MEMORANDUM

Date: November 26, 2024

To: The Honorable Chair and Members
Pima County Board of Supervisors

From: Jan Lesher
County Administrator

Re: **Additional Information for the December 3, 2024 Board of Supervisors Meeting, NaphCare, Inc., - Pima County Adult Detention Center Mortality Report**

Following a series of suicides at the Pima County Adult Detention Center (PCADC) in 2018, the County Administrator asked the County's Chief Medical Officer to conduct a comprehensive review of mortality in that facility. (Attachment 1) Since that time we have carefully tracked and reviewed every single death occurring in the facility in order to identify trends, understand root causes, identify novel opportunities for intervention and ultimately where possible prevent premature deaths in the facility.

To this end the Office of the Medical Examiner has developed sophisticated interactive publicly accessible web based dashboards that allows stakeholders to review mortality within the facility. This collaborative effort has been made possible with the cooperation of the Custodial leadership of the Pima County Sheriff's staff, our Department of Detainee and Crisis Systems (DCS) and the contractor NaphCare.

The attached Annual Report on PCADC In-Custody Deaths provides a summary of these data. (Attachment 2) Overall the mortality trends at the facility are improving and area notable for a single death (of natural causes) occurring during the current calendar year. Likewise we note an overall declining trend in suicide and accidental deaths. Although, undoubtedly multifactorial this likely represents the hard work of the Pima County Sheriff's Department, the improved quality of care delivered by NaphCare, and the deployment of innovative interventions like medication assisted treatment included by our DCS team and its partners.

JKL/dym

Attachments

c: The Honorable Chris Nanos, Pima County Sheriff
Carmine DeBonis, Jr., Deputy County Administrator
Francisco García, MD, MPH, Deputy County Administrator & Chief Medical Officer
Steve Holmes, Deputy County Administrator
Greg Hess, MD, Pima County Medical Examiner
Paula Perrera, Director, Detainee and Crisis Systems

ATTACHMENT 1

MEMORANDUM

Date: September 13, 2018

To: The Honorable Chairman and Members
Pima County Board of Supervisors

From: C.H. Huckelberry
County Administrator

Re: **Suicide Risk at Pima County Adult Detention Complex**

Following a number of well-publicized suicides at the Pima County Adult Detention Complex earlier this year, I asked Assistant County Administrator Garcia and the Behavioral Health Department to provide an assessment of suicide risk at the facility. Attached please find a report providing a historical perspective on suicide and suicide attempts at the Detention Complex; and how these relate to larger national trends.

There are unique challenges to addressing the behavioral health needs of this complex population, and the report identifies risk factors for inmates that may be at elevated risk for suicide. Detainees appear to be at increased risk if they have a pre-existing behavioral health and/or substance use diagnosis, are under monitoring for alcohol or opioid withdrawal, have a history of prior bookings, and/or are within the first week of their current detention. These concrete observations suggest potential interventions and avenues for further program refinement.

The report also documents an unprecedented level of collaboration to address the mental health needs of detainees in an effort to decrease the potential for self-harm at the facility. The Sheriff's staff, the new correctional health services contractor (Centurion), and the Department of Behavioral Health are working collaboratively and effectively to ensure the health and well-being of individuals in custody. This unique level of coordination and intense focus will need to continue as Pima County and the rest of the country confronts increasing opioid and substance abuse complicating suicide risks in all detention settings.

CHH/mp

Attachment

c: The Honorable Mark Napier, Pima County Sheriff
Chief Bryon Gwaltney, Corrections Bureau Commander, Sheriff's Department
Jan Lesher, Chief Deputy County Administrator
Dr. Francisco Garcia, Assistant County Administrator for Community and Health Services
Ellen Wheeler, Interim Director Behavioral Health
Wendy Petersen, Assistant County Administrator for Justice and Law Enforcement
Sarah Davis, Health Data and Systems Manager

MEMORANDUM

Date: September 7, 2018

To: C. H. Huckelberry
County Administrator

From: Francisco García, MD, MPH
Assistant County Administrator

Via: Jan Lesher
Chief Deputy County Administrator

Re: Suicide and Self-Injury Risk at Pima County Adult Detention Complex

Introduction

According to the Centers for Disease Control and Prevention[1], suicide rates have increased significantly between 1999 and 2016. In fact, suicide is now the 10th leading cause of death and one of three leading causes that is continuing to rise at alarming rates. Contributing factors include but are not limited to mental health, substance use, outside stressors, prior suicide attempts and/or criminal activity. Correctional facilities, specifically jails, are facilities with short-term detainees, pre-trial offenders, sentenced prisoners and large populations with co-occurring physical and behavioral health disease. Persons in custody represent one of the populations of special concern for suicide, and a history of recent substance abuse may further increase risk.

The Pima County Adult Detention Complex (PCADC) has seen an increase of completed and attempted suicides at the facility. Completed and attempted suicides in the current year exceeded those 2017. This report provides a historical context for these recent events and makes recommendations as to how we may continue to support the health and well-being of the population in our custody. The timing of this report is significant since the prior correctional health services contractor, Correct Care Solutions (CCS), transitioned out of PCADC on June 30, and a new provider (Centurion) began providing services on July 1, 2018. This transition permits Pima County to refocus resources and develop new approaches to preventing suicide in this population.

Risk for Suicide

There is an established correlation between (diagnosed or undiagnosed) substance misuse and/or psychiatric disorder and the risk of suicide. This risk is increased for individuals in active withdrawal and its management is further complicated in a detention setting. Currently 45 percent of the total PCADC population are enrolled with the Regional Behavioral Health Authority indicating an underlying behavioral health diagnosis. Of that group, 60 percent have a co-occurring substance-use disorder.

[1] Centers for Disease Control Vital Signs: Rising Suicides Across the United States. 2018.

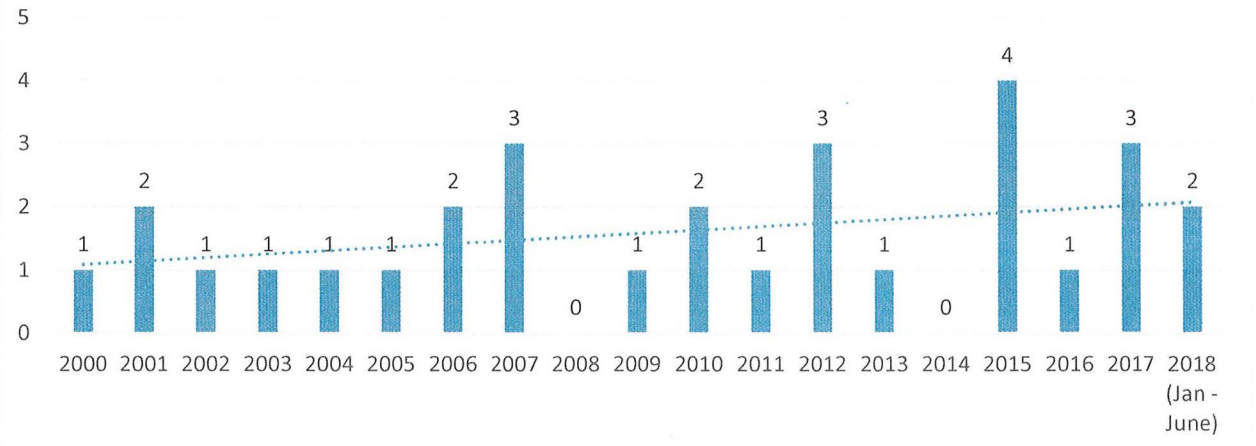
Assessing risk for suicide involves evaluating a number of medical and behavioral factors that play out uniquely in a correctional setting. Clinical risk assessment typically involve a face-to-face evaluation of the patient. It also includes a review of the patient medical history, incident reports, referral information and mental health treatment information when available. Medical and legal records are examined for history of suicidal or self-injurious behavior; current/recent impulsive behavior or social alienation; segregation status, correctional officer interactions, recent bad news; and evidence of coping skills and supports including relationships with family and peers. Implementation of a multi-modal suicide risk assessment ensures safe and appropriate clinical oversight those at risk for suicide.

Historical Analysis of Suicide within Pima County Adult Detention Complex and National Comparison

Detention centers report deaths occurring in a facility to the Department of Justice, Bureau of Justice Affairs. This is the primary federal data source for in-custody deaths and provides a comparator for the purpose of quality improvement and safety.

The PCADC has a relatively high rate of suicide mortality compared to other jail facilities. Between 2000 and 2014, there were 20 completed suicides in PCADC for a mortality rate of 76.8 per 100,000 population. This is higher than the suicide mortality for 20 comparably sized jails (30.6 per 100,000) or other jails in the United States (41.5 per 100,000).[2] More recently—although still rare events—completed suicides within PCADC appear to be trending upward. In 2015, four completed suicides were reported, one in 2016, three in 2017 and two in the first six months of 2018. (Figure 1)

Figure 1. Pima County Adult Detention Center Completed Suicides by Year

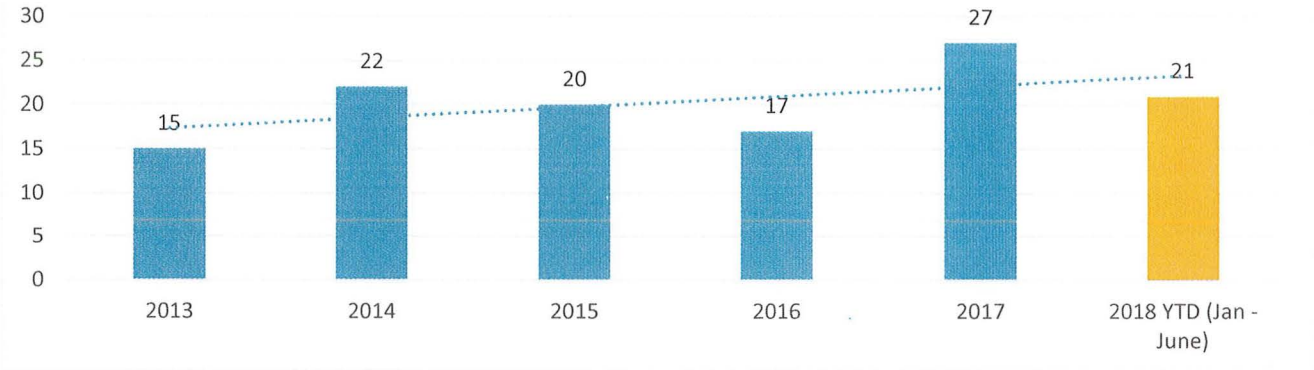


Between 2013 and 2018 (January to June), suicide attempts totaled 122 with 11 completed suicides. Of the 85 suicide attempts since 2015 (when we first began tracking transports), 30

[2] U.S. Department of Justice, Bureau of Justice Statistics. Deaths in Custody and Annual Survey of Jails

attempts (involving 29 individuals) required transportation offsite for medical treatment. The remaining 55 were effectively intervened by PCADC custody and contractor medical staff in the facility.

Figure 2. Pima County Suicide Attempts by Year



Suicide Risk Factors and Trends within Pima County Adult Detention Complex

We conducted a detailed study of suicides and attempts requiring transport offsite for medical management in order to identify critical indicators associated with suicides in detention. Specifically, staff assessed booking information, history of recidivism, jail risk assessment, history of medical care (emergency department and inpatient care) and associated diagnoses, community behavioral health treatment history and Office of the Medical Examiner reports, where applicable.

Completed Suicides, 2015 to July 2018

The average age of the 10 individuals that completed suicide between 2015 and 2018 was 37 with a range between age 19 and 47. Of these, 9 of the 10 inmates had been previously incarcerated at PCADC (median of 13 bookings, range of 0 to 21). Review of booking details for individuals completing suicides revealed that 3 were incarcerated for murder; 2 for robbery, burglary or theft; 3 for domestic violence or aggravated assault; 1 for felony drug-related charges; and 1 for a parole violation.

Upon booking (and periodically during detention), PCADC custody staff conducts a risk assessment to determine appropriate inmate housing. Detainees are classified as Low, Medium, or High Risk based on factors such as level of criminality, type and sophistication of crime, incarceration history, as well as self-reported medical and psychiatric history, among other indicators. Most (8 of 10) individuals that completed a suicide had been designated as low or medium risk by custody staff.

Medical and behavioral health information was also examined for the group with completed suicides. At incarceration, the PCADC medical record indicated that 9 of 10 of these inmates reported a history of poly-substance use most frequently involving heroin. Other identified substances included alcohol, methamphetamine and marijuana. At the time of the suicide, 5 of

the 10 were being actively managed for (alcohol and/or opioid) withdrawal and detoxification. All except one of these individuals had multiple hospital encounters prior to and/or during the current detention. Among the group with completed suicide, the median number of emergency department or inpatient hospital encounters was 9 (mean 8.2, range of 0 to 17). Hospital discharge diagnoses identified that 6 of the 10 individuals had clinical presentations consistent with opiate use, addiction and/or withdrawal.

Suicide Attempts Resulting in Offsite Medical Care, 2016 to July 2018

In an effort to understand the completed suicides, we also examined suicide attempts that resulted in sufficient harm to require offsite medical evaluation and treatment. Since the start of Calendar Year 2016, there were 29 individuals were involved with 30 suicide attempts resulting in offsite hospital care.

All but one had prior bookings at PCADC, with a median of 8 bookings per person (mean 10.8, range 1-41). Charges at booking included the following: 14 (48%) inmates with drug charges; 7 (24%) had charges associated with domestic violence or aggravated assault; 5 (17%) had charges of theft, robbery, or armed robbery; 2 (7%) were charged with sexual misconduct or exploitation; and 1 booked on charges for disorderly conduct. A total 20 of the 29 individuals were booked on felony charges at the time of the suicide attempt.

For the purpose of housing and custodial management, 10 of these individuals were assessed as High Risk, 13 were labeled Medium Risk and 6 designated Low Risk. At the time of analyses 22 of 29 individuals had been released and not re-booked since the suicide attempt, whereas 4 have been booked again at least once, and 3 were still in our custody. Notably, 3 of the 22 released detainees not subsequently rebooked had expired: 2 because of suicide, and 1 due to overdose of methamphetamines and opiates.

For detainees attempting (but not completing) suicide and requiring off-site evaluation and treatment, substance abuse is the largest commonality, specifically poly-substance use with opiates, alcohol, and methamphetamines. Of the 29 attempted suicides, 21 (73%) of these individuals were being managed under alcohol and/or opioid withdrawal protocols by the contracted medical provider (5 for alcohol, 6 for opioids, 10 for both). Only 8 (27%) were not undergoing clinical withdrawal surveillance, although 7 of those 8 had a prior diagnosis of substance misuse noted at the time of hospital encounter.

The medical provider at PCADC regularly queries community behavioral health treatment information for incarcerated individuals. Of those that attempted suicide at PCADC, 19 had a history of prior or current enrollment with a behavioral health provider, whereas 10 had not. Of those in the RBHA system, 3 were categorized as having Serious Mental Illness, 8 were in the Substance Abuse category, 2 were dually diagnosed with General Mental Health / Substance Abuse, and no information was available on 6.

Review of the hospital discharge database reveals that the 29 inmates attempting suicide had an average of 6.86 prior ED and/or inpatient hospitalizations (median 3.5, range 0 to 50). Of those with prior hospitalizations, 49% (12) had medical diagnostic codes associated with

substance abuse, with and without co-occurring mental health disorders. Eight had no prior ED or hospital encounters.

Analysis of Time between Events and/or Booking

In community and institutional settings suicide events sometimes cluster, we therefore examined the temporal relationship between events (completed or attempted suicide resulting in transfer) with length of stay in facility. (Table 2) Among the population attempting suicide, the event occurred a median of 4 days after booking, with a (mean 26.5 of days, and a range of 0 to 307 days). Similarly, completed suicide occurred a median of 3 days after booking (mean of 164.2 days, and range of 1 to 1,235 days). We note an increase in completed suicides and attempts beginning in summer of 2016, with a median of 20.5 days (range of 0 to 196) between unique suicide attempts and completed suicides. It should be noted that there are many periods with no completed or attempted suicides; however, there is an increased frequency between 2017 and 2018.

Table 2. Recent Suicides and Suicide Attempts Resulting in Offsite Medical Care – Time Study

Year	INCIDENT DATE (red = complete; black = attempt)	Unique Hospitalizations (Pima)	Unique Bookings (Pima**)	Detoxification Protocols	Days from Booking	Days Between Incidents
2018 (January calendar year-to-date)	6/XX/2018	9	4	Opioid	1235	23
	5/XX/2018	50	41		10	5
	5/XX/2018	0	1		22	3
	5/XX/2018	0	1		8	1
	5/XX/2018	1	15		1	1
	5/XX/2018	17	12	Alcohol and Opioid	5	1
	5/XX/2018	0	1		307	25
	4/XX/2018	0	1		3	58
	2/XX/2018	33	3	Alcohol	3	6
	2/XX/2018	7	9		33	0
	2/XX/2018	4	6	Opioid	9	7
	2/XX/2018			Opioid	2	0
	2/XX/2018	0	11	Opioid	4	13
	1/XX/2018	1	14	Alcohol and Opioid	2	6
	1/XX/2018	6	7	Alcohol and Opioid	5	58
2017	11/XX/2017	5	35	Opioid	12	3
	11/XX/2017	6	22		3	13
	11/XX/2017	0	3		1	2
	11/XX/2017	6	8	Alcohol and Opioid	3	42
	9/XX/2017	16	3	Alcohol and Opioid	1	23
	8/XX/2017	0	2		9	7
	8/XX/2017	17	11	Alcohol	5	22
	8/XX/2017	3	9		19	10
	7/XX/2017	8	8	Alcohol	36	23
	6/XX/2017	0	1	Alcohol and Opioid	3	3
	6/XX/2017	0	1		2	2
	6/XX/2017	1	12	Alcohol and Opioid	9	9

	6/XX/2017	11	7	Alcohol and Opioid	1	76
	3/XX/2017	10	18	Opioid	0	48
	2/XX/2017	0	2	Opioid	267	22
	1/XX/2017	2	4	Alcohol and Opioid	1	27
	12/XX/2016	3	17	Opioid	11	37
	11/XX/2016	1	1	Alcohol	24	21
	10/XX/2016	2	2	Alcohol	3	20
2016	10/XX/2016	12	21	Alcohol and Opioid	4	83
	7/XX/2016	7	14	Alcohol and Opioid	4	108
	3/XX/2016	17	20		528	196
	9/XX/2015	0	5		1	83
2015*	4/XX/2015	15	19		2	56
	2/XX/2015	4	21		3	

**There are no clinical data on suicide attempts requiring transportation prior to 2016*
***No data on incarcerations occurring outside of Pima County*

Suicide Watch at PCADC and Detoxification Protocols

The contracted medical provider at the jail employs industry standard clinical assessments and processes to identify inmates at risk of suicidality or withdrawal. Suicide watch, and clinical withdrawal assessments and scales are an integral clinical standard for the care of detainees at PCADC.

Suicide watch is a process lead by the contracted medical provider. However, anyone (custodial staff, medical staff, or another detainee) can identify someone at risk of suicide. When a detainee is believed to be at risk, the mental health team is notified via internal crisis line to interface with the patient. Mental health staff at the jail determine clinically if the patient receives intensified monitoring (suicide watch), and a mental health professional assesses the inmate daily until the issue has been resolved. Likewise, custody staff observes the inmate every 5 minutes, until the risk has subsided. Because of the potentially lethal outcomes associated with these findings, it is perhaps not surprising that nearly 200 inmates are on suicide watch every month at PCADC.

Detoxification from alcohol, opiates and benzodiazepines requires specialized clinical supervision. This is especially true in a correctional environment. The first 72-hours are the most difficult with severe physical symptoms including nausea and vomiting, diarrhea, stomach cramps, drug cravings, depression, delirium, hallucinations, seizures, agitation, and anxiety. In the case of alcohol, medical oversight for detoxification is particularly important since alcohol withdrawal may be life threatening and involve a risk of seizure, increased blood pressure, and central nervous system depression. These stressors contribute to the risk of suicidality.

Clinical Institute Withdrawal Assessment–Alcohol (CIWA) and Clinical Opiate Withdrawal Scale (COWS) are standardized screening instruments utilized to identify acute intoxication and withdrawal in order to assist with the ongoing management of the patient. Detention facilities use CIWA and COWS, to monitor individuals at risk for or undergoing detoxification. Table 3 displays the volume and type of inmates on a clinical withdrawal protocol in FY 2016 and FY

2017 for inmate withdrawal volumes. The upward trend in inmates requiring simultaneous opioid and alcohol withdrawal management is notable and speaks to the increasing medical complexity of the detainee population, and may be a contributor to increase in suicidality at the facility.

Table 3. Inmates Receiving CIWA / COWS Detoxification Protocols and Oversight at PCADC

Clinical Withdrawal Protocol	FY 2016	FY 2016 AVERAGE/ MONTH	FY 2017	FY 2017 AVERAGE/ MONTH	% Change
Opioid Withdrawal Protocols ONLY	2532	211	1741	145	-31%
Alcohol Withdrawal Protocols ONLY	3340	278	2404	200	-28%
BOTH Opioid and Alcohol Protocols	794	66	1840	153	132%

Medical Oversight since July 1, 2018

On July 1, the Pima County Board of Supervisors approved a contract with a new correctional health vendor for medical and behavioral health treatment services within PCADC and the Juvenile detention facilities. Centurion, a subsidiary of Centene Corporation and MHM Services, is a correctional health provider in both jail and prison settings and demonstrated experience in behavioral health.

Although very early into the term of the new contract, Centurion appears to recognize the importance of addressing the needs of co-occurring mental and physical health needs among the detainee population. Their proposal included a comprehensive plan for addressing behavioral health and their corporate leadership has notable expertise in suicide prevention in particular. Among the evidence-based practices they employ is an augmented suicide/self-injury risk assessment. The augmented risk assessment enables clinical staff to gauge suicide risk based not only self-reported information, but also on observations of behavior, and identification of both protective and risk factors. Additionally, Centurion has established practices for enhanced monitoring of inmates at risk of withdrawal employing have clinical guidelines for the management of alcohol, drug and opiate withdrawal.

Custodial Practice Improvements

The Sheriff's Department leadership at the Pima County Adult Detention Center has made important modifications to improve the safety of detainees and staff and prevent self-harm. Most notably inmates with a history of suicide attempts are not housed by themselves. Additionally, in the mental health and detoxification housing units, blankets have replaced bed sheets, smaller towels have replaced standard bath towels and bunks were modified to lower the risk of hanging. Redesigned staff space now permits the medical team to be co-located in the mental health and detoxification units, providing improved access and visibility to individuals at risk for suicide. Plans are in place for increased custodial monitoring for all inmates with special attention to the mental health and detoxification units. When suicide attempts do occur, Sheriff's Department staff ensure the safe on-site and off-site transport of the detainee for medical and mental health assessment and treatment. Continued partnership between medical

staff and custody facilitates the observation of inmates and enhances access to mental health services for those most at-risk for suicide.

Conclusions

We have identified clinical and behavioral health indicators of risk of suicidality for an inmate. These include current and/or prior mental health or substance misuse history or diagnoses, severity of the crime committed, and history of recidivism. For the population that attempted suicide requiring offsite medical evaluation, all but one was managed on detoxification protocol (for alcohol, opiates or both). Detoxification of substance-involved detainees is an essential component of health services for jailed populations. As opioid and substance misuse grows in Pima County, the populations in the jail with such a history will also continue to increase. Notably, the majority of inmates attempting suicide did so within three to four days of incarceration, identifying a critical window of time that may merit more intensive medical and custodial monitoring.

Pima County, its correctional health contractor and the RBHA exchange real-time community behavioral health treatment information on each detainee that enters the jail, through the Justice – Health Information Data Exchange. This data exchange feeds information such as detainee Medicaid enrollment status, behavioral health system engagement and community treatment provider. We anticipate that the new AHCCCS contract will present the County and its contractor with challenges to accessing critical clinical and administrative information in real-time to support comprehensive treatment for individuals with mental health and substance use disorders.

Recommendations

As in any other detention setting, the population in PCADC has a significant risk for suicide. Pima County staff, the Sheriff's Department Custody Staff and the contracted medical provider continue to work collaboratively and transparently to prevent suicides in this facility. To that end Pima County staff respectfully submit the following recommendations:

Staff proposes to collaborate with the correctional health contractor and the Sheriff's custody staff to develop processes that 1) identify detainees with risk factors (substance misuse, behavioral disease, prior incarceration); and 2) closely monitor detoxification, with special attention to the first 72 to 120 hours in custody, for the purpose of preventing suicides.

Staff should continue to develop appropriate and timely data sharing processes with behavioral health partners to facilitate clinical care for individuals in detention, and to facilitate their transition to community behavioral health providers.

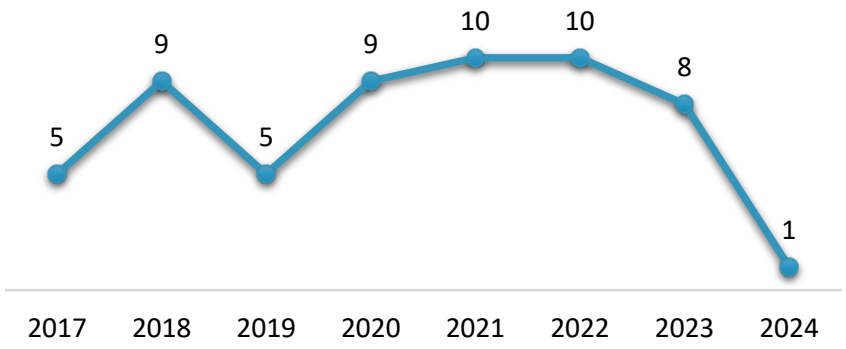
c: The Honorable Mark Napier, Pima County Sheriff

ATTACHMENT 2

PCADC In-Custody Deaths
2017-2024

Arizona Revise Statute 11-593 B defines the circumstances under which a death is reported to and investigated by the Medical Examiner. These include deaths occurring while under the supervision of a custodial agency. For this reason, every PCADC death undergoes examination by the Pima County Office of the Medical Examiner (PCOME) to ascertain the cause and manner of death. In total since 2017, there were 57 in-custody deaths. Please note that two deaths occurred in hospital after compassionate release from custody; they are not included in this report. One compassionate-release death was certified as a natural death due to complications of COVID-19. The other was certified with an undetermined cause and manner of death.

PCADC In-Custody Deaths by Year



Decedent Demographics:

- The majority of decedents are male (93%)
- Decedent age ranged from 18 - 76 years old; average age is 41

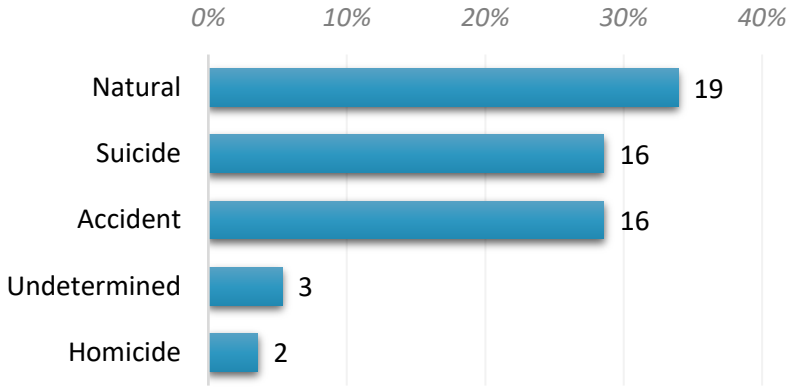
Sex	Male	53	*93%*
	Female	4	*7%*
Age	18-19	2	*4%*
	20-29	13	*23%*
	30-39	15	*26%*
	40-49	12	*21%*
	50-59	9	*16%*
	60-69	3	*5%*
	70-79	3	*5%*

PCADC In-Custody Deaths
2017-2024

Manner of Death:

- Natural deaths make up the largest proportion of PCADC in-custody deaths (34%), followed by suicides (29%), and accidental deaths (29%).

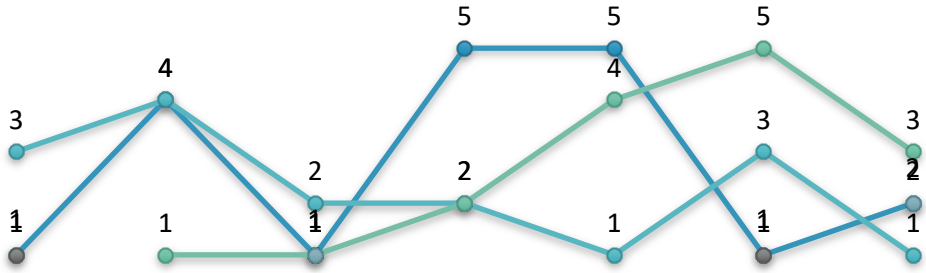
PCADC In-Custody Deaths by Manner of Death



Trends in Manner of Death from 2017 - 2023:

- Natural deaths were highest in 2020 and 2021 (five each year)
- Average of two suicides per year (high-point was in 2018 with four suicides)
- Accidental deaths increased annually, reaching a high of 5 in 2022; 14 of 16 accidental deaths were due to drug overdose
- Undetermined deaths and homicides are less common, totaling three and two, respectively, since

PCADC In-Custody Deaths by Manner of Death and Year



	2017	2018	2019	2020	2021	2022	2023
Natural	1	4	1	5	5	1	2
Suicide	3	4	2	2	1	3	1
Accident		1	1	2	4	5	3
Homicide	1					1	
Undetermined			1				2

PCADC In-Custody Deaths
2017-2024

Overview of Causes of Death:

- Excluding deaths due to COVID-19, there were 17 deaths from natural causes
- Drug overdose is the second leading cause of in-custody deaths (15 deaths)
  - Fourteen overdose deaths were accidents and one was a suicide
  - Drugs contributing to accidental overdose deaths include fentanyl (10 deaths), methamphetamine (7 deaths), heroin (1 death), olanzapine (1 death), and opiate unspecified (1 death)
  - Drugs contributing to intentional overdose include abrin (1 death)
- Intentional aspyhxia (from hanging) is the third leading cause of in-custody deaths (14 deaths)
- Drugs were involved in two natural cause deaths and both restraint-associated deaths
  - Drugs involved include methamphetamine (3 deaths) and fentanyl (2 deaths)
- COVID-19 was the cause of death in two decedents; it was contributory in one overdose death
- Of three undetermined manner deaths, two decedents had an undetermined cause of death and one death was due to pancreatitis.

PCADC Related Deaths by Manner, Cause, and Drug Involvement