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Egyptian Human Rights Authority
Report of findings
Lawrence Correctional Facility
HRA #24-110-9010
November 15, 2024

The Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of a possible rights violation in the care provided to an inmate at Lawrence Correctional Facility, located in Sumner, Illinois. The complaint is as follows:

Inadequate mental health treatment

If the allegation is substantiated, the allegation would violate protections under Illinois Department of Corrections regulations (20 Illinois Administrative Code 415.40) and Department policies.

Lawrence Correctional Facility is a medium-security prison that recently transitioned to a maximum-security prison for adult males. Lawrence Correctional houses 889 inmates (single cell), 627 of those have mental health needs.

To investigate the allegations, these matters were discussed with the attorney and the psychology administrator for the prison. Chart information, with a signed release, relevant policies and regulations that govern Illinois Correctional Facilities were reviewed.

Complaint Summary

The complaint alleges that mental health services are prohibited in R-7 module and that individuals on crisis are left unattended and in custody without treatment.

Interviews

The HRA interviewed the psychology administrator for the prison along with the prison's attorney. The HRA was informed that the prison provides crisis care on all of the units. Mental and Behavioral Health Technicians conduct wellness rounds each week and provide help as needed. Group sessions are available all the time. They are having staffing issues currently. The prison is authorized to have 8 mental health providers and 4 mental health technicians. Currently, they are operating with 1 part time assessor and

another on an as needed basis. They have two full time behavioral health technicians, and their mental health regional staff are helping when needed. The Southern regional psychology administrator and Wexford Health Sources (Wexford) are filling in currently.

The facility recently transitioned from a medium to a maximum facility. Some staff quit when that occurred. They have job postings for those vacancies through Wexford who is a contractor with the Illinois Department of Corrections (IDOC) along with one state job posting. Each prison is authorized as a mental health authority to oversee the services provided by Wexford. They offer individual and group counseling, psychiatric and psychological assessment, psychotropic medication management, crisis rounds, crisis services and restrictive housing monitoring rounds. Restrictive housing monitoring rounds means they check on each cell to see if there are any mental health issues by talking to inmates and observing the cell to ensure there is no mental health decompensation.

To request services, inmates can either complete a resident request form, request services during rounds, or ask for a crisis intervention team member. The forms are given to correctional officers or there are boxes to leave them in. If there is an emergent need, the individual can be seen within 2 hours. Routine needs are completed within 14 days. R-7 is a housing unit. Group sessions were not being held on R-7 at the time of the complaint, because they had not built a group area on that unit yet. It was a step-down unit, but now it is currently open as a regular unit, so there are groups being held there. Once inmates complied with their behavioral health plan, they could be transferred to a unit that offered group services. Ideally, R-7 was a short-term placement until an inmate was stable enough to participate in groups. It was primarily for individuals who were having behavioral problems. This inmate had one group in July but when he was on unit R-7, services were provided on an individual basis. So, mental health services were provided, he just could not participate in groups.

If an inmate gets a disciplinary report resulting in restrictive housing placement, the mental health providers review those to see if the person's mental health played a role in that behavior. They also determine if placement in restrictive housing was causing a problem for their mental health symptoms. If so, then they would request a reduction in restrictive housing time consideration which is submitted to the adjustment committee (AC). The AC is an operational security investigation division. When an inmate is given a disciplinary report, the AC hears the issue and conducts an investigation to determine if the allegation is founded or unfounded. The inmate can present evidence as to their side of story. If founded, the AC will recommend disciplinary action which must be approved by the Warden before it is implemented. There is a grievance form inmates can submit to the grievance office (clinical services processes and correctional counselor reviews). They ask for mental health to address the grievance and the Warden reviews. Inmates can also elevate the issue to the Springfield office if they are not satisfied with the outcome. The Adjustment committee is defined in the prison policy 05.12.103 as "a committee appointed by the Chief Administrative Officer of each facility consisting of, at minimum, two persons, at least one of which being from counseling staff to the extent possible, and at least one of which being of a minority race."

Medications that an individual is on upon imprisonment is continued in prison. There is no interruption in psychiatric medications. If behavioral issues occur, the mental health provider can schedule a psychiatric care appointment, if needed, or during rounds if there are problems. 30, 60 or 90 days are timeframes for regular psychiatric appointments depending on a person's needs. This inmate had appointments more frequently than monthly. He was assigned to a psychiatrist that he met with twice in August, once in September and four times in October. They discussed medication adjustments and labs were ordered. The inmate was also provided with individual counseling in September as he was on crisis watch. Crisis watch entails the corrections officers providing at the door checks and observations of behaviors. Additionally, the crisis team sees them once a day to complete a crisis assessment and other behaviors are observed. A licensed provider will always be contacted. This inmate was seen 4 times in October by a doctorate level licensed social worker or psychiatrist. The psychiatrist's interactions with him involved meeting with him for daily crisis responses twice.

The inmate that is the subject of this investigation participated in a coping skills class. The HRA was informed he had self-injurious behavior by swallowing objects (bleach, pills beyond recommended dosages, toothbrush). The medical staff treated him, then mental health staff placed him on crisis watch status. There, he was monitored at continuous, 10 min, 15 min or 30 min watches. He was placed in the crisis care area designed to be less dangerous for suicide, changed into a smock and was not allowed to have utensils for food.

He was transferred in November to a prison treatment center because he required a higher level of care due to higher level of suicide risk. He was placed on continuous watch before transferring. At the treatment center, they have 10 hours of structured programming and 10 hours of out of cell time unstructured. There is a lot of group therapy provided. If the treatment center has questions from the inmate's records, they will contact Lawrence Correctional.

Chart Information

Mental Health Progress Notes: The inmate's mental health treatment records were reviewed and are summarized below:

On 8/1/23 through 8/11/23 the inmate was on continuous observation crisis watch. An observation log was reviewed which showed observations and documentation every 10 minutes.

On 8/11/23, a mental health progress note documented the inmate was examined by the psychologist for daily contact and was discharged from crisis watch. It was documented the inmate would be examined every 30 days and weekly during rounds. He will be added to the group list. He was educated on how to attain mental health services. On 8/15/23, a mental health progress note documented the inmate was examined for a 1–5-day post crisis and mental health follow up. He reported being alright and trying to stay

in a good place. It was documented that he would be examined post crisis and every 30 days per his plan, he will continue to meet with the psychiatrist and was added to the groups list. On 8/20/23, he was placed on suicide and crisis watch due to reporting that he swallowed objects and pills. This was discontinued on 8/22/23. It was reported to the psychiatrist and mental health professionals that he was having difficulty dealing with the death of a parent.

On 8/22/23, mental health progress notes documented that the inmate was unavailable for scheduled psycho-educational group today.

On 8/23/23, mental health progress notes documented that the inmate reported that he needs the "one on ones, the MH groups, I need to make sure I'm in all groups." He expressed several frustrations with the facility which included not being offered groups on R-7. He questioned why clinical services were offered but not mental health groups. He stated that if he is getting proper treatment he does not need to go on crisis. He reiterated that he needs assistance and should not have to "go through loopholes." He stated he wanted to develop not regress. A referral was made to behavioral health so he could be examined bimonthly until he is offered mental health groups. A referral was made to the R-7 counselor regarding the patient's interest in joining clinical groups. A referral to Mental Health Management dated 8/23/23 was reviewed which documented the reason for the referral as "MHP [Mental Health Professional] met with the patient who recently moved from RH [restrictive housing] to GP [general population] (7 house). Patient has voiced numerous concerns about not receiving sufficient mental health services, especially when unable to participate in mental health groups. Patient would benefit from BHT [Behavioral Health Technician] support 2x a month to address coping skills, stressors, and other issues that may arise."

The HRA made inquiries into the difference between clinical services and mental health. It was explained that the Clinical Services Department provides support and services to individuals in custody in order to assist them in their adjustment, involvement in programs, and reintegration into society. The department functions under a case management system. The Clinical Services Department consists of a Clinical Services Supervisor, Casework Supervisor, Correctional Assessment Specialists, Correctional Counselors, Office Coordinator, Office Assistant, and Office Associates. Counselors are responsible for providing individual counseling for their caseloads. In most cases, the counselor is the initial person who assesses the various requests made by an individual in custody. Counselors evaluate and refer individuals in custody to the Assignment Committee for security reductions, institutional transfers, pre-release placement, furloughs and job placement. The counselor is responsible for providing crisis intervention and referrals of individuals in custody to mental health services. Initial efforts to resolve grievances should also be initially presented to counselors. Clinical Services personnel handle most responses required on incoming requests for information. In general, the Clinical Services Department is concerned with the delivery of services to individuals in custody. The Mental Health Department provides non-emergent and emergency mental health care. The makeup of the mental health team may consist of a Psychiatric Provider, Mental Health Professional (MHP), Behavioral Health Technician

(BHT), and Mental Health Registered Nurse (RN). The prison representative stated that "individuals from the mental health team are scheduled for providing nonemergency care 7 days a week. Individuals are scheduled for treatment in a group setting. There is considerable evidence base that demonstrates the clinical effectiveness of treating a range of mental health disorders in a group environment. Group is the primary treatment modality with individual, one-on-one treatment, being secondary. Individual therapy is a secondary approach which requires MHP clinical recommendation." It was also noted that any gesture for intent to harm oneself or another will likely result in a crisis placement. Crisis placement is a treatment measure for separating the individual in crisis apart from others wherein close observation is made. A MHP must perform an assessment prior to crisis discharge.

On 8/28/23, a request for referral was reviewed in which the inmate asked why his session this date with a behavioral health technician was ended. The staff remarks indicated it had been rescheduled.

On 8/29/23, a psychiatric progress note for crisis follow up documented that the psychiatrist spent time processing with the inmate his need for help. It was noted he "missed his BHT appointment for unknown reasons." It was documented that the psychiatrist would ask them to reschedule ASAP.

On 8/31/23, the inmate met with a BHT. It was documented that he engaged in the conversation.

On 9/12/23, a suicide potential evaluation was completed, and it was indicated the assessor had no concerns and would be seen by a mental health professional. On 9/13/23, the inmate met with a psychiatrist who documented that the inmate stated he knew he needed a higher level of care. The care plan stated he would be seen weekly by a mental health professional. A referral was also made to behavioral health for additional support. On 9/28/23, psychiatrist progress notes documented that the inmate presented with multiple complaints and stated he has trouble sleeping. Care options were discussed, and it was decided that another medication would be added.

On 10/15/2 the inmate refused the suicide potential [risk] evaluation. He was placed in crisis care due to his statement that he wanted to die and took an overdose of medication. He was placed on "overdose protocol." On 10/16/23, the psychiatrist notes documented that the inmate stated he was ready to be off watch and indicated no thoughts of self-harm. On 10/17/23, he was described as "belligerent", telling the evaluators to do their job, and noted to be hostile. The patient refused to leave the room despite being asked to. He later met with a psychiatrist whose notes documented that the inmate was upset with security for "rolling his door open" when he was sleeping, and a peer attacked him. He was upset with mental health staff because he felt he should have been on continuous watch. When a lack of change in his watch status was discussed, he stated "I'll show you what's unsafe, I'm going to kill myself." He was placed on continuous watch with daily follow up, placed in a smock, and a protocol for finger foods no utensils. Psychiatrist notes on 10/24/23 document that the inmate was cooperative and was discussing what

had happened. On 10/30/23, the psychiatrist notes documented that the inmate reported having made contact with medical for being hit in the head. There was no evidence of instability with stressor/external conditions, and it was recommended that the crisis placement be discontinued with a follow up with mental health. It was also documented that he would benefit from transfer to a facility with capability for providing outpatient mental health care with a behavior modification program. A referral was made to "regional" with a recommendation to transfer the inmate to a fellow facility to meet his mental health needs.

On 11/1/23, an evaluation for suicide potential was completed for a post crisis follow up. It documented there had been 2 previous suicide attempts. The evaluation showed a score of 4 out of 11 anything over 5 would require crisis watch.

On 11/2/23, a mental health progress note stated the inmate's level was "crisis placement" and it was noted this was a daily crisis placement assessment. The inmate reported having gotten upset between crisis discharge on 10/30 and movement back to restrictive housing. He had reported that he swallowed a toothbrush but stated during this interview that he had not, which was consistent with medical findings. The inmate reported contact with psychiatry on 10/31 and it was noted that he was "reactive to external conditions with poor impulse control, threat to self-harm, and manipulation resulting in crisis placement." He was informed that a higher level of care referral was initiated and verbalized agreement for the need.

On 11/5/23, a progress note stated the inmate's level was "general/outpatient." The visit was for a 90-day mental health follow-up to identify stressors. The inmate stated that on 10/15 he was asleep when he was woken by a crash of his television being broken. He stated another inmate was in his room with the door shut and hit him in the head. He blacked out and when he woke later in the afternoon he requested medical and mental health and was denied. As a result, he took "a bunch of psychotropic pills in order to get assistance from medical to clean the blood off my ear. Talk to someone about my incident [sic]. Now I'm on investigative status." It was documented that the doctor "provided the patient the ability to talk and to express his concerns and provided encouragement when appropriate." It was noted he did not report and did not have signs of self-harm or harm to others and follow up would occur in 90 days.

On 11/13/23, an evaluation of suicide potential was conducted as an emergency referral. It was documented that he was angry about property being stolen and was threatening to swallow a toothbrush and excessive psychotropic medication. He refused to participate in the evaluation. After consultation with the psychiatrist, it was determined he needed crisis care placement for close observation. A daily note on 11/14/23 documented that he did not think he belonged on crisis care and said he threatened to swallow objects because no one was listening to him. On 11/15/23, a progress note documented he was restless, agitated, irritable and paranoid over the incident from 10/15 and upset that he did not have his property back. Evaluations for suicide potential were completed daily between 11/16/23 and 11/19/23 with recommendations to remain in crisis care.

On 11/20/23, a progress note was reviewed in which the inmate stated he found out who stole his property and confronted them in the yard. It was also noted a piece of metal was found in his possession on this date. The mental health technician documented a change to 15-minute observation. It was noted the primary identified problem areas were "patient thinking styles and lack of insight for restructuring for problem-solving and behavior modification." On 11/22/23 a suicide potential evaluation was completed. It was documented that they talked about groups and the inmate was informed that he was "not in an eligible house" for groups. Close supervision and continued placement in a crisis care unit were recommended. It was documented on the 11/27/23 daily progress notes that the inmate expressed a need and interest in a higher level of care. He would benefit from Cognitive Behavioral Therapy and behavior modification. A consent for mental health treatment and a confidentiality disclosure form dated 11/28/23, documented that the inmate verbalized consent but was unable to sign due to crisis placement. He was admitted to the higher-level care treatment facility that day.

A treatment plan was in place which listed a goal for the inmate to name 2 measurable skills to manage mood and implement the identified coping skill. He would see a mental health professional every 7 days. Interventions include: motivational enhancement therapy, cognitive behavioral therapy, dialectic behavioral therapy, skills training, and/or psycho-education. It was stated that the inmate may receive support, psycho-education, and groups through behavioral therapy staff as clinically determined. He was also recommended for a higher level of care.

Incident reports, dated 10/15/23, were reviewed and there was not one that documented a peer attacking this inmate in his cell. The first incident report completed at 5:30 pm by a corrections officer stated that the officer responded to an alarm from the inmate's cell. When the officer arrived, the inmate stated he was going to kill himself. The officer asked the inmate to come to the front of the cell to be handcuffed but he refused and stated he had pills he had saved that he would take. The officer called a lieutenant for assistance. After arrival of the lieutenant, the inmate brought his closed fist to his mouth and took a drink from a milk carton. Though no pills were observed, the inmate was cuffed and escorted to healthcare. The lieutenant completed another incident report at 5:30 which corroborated what the officer had stated in his report. Additionally, it was noted that the inmate stated he was going to swallow a metal object. When patted down, a 90-degree cable end was found in the inmate's pocket. This report mentioned the cut on the inmate's ear and documented that the inmate stated he cut himself before the lieutenant came to his door and that he "had a lot going on." The final incident report was completed at 5:45 pm by a mental health professional and documented that they attempted to conduct a crisis evaluation of the inmate, but he refused to answer any crisis questions. He was placed on a 10-minute crisis watch.

Policies

Administration of Discipline for Individuals…Designated as Seriously Mentally Ill policy states "The Department shall recognize the potential for mental health conditions to impact behavior and, as such, shall ensure the involvement of a mental health professional during the processes of hearings and administration of discipline for

individuals in custody designated as seriously mentally ill to prevent further deterioration …

Disciplinary Process

1. When an individual in custody who has been designated as SMI [seriously mentally ill] is issued a Disciplinary Report, DOC 0317, for a major offense listed in Attachment A, where the disciplinary action may include restrictive housing or other special management unit time:

a. The Shift Supervisor shall, within 24 hours, notify the facility's Office of Mental Health Management.

b. The facility Mental Health Authority shall assign a reviewing Mental Health Professional (MHP) who shall review the individual in custody's mental health records and DOC 0317 and, within 48 hours of the original notification, provide a completed Mental Health Disciplinary Review, DOC 0443, to the hearing investigator who shall consider the report during their investigation in accordance with Department Rule 504. The DOC 0443 shall, at a minimum, provide:

(1) The reviewing MHP's opinion if the individual in custody's mental illness contributed to the underlying behavior of the offense for which the DOC 0317 was issued; and

(2) The reviewing MHP's opinion of overall appropriateness of placement in restrictive housing status or in other special management units based on the individual in custody's mental health symptoms and needs; including, potential for deterioration if placed in a restrictive housing or other special management unit or any reason why placement in restrictive housing status or other special management unit would be inadvisable, such as the individual in custody appearing acutely psychotic or actively suicidal, a recent serious suicide attempt or their need for immediate placement in a Crisis Treatment Level of Care …

Observation and Follow-up

1. Observation of individuals in custody in restrictive housing or other special management units shall be conducted in accordance with existing policies and procedures.

2. Referrals for mental health services and response to individuals in custody with serious or urgent mental health problems, as evidenced by a sudden or rapid change in an individual in custody's behavior or behavior that may endanger themselves or others if not treated immediately, shall be handled in accordance with Administrative Directive 04.04.100.

3. If, at any time, clinical indications suggest continued placement in restrictive housing status or in other special management unit poses an imminent risk of substantial deterioration to the individual in custody's mental health, the information shall be reviewed by the facility mental health authority.

4. Any recommendations by the mental health authority for reduction in restrictive housing or other special management unit time or termination of restrictive housing or other special management unit status shall be discussed with the CAO [Chief Administrative Officer].

5. The CAO shall adjust the restrictive housing or other special management unit term in accordance with the recommendations or, if the CAO does not agree with the recommendation of the mental health authority, they shall submit the issue to the respective Deputy Director for final determination."

Inpatient Mental Health Policy states "The Department shall establish and maintain a system of admission and care at specialized or designated facilities for individuals in custody whose mental health needs cannot be met at the outpatient or residential treatment unit level of care; and shall ensure individuals in custody are stepped down in such a manner to ensure a continuum of care.."

Suicide Prevention and Intervention and Emergency Services Policy requires that the Department "ensure a plan for prevention and intervention of emergency mental health situations is established and maintained and shall ensure individuals in custody are provided with emergency mental health services, as clinically indicated …

Crisis Treatment Supervision Levels

The following supervision levels shall be utilized for monitoring individuals in custody who have been placed on crisis watch. Individuals in custody shall be assigned a supervision level in accordance with his or her mental health status and shall be stepped down into the next less intensive supervision level upon termination of the current supervision level, unless determined unnecessary by a Mental Health Professional (MHP). Supervision levels may only be terminated by an MHP in accordance with the provisions herein:

1. Continuous Watch Status – a formal monitoring status that provides for continuous, uninterrupted verbal and visual line-of-sight monitoring of individuals in custody placed in a designated suicide resistant crisis care area, and determined by an MHP to be acutely mentally or emotionally distressed, at imminent risk for self-harm or who have made a recent suicide attempt. Although the monitoring of the individual in custody is continuous, the staff documentation of the individual in custody's behavior shall be at ten-minute intervals, or more frequently as notable behaviors or events occur. Individuals in custody in Continuous Watch Status may be:

a. Placed in restraints for mental health purposes in accordance with Administrative Directive 04.04.103; or

b. Placed in a crisis cell. Possession of property shall be at the discretion of the MHP, based on clinical appropriateness. If clinically determined that issuing property is contraindicated, the reason shall be documented on a Mental Health Progress Note, DOC 0282. Restoration of property shall be at the discretion of the MHP, and as soon as clinically appropriate, as indicated by the individual in custody's mental health status and individualized treatment plan.

2. Suicide Watch Status – a formal monitoring status that provides for verbal and visual monitoring and documentation at staggered intervals, a minimum of once every ten minutes, for individuals in custody in a suicide resistant crisis care area who are determined by an MHP to be acutely suicidal or at risk for immediate self-harm. Individuals in custody in Suicide Watch Status may be:

a. Placed in restraints for mental health purposes in accordance with Administrative Directive 04.04.103; or

b. Placed in a crisis cell. Possession of property shall be at the discretion of the MHP, based on clinical appropriateness. If clinically determined that issuing property is contraindicated, the reason shall be documented on a DOC 0282. Restoration of property shall be at the discretion of the MHP, and as soon as clinically appropriate, as indicated by the individual in custody's mental health status and individualized treatment plan.

3. Close Supervision Status – a formal monitoring status that provides for verbal and visual monitoring and documentation, at staggered intervals, a minimum of once every 15 minutes, for individuals in custody in a crisis care area who are determined by an MHP to be acutely mentally or emotionally distressed, potentially suicidal or pose a threat of serious physical harm to self or others in the immediate future. Possession of property shall be at the discretion of the MHP, based on clinical appropriateness. If it has been clinically determined that issuing property is contraindicated, the reason shall be documented on a DOC 0282. Restoration of property shall be at the discretion of the MHP and as soon as clinically appropriate as indicated by the individual in custody's mental health status and individualized treatment plan.

4. Periodic Check Status – a formal monitoring status that provides for verbal and visual monitoring and documentation, at staggered intervals, a minimum of once every 30 minutes for individuals in custody in a crisis care area, who have been determined by an MHP to be at increased risk for experiencing a mental or emotional crisis. Possession of property shall be at the discretion of the MHP, based on clinical appropriateness. All individuals in custody placed onto Periodic Check status shall at a minimum be issued a jumpsuit and or pants and shirt consistent with their appropriate housing placement (i.e. - general population, restrictive housing, etc.). If it has been clinically determined that issuing property is contraindicated, the reason shall be documented on a DOC 0282. Restoration of property shall be at the discretion of the MHP, and as soon as clinically appropriate, as indicated by the individual in custody's mental health status and individualized treatment plan …

<u>Referrals for Emergency Mental Health Situations</u>

2. Staff shall immediately notify the Crisis Intervention Team, through his or her chain of command, of any situation whereby an individual in custody exhibits behavior indicative of mental or emotional distress, imminent risk for harm to self or an attempted suicide.

3. Crisis Intervention Team Response

a. At least one Crisis Team member shall be on site at all times. The designated Crisis Intervention Team Leader shall be available by phone when not on site.

b. The Chief of Mental Health and the respective Regional Psychological Administrator shall be notified within 24 hours of the suicide of an individual in custody, and within 72 hours of any attempted suicide.
c. Upon notice of a potential crisis situation, a Crisis Intervention Team member shall:
(1) Implement necessary means to prevent escalation and to stabilize the situation.
(2) Ensure that the individual in custody is properly monitored for safety.
(3) Review the situation with the Crisis Intervention Team Leader or an MHP to determine what services or referrals shall be provided, including psychiatric intervention. If the Crisis Intervention Team Leader is not on grounds and cannot"

Mental Health General Provisions policy states that "The Department shall ensure individuals in custody have access to adequate Mental Health services …
Mental Health Services
a. Individuals in custody who are determined to be mentally or emotionally distressed, either due to chronic mental illness or situational stress, or have been staff-referred or self-referred to the Office of Mental Health Management, shall have access to the following mental health services, as clinically indicated:
(1) Screening, assessment and evaluation;
(2) Mental health treatment;
(3) Monitoring of mental health status;
(4) Programs such as specialized leisure time services and special educational services; and
(5) Transfer to a specialized mental health setting that can provide the determined appropriate level of care or transfer to a licensed mental health care facility when the individual's needs exceed the treatment capabilities of the Department … NOTE: Individuals in custody who exhibit severe problems in adapting shall be transferred to an appropriate level of care setting or facility, such as the Dixon Special Treatment Unit, Dixon Psychiatric Unit, Pontiac Mental Health Unit, Logan Mental Health Unit, Joliet Treatment Center, Elgin Inpatient Treatment Center or the Department of Human Services."

Memorandum 12/22/23 states "individuals residing in Housing Unit 7 that are not using the telephone or shower, should be locked in their cells." Signed by the warden.

The Orientation Manual states this about medication administration. "Taking your medication as ordered by your practitioner will promote and maintain good health. Medications will be delivered in two ways: 1) 'Bubble Pack' which holds a 30-day supply of medication 2) Direct Observation Therapy which means the nurse will deliver your medication one dose at a time and will directly observe you taking the medication … Each drug will be packed in a separate blister-pack. The label will clearly indicate how you are to take the medication. If you have any questions, ask the nurse. If, for any reason, you are unable to take your medication, you must return it to the nurse. Storing or having extra medication is not allowed … The blister-pack will contain only regularly prescribed non-controlled medication. Controlled medication will be administered by the

nurse. You must take all controlled medication and/or designated watch take medication when it is administered. Individuals in Custody found abusing medication will have to report to the housing unit pill line for each and every dose of medication. All Individuals in Custody may be subject to mouth checks."

Statutes

The Department of Corrections regulations in the Illinois Administrative Code state that, "This Part applies to adult and juvenile correctional centers and programs within the Department of Corrections" (20 Ill. Admin 415.10).

Regarding Mental Health Services in part 415.40, the Illinois Administrative Code states "persons committed to the Department shall have access to mental health services as determined by a mental health professional."

Regarding mental health examinations and treatment for guilty but mentally ill, part 415.50 states "a) Within 48 hours after admission to a reception and classification center, each offender adjudicated guilty but mentally ill shall be screened by a mental health professional. b) an examination by a licensed or registered mental health professional shall be performed…within four days after the offender's admission to a reception and classification center. The purpose of the examination is to determine the mental health status of the individual at the time of admission to the Department and to make any appropriate recommendations necessary for the care of such individuals." Anyone demonstrating acute symptoms of mental illness or who are determined to be dangerous to self or others shall be treated in accordance with the procedures applicable to other offenders. Treatment may include routine or emergency placement in a specialized mental health setting. If they are determined not to need such a placement, they may receive treatment in a general institutional setting when services are clinically recommended by a mental health professional. Part 415.50 continues to say "c) once placed in a general institutional setting, these offenders shall be examined or evaluated by a mental health professional at a minimum of every three months for the first six months and then every six months thereafter."

If a placement in a specialized mental health setting is necessary, Part 415.60 states "A review of each offender … shall be made at least once every six months. 1) the review shall be conducted by a staff psychiatrist and the administrator of the mental health center or unit or designee. 2)written results of the review shall be given to the offender. 3) if the recommendation is for the offender to continue in the program at the mental health center or unit, the individual may request a review of that decision by the Placement Review Board."

Conclusion

The complaint alleged inadequate mental health care was being provided. Allegedly, mental health services are prohibited on R-7 module and that individuals on crisis are left unattended and in custody without treatment. The HRA interviewed the attorney and the

psychology administrator for the prison. It was noted that the prison currently has low staff, but the psychology administrator and Wexford Health contracted provider were filling in until the mental health positions could be filled. The prison has recently transitioned from a medium to a maximum secure facility. At the time of the complaint, R-7 module was a unit which mostly housed inmates who were having behavioral problems. Ideally, it was a temporary placement until the inmate was stable enough to return to a regular module. Group sessions were not offered on this module for safety reasons and because a group room had not been built yet. However, one on one services were provided to the inmate. The HRA was informed that this module is now a regular housing unit where groups are being held. The HRA reviewed this inmate's treatment records and found that there were several incidents of self-injurious behaviors which warranted crisis placement. The HRA reviewed observation logs showing 10-minute checks were completed each time the inmate was on crisis placement for suicide watch. While on crisis placement, but not suicide watch, the inmate received daily checks and met with either mental health professionals or a psychologist weekly. Documentation showed that some weeks he received multiple one on one counseling sessions. The inmate's care plan required weekly meetings with mental health professionals. It was stated in the plan that he may receive groups through behavioral therapy staff as clinically determined. It was noted that in August, during a session with his psychologist, the inmate questioned why clinical services offered groups, but mental health services did not, stating that if he had appropriate services he would not need to be placed in crisis. The HRA asked what the difference was between clinical services and mental health services. The HRA was informed that clinical services counselors are assigned to all inmates, even those without mental health needs. Clinical services counselors are concerned with the delivery of services to individuals in custody and operates under a case management system. Whereas the Mental Health Department provides non-emergent and emergency mental health care by mental health professionals and operates under a clinical treatment system. The psychologist documented that a referral was made to the R-7 counselor advising of the inmate's interest in clinical groups and stating he would benefit from those. The HRA reviewed several notes beginning in August and continuing through November documenting that the inmate would benefit from a higher level of care. He was transferred to a mental health treatment facility within the Department of Corrections the end of November. The Illinois Administrative Code (20 Ill. Admin 415.50) requires inmates, who are found guilty but mentally ill, to be examined or evaluated by a mental health professional at a minimum of every three months for the first six months and then every six months thereafter and receive services that are clinically recommended by a mental health professional. This inmate was receiving weekly interventions via one-on-one counseling but was unable to participate in groups when he was on a unit that did not offer groups. However, the psychologist did send a referral regarding his interest in groups and referred the inmate to a higher level of care that ultimately resulted in a transfer to another facility for those services. Therefore, the HRA finds the allegation **unsubstantiated.** The following suggestions are made:

1. It was explained to the HRA that mental health services are primarily provided in group sessions. The prison spokesperson stated, "there is considerable evidence base that demonstrates the clinical effectiveness of treating a range of mental

health disorders in a group environment." However, at the time of this complaint, module R-7 was not offering group sessions for behavior management inmates. It was also noted in this inmate's records that he continually requested groups but was told he was "not in an eligible house for groups." The HRA suggests that the facility address behavior management in individual care plans rather than having a blanket practice of not providing group sessions for all inmates on a specific module.

2. Lawrence Correctional should ensure that when a higher level of care is recommended by mental health professionals, that level of care is provided as soon as possible. In this case, the inmate was transferred to another facility for higher level of care, but there was documentation for 2 months prior to transfer that it was recommended.

3. The inmate had a detailed discussion with his mental health professional about a peer attacking him in his cell on 10/15/23 resulting in the inmate overdosing on medication in order to receive medical and mental health care. However, the only incident reports documented a possible suicide attempt by the inmate. There was no documentation of an attack by a peer or any investigation of the alleged attack once it was reported to the mental health professional. Further, the lieutenant documented metal found in the inmate's pocket, but the corrections officer did not. The HRA suggests that Lawrence Correctional retrain staff on the importance of thorough documentation. When alleged abuse is reported to staff, Lawrence Correctional should ensure those allegations are properly investigated.

RESPONSE

Notice: The following page(s) contain the provider response. Due to technical requirements, provider responses appear verbatim in retyped format.