenges, chronic illness and infectious disease, and delivering medical care while maintaining security were discussed. Various practices such as educating incarcerated individuals on general health, wellness, and infectious disease, and methods aimed at increasing compliance were also discussed.

Aging population with Co-Occurring Issues

The population of individuals incarcerated in prison is aging significantly. As a result, healthcare needs, including chronic care needs, among individuals who are incarcerated have risen for DOCs across the country. Respondents in every site we visited discussed the health challenges of their populations, and the compounding challenges that they were experiencing as their populations grow older. One of the issues mentioned was that DOCs often received individuals who were already in poor health and "many of them were not receiving medical care before they came into prison" (Respondent 2).

> "Some of these folks really before they came into the custody system or the legal system, they never saw a doctor at all…we're dealing with folks who have had possibly diabetes…who hasn't had it treated adequately for decades, hypertension that hasn't been treated for decades."—Respondent 76, Chief Medical Officer

In addition to the already challenging aspects of caring for individuals with pre-existing health conditions, practitioners also discussed the high prevalence of mental and behavioral health issues in their populations. For example, one agency estimated the prevalence of their population with substance use disorder at around 75%. The challenges related to co-occurring disorders, including substance use disorder, are exacerbated by other issues brought on by old age. Respondents described the bulk of deaths they see are those related to natural causes, or specifically, chronic conditions such as cancer or heart disease.

> "We're seeing probably over the last five years just an aging population and we're seeing natural causes of deaths associated with aging, a lot of heart conditions."—Respondent 74, Health Administration

> "I think we've seen generally our populations getting older. On average, they have a lot more chronic health conditions, co-occurring issues, substance use and mental health issues….Folks are on more than five medications."—Respondent 28, Operations Manager

Respondents discussed age-related illnesses as well, with one respondent describing the significant growth in their system's dementia unit (Respondent 74). Yet another respondent noted a "definite need" for a long-term care facility despite having a facility that provides this already (Respondent 49). Others discussed different actions that their DOCs had taken to accommodate the rising health needs, such as adding assisted living and geriatric units and providing annual physical exams or certain health screenings for older individuals. All DOCs we spoke to provided annual exams to individuals once they reached a certain age.

> "We're also adding senior living enhancement programs…where folks who are over 50 or even 60 years old can go do certain programming….But staffing is certainly a challenge when you look at our aging population....In an ideal world, if you have an aging inmate population, you have more staff to be able to treat them."—Respondent 53, Administration

Early release policies, such as compassionate release, medical furlough, early medical release, special needs parole, and medical parole in the context of the aging and infirmed population were also discussed by multiple respondents. Respondents tended to view these practices favorably as improving the quality of life for very infirmed individuals. However, there are significant barriers to implementing them in practice. These mostly include a lack of available beds in the community and hesitance by nursing homes to house justice-involved individuals.

> "A good picket fence will keep some of these guys in. But I can't just let them out the front door with nowhere to go…there's a real challenge finding those sorts of beds....Nursing homes don't want that. And many of these folks don't have a community resource of their own to go to."—Respondent 29, Operations Manager

Medical release programs were leveraged particularly during COVID-19 to prevent the spread of the illness. As typical for all early release programs, there were eligibility criteria associated with who could be decarcerated. In one DOC, this meant that the bulk of their remaining population are those with the highest acuity and security risk.

Common Challenges Related to Medical Care Provision

DOC practitioners discussed several challenges related to providing medical care to incarcerated persons:

- Lack of healthcare providers and security staff
- Aging of the population, many with co-occurring issues (mental health, substance use)
- Lack of compliance among incarcerated individuals

Chronic health issues and increasing compliance

Beyond issues related to aging specifically, respondents mentioned other challenges, including a lack of compliance among incarcerated individuals with prescribed medication and nutrition, as well as a challenge with incarcerated individuals failing to report health concerns. This issue of encouraging incarcerated individuals to comply with health directives or reporting health issues was discussed especially in one DOC by multiple respondents overseeing healthcare and quality improvement.

> "The other issue is some of the population just doesn't report when they have something wrong….And I don't know what the solution is to make them to where they'll come when they need help more."—Respondent 4, Nursing Services Manager

The medical director of one DOC described compliance among incarcerated individuals as being "no different than in the community," further noting that if incarcerated individuals are "competent to make decisions, they maintain autonomy" to make certain health decisions for themselves (Respondent 2). Therefore, education is vital to ensuring incarcerated individuals understand health risks adequately to make informed decisions. All DOCs provided education for incarcerated individuals around different illnesses, as well as around general health and wellness. Education could be through signage or formal programs, or through the routine interactions between healthcare staff and incarcerated individuals. For example, multiple respondents discussed education they do for individuals with diabetes.

> "Compliance is a big issue, like for diabetics. For instance….We can put them on a special diet in the chow hall, but they can still buy whatever they want in the canteen."—Respondent 4, Nursing Services Manager

> "Nursing will do that especially with diabetics, because when they leave, if they have to administer their own insulin, they're going to be taught how to do that."—Respondent 52, Chief of Clinical Services

A medical director at one DOC also discussed a recent program they initiated aimed at increasing compliance with chronic medications.

> "We have started calling every offender that has an excess of medication…and we have that compliance discussion with them. We go over the risks, benefits. We ask them flat out, do you not want to take the medication anymore? And if they answer, no, I don't want to take it anymore, we discontinue that medication. But we are seeing…that it's already started to improve compliance."—Respondent 2, Chief Medical Officer

In addition, one DOC was in the process of having running coaches start volunteering at all of the facilities to improve general health and wellness among the population. Although respondents agreed on the benefits of educating incarcerated persons on issues related to their health, respondents noted it can be challenging to focus on prevention when they are forced by staffing and resource constraints into being reactive to issues as they arise.

> "We're mostly reactive when it comes to that [medical care]. I'd love to get to the place that we had enough staff to provide more education and be more proactive, focused more on health in general…We just don't have the resources. Right now, our focus is on triaging cases and focusing on the most severe and addressing those first so they don't result in a pretty negative outcome."—Respondent 74, Health Administrator

Infectious disease

Given the close proximity in which individuals are housed within prison facilities, infectious disease can spread easier and quicker than in the community at large. One respondent

discussed a recent RSV outbreak, stating that "what's going on in the community is going on [in prison] on a different level" (Respondent 34). Therefore, managing infectious disease is critical. Beyond screening individuals at intake, DOCs also take different measures to prevent or manage the spread of illness, including education, incentives, and treatment. One DOC mentioned having posters in the medical departments and some in the housing units about Hepatitis C, COVID-19, Influenza, and general wellness and nutrition. Another site that provides education around infectious diseases such as HIV; Tuberculosis; and Hepatitis A, B, and C discussed their use of scrolling messages on the bottom of television screens as a way of providing information on health risks to incarcerated individuals.

> "We utilize that pretty frequently. For example, around Hepatitis C, here's what Hepatitis sort of looks like. If you believe that you may have been infected, please send the kite to your local clinic and we'll give you some information about that."—Respondent 74, Health Administrator

The same DOC also noted their success in using peers to educate incarcerated individuals on the negative health effects (e.g., risk of infection) of injecting diverted MAT medications because peers serve as credible messengers to the population.

To manage the COVID-19 pandemic, DOCs engaged in several practices to encourage individuals to get the vaccine, such as monetary incentives or credit for the commissary. One site also used outside work detail as an incentive to get vaccinated and waived the sick call co-pay as a way of encouraging individuals to seek medical care when they had COVID-like symptoms.

Challenges with Lack of Providers and Security Staff

As noted in the first section, DOC staffing levels have affected nearly every aspect of operations. This is true when it comes to medical care provision as well. Difficulties that were described in the context of medical care included shortages of nursing staff and in-house specialists, as well as lack of community providers who were able to serve the population of incarcerated individuals. Shortages of security staff also impact medical care provision, especially when medical transports are needed.

> "The staffing is probably the biggest [issue]. And just [the need for] more providers in the community to be able to serve our population well."—Respondent 53, Administration

Some of the ways that DOCs have tried to overcome these barriers is to be strategic with resources and scheduling, increase the use of telehealth, and add on-site care through a dedicated staff position or mobile units that can provide commonly ordered tests such as CTs and MRIs. One DOC also discussed how they were exploring the idea of engaging medical residents to supplement their lack of dedicated physicians. DOCs further discussed the use of peer supports to care for their aging population while simultaneously not adding to staffing burden.

Being strategic with resources and scheduling

In multiple sites, DOCs had dedicated facilities where they treated incarcerated individuals with certain medical issues. Dedicated facilities create efficiencies such that on-site specialists can be dedicated to one location, and medications can similarly be delivered to a single location.

> "Dialysis is all at our [FACILITY]. Oncology is all at [FACILITY]. We have an oncologist on site. We get oncology meds that are delivered directly there. Anything that we can do and treat on site, we keep on site. All the dialysis, all of our hemophiliacs are in [FACILITY]. So we keep conditions in one specific location so that we can keep that treatment coordinated."—Respondent 50, Director of Healthcare

Given the added security risks and the need for staff when doing outside medical transports, keeping incarcerated individuals on site is always more desirable. However, when individuals need to be seen by community providers, DOCs are strategic in their scheduling of these visits. Sometimes this means temporarily moving incarcerated individuals to a facility located closer to a hospital.

> "We identify an outside community center that will see our patients, then sometimes what we do is try to get follow up care inside of our facility. So, if they have a surgery, but then need a week follow up, they can either do it telemedicine or we can bring them [providers] inside our facility to see them. And what it also does is it allows us to consolidate all of those individuals that need that [procedure] at one facility."—Respondent 50, Director of Healthcare

Telehealth

Telehealth or telemedicine was frequently discussed as a force multiplier in DOCs' ability to provide care to their population. Telehealth allows for incarcerated individuals to connect virtually to a provider when there is no provider available in person. This removes geographic location as a barrier to receiving care. Furthermore, telehealth visits remove the need for security staff to transport the individual to an appointment in the community, making this a more secure option for DOCs. In many cases, the COVID-19 pandemic was credited as having been the impetus for expanding the use of telehealth and instituting many of the processes in place with using this technology. Ultimately, respondents widely viewed telemedicine as helpful in getting individuals seen much quicker by healthcare professionals, while being safer for custody staff and medical staff.

One DOC discussed how they use their telehealth equipment to get individuals into clinics "much quicker than…in the community" and to provide round-the-clock access to the nurse triage system when a nurse is not on site (Respondent 4). Another site similarly discussed using a program providing access to an after-hours on-call emergency room provider. By using telehealth to access the providers virtually, the DOC had reduced their number of emergency room send-outs, which ultimately translated to better security.

> "We actually saved what would be potentially 100 ER visits that we wouldn't have before because before, it was calling the doctor on call and just [telling] them what was going on. And nine times out of ten they weren't coming into the facility.

> They would send them out [to the emergency room]."—Respondent 50, Administration

Sites described some challenges with telehealth as well. These challenges included that virtual appointments were simply not useful for certain ailments, such as those where physical touch is required (e.g., orthopedic care). Additionally, another site described how telehealth visits did not totally eliminate the need for security staff to be present, meaning there was still some impact on custody staff's workload. Privacy concerns were also brought up as challenges needing to be navigated, given that incarcerated individuals were often attending virtual appointments in the presence of custody staff and wherever the facility provided the video terminals. One site with rural facilities also discussed their difficulties related to a lack of stable internet access. Despite these challenges, the overall sentiment from respondents was that telehealth is an added benefit to DOC operations that alleviates many of the challenges DOCs have been facing related to staffing and getting individuals seen by providers in a timely manner.

On-site or dedicated care

In addition to expanding their telehealth program, one DOC discussed two recent successes they had with hiring an internal endocrinologist and starting an oncology clinical management program. The chief medical officer described the multiple benefits of hiring an endocrinologist dedicated to the DOC:

> "He's dedicated to us, so he's able to give immediate consultation. He's able to establish standard practices and policies across the state so that we're treating diabetes consistently….Since we've had him, we've completely cleared our backlog for endocrinology."—Respondent 2, Chief Medical Officer

Strategies to Overcome the Effects of Staff Shortages on Medical Care

DOCs implemented changes to overcome barriers to providing medical care caused by staff shortages:

- Dedicated facilities based on medical conditions, such as dialysis, oncology, and dementia
- Scheduling pre-procedure preparations, transports, and follow-ups more efficiently
- Increased use of Telehealth
- Dedicated care specialists to serve the DOC
- Clinical case management program
- Use of peer care assistants

Additionally, the CMO described an oncology clinical case management program they recently started as critical in "condens[ing] the timeline from the time of suspicion to the time of either confirming the diagnosis or ruling out and starting treatment," which can be vital in effectively treating cancer.

> "We have a provider and two nurses that are assigned to do oncology clinical case management. At any time there's a suspicion of a cancer diagnosis, that case is referred to them, and then they track it…They have direct ability to enter and approve referrals and get those consults scheduled so that nothing gets dropped in that time frame."—Respondent 2, Chief Medical Officer

Peer supports for medical care

Peer supports, such as peer care assistants, can also help offset staffing challenges. These programs typically involve training a number of incarcerated individuals in different skills related to assisted care and activities of daily living. Most of the DOCs implement other types of peer programs for suicide prevention as well; these will be discussed further in the suicide prevention section. In some sites, peer support programs aimed at assisting elderly or infirmed individuals are especially beneficial because they do not add to the staffing burden. The sites we interviewed that had some form of peer program for medical care and assistance viewed these programs as very successful. Not only do these programs reduce burden on staff, but they also provide elderly or sick individuals with companionship and a way for medical staff to constantly monitor individuals' health status. The programs also provide beneficial skills to incarcerated individuals that could translate to employment outside of prison.

> "We have what we call inmate care assistants or offender care assistants, and those are offenders that actually go through a training on how to provide assisted care to some of the sicker offenders. They help with their ADLs [Activities of Daily Living]….We train them how to recognize different things like signs and symptoms of hypoglycemia….They're trained how and when you need to notify medical staff."—Respondent 4, Nursing Services Manager

> "I ask [peer support workers], who are they concerned about in the facility? And they usually are prepared with a list of names for us to look into…we will work on those different cases and to make sure that the correct medical care is being provided and somebody's deterioration is being monitored as closely as possible."—Respondent 27.2, Mental Health and Substance Use Director

Training

When it comes to training related to medical staff or care, respondents discussed both gaps and beneficial practices. For example, in one site that contracts some of its healthcare services, a gap was identified where contracted nurses were not required to undergo basic correctional nurses training. This resulted in uneven knowledge of policies across agency and contract nurses.

> "They [agency nurses] don't go through our basic correctional training. They rely on their own in-house training services…You will talk to some of the staff…and they're like, nobody's trained me…I don't know the policies. They don't actually go through the electronic health record with them. They don't have access at times to our policies."—Respondent 48, Nurse Supervisor

Spending time to train staff on how to find policies and protocols was mentioned by multiple respondents as critical because "everybody can't know everything about all things" (Respondent 2).

> "I will say one thing that I do like about Department of Corrections is, everything is online and it's all kind of tabbed out by department….You may not be aware of it off the top of your head, but you know where to go to get the resource that you need to address it."—Respondent 49, Chief of Quality Improvement

A respondent at one DOC also discussed how some policies may be difficult to find for nursing, so they created protocols for nursing staff to quickly refer to in those situations.

> "We've recently developed a few new protocols of things that just happened at the facility that don't happen all the time, but that we might need [and are] hard to find. The policy on the process, it's not as easy for nursing to find because it might be in custody's policy or something like that."—Respondent 4, Nursing Services Manager

Numerous respondents described the work of DOC personnel as interconnected. Cross-training staff was described as helpful for custody and medical staff to understand how the needs and concerns of the other would be impacted by their decisions, as well as improve the ability to effectively respond to a medical emergency (e.g., provide CPR, Narcan training) without having to wait on medical staff to arrive. In one DOC, custody staff were trained in different minor medical tasks, such as checking blood sugar, because the facility was not staffed 24/7 with medical providers.

Information Sharing and Electronic Health Record

Multiple respondents stated that information sharing, especially from the DOC's central office to facility-based staff, increased during COVID-19. This was viewed as a positive change by respondents as it meant that all facilities and staff were receiving the same information and directives.

> "We put out more centralized direction now too, from the Bureau of Health Care…Every Thursday we send out a leadership email and it goes to all the administrators on the parole side, community corrections, and in the institutions. It's just memos that we're putting out, information that we want everybody to have."—Respondent 53, Administration

Benefits to Using Electronic Health Records

EHRs provide the ability (1) to share information across facilities and providers as incarcerated individuals are transferred from one facility to another and (2) use a streamlined quality assurance and improvement process through the generation of automated reports that replace the need to compile medical charts manually.

Electronic health records (EHRs) were repeatedly discussed as a mechanism for increasing DOCs' ability to share and track information and maintain accountability. One respondent discussed how their DOC tracks different metrics like backlogs of laboratory tests or chronic care visits through weekly reports from their EHR, allowing them to stay on top of issues so they can be immediately addressed.

> "We keep track and we have reports every single week on outside consults that are needed that are backlogged…We are able to get those reports directly from that system [EHR], so we don't have to pull charts. And you remember all those paper charts…That's the mitigation where we can say, this facility has 200 lab results that have not been reviewed and there could be potentially a bad

> outcome in there. We need to have those addressed immediately."—Respondent 50, Director of Healthcare

Despite the common perspective that EHRs were an integral part of DOCs ability to provide care, there were some common challenges that were described, particularly around restrictions in accessing information within the EHR. Custody staff do not have access to the EHR, which can be problematic if a facility does not have 24/7 medical staff available. In one DOC, medical staff share pertinent information through end of shift reports. In this same DOC, the lack of access to the EHR also meant that custody staff were unable to access information on individuals' DNR status when nursing staff were unavailable. The DOC ensures that active DNRs are clearly communicated to custody staff during each shift. Another site discussed how they made changes to their incarcerated person database such that it displays information that would be useful to know for custody and other staff who cannot view the full medical record. Having the relevant information available for custody staff and administrators to review can help them make more informed decisions while maintaining individuals' health privacy.

> "We've made tremendous enhancements to our inmate database system…So if there's general information that someone needs to know about medical restrictions, for example, it'll say can't do outside work, they have to have access [to the] bottom bunk, bottom tier. There's more transparency…But again, not divulging confidential medical information…So when people are making decisions, they have access to that information without full access to a medical record."—Respondent 53, Administration

Other challenges with implementing the EHR that were discussed by sites included having to keep substance use disorder information separate from the medical record per 42 CFR Part 2. As noted by one respondent, being able to integrate these records is important for treating individuals with co-occurring disorders. In addition, one respondent noted the effect that transitioning to an electronic system has had on the need to update DOC's policies. Rather than affecting the care or the treatment, the respondent noted that they "need to translate that language into how it interacts with the electronic health record….It's basically the documents themselves. We've had to create so many documents for this new electronic health record" (Respondent 48). Another site also described how they identified a gap with their EHR, where certain information was failing to make its way back into the system, potentially leading to a lack of follow-through in care.

> "What would happen with our system is that if [the third-party administrator] denied that consult, that information was not making its way back electronically into our system to notify the provider that the consult had been denied. We were able to rectify this in this situation that the individual didn't die, but absolutely could have had the provider not followed up. If it was a larger facility or a provider [that] had a larger caseload, it would have been much easier to sort of forget about this patient."—Respondent 74, Health Administrator

All DOCs we interviewed strive to provide the best care for their population given multiple constraints. Many of these constraints had to do with a lack of staff or resources and the general challenges with meeting the multiple and complex needs of the incarcerated population. To

navigate these challenges, DOC staff have worked to increase efficiencies in getting offenders access to providers, track and monitor healthcare delivery, provide preventive education to incarcerated persons on health and wellness, and implement processes to help identify and improve practices.

5.4 Theme 4: Improving Response to Emergencies

Beyond general medical care provision, all DOCs spoke of how critical a timely and effective response to an emergency, such as a medical emergency, is. Respondents described the different trainings and drills they engage in to better respond to an emergency, with some also discussing situations in which deficiencies in their protocols had been identified and improved.

Training

All DOCs engage in periodic drills designed to train staff in responding to emergency scenarios. Some of these emergency scenarios are designed to teach staff how to respond to a suicide. All DOCs noted that suicides by ligature were the most common types of deaths they experienced. As a result, trainings designed to teach staff how to respond to this type of incident were common.

All DOCs were also required to complete some form of emergency code drills. The types of scenarios could vary, and oftentimes, they mimicked recent experiences. Drills were mentioned as being completed at least quarterly, during different shifts, and often at least one of these trainings had to take place in restricted housing. A common theme across the DOCs was that they sought to prepare their staff for the most effective response to an emergency incident by ensuring they were properly trained for different scenarios and had access to the right equipment. One site described specific issues that had led them to implement additional training or to change their emergency response and equipment and provide training on these updates.

Improving Response to Medical Emergencies

All DOCs identified training, policies, and or tools that they implemented to improve staff response to emergency situations, including the following:

- Conducting emergency code drills and scenario-based training
- Providing first aid training to custody personnel
- Implementing policies such as code-in-place to allow for uninterrupted first aid
- Creating efficiencies in response such as ensuring “code bags” are well-organized with the proper equipment

> “I can at least think of three cases off the top of my head where it seemed like nursing staff didn't feel prepared to address an emergency situation…it seems like there needs to be more training and we have recommended more training around crisis situations before doing more practices.”—Respondent 37.2, Quality Improvement Specialist

> “We had an incident…where a patient had cut themselves. There was a lot of blood. The nurse kind of froze. And then we learned in that moment through a

> [root cause analysis] that our emergency bags don't have emergency type of trauma tourniquets in them...So we ensure that everybody has a trauma tourniquet in their emergency bag. We reviewed the education about how to apply them."—Respondent 39, Healthcare Administrator

Some additional challenges were also mentioned. For instance, staff viewed first aid training for custody personnel as necessary, particularly when medical staff were unavailable or would take a long time to respond to an incident. Additionally, security is always a top priority in prison. A respondent described how security protocols slowed down the response to some emergencies to prevent staff from being manipulated and possibly harmed.

With regard to training modalities, a respondent at one site echoed the value of scenario-based trainings and the value of in-person trainings or leveraging technology when that is not possible.

> "I think really looking at how we can use technology to really enhance our training and our return on investment for our training dollars and maximizing that…And make it impactful and scenario based using the real world, using adult learning technologies rather than just sending out a PowerPoint." – Respondent 79, Training Director

Creating Efficiencies

Other examples were provided by one site with regard to improving the response to medical emergencies. Some problems and solutions that were identified were relatively simple but were described as time saving measures when seconds count. These changes included making sure emergency code bags were organized and nurses were trained on where items were located, as well as instituting code-in-place policies that call for first responders to code where an incident is happening, allowing for uninterrupted administration of CPR.

> "Our code bags that nursing used…were these big duffel bags, and there was no organization in them whatsoever. When the nurses went to a code, and you're trying to find something, you're slinging stuff out all over the place, and it didn't work well…We now have an ISO code bag that has pockets in it, and we know exactly where everything is. It's labeled. It works much more efficiently when you're in an emergency situation. We also do a yearly training with the nurses where they have to use that emergency bag."—Respondent 4, Nursing Services Manager

> "Code in place has been pretty huge…and there's signs hanging up all over that say code in place. So, if there is a code…you clear the area, we respond to that code right where it is. Even when EMS comes on site, EMS comes right to where that code is. We do not transport the offender or anything like that, we code them right where they're at… the major benefit of that is it's an instant response. There's not any stopping CPR to get them on a stretcher."—Respondent 4, Nursing Services Manager

Additionally, custody staff often have "cut down tools" or "J tools" located nearby in a control center if needed to respond to individuals attempting suicide through ligature. In at least one site, security staff are required to carry the tools on their person in specialized units, such as

restricted housing and mental health units, where the risk of suicide is higher than in general population, allowing for a quicker response.

DOC custody and medical staff have policies and training in place to respond to emergency medical situations as efficiently and effectively as possible. Respondents touted the value of scenario-based training and drills to prepare staff for different situations. Respondents also described how they have worked to improve their protocols and equipment over time based on lessons learned from prior experiences.

5.5 Theme 5: Suicide Prevention Programs and Practices

Preventing and reducing suicide in their facilities is a major concern for DOCs, which engage in multiple practices, both directly and indirectly, to address this issue. Direct measures include those that reduce the opportunity for a suicide to be completed, such as programs and practices that keep individuals under close observation or environmental measures designed to make suicide more difficult. Indirect measures include practices aimed at improving the mental health of the population served or other factors that may affect individuals' propensity to engage in self-harming behaviors.

Screening

As part of the multiple screening processes that individuals undergo when entering prison, their mental health status is also assessed and they are classified based on their needs, which dictates how often they are seen by clinicians. In addition to being screened at intake, DOCs also regularly screened individuals at different points during their incarceration, including when transferred to a different facility or housing unit or other major changes. DOCs also implemented more frequent screening when individuals were placed into restrictive housing or a treatment unit or if the individual had recently been faced with distressing news. Typically, screeners were performed by mental health professionals or nurses, and custody staff also performed assessments in some cases. The sites mentioned different screening tools, such as the Columbia suicide risk screening tool. At one site, the Director of Behavioral Health identified a need for a self-directed violence (including suicide) risk assessment tool that was specific to the correctional environment. To fill this gap, they worked with outside research partners to adapt a core competency model for suicide prevention to the correctional environment.

> "There was nothing out there that was correction specific, that was suicide prevention training with the understanding that a lot of it is not suicidal in nature… we started the adaptation of the core competency model to corrections and expanding it beyond suicide prevention to self-directed violence…[it is] to our knowledge, the only training program for Correctional Behavioral Health Clinicians targeting this full scope of the problem of self-directed violence."—Respondent 1, Director of Behavioral Health

One challenge with screeners is that their utility often depends on people answering questions about their mental health status honestly. Some respondents spoke of experiences where individuals avoided being truthful to prevent being flagged or placed on mental health watch. Because staff lack complete information on potential triggers that are occurring outside of the

prison, it was difficult to identify when individuals may be at heightened risk. Multiple respondents discussed how different technologies that allowed for more expansive or constant screening, such as telephone screening or electronic monitoring bracelets, would be beneficial to identifying when an individual was at risk of suicide. Yet, DOCs often lack the staff or resources to implement these screening technologies.

> "There's things that happen outside the institutions that are beyond our control that we don't know about. As these things come to our clinicians' attention, that's when they would say, okay, I know that when somebody gets bad news or if we discover that there was a death in the family, we would do a suicide risk assessment at that point in time. They might say something as simple as I'm experiencing heightened depression."—Respondent 51, Director of Psychology

One respondent discussed how targeting biometric bracelets to individuals who have to be housed in a single cell would be beneficial, because the DOC rarely sees individuals in double cells commit suicide: "So if we were to target folks who are single cell with those bracelets, that could just add another tool" (Respondent 29). Other technology, such as programs that screen for certain keywords or phrases, was mentioned as used in one facility in the email system. According to the superintendent of this facility, the use of certain words triggers a notification to the officers in charge of reviewing email messages, who then bring these individuals to the attention of the Psychology unit. In another site, interdisciplinary teams consisting of custody, medical, and behavioral health staff meet weekly within facilities to talk about issues within the facility or cases that may become an issue. The Director of Behavioral Health of this department noted this practice as hugely beneficial in that it brings together multiple areas of knowledge.

Opportunity Reduction Measures

Beyond general screening processes that DOCs engage in, they are also finding ways to prevent suicide through reducing the opportunity for suicide to occur. These measures include changing the physical infrastructure (e.g., installing windows on doors to increase visibility), adding ligature tie-off resistant features to cells and other locations, and changing housing assignment policy and rounds to facilitate easier or more frequent observation.

Opportunity Reduction Measures for Suicide Prevention

DOC staff described multiple ways they try to mitigate access to means and opportunity for self-harm, including the following:

- Removing/modifying features that could be used as ligature tie-offs (handrails)
- Installing windows in closet doors
- Housing individuals in double cells
- Implementing technologies that improve observation (electronic rounds tracking systems, cameras)
- Increased training on conducting quality rounds

Different sites mentioned instances where they had changed certain environmental features of their facilities, typically in response to incidents that had occurred within the facility. For example, one site replaced windowless closet doors in every facility with those that had windows. A superintendent of a facility also described how they had replaced the

handrails and other features in the bathrooms with anti-ligature features. DOCs varied in terms of their camera usage for individuals in mental health or suicide watch. Some DOCs had fixed cameras within these units, while other DOCs set up cameras outside of units.

> "A number of years ago, we had a suicide where the cell window was covered because the gentleman was using the bathroom. We've prohibited those coverings...We've replaced all of the mop closet doors with ones with windows…so that we could reduce that risk."—Respondent 29, Operations Manager

> "We have two holding cells down in our HQ that the doors are different. If we have offenders that are placed on a mental health watch, the doors have big glass windows on the top and on the bottom so the staff don't have to be up there to be able to see what's going on inside the cell."—Respondent 71, Captain

Multiple respondents talked about the suicide risk associated with housing individuals in single cells. In one DOC, they changed their housing policy after they had discovered through an analysis of decades of suicides that the vast majority occurred in single-cell units, and those that did not occurred while a cellmate was not present. As a result, this DOC prioritized placing individuals in double-cell housing, unless a single-cell placement was necessary. Respondents discussed some valid reasons to assign individuals to a single cell despite the higher risk of suicide. These include cases in which an individual may be violent, have certain types of medical conditions, or be at high risk of being victimized. Risks to physical and mental health are also considered. During COVID-19, one site initially engaged in medical isolation and quarantined individuals in single cells, yet changed this protocol after they experienced a suicide in one of the quarantine units.

Rounds conducted by security staff are a vital part of DOCs suicide prevention strategy. Ensuring that security staff engage in meaningful rounds and at the frequency dictated by policy is important in identifying individuals who are attempting or may attempt suicide. One respondent discussed how he trains custody staff in conducting rounds with the goal of suicide prevention.

> "We're trying to reiterate to them and teach them that your round is the most fundamental suicide prevention defense mechanism that we have…I've made a section of the suicide prevention training that is specifically geared towards teaching corrections officers how to do rounds through the lens of suicide prevention….I teach them how to do a good round, what you should be looking for."—Respondent 51, Director of Psychology

Individuals placed within special observation cells, such as those on a mental health watch, are typically under closer observation. For example, one DOC uses cameras in the cells that are monitored 24/7, but most of the observation comes from having someone at the cell at all times. In another site, the Director of Psychology noted that while the DOC also uses cameras for mental health watches, having a custody officer present is much more beneficial in preventing suicide.

> "If I'm in here by myself, the camera isn't going to stop me from killing myself. Right? It's actually the person. It's the corrections officer who intervenes. You need somebody watching the cameras, right?...And so we're big on trying to reduce the amount of time that people are alone. That's why the correction officer rounds [are] so valuable. Because when they're doing their round…when they look in that cell at that moment in time, the person's not by themselves."—Respondent 51, Director of Psychology

The importance of assessing whether rounds were completed was also mentioned by multiple security staff supervisors. One supervisor noted he randomly reviews camera footage at least once a week to ensure that rounds are conducted by officers. One site also mentioned different tracking measures, including electronic tracking systems with QR codes to ensure officers were conducting their rounds according to policy. Having systems in place to monitor custody staff and ensure they are engaging in high-quality rounds is vital.

Peer Support Programs

At every site we interviewed, some form of peer support program was implemented to help aid in suicide or substance use prevention or improve general health and wellness among incarcerated individuals. Peer support programs use incarcerated individuals to conduct specific tasks with the understanding that these individuals are more approachable than correctional officers and have experienced the same issues as other incarcerated individuals. With regard to the programs that dealt with mental health and suicide risk, they varied in some respects. Some involved peer observers for mental health watches, while others included peer supports that involved more coaching and interacting with individuals on a regular basis. Some of the benefits of the various peer support programs included the increased trust and legitimacy peers had with incarcerated individuals; staffing relief; and the skills and pride that the jobs provided to individuals working in the peer support programs.

One agency spoke of the success of their certified peer specialist program, which further supports and can sometimes fill in gaps in what their mental health staff are doing. In this program, peer specialists are available to lead

Peer Supports for Suicide Prevention

DOCs use a variety of peer support programs to aid in suicide prevention and mental health support.

Certified peer specialists and supports programs

These programs provide support to other incarcerated individuals by offering one-on-one or group sessions, identifying individuals who are vulnerable, and being available for individuals in need on an on-call basis. In one DOC, CPS staff were trained to use the Wellness Recovery Action Plan (WRAP) approach, an evidence-based, personal wellness tool and self-directed peer group intervention that includes self-reflection and questions based on five key concepts: hope, personal responsibility, self-advocacy, education, and support.

Peer observers for suicide watch

These programs supplement or replace the use of correctional officers in mental health observations or suicide watch. Benefits to these programs include lessening antagonism between individual under watch and correctional officers and easing staff burden.

For more information on WRAP see https://www.wellnessrecoveryactionplan.com/

support groups or meet and talk with other incarcerated persons when there is a need or at intake if individuals are unable to see Psychology staff right away. Certified peer specialists work around the clock during all three shifts, and so are always available to connect with individuals when needed.

> "I will say our certified peer specialist program…I believe has been extremely beneficial to our services…It's widely accepted by our security staff, which obviously has made the initiative much better. We've implemented them in all of our key areas. We certainly have them in our classification centers because it's peer to peer support where these folks are just coming into the system."—Respondent 53, Administration

At another site, they run a robust peer support coaching program that provides a number of services, including individual coaching sessions and hospice companionship. In this program, peer workers also work to identify and connect with individuals who may be vulnerable. The peer coaches are trained by agency staff in different topics such as resiliency, stress, and coping strategies.

> "They're basically ambassadors of wellness and resilience, trying to bring stability and community to each correctional entity. They do individual coaching sessions via signup sheets and or request slips…And they also do tours in [the segregation unit and] they do tours in the infirmary. They certainly look for any vulnerable people. They do orientations with people who have never been incarcerated before."—Respondent 27.2, Mental Health and Substance Use Director

One Behavioral Health Director described his agency's use of peer observers for individuals on mental health watch as impactful. In these programs, custody staff still conduct rounds, but the constant observation component is provided by a peer. According to the respondent, the program was beneficial for both the individual under watch and the peer observer, all while lessening the impact of constant observation on staffing levels.

> "Custody staff are still observing, but they're not right there doing the constant [observation]. We have found that level of peer to peer to lessen the tenor in the room....And it just calms the whole situation down. We have found that it is really good for each person involved."—Respondent 1, Director of Behavioral Health

In every case, programs that used peers to identify and connect with individuals in need or observe individuals at risk of harming themselves were viewed favorably by respondents for their positive impacts on the peers themselves and the individuals receiving the assistance.

Specialized Units

At all sites we interviewed, restricted housing was used as minimally as possible to protect against adverse outcomes, including suicide. In two agencies, respondents said most of their suicides occurred in restrictive housing. In one agency, suicides that had occurred within the DOC were overrepresented in the restrictive housing unit.

> "In restrictive housing though we have learned it's a dangerous place for people to be…Half of all the suicides we have on record have happened in restrictive

> housing, but our restricted housing population only accounts for 5%."—Respondent 51, Director of Psychology

All sites were actively engaging in ways to decrease the amount of time that individuals spent in restrictive housing. One site was currently conducting a study to evaluate how to decrease the amount of time individuals spend in restricted housing. Another agency began implementing 3 hours of out-of-cell time per day for any individual who had over 31 days within the unit. Finally, another agency had changed their policies with administrative segregation with a focus on getting people out as quickly as possible.

> "We try to get segregation people out as quickly as possible, whether they're mentally ill or not. If somebody goes into segregation for a nonviolent infraction or something, they might go to segregation….Our medical, mental health staff have had to approve the segregation placement before it occurs unless absolutely necessary, somebody started really getting out of control and then it will be immediately a mental health worker out there. So that is really about making sure that those folks are not at risk. Then there's a whole review process for people who are in administrative segregation once a week. Once a month there's a larger review, 60 days as a review from here…And this relates to long term segregation… We rarely have people in longer term segregation."—Respondent 27.1, Health Services Director

Some agencies used diversionary units in lieu of sending individuals to restrictive housing. These units often had more supports and out-of-cell time for individuals. At one site, an analysis comparing diverted individuals to those in restricted housing showed much better outcomes for individuals in a therapeutic diversion unit, including reductions in self-injury and disciplinary issues.

> "Specialized units have been something also very successful for us…When mentally ill individuals break some kind of institutional rule, instead of going to a restricted housing unit, now they go to a diversionary treatment unit… Sometimes there's crossover, [in] therapeutic communities, you're going to have inmates that are struggling with mental health and drug and alcohol. We have all these different types of programs that we can really appropriately divert our inmate population to the exact resources that they need."—Respondent 53, Administration

> "You think about the individual with significant mental health issues and behavior problems. They're going to restrictive housing because of the behavior problems…We divert them from restrictive housing into the therapeutic diversion unit."—Respondent 1, Director of Behavioral Health

One agency worked to create outpatient treatment units that mimicked therapeutic diversion units but were staff neutral. In other words, rather than increasing the post orders for custody staff, they created units that operate under an honor code, where positive peer pressure kept the unit a supportive environment without adding to staff workload.

> "Finding those guys, getting them into the unit, and then there's that level of kind of peer culture there…We can't have any type of significant behaviors going on in that unit, so there is a little bit of that honor code to it. This is a protected

> environment. We need you to help keep it good."—Respondent 1, Director of Behavioral Health

General Wellness

Agencies also spoke of different initiatives they engaged in to increase incarcerated individuals' mental health status by improving their general health and wellness or the health of their environments. One Director of Behavioral Health described their use of an educational campaign to bring awareness to both incarcerated individuals and staff on suicide prevention.

> "We're working with AFSP [American Foundation for Suicide Prevention] on bringing their Talk Saves Lives curriculum into [SITE]....We do some wellness-oriented suicide prevention. Flyers out to staff. We do a version that's prison focused for the inmates. We'll get it out through the tablets."—Respondent 1, Director of Behavioral Health

In other agencies, respondents mentioned different programs, such as yoga and running, that are geared toward general health and wellness and improving the mental health status of incarcerated individuals. Practices that make it easier for individuals to maintain close ties to family were also mentioned. For example, video visitation was mostly a byproduct of the COVID-19 era, but it has proved valuable for allowing more frequent and easier contact between incarcerated persons and their families. Most facilities use a video kiosk for these visitations, but at least one agency was looking to expand this ability to the offender's tablets so that they can have a visitation in their cell.

> "One of the other things that I think the department is moving forward with eventually is looking at the tablets so they can have visitation on their tablets. And I think that's huge when you're looking at trying to prevent suicide because they still preserve that connection with their family on the outside."—Respondent 55, Major

Preventing suicide by using screening and classification, implementing opportunity reduction measures, and improving mental health and wellness among incarcerated persons was a major focus of all DOCs we spoke to. DOCs faced similar sets of challenges in effectively identifying and treating individuals at risk, or ensuring the environment was not conducive to death by suicide. Best practices identified by respondents included peer support and peer observer programs, therapeutic diversion units, and high-quality and frequent rounds that allow custody staff to easily observe individuals within cells. Additionally, housing practices that limit placing individuals in single cells and environmental measures that prevent ligature tie-off points and increase visibility were also discussed as valuable measures in preventing suicide.

5.6 Theme 6: Preventing Intoxication Deaths

Controlling Contraband

Correctional institutions often find themselves battling the introduction of drugs and alcohol into their populations from a variety of sources including staff, visitors, home-brewed agents from incarcerated persons themselves, objects being thrown over perimeter fences and walls, and by

way of mail. In one site, contraband has found its way into the prison by being dropped in the parking lot and retrieved by incarcerated persons on outside work detail.

> "We had people at one time coming through the parking lot and dropping drugs into the big flowerpots, and the work crews would go out there, pick it up, and stick it into their boots."—Respondent 73, Investigator

Another method of smuggling contraband into facilities is through drones, though none of the sites we interviewed reported this to be a major issue for them. Most facilities reported methamphetamine, heroin, suboxone, and ketamine contraband and usage by incarcerated persons; however, there has also been a rise in the presence of synthetic drugs in facilities, similar to what is occurring in many communities. The use of these synthetic drugs such as fentanyl has created novel issues for prisons to brainstorm on how to keep them out of their facilities. Similar to fentanyl, one site also reported a rise in xylazine[13] contraband within their facilities. In addition to illegal drugs and narcotics, respondents also discussed how different medications, even over-the-counter medications such as Tylenol, must be heavily restricted to prevent nondirected usage and overdose.

Mechanisms to Control Contraband

DOCs described various mechanisms they use to control contraband from entering into their facilities. These include the following:

- Using electronic mail
- Scanning paper mail for illegal substances
- Using technology to scan anyone entering the facility (staff, visitors) for contraband
- Moving to televisits to limit traffic into the facility

> "They would fill ink cartridges with that [fentanyl] and then they would print off something using that as the kind of fluid in the ink cartridge and they'd just tear it up….[They] eat it."—Respondent 3, Quality Improvement Specialist

> "We had a woman who had been hoarding her own medications and she saved it up and she just took it all….She killed herself with her medication, her prescribed medication."—Respondent 33, Superintendent

The first step for many of the facilities is to try to stop or limit the amount of contraband coming into the facility itself. As a preventive measure, several DOCs have switched to electronic mail services that scan incoming mail for incarcerated individuals that they can then review on a computer or tablet. According to respondents in charge of security, these services are highly effective at curbing contraband coming in through drug-soaked paper or adulterated ink. However, a major gap remains in that legal mail cannot be processed through these electronic services. This challenge was mentioned by respondents at multiple DOCs, who described incidents of legal letterhead and envelopes being used improperly by individuals attempting to smuggle contraband into facilities. Facilities that still operate via paper mail use extensive

[13] Xylazine, often referred to as "tranq," is a non-opioid sedative or tranquilizer used for veterinary purposes.

scanning processes to reduce the introduction of contraband. Canine units have also been deployed in contraband searches; however, the presence of canine units is rare.

> "There are regional teams… we have to request support for the canines to come to us… If we had a dog here besides relying on electronic scan [on legal mail] itself… the dog can smell it."—Respondent 55, Major

Increasing televisits has been another way DOCs curb the introduction of contraband, with many respondents noting the positive impact that decreasing outside traffic into the facility has had on the introduction of illegal substances, cellphones, weapons, and other contraband. Despite a switch to mostly televisits, facilities still face issues with contraband, implying other ways that contraband enters facilities such as through staff. As a result, some DOCs began to require their staff to wear vests that can be more easily removed and scanned for contraband prior to entry into the prison.

> "One of the things we did change was our vests. We used to have staff vests that employees wore underneath their clothing. And we found that those vests were [an] avenue to mule contraband. We changed the vest to unzip vests… we could still send it through the scanner and review and make sure there was no contraband...."—Respondent 2, Chief Medical Officer

One agency uses technology-based drug detection within their visitation areas as well to detect contraband. Another effective method facilities have found is to double down on reducing the presence of cellphones within their facilities.

> "We do use electronic drug detection devices… When [visitors] come in, it's a machine. Basically, they swab their hands, their pockets and shoulders. They run this through the machine… to detect any type of contraband [such as] cocaine, heroin, all different types… including any type of synthetic marijuana."—Respondent 55, Major

Finally, DOCs may employ investigators who gather intelligence and interrupt the introduction and movement of contraband through—and sometimes between—facilities throughout a state.

Narcan

The second step for facilities is ensuring their staff are adequately trained to recognize the signs and can react to a potential overdose. With a focus on emergency medical response, many facilities rely on Narcan training, CPR, AED, and other related emergency response training for correctional officers. Agencies reported correction staff and officers carry Narcan on their person at all times. One facility noted that their medical team has strategically placed emergency access bags throughout the facility to improve response time. Another facility has implemented the use of Narcan dispensing machines.

> "We're really hoping to install Narcan dispensing machines in the exits of each facility and also at probation offices."—Respondent 27.2, Mental Health and Substance Use Director

> "I think that the Narcan response has dramatically changed the game when it comes to overdoses here."—Respondent 71, Captain

Medication-Assisted Treatment

MAT programs are another avenue that have been highly beneficial for DOCs in addressing substance use and intoxication-related deaths. Several DOC sites have combined partnerships with MAT providers, the Comprehensive Opioid, Stimulant, and Substance Use Program (COSSUP), and external alcohol and drug recovery support programs to provide services to incarcerated individuals during their sentence and to provide resources and support upon release. Through these programs, incarcerated persons are able to seek treatment for opioid use via the medication approved by the DOC. Some DOCs also have MAT training within their academy that all officers take part in. To help persons suffering with opioid use disorders receive treatment, one site allows them to self-refer without disciplinary action. All of DOCs we interviewed view their MAT programs as an asset, and many respondents were proud of the number of incarcerated individuals with opioid use disorder they were able to treat while in custody and prepare for reentry. One site discussed their success at implementing a MAT program and credited this to bringing the custody staff on board from the beginning and continuing to provide training on the program through roll call trainings and basic training in the academy. According to the Health Administrator for this site, gaining buy-in from custody staff was achieved through a visit to another state DOC, where they were able to hear from their peers about the implementation of the MAT program in practice from a security perspective. This peer-to-peer sharing exercise was viewed as vital to gaining officer buy-in and quell concerns around diversion.

Medication-Assisted Treatment

MAT programs are long-term intervention and treatment programs targeted toward opiate abuse and addiction using various medications (e.g., Suboxone, Buprenorphine, Methadone). Providing MAT takes significant planning and resources.

DOCs noted challenges related to MAT programs including the following:

- Number of incoming offenders with MOUD
- Need for a continuum of care between jails and prisons
- Diversion of medications
- Access to and availability of needed medications
- Dedicated staff to implement program

Benefits raised include the following:

- Preventing overdose
- Improving health and mental health status

> "I think why we've been successful in [STATE] and one of the reasons why we haven't had an overdose death for the last couple of years really has been because we brought the officers in on board from the beginning of implementation and provided some education, roll call trainings in little short 15 minute clips. We have a MAT training that's in the academy."—Respondent 74, Health Administrator

In addition to treatment while incarcerated, sites also discussed how they leverage MAT to prepare individuals for reentry, given the high risk for overdose among individuals with a substance use disorder.

> "We look on our [database and visualization program]…and we find that they have OUD and they're releasing in six months….Our MAT team makes an

> appointment with them…So, we want to get them on MAT as a buffer until they get followed. Right now, we're catching about 85% of the people that have OUD and are releasing. About 50% of those will accept some form of MAT."—Respondent 76, Chief Medical Officer

> "I think the MAT work we've done and the peer counseling is some of the best in the country…we saw in this last year's data, of the people who were on MAT in our correctional facilities who got released, 70% of them were accessing MAT through Medicaid within 45 days of release."—Respondent 30, Administration

Implementing MAT is not without its challenges. Some of the challenges that respondents mentioned include being able to respond to the sheer volume of incoming persons with opioid use disorder. Multiple respondents across DOCs discussed the increase in administering MAT has been caused by an increase in jails administering MAT. Ensuring there is a continuum of care between jail and prison is made more challenging as DOCs have to respond to these increases. Having continual access to and availability of medications was also mentioned as a concern by one facility that had a high proportion of its population on MAT. The superintendent of one facility reported running out over a weekend and having to rely on another prison to provide supplemental inventory. However, if a steady supply can be provided the benefits seem to have widespread effects.

> "We have MAT in the building. It's hard for people to overdose… on that type of drug… And we've had fewer people try to bring in contraband as a result." – Respondent 33, Superintendent

Other concerns surrounding MAT and similar programs include the diversion of prescribed medications for other items, such as commissary items, to other incarcerated persons who may not previously have been prescribed medications. DOCs have reported serious health issues related to individuals using diverted MAT medications as well. At one site, the DOC switched the form of their medication from dissolvable film to crushable pills to make diversion more difficult[14] and added additional health education around the dangers of diversion. As one respondent discussed, the potential for their population with opioid use disorder to grow due to diversion is a thorny issue to contend with but does not overshadow the benefits to MAT.

> "They could have not been a user of anything, however, many years into their incarceration, months, or years…you do a urine drug screen, and they have buprenorphine in their system, and they weren't prescribed it. But now they have an addiction, and they want to be on the MAT program. So that complicates things."—Respondent 39, Healthcare Administrator

> "We have several offenders on that inmate program and at least twice a week, staff are writing reports for diverting medication while they're doing that program. They're burying the Suboxone to take back to their cells to sell to somebody. That has been a huge issue."—Respondent 71, Captain

[14] This agency reported an issue with individuals receiving MAT diverting their partially dissolved medication film to others, who would then inject the mixture of saliva and medication. Switching to crushable tablets resolved this method of medication diversion.

The additional staff needed in the administration of MAT programs was also mentioned as an issue, particularly given the high and increasing number of people requiring MAT (including those with co-occurring disorders) and staffing shortages in many DOCs. One site described some of the ways they navigated this staffing issue, including creating an outpatient treatment program and leveraging tablets to connect individuals with resources.

> "I would say our biggest issue is definitely medication assisted treatment…MAT is an early intervention. What we tried to do is accompany the medical component of that. If they are taking medications, behavioral health will offer these folks groups. And we're kind of going through a lot of issues with policy right now and trying to determine exactly what that looks like and what our capabilities are in in managing that. And that is a definitely a staffing issue coupled with a very high level of opioid use disorder folks that are within the criminal justice population."—Respondent 78, Behavioral Health Administrator

> "We've learned over the past several years that the unit-based model for substance use treatment is great. Unit-based anything is hard to do in prison. Especially with a staffing issue. So, we've created a more agile kind of outpatient [program]…We send the substance abuse counselor to you wherever you are. And so, more agile, leveraging some of the resources on the tablets…really just a great way to extend the reach with the resources we have. [The program] is connecting with the prescribing, with the reviews for that, so in that way, we've actually got the T part of MAT and it's not just MOUD."—Respondent 1, Director of Behavioral Health

Treating Co-Occurring Disorders

Multiple sites reported a large segment of their population having a substance use disorder and, in many cases, a co-occurring disorder. One respondent reported that their screeners identified 75% of the population as having a co-occurring disorder. To address this overlap, the site tries to integrate substance use treatment into other programs, including education programs and treatment units for individuals with mental health issues.

> "We're integrating substance use treatment into the education programs where the folks that have that need…our substance use treatment folks are coming in and providing services there. Our specialized treatment units, I mentioned the therapeutic diversion unit, bringing the substance use treatment into there for that co-occurring aspect. So, finding the ways that we can interconnect it."—Respondent 1, Director of Behavioral Health

The DOCs we interviewed described their population with substance use disorder as growing, with many of these individuals having co-occurring disorders as well. The growing population presents a challenge to preventing intoxication-related deaths; however, all DOCs are proactively engaging in activities to prevent or reduce these types of deaths. These activities include various practices aimed at reducing contraband, treating substance use and making overdose reversal drugs such as naloxone readily available for staff. Although not without their challenges, specific practices such as switching to electronic mail services, expanding Narcan training and availability, and the implementation of MAT programs were touted as particularly beneficial in reducing or preventing intoxication deaths.

5.7 Theme 7: Reviews and Quality Improvement

All four DOCs had a process for conducting death reviews or incident investigations. The requirements for conducting the reviews or investigations were written in policy or in state law. The reviews were often multidisciplinary and involved several layers of assessment. DOCs reported that following a death review or incident investigation, policy changes or less formal process modifications were implemented. Furthermore, some DOCs conducted ongoing research and data reviews to look at trends and provide more robust and consistent identification of issues.

Death Investigations

Death investigations were multifaceted in nature and conducted at multiple levels by multiple parties, both internal and external to the DOC. DOCs may report all deaths or only unnatural or unexpected deaths to a state law enforcement agency, such as the state police or state bureau of investigation, to determine whether there is malpractice or whether the death was natural. During investigations, crime scenes are secured and processed; staff and incarcerated individuals are interviewed; and security documentation, health records, and video are obtained and reviewed. Autopsy reports, once completed, are also gathered. For one DOC, two separate state-level investigations are required and include six areas of review, including pre-existing medical or mental health conditions, quality of suicide risk assessments, documentation of complaints by incarcerated individuals, pre-incarceration health history, cultural or environmental understanding of the staff and decedent, and supervision.

Death Investigations

For unnatural or unexpected deaths, all DOCs engaged in multiple investigations. These include an investigation of the incident by one or more external agencies, as well as internal reviews (e.g., facility-level custody review, clinical review). Suicides and suicide attempts sometimes also warranted a separate internal review. The typical elements involved in death investigations include the following:

- Preserving the crime scene
- Interviewing staff and other incarcerated individuals
- Gathering and reviewing documentation (e.g., physical evidence, photographs, video footage, medical records, logs, documentation of rounds)
- Determining cause of death by medical examiner
- Meeting relevant parties at the facility and DOC levels to review the incident

In addition, the DOCs conduct internal reviews. At all four DOCs, custody and clinical staff conducted separate internal reviews. The custody side of the prison does a review to assess non-clinical issues related to the facility and security protocols. These included reviewing video and electronic rounds reports, interviewing staff and incarcerated persons, and pulling training records and medical information to look at interactions with the deceased individual and whether the decedent had any indicators of imminent crisis. Facility reviews did not always include clinical staff and they were not always conducted following a death.

> “There's sometimes an after-action review. And that is where the facility team is going to go in and they're going to look at the non-clinical specific response actions, those types of things. We ensure that with the individual that passed

> away, did we miss anything? Did we hit our rounds when we were supposed to?"—Respondent 80, Administration

The internal clinical reviews typically involve committees that examine if standards of care are being followed and if there are procedures that need to be improved. These in-depth and layered reviews were led by staff from either clinical or quality assurance or improvement. Participants on the committees included chief medical officers, medical directors (DOC and facility), healthcare administrators, nurses and providers, behavioral health staff, quality improvement or assurance staff, legal representatives, facility superintendents, and sometimes contract-agency staff.

Other Reviews

Suicide

Suicides were included in the death reviews and investigations the DOCs conducted, but sometimes a separate and additional review was completed. In all sites, both attempted and completed suicides are reviewed. One site tracks incidents involving self-harm or attempted or completed suicides in a weekly report from the facility that helps leadership determine whether any changes are necessary to their service provision.

> "We have reports that come to the bureau. They come specifically from that institution where it tells us everything that's going on, what is happening medically, what the physicians are doing…and if we need to step that up or anything. Those reports are every single week so those are mitigation strategies we have in place to make sure that we're reviewing those all the time. We don't wait for deaths to look at [it]."—Respondent 50, Director of Healthcare

Through their various review processes, all sites were able to identify and track emerging trends with suicides. For example, one site started to see an uptick in the number of suicides among individuals with chronic pain issues. As a result, the site implemented additional trainings for their healthcare provider staff and screening questions to assess suicide risk that medical providers ask during health appointments. If individuals respond in affirmatively to the screeners, there is an automatic referral to psychology within their electronic health record, meaning that providers do not have to manually refer the individual to psychology.

> "One of the big triggers that we're seeing right now with some suicides, we're seeing some chronic pain issues…We're always identifying ways that if you see this as a trigger, this needs to occur."—Respondent 49, Chief of Quality Improvement Specialist

Nonfatal incidents

Reviews of incidents not involving a death or that were "near misses" in which serious injury or death could have occurred were conducted by the DOCs. Some DOCs conduct nonfatal incident reviews for every incident in the very same way a death review is conducted, while other DOCs did not conduct them as consistently or as robustly. One operations manager indicated that "it would be good practice for us to make sure we get better at doing those on all of those sorts of near misses. But I don't think we do it consistently" (Respondent 29). For

nonfatal suicides, one DOC said that they conduct case reviews because they want to hold themselves accountable. Like formal death investigations, these incident and near miss reviews sometimes led to changes in practice.

> "There was a near miss with two people with the same name…their [ID] number was only off by like one number, so one of them accidentally got the other one's medication, and so we're looking at that."– Respondent 4, Nursing Services Manager

DOCs conducted other reviews or meetings either on site at facilities or at the central office. On-site meetings were conducted to ensure facility staff were up to date with information on suicide watches, psychological placements, new admissions, and general observations that may be important for staff to know. At one site, these meetings have resulted in better communication between security and medical staff, which has led to a better understanding of behaviors and the ability to address situations.

> "One of the things that we do, we have our morning meeting. We have our facility management team and we start off with our segregation and due process review. We do our mental health unit review. We do medical mental health checks next. We review everybody who's on full precautions, constant observation, mental health checks….And then we review all of the people in our medical unit, we talk about any E.R. trips….Just so everybody's on the same page."—Respondent 33, Superintendent

Challenges and Quality Improvement

All sites had extensive review processes for unexpected deaths that reviewed the incident from the security perspective and the clinical perspective. There were some noted challenges to conducting the death and incident reviews. Oftentimes, multiple reviews were conducted by different parties, which sometimes resulted in duplicate efforts. Information sharing between different parties, therefore, was noted as something that could be improved, as well as processes that could close the loop on such investigations. This could include establishing mechanisms that allow for the findings of reviews to make its way back to all necessary parties. The DOCs recognized that they were not always successful in providing feedback from the reviews to the facilities and staff. One DOC is creating a new office to oversee the various parts of death investigations and pull all the findings together.

Common Challenges in Conducting Death and Incident Reviews

Though DOCs made extensive efforts to conduct layered, in-depth death and incident investigations, there were challenges, including:

- Inefficiencies when multiple reviews were conducted by different parties within the DOC
- Lack of information sharing between parties involved in the reviews and staff involved in the incidents
- Insufficient follow-up to ensure findings are incorporated into training, policies, and processes

> "It's been a little problematic because I'm not getting the feedback loop. So, what we've done here is we do what I call an immediate feedback loop, which is the after-action review on site, which is fantastic….We had [a death]…and the next morning it was sit down and go through, these are the factors that we can influence, and these are the practices that we're going to change. And some of it was around training."—Respondent 33, Superintendent

> "I think we've struggled with getting information back to the facilities…And I think that we could do a better job disseminating that to everybody because it really is not fair to that unit officer to not know that this is what we found last time."—Respondent 29, Operations Manager

The value of providing positive feedback was also mentioned.

> "We're doing case reviews, recording that we did it so that we can hold ourselves accountable….I've actually watched some of the videos where you just see that officer doing a good job….It's one of those things that when you catch them, you highlight them."—Respondent 1, Director of Behavioral Health

Importantly, after feedback has been delivered, following up with facilities to ensure findings and recommendations are acted upon is important. A respondent overseeing quality assurance and improvement described periodic monitoring as a way to make sure issues identified in the death and incident reviews and other assessments have been corrected, similar to those conducted in hospitals by healthcare monitors.

Healthcare quality improvement

In addition to death and incident reviews, all DOCs had processes in place to assess quality in their healthcare provision. Through the various processes they employed, respondents mentioned multiple situations in which issues had been identified and addressed with additional training or changes to policy or practice. As one quality improvement specialist summarized, "we measure, we see where we can improve, we find ways to improve that, and then we measure again." (Respondent 49). Quality improvement staff also described the value in communicating back to the facilities and to staff when things are done well, not just when things could be improved.

Tracking and Improving Healthcare Delivery

DOCs track and assess the quality of healthcare delivery through multiple means, including:

- Formal committees
- Third-party reviewers
- Healthcare provider surveys
- Grievance tracking of incarcerated persons

Example: In one site, respondents described how their formal Mortality and Morbidity review meetings help inform their everyday practices, including screening guidelines, as well as facilitate information sharing across facilities.

Two sites described situations in which they identified, through their review processes, where nursing sometimes lacked all of the information needed for the medical providers to make decisions regarding patients. This created inefficiencies where nursing staff would then have to gather additional information or conduct

additional assessments to provide to the doctors. Once this issue was identified, the sites implemented structured nursing protocols that guided nurses through all of the steps and the information they needed to gather and communicate to the provider.

> "We recognized that we had some issues when nursing was having to call the doctor....So we initiated SBAR [Situation, Background, Assessment, and Recommendation], and that's available in all our nursing protocols. There's a form, too, that the nurse fills out before she actually calls the doctor that covers those things."—Respondent 4, Nursing Services Manager

> "We've come up with nursing evaluation tools, which are a set of questions that guide you through a process and then it leads to other things. And at the very end of it comes the plan."—Respondent 48, Nurse Supervisor

Sites also spoke of tracking and monitoring grievances as a way of keeping on top of issues and identifying needs for training or changes in protocol. The Quality Improvement (QI) office at one DOC conducts monthly quality improvement checks to monitor specific medical processes and operational deficiencies related to issues such as diabetes, hypertension, or MAT. In addition, the Quality Improvement office asks facilities to self-select deficiencies they have noted themselves and report back how they plan to address them every other month.

> "It's mandated now within seven days, whoever saw the inmate and ordered that original consult needs to meet with them and tell them [the plan]…What I was seeing here, our grievances were going up, the inmates were saying, 'hey, you know, I was having an MRI. Nobody did anything. It's been six weeks.'"—Respondent 52, Chief of Clinical Services

> "Instead of us dictating every month what the sites look at…next month, the site identifies one QI monitor to look at and it can be based on many things…It's not all driven out of central office to the site. It's also driven from the site to us, but with the expectation that it's still completed in the same type of format."—Respondent 49, Chief of Quality Improvement

Data and Reporting

All of interviewed DOCs had an internal data collection and research capacity. Data are reviewed for quality assurance and improvement purposes and to monitor different trends. Multiple respondents described their role or function as being data-driven. The Director of Healthcare at one DOC indicated that they use data to track backlogs, chronic care visits, and consultations and generate weekly reports. These reports serve as a mitigation strategy for preventing a critical incident.

One DOC uses an internal dashboard to track deaths and other critical incidents such as attempted suicides, showing trends by facility, demographics, custody level, and type and cause of death. The data are updated on a monthly basis. Although the data are available and sometimes requested, an analyst that works on the dashboard was unaware of how the data are being used and felt that the research leg of their department was not used very often.

At the DOC level, all four sites are successful at collecting and tracking data, but at least one superintendent at the facility level shared that they would like to have more access to data.

> "I don't get reports on data…I would love to be able to sit down with my superintendent group and say, 'Hey, we're going to go over some data, the places in your institution where you are highly likely to have a suicide are bing bing bing. The most common manner of suicide is bing bing bing.'" – Respondent 33, Superintendent

Transparency in Reporting

While three of the DOCs operated public dashboards, none of them included data on deaths in custody. Two of the DOCs published reports that included data on use of force and or in-custody deaths. The death and use of force data included in the reports produced by the DOCs include the following:

- Total number of deaths, and by cause
- Average age at death (across all causes, and by cause)
- Date, cause, contributing factors, location, and investigation status of each death
- Recommendations and findings from death investigations
- Total number of uses of force incidents, and by type

All interviewed DOCs were involved in state-level death investigations, and all conducted additional internal death and nonfatal incident reviews with separate custody and clinical reviews typically completed as part of this process. Some DOCs conducted suicide reviews, while some facilities met every morning to discuss the status of individuals and note issues staff should be aware of for that day. Although the death reviews sometimes led to policy changes, there were challenges related to who attended the reviews, the documentation that was provided, and how feedback from the reviews was received. "Closing the loop" and ensuring the information from these reviews made its way back into practice, policy, or training was something that respondents mentioned frequently as an area that was important and in need of improvement. Quality assurance and improvement staff do much to monitor prison operations, especially healthcare provision. The processes in place have allowed some DOCs to make changes in their nursing and other medical care protocols that can help to mitigate unnecessary deaths in prison. Finally, all four DOCs have an internal capacity for data collection, analysis, and reporting; however, at least one respondent felt that more could be done to share data and trends back to facilities.

5.8 Findings from Document Review of Select Prison Policies

We focused our document review on agency policies related to a few key areas of concern for DOC staff. These include policies related to the use of telemedicine, peer support programs, and mail (as it relates to contraband interdiction).

Common Elements of Telehealth Policies

The document review revealed two out of the four DOCs we interviewed had publicly available policies detailing their telemedicine program, either through a standalone policy or embedded within their general health administration policy. Some of the common elements included in these policies include the following:

- Description of the responsible person(s) in charge of:
  - Maintaining equipment
  - Scheduling appointments
  - Assisting with appointment (e.g., administering tests for provider)
  - Following up with provider to ensure documentation is completed
  - Updating records
- Description of other staff who should be present during an appointment
- Description of documentation that is required
- Emphasis on continuity of care
- Requirement that patient's EHR is updated with appropriate documentation on the same day as the visit

The primary difference in agency policy related to the agency staff involved in telehealth appointments. For example, one site requires facilities to designate a LPN as the facility's telemedicine coordinator, who is the sole responsible person whereas at another agency, the telehealth procedures are not all required of a single person—administrative staff, nursing staff, and a designated "telepresenter" are responsible for different pieces.

Common Elements of Peer Support Programs for Mental Health and Suicide Prevention

Agencies had policies on peer support programs for individuals with substance use disorder, mental health, and suicide prevention as well as peer supports for DOC staff. Some agencies had multiple types of peer support programs. Regarding the programs related to mental health and suicide prevention, public-facing policies for the various programs were found at three of the four sites. Some of the common elements of these policies are as follows:

- Requirement of an application process
- Requirement for training by staff before engaging in work
- Requirement for documentation of activities and work performed

There were also some differences in the level of detail provided across the sites, including in discussion of the following:

- Selection criteria

- Training and certification requirements for staff
- Evaluation processes of the program
- Oversight structure for the program
- Reasons for dismissal from the peer support program

Common Elements of DOC Mail Policies

All DOCs we interviewed mentioned the mail as a potential port of entry for contraband into facilities. We reviewed each DOCs mail policies to determine how they might differ or align in monitoring incoming mail for contraband. Some common elements of the policies included the following:

- Information on types of mail subject to search and review by staff
- Guidance that legal or "restricted" mail (e.g., letters from an attorney's office) has to be opened within the presence of the incarcerated person

There are some differences in the procedures and level of detail provided in the policies, with only one or two agencies including the following elements:

- Protocols around photocopying mail (e.g., all mail vs. in response to reasonable suspicion or evidence of contraband)
- Description of specific scanning technologies (e.g., X-ray imaging, ion scanning technology, K9 air scans) and when they could be used
- Protocols around personal protection equipment (e.g., nitrile gloves, N95 masks) that staff should wear when handling mail to prevent dangerous exposures to contraband

5.9 Summary

Practitioners within prisons contend with multiple challenges in keeping their incarcerated populations well during their periods of confinement. Not only does this population tend to have more mental, behavioral, and medical health issues than the general population, but the aging of the prison population is also compounding many of these issues (Kaiksow et al., 2023; Maruschak et al., 2021a; Maruschak et al., 2021b; Widra, 2023). Furthermore, prisons across the country are experiencing difficulties in recruiting and retaining high-quality custody and medical staff (Russo et al., 2019). Staffing shortages produce ripple effects across all areas of prison operations, directly affecting the ability of staff to provide high-quality security and medical care. In this study, we spoke to respondents in four DOCs about some of these challenges and more, along with the programs, policies, and practices they engaged in that offset some of these challenges. Several common themes emerged from these conversations, including ways DOCs work to address staffing shortages, such as using agency or contract staff, creating new units dedicated to staff recruitment and career development, and leveraging incentives (such as competitive retirement packages) to compete with private companies. The challenges related to providing high-quality medical care included a lack of staff or resources, as well as the general challenges with meeting the needs of an aging and sicker incarcerated population. Practitioners discussed working to increase efficiencies in providing access to

providers, tracking and monitoring healthcare delivery, providing preventive education to incarcerated persons on health and wellness, and implementing processes to help identify and improve practices. In addition to general medical care, DOC staff have also taken steps to improve response to emergency medical situations, including implementing new policies, scenario-based training, and equipment, some of which were implemented based on lessons learned from prior experience.

Beyond naturally occurring deaths, suicides were a constant area of concern for practitioners. DOCs took specific steps to prevent suicide, including implementing screening and classification processes, implementing a wide variety of opportunity reduction measures, and working to improve mental health and wellness among incarcerated persons. Peer support/observer programs, therapeutic diversion units, high-quality/frequent rounds, housing practices, and improved environmental features (removing ligature tie-off points/increased visibility) were identified as key in preventing suicides. Respondents at all DOCs further described challenges with preventing individuals from dying by intoxication or overdose, particularly because their populations with substance use disorder are increasing. Key practices include reducing contraband through additional checks and using electronic mail services; treating substance use through MAT programs; and making overdose reversal drugs such as Narcan and related trainings readily available for staff.

When deaths or critical incidents do occur, having robust review processes in place can help identify issues that can prevent similar incidents from happening in the future. However, there are challenges related to these reviews in that the findings may not always make it back to all relevant parties, and mechanisms to determine whether the findings are incorporated into practice, policy, or training are often missing. Despite this gap, it was clear from our conversations that having a strong commitment to continuous quality improvement often made a difference in improving practice.

6. Conclusion

Deaths occurring in the context of law enforcement interactions, jail, or prison custody continue to be a concern for practitioners, policymakers, and the public at large. Understanding why these deaths occur and identifying effective policies, practices, and programs that can help reduce them is a key charge of the DCRA Study and this corresponding report. As part of Phase 2 of the DCRA Study, we conducted case studies with three law enforcement agencies, three jails, and four state prison systems to hear directly from practitioners about the beneficial practices, programs, and policies they implement that can help prevent or reduce deaths in custody and about the challenges they face in achieving these goals. The practitioners we interviewed take their obligation to preserve life very seriously and take great efforts toward this goal. Although deaths in custody are a serious issue, they are publicized more frequently than the everyday activities that practitioners engage in to prevent deaths (e.g., from providing care to interrupting suicide attempts or drug overdose). Analyzing 89 interviews with practitioners holding a variety of positions, we identified key themes within each sector related to agencies' ability to achieve their missions and objectives while keeping the populations they serve—and their staff—well. Given differences in the nature of each sector, some of the themes were unique to the context of the sector; however, there were a number of cross-cutting themes that emerged consistently. These include both challenges and facilitators in preventing or reducing deaths in custody.

6.1 Cross-sector Challenges in Preventing or Reducing Deaths

Some of the most consistent challenges across sectors include difficulties in recruiting and retaining high-quality staff and the negative impact staffing shortages have on daily operations and long-term preventive strategies. For example, staffing shortages in all three sectors have impacted the ability of agencies to train their staff at the level or as quickly as they would like. In addition, practitioners across sectors discussed a perceived increase in mental health, behavioral health, and physical health challenges among the justice-involved population, which adds further strain to their ability to manage or care for individuals amid existing resource constraints.

6.2 Cross-sector Facilitators in Preventing or Reducing Deaths

Apart from these challenges, we identified some common facilitators that speak to practices that may help prevent or reduce deaths in custody. These include having clear, easy-to-follow policies that are also readily accessible to staff when needed. Additionally, the importance of rigorous and consistent training that is tied to policy was touted by practitioners across sectors. Scenario-based trainings in particular were mentioned as beneficial in preparing staff for responding quickly and effectively in critical incidents, including medical emergencies. Respondents across sectors frequently mentioned training to enhance interpersonal skills and effective communication with the communities served and system-involved individuals. Practitioners also mentioned the value of interdisciplinary training for all staff, such as ensuring law enforcement and correctional officers are adequately trained in mental health and suicide

awareness, and that mental health practitioners are adequately trained in issues relating to security. In addition, accountability mechanisms involving critical incident reviews and periodic assessments of relevant data (e.g., electronic health record data, use of force incidents) can help identify gaps and recommend changes to policy, practice, or training for better future outcomes. Further ensuring there are procedures in place to coordinate and share information gleaned from these reviews with all relevant parties is another area that respondents across all sectors agreed is beneficial. Ultimately, the findings suggest that adopting clear and accessible policies, rigorous training, and strong accountability mechanisms may help law enforcement agencies, jails, and prisons carry out their missions while mitigating deaths in custody.

6.3 Limitations and Opportunities for Future Research

This report showcases the perspectives of practitioners working in law enforcement, jails or prison systems, providing valuable context to the everyday challenges and successes they experience in trying to keep their populations well. Although these are critical perspectives to highlight, the current study does not include other important perspectives that can provide added insight to the findings we present in this report. Among others, this includes the perspective of community members, impacted families, incarcerated individuals, and medical examiners. Time and resource constraints required a narrow focus on criminal justice system practitioners, and further, agencies that were engaged in practices to reduce deaths in custody. The findings presented here might differ if the study included agencies not engaged in such practices. The sample size of agencies and interview respondents for each sector were also limited due to resource constraints. However, across the agencies included in the study saturation was achieved in each sector, meaning that the sample sizes were sufficient for the purpose of the current research questions. Although outside the scope of the current study, future work should incorporate interviews or focus groups with other stakeholders and agencies to provide additional context to the findings presented here. In addition to expanding the scope of data collection, the findings from the case studies revealed other opportunities future research. These include conducting more research on the relative impacts of different trainings (e.g., de-escalation training, bystander intervention) and training modalities (e.g., virtual reality) that practitioners view as beneficial on deaths in custody and conducting more rigorous research on the variety of programs, practices, and technologies used by criminal justice agencies to prevent or reduce deaths in custody. Additionally, more research is needed around different oversight and accountability mechanisms and their impacts on deaths in custody over time.

7. References

Augustine, D., & Kushel, M. (2022). Community supervision, housing insecurity, & homelessness. *Annals of the American Academy of Political and Social Science, 701*(1), 152–171. https://doi.org/10.1177/00027162221113983

Carson, A. (2021). *Mortality in state and federal prisons, 2001–2019—Statistical – statistical tables* (NCJ 300953). U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. https://bjs.ojp.gov/library/publications/mortality-state-and-federal-prisons-2001-2019-statistical-tables

Chapman, B. (2019). Body-worn cameras: What the evidence tells us. *National Institute of Justice Journal*, *280*, 1–5.

Couloute, L. (2018). *Nowhere to go: Homelessness among formerly incarcerated people.* Prison Policy Institute. https://www.prisonpolicy.org/reports/housing.html#methodology

Dalbir, N., Wright, E. M., & Steiner, B. (2024). Mental illness, substance use, and co-occurring disorders among jail inmates: Prevalence, recidivism, and gender differences. *Corrections*, *9*(2), 264–286.

Farber, H. B. (2024). Write before you watch: Policies for police body-worn cameras that advance accountability and accuracy. *American Criminal Law Review, 60*, http://dx.doi.org/10.2139/ssrn.4778640

Gardner, A. M., & Scott, K. M. (2022). *Census of state and local law enforcement agencies, 2018—Statistical tables* (NCJ 302187). Bureau of Justice Statistics. https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/csllea18st.pdf

James, D.J. & Glaze, L. E. (2006). *Mental health problems of prison and jail inmates* (NCJ 213600). Bureau of Justice Statistics. https://bjs.ojp.gov/content/pub/pdf/mhppji.pdf

Kaiksow, F. A., Brown, L., & Merss, K. B. (2023). Caring for the rapidly aging incarcerated population: The role of policy. *Journal of Gerontological Nursing*, *49*(3), 7-11. https://doi.org/10.3928/00989134-20230209-02

Maruschak, L.M., Minton, T.D., & Zeng, Z. (2023). *Screening and treatment in local jails, 2019.* Bureau of Justice Statistics. https://bjs.ojp.gov/library/publications/opioid-use-disorder-screening-and-treatment-local-jails-2019.

Maruschak, L. M., Bronson, J., & Alper, M. (2021a) *Indicators of mental health problems reported by prisoners* (NCJ 252643). Bureau of Justice Statistics. https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/imhprpspi16st.pdf

Maruschak, L.M, Bronson, J., & Alper, M. (2021b) *Medical problems reported by prisoners* (NCJ 252644). Bureau of Justice Statistics. https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/mprpspi16st.pdf

RTI International. (2024). Understanding and Reducing Deaths in Custody: Interim Report. Research Triangle Park, NC. https://www.ojp.gov/pdffiles1/nij/309441.pdf

Russo, J, Woods, D., Drake, G.B., and Jackson, B.A., (2018). *Building a high-quality correctional workforce: Identifying challenges and needs*. RAND Corporation. https://www.rand.org/pubs/research_reports/RR2386.html

Widra, E. (2023). *The aging prison populations: Causes, costs, and consequences*. Prison Policy Initiative. https://www.prisonpolicy.org/blog/2023/08/02/aging/

Zeng, Z. (2023). *Jail inmates in 2022 – Statistical tables* (NCJ 307086). Bureau of Justice Statistics. https://bjs.ojp.gov/document/ji22st.pdf

8. Appendix

8.1 Semi-structured Interview Guide (Law Enforcement)

General/Background Questions

1. What is your current role?
    - How long have you been in this role?
    - Describe your background and what led you to this current position
    - What are your responsibilities in this role?
2. What is your role in preventing, responding to, or investigating death in custody incidents?

[Probe for each of the above (prevention, response, investigation) if not mentioned]

When Deaths in Custody Occur

3. In your experience, what types of deaths, and circumstances leading to death in custody are most prevalent?

PROBE: medical vs non-medical issues associated with these deaths, such as mental health, behavioral health, violence.

4. Can you describe what happens when a death in custody occurs? What policies / practices are followed when a death occurs in custody?
    - What are your responsibilities when this occurs?
5. Who are the other individuals involved when a death in custody occurs?
    - Who determines the cause and/or manner of death?
    - What are their roles/responsibilities?
    - Who oversees the investigation or death review?

Policies and Practices Around Death in Custody

6. What policies does your organization have in place to prevent deaths in custody?
    - [Share high level overview of findings that are mentioned in environmental scan and ask about them]

[Prompts:

a) de-escalation;

b) defensive tactics; control holds; vascular neck/chokeholds;

c) less lethal tools: Taser/CED, baton strikes, chemical agents/pepper spray;

d) render/request medical care after a person is shot/injured;

e) officer oversight/early warning systems;

f) vehicular pursuit policies

g) suspect/arrestee transport]

7. What practices does your organization engage in, either directly or indirectly, that prepare officers for a tailored response?
    - [Prompt: This could include incidents involving individuals with MH/Substance Use disorder, disabilities (vision/hearing), medical conditions, or who are intoxicated.

In situations when tactical responses are required, at what point is SWAT (or other tactical response model) engaged?]

8. How does your agency screen for or identify situations and persons to determine potential mental health issues or substance use disorder during a call for service? [Prompts: officer training; policies]

[PROMPT: Is there a practice or policy in place to notify the jail during the booking process the person may be at risk for an overdose?]

9. Across these policies and practices, walk me through how these work in practice.
    - What are the challenges?
    - How closely are these policies followed, or is there room for adjustment as needed?
10. Do you feel your institution has the resources and the support it needs to successfully implement and maintain practice of these polices?
    - What challenges or barriers do you feel your agency faces with the implementation of these policies?
    - [If not given, probe for support from leadership and coworkers, and/or exogenous factors such as aging prison population and COVID-19]

Changes in the Policies and Practices

11. Tell me about significant changes in policies and practices over the last several years?
    - What prompted these changes? [COVID-19? Other events?]
    - Tell me about the change process
        i. Barriers, facilitators
12. How successful have these changes been implemented?
    - How were these changes supported throughout the organization?

- How do you feel these changes have affected deaths in custody at your institution?

13. Overall, how effective do you think your institution's policies around preventing and/or reducing deaths in custody?
    - [Probe for more information as necessary]

Training

14. Tell me about the training you or your coworkers have received regarding deaths in custody?
    - [Probe for content and frequency of training]
    - [Probe for prevention and response training (e.g., de-escalation, less lethal weapons; medical triage; mental health response]
    - [Probe to see where they get their trainings (in house, or what qualifies as a CE)]
15. How are training needs and programs around deaths in custody/use of force developed?

Reporting and Sharing Information Publicly

16. How does your agency collect and report data on deaths in custody? *[Skip if not applicable to interviewee]*
    - What types of data do you collect?
    - Where is this data stored and to whom is it reported?
    - How does your agency use this data internally? {Probe, use for policies]

Other factors

17. What partnerships, if any, does your agency utilize to assist in preventing deaths in custody (i.e., community partnerships, outside agencies, etc.)?
18. What would you say is the key thing your agency does to reduce/prevent deaths in custody?
19. What would your organization need to implement or change to further reduce preventable deaths?
    - If you could only pick 1-2 changes what would be the most impactful?
20. Is there anything else that we haven't discussed that you'd like to add?

8.2 Semi-structured Interview Guide (Corrections)

General/Background Questions

1. What is your current role?
    - How long have you been in this role?
    - Describe your background and what led you to this current position
    - What are your responsibilities in this role?
2. What is your role in preventing, responding to, or investigating death in custody incidents?

[Probe for each of the above (prevention, response, investigation) if not mentioned]

- How long have you been in this role?
- What are your responsibilities in this role?

3. Tell me about your facility (site, organization, institutions) *[If not applicable, skip]*
    - Age of Facility:
    - Date of Last Major Renovation/Construction/Update:
    - Size (Sqft) of Facility & Facility Capacity
    - Geographic location: Urban: ☐ Rural: ☐
    - Security Level
    - Prison Design:
    - Facility Accreditation:
    - Observation type: Direct Observation: ☐ Indirect Observation: ☐
    - Cells & Occupancy/Cell
    - Tiers
    - Current Average Daily Population & Average length of stay
    - Restrictive Housing Units: ☐ Yes, number _____ ☐ No
    - Use of Dorms: ☐ Yes ☐ No
    - Number of CO's & CO to Inmate Ratio. & CO Vacancy rate

When Deaths in Custody Occur

4. In your experience, what types of deaths, and circumstances leading to death in custody are most prevalent?

[PROBE: medical vs non-medical issues associated with these deaths, such as mental health, behavioral health, violence.]

5. Can you describe what happens when a death in custody occurs? What policies / practices are followed when a death occurs in custody?
    - What are your responsibilities when this occurs?
6. Who are the other individuals involved when a death in custody occurs?
    - Who determines the cause and/or manner of death?
    - What are their roles/responsibilities?
    - Who oversees the investigation or death review?

Policies and Practices Around Death in Custody

7. What policies does your organization have in place to prevent deaths in custody?
    - [Share high level overview of findings that are mentioned in environmental scan and ask about them]
8. What practices does your organization engage in, either directly or indirectly, that have wellness in mind for those in custody?
    - Indirect may include information distributed to those in custody, medical assessment, physical infrastructure (different types of housing units and practices within them), inmate education, etc.
        i. [Emphasize focus to practices working particularly well, if necessary]
    - Type of video surveillance in facilities:

☐ Fixed Camera ☐ Pan-tilt ☐ Zoom ☐ Analogue ☐Digital

☐ Body worn ☐ Other ☐ Blind Spots: ☐ Intentional ☐ Unintentional

- Medical Facility information

Number of Staff: _____ ___	Budgeted no. of Staff: _____ ___	Planned: _____ ___	Actual: _____ ___	Vacancies: _____ ___

Level of Care on Site: _____ ___	Distance to Hospital: _____ _	Private Space for MHPs: ☐ Yes	Does Staffing Inhibit Use of Outside	☐ Yes ☐ No

☐ No Hospitals :

- Specialized Units
    i. Specialized Medical Units (if yes, ask how many)
    ii. Specialized Menta Health Units (if yes, ask how many)
    iii. Suicide Prevention Units (if yes, ask how many)
- Features in common areas or recreation spaces:

☐ Work Programs with Heavy / Dangerous Equipment	☐ Free Weights	☐ Potential Weapons (describe below)	☐ Other

9. How does your institution screen for patients to determine potential mental health risks or substance use disorders?
    - When does mental health screening occur?
        i. At what points are individuals screened? (At intake? What factors determine if someone is screened outside of intake).
        ii. What screening and evaluation tools are used to assess inmates?
        iii. How often are follow ups conducted?
        iv. Do high risk inmates have any type of wearable identifiers
    - When does substance use disorder screening occur?
        i. At what points are individuals screened? (At intake? What factors determine if someone is screened outside of intake).
        ii. What screening and evaluation tools are used to assess inmates?
        iii. How often are follow ups conducted?
10. Across these policies and practices, walk me through how these work in practice.
    - What are the challenges?
    - How closely are these policies followed, or is there room for adjustment as needed?
11. What types of anti-contraband measures are in place within your institution?
    - Probe about mail and visitation practices, internal programs, detection technology, testing, and treatment availability in the event of an overdose (e.g. Narcan)

☐ Metal Detectors ☐ K9-Units

☐ Cell Phone Detection Technology ☐ Digitized Mail

☐ Mail scanning technology

☐ Video Visitation ☐Body Scanners ☐ Gang Units Intel ☐Narcan Available ☐ Other

☐ Swab-Type Testing: ☐ IMS ☐ U/A ☐ Other

12. Do you feel your institution has the resources and the support it needs to successfully implement and maintain practice of these polices?
    - What barriers do you feel your agency faces with the implementation of these policies?
    - [If not given, probe for support from leadership and coworkers, and/or exogenous factors such as aging prison population and COVID-19]

Changes in the Policies and Practices

13. Tell me about significant changes in policies and practices over the last several years?
    - What prompted these changes? [COVID-19? Other events?]
    - Tell me about the change process
        i. Barriers, facilitators
14. How successful have these changes been implemented?
    - How were these changes supported throughout the organization?
    - How do you feel these changes have affected deaths in custody at your institution?
15. Overall, how effective do you think your institution's policies are around preventing and/or reducing deaths in custody?
    - [Probe for more information as necessary]

Training

16. Tell me about the training you or your coworkers have received regarding deaths in custody?
    - [Probe for content frequency of training]
    - [Probe for prevention and response training (e.g., de-escalation; suicide screening; medical triage or other training that provide emergency intervention; mental health response; use of force)]
17. What, if any, training or education do inmates / those in custody receive regarding preventing deaths in custody?
    - [Probe for content and frequency of training]
    - [Probe for prevention and response training (e.g., de-escalation, suicide screening, or other training that provide emergency intervention)]
18. How are training needs and programs around deaths in custody developed?

Reporting and Sharing Information Publicly

19. How does your agency collect and report data on deaths in custody? *[Skip if not applicable to interviewee]*
    - What types of data do you collect?
    - Where is this data stored and to whom is it reported?
    - How does your agency use this data internally? [Probe, use for policies]

Other factors

20. What partnerships, if any, does your institution utilize to assist in preventing deaths in custody (i.e., community partnerships, outside agencies, etc.)?
21. What would you say is the key thing your agency does to reduce/prevent deaths in custody?
22. What would your organization need to implement or change to further reduce preventable deaths?
    - If you could only pick 1-2 changes what would be the most impactful?
23. Is there anything else that we haven't discussed that you'd like to add?