Homicides of Mental Health Workers by Patients

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Abstract

Using electronic search methodologies, we identified 33 cases in which mental health workers had been murdered by patients in the United States since 1981. Although an apparently rare event, with a frequency of approximately 1 homicide per year, our data indicate many of these homicides may have been preventable. The group most likely to have been victims of homicidal attacks was young women caseworkers, most of who were killed during unaccompanied visits to residential treatment facilities. The group most likely to have been perpetrators of violence was males who carried a diagnosis of schizophrenia. The most likely method of homicide was by gunshot (42.4%) but 57.6% of homicides were committed by other means, which may have been prevented by careful implementation of safety protocols. Perpetrators were likely to have had a prior history of violence, criminal charges, involuntary psychiatric hospitalization or non-adherence to medications. Despite convincing evidence for chronic mental illness in the perpetrators, they were more likely to be imprisoned than hospitalized after trial. Safety and public policy recommendations are offered in conclusion.

Introduction

Within the last decade, two psychiatrists in the Washington, DC area that were known to the authors, were killed by their patients. In this report we attempted to determine how frequently homicides of psychiatrists and other mental health could be expected to occur. While the general literature on violence towards mental health workers remains relatively sparse, reports using a variety of methodologies indicate that acts of violence among those with untreated persistent mental illness may be quite common. For example, studies using survey techniques report that 50-60% of mental health workers can expect to be threatened, 30-40% can expect to be assaulted, 40% can expect to receive some type of physical injury, and up to 5% can expect to withstand serious physical harm [1-3].

Retrospective studies using population based strategies or registries also suggest that violence perpetrated by the persistently mentally ill is quite common. Using data from the Epidemiologic Catchment Area (ECA) Study, Swanson et al[4], estimated the lifetime prevalence of violence to be 16.1% in patients with serious mental illness (schizophrenia, major depression, or bipolar disorder), 35% in patients with substance abuse or dependence, 43.6% in patients with both serious mental illness and substance abuse, and 7.3% in subjects with no major mental disorder. In the most recent data available from the U.S. Department of Justice's National Crime Victimization Survey[5], the rate of workplace violence between 2005 and 2009 was reported to be 5.1/1000 persons overall, 10.1/1000 for physicians and 8.1/1000 for nurses. For mental health workers the rates were 20.5/1000 overall, 17.0/1000 for professional workers and 37.6/1000 for custodial workers. The rate of violence towards mental health workers was second only to the rate for

law enforcement workers (47.7/1000). In the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE), 19.1% of 1,410 patients with schizophrenia had exhibited some type of violence over the prior six months, while 3.6 % had exhibited "serious violence"[6]. Furthermore, violence declined from 16% to 9% in CATIE trial participants retained in the study who received one of five antipsychotic medications[7]. Factors associated with a history of violence included childhood antisocial behavior, substance use, victimization, and economic deprivation. Negative symptoms were negatively correlated with a risk for violence. In a meta-analysis of 110 studies reporting on 45,533 individuals with psychiatric disorders it was found that 18.5% had a history of violence[8]. Violent patients were most likely to have had a diagnosis of schizophrenia, recent substance misuse, and non-adherence with psychological therapies or medications. Using a Swedish registry of 82,647 patients who were prescribed antipsychotics or mood stabilizers, Fazel et al[9] reported that 6.5% of men and 1.4% of women were convicted of violent crimes. Compared with periods when participants were not on medication, violent crime fell by 45% in patients receiving antipsychotics and by 24% in those receiving mood stabilizers.

Prospective studies have also found elevated rates of violence among those with chronic mental illness. Newhill et al[10] followed 1136 patients who had been admitted to one of 3 psychiatric hospitals for 1 year. While the authors found that the rates of violent or aggressive acts were quite common, patients with borderline personality disorder were significantly more likely to commit violent acts even when intentional self-harm was excluded. Langeveld et al[11] followed 178 patients

with a first episode of psychosis in Norway for 10 years. Twenty percent were reportedly apprehended or incarcerated vs. 1.6% of the general population. Fifteen percent reportedly perpetrated or engaged in threatening or physically violent behavior. Apprehension or incarceration decreased over time to the level found in general population except in those with illicit drug use.

Methods

For this report we searched the medical literature (PubMed) and the internet at large to find cases in which mental health workers in the United States had been killed by patients. We excluded cases that occurred in correctional settings that were not part of a psychiatric hospital or health care system, cases related to court ordered child custody evaluations, cases occurring in child protective service agencies, and cases occurring in state social service agencies that were not specifically geared towards psychiatric treatment. All data were collected from public sources including publications in journals, newspaper accounts and court records (when available). Data regarding diagnosis and treatment history were not verified independently.

We attempted to capture: the age, sex and occupational role for the mental health workers; the age, sex and probable diagnosis of the perpetrators; the method of homicide; the setting of the homicide; a history of prior involuntary hospitalization for the perpetrators; a history of prior violence for the perpetrators; and a history of prior criminal convictions for the perpetrators. We also attempted to summarize the disposition of the perpetrators following the homicides, i.e. to

determine if they were killed at the site of the crime, committed suicide, were found guilty and sentenced to prison, or were committed to psychiatric hospitals.

Results

Table 1 contains demographic data on victims and perpetrators and Table 2 summarizes information regarding the setting and method of homicide, and prior histories of involuntary treatment, medication non-adherence, violence, or criminal charges.

The case of Stephanie Moulton illustrates many of the features that we describe in this report. Ms. Moulton was 25 years old, 5 feet and 1 inch tall, and weighed 110 pounds when she was killed by Desahwn James Chappell in 2011. Ms. Moulton was the first in her family to graduate from college. She had an associate's degree in mental health and a bachelor's degree in social work. She was drawn to the mental health field partly because she had an uncle with schizophrenia. After graduation from college she began work with the North Suffolk Mental Health Association, a non-profit organization that provides community-based contract services, including residential care, to the Massachusetts Department of Mental Health, for approximately 600 patients. This type of contractual arrangement is increasingly common with the closure of state mental hospital beds and outpatient programs. The North Suffolk Mental Health Association had previously been fined by the Occupational Safety and Health Administration for failing to provide adequate safeguards against workplace violence.

The family of Deshawn James Chappell had noticed his increasingly bizarre behavior since 2003. During that year he was arrested for the assault and robbery of a homeless man, during which he slashed the forehead of his victim, and produced an eye injury that required surgery. After this incident Mr. Chappell's psychosis appeared to worsen and he began using alcohol and marijuana on a regular basis. He was later hospitalized at Massachusetts General Hospital and was given a diagnosis of schizophrenia. His condition seemed to improve with antipsychotic medications, but he frequently failed to take prescribed medications after discharge from hospital. He had at least 4 additional hospitalizations and several arrests for assaults. In 2006, he attacked his stepfather, fracturing the bones of his orbit. Chappell was committed to the Bridgewater State Hospital for 3 months and was released. The terms of Chappell's release are not known, but it is interesting to note that Massachusetts is one of only 5 of the United States that does not have an assisted outpatient treatment (AOT) law, also known as civil outpatient commitment. In 2010 Chappell had an altercation with a group home resident and he was transferred to several other group homes before coming to reside at the home in Revere, Massachusetts managed by the North Suffolk Mental Health Association. In November 2010 Chappell began calling his mother complaining of paranoid thoughts and of intense auditory hallucinations. His mother believed that he had again stopped taking his medications. In January 2011, Stephanie Moulton called Chappell's mother and confirmed that he had not been receiving antipsychotics and said she would try to get them started again. On January 20, 2011 Chappell and Moulton were alone inside the group home when he beat her,

stabber her, slit her neck and then dumped her body in a church parking lot. It is not known what transpired between the two of them prior to the murder. The murder occurred two days before Governor Deval Patrick release his annual state budget, which proposed funding cuts for mental health services for the third year in a row. Chappell was found guilty of first-degree murder on October 28, 2013 in the Suffolk Superior Court and was sentenced to life in prison. Stephanie Moulton's family filed suit against the North Suffolk Mental Health Association for failing to protect Stephanie's safety and later helped to establish the Stephanie Moulton Safety Symposium, which is now hosted on an annual basis by the Massachusetts Department of Mental Health.

Of the 33 victims, 20 (60.6%) were licensed professionals (psychiatrist, physician, psychologist, nurse, social worker) and 13 (39.4%) were technical or case workers. As a class "case workers" were the most likely group to have been exposed to attack. Fifteen (45.4%) of the victims were men and 18 were women. The mean age of the victims overall was 41.6 years but for female victims the mean age was 35.4 years and for male victims was 49.1 years. Therefore, the most common subgroup to have been the victim of a homicide was composed of young women case workers with relatively little experience in the field. Victim characteristics are summarized in Table 3.

Twenty-seven perpetrators were male (81.8%), 4 were female (12.1%) and for 2 the gender could not be determined (6.1%). The mean age of the perpetrators was 34.5 years, with a tendency for female perpetrators to be older (44.3 years) than male perpetrators (33.0 years). Seventeen perpetrators were thought to have

had a diagnosis of schizophrenia and 1 was given a diagnosis of the closely related schizotypal personality disorder (54.5% taken together). Four perpetrators were thought to have a diagnosis of bipolar disorder (12.1%) and 1 (3.0%) was given a diagnosis of major depression. Public records did not yield a diagnosis for 10 (30.4%) perpetrators. The lack of diagnosis in public accounts was frequently due to concerns over confidentiality, especially in cases where the perpetrator did not have a criminal record, or in which the perpetrator was killed during the incident or committed suicide. The most common subgroup to have been a perpetrator of homicide was composed of young males diagnosed with schizophrenia.

Eleven homicides (33.3%) occurred during visits to residential facilities, 6 occurred in public clinics (18.2%), 5 occurred in private offices (15.2%), 6 occurred in private hospitals (18.2%), 4 occurred in public hospitals (12.1%) and 1 occurred while in transit with a patient (3.0%). Therefore, the most common setting for homicides of mental health care workers was during visits to patients in residential facilities. There was relatively little difference in the frequency of homicides that could be explained by public versus private hospital settings, or public versus private clinic settings.

The most common method for homicide was by gunshot (42.4%). Four victims (12.1%) were killed by beating, 3 (9.1%) by a combination of beating and stabbing, and 1 (3.0%) by a combination of beating and strangling. Ten victims (30.3%) were killed by stabbing or laceration with a sharp object. One victim was killed by strangling (3.0%). One could argue that it is very difficult for an individual mental health care worker to defend themselves against gunshots without

comprehensive institutional procedures for weapons screening or more restrictive legislation regarding gun possession. However, non-gunshot methods for homicide constituted the majority when grouped together (57.6%) and it may be argued that these are quite preventable if appropriate safety precautions and educational requirements for mental health workers were to be enforced.

Sixteen of the perpetrators (48.5%) had a prior history of criminal charges, 6 (18.2%) did not have such a history, and inadequate information was available for 11 (33.3%). Seventeen of the perpetrators (51.5%) had a prior history of violence, 3 (9.1%) did not have such a history, and inadequate information was available for 13 (39.4%). Thirteen of the perpetrators (39.4%) had a prior history of non-adherence to medications, while inadequate information was available for the remaining 20 (60.6%). Seventeen of the perpetrators (51.5%) had a prior history of involuntary hospitalization, 2 (6.1%) did not have such a history, and inadequate information was available for 14 (42.4%). Thus, a prior history of criminal charges, violence, non-adherence to medications, and involuntary hospitalization were quite common among perpetrators and should be seen as warning signs for potential violence. Following the homicides, 15 perpetrators (45.5%) were found guilty of criminal charges and were imprisoned, 8 (24.2%) were committed to psychiatric hospitals, 4 (12.1%) committed suicide, 2 (6.1%) were killed at the crime scene, and 1 (3.0%) was awaiting trial at the time of this writing. Legal status could not be determined for 3 (9.1%) perpetrators. Perpetrator characteristics and crime details are summarized in Table 4.

Discussion

We were able to identify 33 cases since 1981 in which mental health workers were murdered by patients in the United States. Therefore, one might expect that such events can be expected approximately once per year. We cannot conclude that our list of cases is complete, especially since many documents and news reports related to homicides of mental health workers prior to the widespread use of the internet in the 1990's may have been difficult to locate. We also excluded cases of homicide outside of psychiatric settings providing direct care to the perpetrators; we believe many homicides committed in other social service agencies may also involve perpetrators with mental illnesses.

Homicides seem to have been committed against a wide range of professional roles within the mental health system. Indeed, the prolonged training necessary to become a psychiatrist or psychologist, and long experience as a practitioner, did not seem to protect particular victims from these tragic events. Nevertheless, the largest single group to have been victimized appeared to be young women case workers who had been sent, usually unaccompanied, to perform tasks within residential treatment settings. This would appear to be a practice that could be remedied quite easily with appropriate safety measures followed in these settings. While residential facilities were a common site for the homicides we found, it is important to note that no particular clinical setting seemed to be immune from the risk for attack. It may be misguided for practitioners in private offices to feel safe without putting into place specific safeguards.

With regards to the perpetrators, our summary seems to be consistent with other reports concerning the risk of violence among the mentally ill, in that most perpetrators were males, had a diagnosis of schizophrenia, and frequently had prior histories of violence, arrest, involuntary hospitalization or non-adherence to treatment recommendations.

Based on the data we have gathered we offer the following safety recommendations for practitioners:

1. Develop the capacity to assess the dangerousness level of patients in a prescreening interview before the first appointment.
2. Take special care with evening or weekend appointments or in other situations in which additional office personnel are not present.
3. For patients that have a history of violent acts or poor impulse control, see the patient along with family members or with other colleagues.
4. Have a security barrier between the waiting room and the consulting room so that patients cannot easily "barge in". This might include electronic locks or video surveillance of the waiting room, which would allow practitioners to see who is waiting prior to admitting them to the office.
5. Sit behind a desk rather than in a more traditional "psychotherapeutic" environment. This barrier would allow some defense against assaults that do not involve firearms.
6. Have an escape route: don't sit between the patient and the only available exit from the office.

7. If feasible, have an emergency alert system. However, these are only effective when the consulting room is in an institutional setting with enough personnel present who are equipped to respond to the alert.
8. Home visits to patients with a history of violence or involuntary treatment should be made by teams with adequate training and not by individuals.
9. For patients who become threatening, obtain consultation sooner rather than later. In isolated outpatient settings, consultation with other colleagues may be the only way to get further guidance and support. In institutional settings threats should be reported to appropriate administrators immediately. These reports do not usually constitute a violation of privacy laws.
10. For direct threats of violence, or threats that occur outside of office or institutional setting, law enforcement agents should be informed. One must evaluate the need for restraining orders understanding that they sometime provoke increased threats or violence. One must also determine if there is a sufficient level of dangerousness to merit criminal charges or involuntary psychiatric detention.

Based on the data we have gathered we also raise the following policy considerations for administrators and government officials:

1. Mental health workers should receive training in violence risk assessment as a core competence and this training should be reviewed periodically.
2. In the United States there are currently 5 states that do not have legislation allowing assisted outpatient treatment (AOT), or outpatient commitment. In this report, we were not able to determine which, if any, of the perpetrators

had such an order pertaining to them. However, there is substantial evidence that AOT reduces violence in the community perpetrated by individuals with persistent mental illness[45].

3. Even in states with adequate AOT laws, there is frequently not an efficient method to implement the law or to enforce the court orders remanding the patient to treatment. We believe this is an urgent problem that state governments must work to resolve.
4. Patients with prior history of criminal convictions, arrest, violence, and involuntary hospitalization should have these factors clearly noted in the medical record and these factors should be given adequate weight when planning treatment.
5. Consideration should be given to the idea of having involuntary psychiatric treatment become a matter of public record, so that more adequate screening for gun possession and determination of the appropriate site for detention (psychiatric hospital versus prison) can be more easily made.

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Table 1. Demographic Data on Victims and Perpetrators.

Case	Worker	Occupation	Year	State	Age	Sex	Perpetrator	Age	Sex	Diagnosis
1	Ernest Pullman[12]	Psychiatrist	1981	CA	55	M	n/a	n/a	n/a	n/a
2	Alan Shields[12]	Psychiatrist	1981	MA	32	M	James Palmer	27	M	Schizophrenia
3	Deanne Coombs[13]	Psychologist	1981	MA	32	F	James Palmer	27	M	Schizophrenia
4	Juan Ocana[14]	Psychiatrist	1981	FL	48	M	John McGoff	35	M	n/a
5	Brian Buss[15]	Psychiatrist	1985	OR	37	M	Kedron Ellis	39	M	Bipolar disorder
6	Michael McCulloch[16]	Psychiatrist	1985	OR	41	M	John Eaton	39	M	Schizophrenia
7	Dr. O[17]	Psychiatrist	1986	FL	38	M	Mr. F	32	M	Schizophrenia
8	Norman Fournier[18]	Social worker	1987	WA	51	M	n/a	n/a	n/a	n/a
9	Linda Rosen[19]	Social worker	1988	PA	27	F	Edith Anderson	32	F	n/a
10	Robbyn Panitch[20]	Social worker	1989	CA	36	F	David Smith	27	M	Schizophrenia
11	Rebecca Binkowski[21]	Case worker	1993	MI	25	F	David Stappenbeck	26	M	Schizophrenia
12	Sharon Edwards[22]	Nurse	1995	MD	26	F	Benjamin Garris	16	M	n/a
13	Donna Millette-Fridge[23]	Social worker	1998	CT	36	F	Adrian Isom	28	M	Depression and substance abuse
14	Reuven Bar-Levav[24]	Psychiatrist	1999	MI	72	M	Joseph Brooks	27	M	Schizophrenia
15	Judy Scanlon[25]	Nurse	1999	NY	44	F	Diane Wylie	46	F	Schizophrenia
16	Laura Wilcox[26]	Case worker	2001	CA	19	F	Scott Thorpe	41	M	Schizophrenia
17	Nicole Castro[27]	Case worker	2002	MD	23	F	John Lutz	64	M	Schizophrenia
18	Erlinda Ursua[28]	Physician	2003	CA	60	F	Rene Pavon	37	F	Bipolar disorder
19	Teri Zenner[29]	Case worker	2004	KS	26	F	Andrew Ellmaker	17	M	Schizotypal personality
20	Wayne Fenton[30]	Psychiatrist	2006	MD	53	M	Vitali Davydov	19	M	Schizophrenia
21	Marty Smith[31]	Case worker	2006	WA	42	M	Larry Clark	33	M	Schizophrenia
22	Genine Holznagel-Leary[32]	Case worker	2007	AK	32	F	Brian Galbraith	53	M	Schizophrenia
23	Louis Martin[33]	Psychiatrist	2007	NE	78	M	Eric Lewis	35	M	Schizophrenia
24	Diruhi Mattian[34]	Social worker	2008	MA	53	F	Thomas Belanger	18	M	Bipolar disorder
25	Kathryn Faughey[35]	Psychologist	2008	NY	56	F	David Tarloff	39	M	Schizophrenia
26	Scott Fleming[36]	Case worker	2010	AR	40	M	Samuel Lands	24	M	Bipolar disorder
27	Donna Gross[37]	Technician	2010	CA	54	F	Jesse Massey	37	M	n/a
28	Stephanie Moulton[38]	Case worker	2011	MA	25	F	Deshawn Chappell	27	M	Schizophrenia
29	Mark Lawrence[39]	Psychiatrist	2011	VA	71	M	Barbara Newman	62	F	n/a
30	Jennifer Warren[40]	Case worker	2012	OR	38	F	Brent Redd	30	M	Schizophrenia
31	Stephanie Ross[41]	Case worker	2012	FL	25	F	Lucious Smith	53	M	n/a
32	Michael Schaab[42]	Case worker	2012	PA	25	M	John Shick	30	M	n/a
33	Theresa Hunt[43]	Case worker	2014	PA	53	M	Richard Plotts	49	M	n/a

Table 2. Setting and Method of Homicide, Historical Predictors of Violence, and Status of Perpetrator

Case	Perpetrator	Setting	Method	Involuntary Hospitalizations	Non-adherence	Violence	Criminal Charges	Status of Perpetrator
1	n/a	Hospital	Gunshot	n/a	n/a	n/a	n/a	n/a
2	James Palmer	Office in clinic	Gunshot	n/a	n/a	n/a	n/a	Suicide
3	James Palmer	Office in clinic	Gunshot	n/a	n/a	n/a	n/a	Suicide
4	John McGoff	Office in clinic	Gunshot	Yes	n/a	n/a	Yes	Guilty of first degree murder and imprisoned
5	Kedron Ellis	Private hospital	Beating with object	Yes	Yes	No	No	Guilty and insane and hospitalized
6	John Eaton	Private office	Gunshot	Yes	Yes	Yes	No	Hospitalized with civil commitment without trial
7	Mr. F	Public hospital	Gunshot	Yes	Yes	Yes	No	Not guilty by reason of insanity and hospitalized
8	n/a	Home visit	Gunshot	n/a	n/a	n/a	n/a	n/a
9	Edith Anderson	Private hospital	Gunshot	n/a	Yes	n/a	n/a	Guilty of third degree murder and imprisoned
10	David Smith	Office in clinic	Stabbing	Yes	Yes	Yes	Yes	Guilty of first degree murder and imprisoned
11	David Stappenbeck	Transporting patient	Stabbing	Yes	n/a	Yes	Yes	Guilty of first degree murder and imprisoned
12	Benjamin Garris	Private hospital	Stabbing	n/a	n/a	n/a	n/a	Guilty of first degree murder and imprisoned
13	Adrian Isom	Office in clinic	Stabbing	n/a	n/a	n/a	n/a	Killed at scene
14	Joseph Brooks	Private office	Gunshot	n/a	Yes	n/a	n/a	Suicide
15	Diane Wylie	Home visit	Beating with object	Yes	n/a	Yes	Yes	Guilty of first degree murder and imprisoned
16	Scott Thorpe	Clinic	Shooting	n/a	Yes	n/a	Yes	Incompetent to stand trial and hospitalized
17	John Lutz	Home visit	Beating and stabbing	Yes	n/a	n/a	n/a	Incompetent to stand trial and hospitalized
18	Rene Pavon	Public hospital	Beating and strangling	Yes	Yes	Yes	No	n/a
19	Andrew Ellmaker	Home visit	Stabbing	Yes	n/a	n/a	n/a	Guilty of first degree murder and

								imprisoned
20	Vitali Davydov	Private office	Beating	No	Yes	No	No	Guilty but not criminally responsible and hospitalized
21	Larry Clark	Home visit	Beating and stabbing	n/a	n/a	Yes	Yes	Guilty of first degree murder and imprisoned
22	Brian Galbraith	Residential facility	Stabbing	n/a	n/a	Yes	Yes	Guilty of first degree murder and imprisoned
23	Eric Lewis	Public hospital	Beating	Yes	Yes	Yes	Yes	Guilty of second degree murder and imprisoned
24	Thomas Belanger	Home visit	Stabbing	n/a	n/a	n/a	Yes	Guilty of manslaughter and imprisoned
25	David Tarloff	Private office	Meat cleaver	Yes	Yes	Yes	Yes	Guilty of first degree murder and imprisoned
26	Samuel Lands	Residential facility	Gunshot	Yes	Yes	Yes	Yes	Guilty of first degree murder and imprisoned
27	Jess Massey	Public hospital	Strangling	Yes	n/a	Yes	Yes	Guilty of first degree murder and imprisoned
28	Deshawn Chappell	Residential facility	Beating and stabbing	Yes	Yes	Yes	Yes	Guilty of first degree murder and imprisoned
29	Barbara Newman	Private office	Gunshot	No	n/a	No	No	Suicide
30	Brent Redd	Residential facility	Stabbing	Yes	n/a	Yes	Yes	Guilty and insane and hospitalized
31	Lucious Smith	Home visit	Stabbing	n/a	n/a	Yes	Yes	Incompetent to stand trial and hospitalized
32	John Shick	Private hospital	Gunshot	n/a	n/a	Yes	Yes	Killed at scene
33	Richard Plotts	Private hospital	Gunshot	Yes	n/a	Yes	Yes	Awaiting trial

Table 3. Summary of Victim Characteristics

Professional Status	
Psychiatrist	10 (30.3%)
Physician	1 (3.0%)
Psychologist	2 (6.1%)
Nurse	2 (6.1%)
Social Worker	5 (15.1%)
Technical or Case Worker	13 (39.4%)
Female Gender	18 (54.6%)
Mean Age	
All victims	41.6 years
Female victims	35.4 years
Male victims	49.1 years

Table 4. Summary of Perpetrator and Crime Characteristics

Male Gender	27 (81.8%)
Mean Age	
All perpetrators	34.5 years
Male perpetrators	33.0 years
Female perpetrators	44.3 years
Diagnosis	
Schizophrenia	17 (51.5%)
Schizotypal personality	1 (3.0%)
Bipolar disorder	4 (12.1%)
Major depression	1 (3.0%)
Unknown	10 (30.4%)
Location	
Residential Facility	11 (33.3%)
Public Clinic	6 (18.2%)
Private Clinic	5 (15.2%)
Public Hospital	4 (12.1%)
Private Hospital	6 (18.2 %)
In Transit	1 (3.0%)
Method	
Gunshot	14 (42.4%)
Beating	4 (12.1%)
Beating and stabbing	3 (9.1%)
Beating and strangling	1 (3.0%)
Stabbing	10 (30.3%)
Strangling	1 (3.0%)
Prior History	
Criminal charge	16 (48.5%)
Violence	17 (51.5%)
Non-adherence	13 (39.4%)
Involuntary hospitalization	17 (51.5%)
Status	
Imprisoned	15 (45.5%)
Committed to hospital	8 (24.2%)
Suicide	4 (12.1%)
Killed	2 (6.1%)
Awaiting trial	1 (3.0%)
Unknown	3 (9.1%)