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Peoria Regional Human Rights Authority
Reports of Findings
Case #09-090-9017
Henry County Jail

The Peoria Regional Human Rights Authority (HRA), a division of the Illinois Guardianship and Advocacy Commission, accepted for investigation the following allegations concerning Henry County Jail:

1. A detainee with mental health needs did not receive needed mental health treatment, including medications and physician/nursing care.

2. Three individuals on suicide watch and whose conditions were unstable were subjected to unsafe and uncomfortable conditions.

3. Detainees are required to pay $20 to see a physician, $10 to see a nurse and pay fees to access needed medication.

If found substantiated, the allegations represent violations of the County Jail Act (730 ILCS 125) and regulations that govern county jails (20 Ill Admin. Code 701.90).

The Henry County jail has 132 beds and an average daily census of 120. Approximately 4 to 5 detainees at any given time have mental health needs.

To investigate the allegations, an HRA team met with and interviewed jail officials, toured the jail, reviewed pertinent, available jail information and, with consent, examined the record of a detainee. Contact was also made with officials of the Illinois Department of Human Services.

COMPLAINT STATEMENT

The complaint states that detainees with mental health needs did not receive needed mental health treatment, including medications and physician/nursing care, without paying a fee. Detainees on suicide watch were reportedly treated in an in appropriate manner. According to the complaint, three individuals on suicide watch and whose conditions were unstable were placed in the same cell and required to sleep on the concrete floor without access to mattresses. According to the complaint, one individual had to sleep on the concrete floor from October 5, 2008 through December 29, 2008. The detainees were eventually given mattresses, however, only two mattresses were given for three individuals. The mattresses were reportedly two inches

thick; a "suicide blanket" described as a Velcro suit was also provided. The complaint states that a detainee was on prescribed medication and then when his prescription ran out, the physician would not prescribe the same medication; Thorazine was prescribed instead which is a medication that the detainee had never used before. Detainees are allegedly required to pay $20 to see a physician, $10 to see a nurse and additional fees to access medication.

FINDINGS

Interviews

The HRA team interviewed the administrator who oversees the jail. He reported that the jail employs approximately 29 employees. While the jail can hold 132 detainees, the average daily census is 120 detainees with approximately 4 to 5 detainees having mental health needs. A minimum of 3 employees work on third shift; 4 employees work the weekends and on second shift. Six employees work during the weekdays. The jail is comprised of 8 main cells; each cell holds 14 individuals. There are two female cells each of which holds 8 individuals. A state inspector examines the jail on an annual basis.

With regard to services at the jail, the administrator reported that the jail utilizes a standard suicide prevention questionnaire to determine suicide risks and safety needs. A contracted nurse and physician from a private medical agency provide medical services. The physician visits the jail approximately once per week and a nurse is at the jail for about 32 to 40 hours each week.

The administrator described suicide watch protocol and stated that persons on suicide watch are put in a separate cell and they are monitored every 15 minutes; 15 minute checks are documented. The individual's clothing is replaced with a suicide smock which is specially designed protective clothing. If there is not enough room to place an individual on suicide watch in a separate room, the individual will be placed in a cell with other individuals on suicide watch. The administrator reported that a shared room for individuals on suicide watch has not been a problem. However, if a detainee is combative, the individual would be kept separate per the administrator. The nurse would be notified when a detainee is placed on suicide watch and the detainee can only be released from suicide watch with physician approval. Suicide mattresses are provided; these mattresses are seamless and made of a more solid foam. The mattresses are placed on raised fiberglass cots. According to the administrator, every detainee is to have a cot, however, not all detainees will receive a mattress if they are all taken. The administrator reported that the holding cell includes a raised concrete bench; the holding cell may have been used for suicide watch in the past.

The HRA team inquired about training for jail staff. The administrator stated that the booking officer receives training on screening for suicide risk. When asked if the jail uses therapeutic crisis techniques, the administrator indicated that he believed this was part of the training but also stated that there is "No way to take someone down without force." Although the administrator later stated that staff "can sometimes talk out" a situation with an aggressor. All jail staff who have contact with detainees receive training.

Medication issues were discussed. The administrator stated that there is a county co-pay charge of $5 for medications if the detainee has money; detainees who do not have funds can still access medications. Co-pays are also charged if a detainee requests to see a nurse ($5) or a physician ($20). The administrator reported that state statutes allow for the co-pay charges. According to the administrator, charges are deducted from inmate commissary accounts. Commissary accounts usually includes funds that an inmate arrives with in addition to funds received from family or friends. If a charge will leave a zero account balance, then only a portion of a medical fee is charged; the charge may be subtracted at a future time should the inmate receive additional funds. Detainees who are on current medications will continue to receive those medications until the physician evaluates and determines whether or not to continue/discontinue the medications or prescribe new medications. The HRA did not find any signed medication consents.

In regard to the individual detainee identified in the case, the administrator verified that he was on suicide watch and had been in the holding cell. The administrator stated that a detainee would not have to wait several weeks to obtain a mattress. Instead, he would have received a mattress within a few days or he would have been transferred to a cell with a cot. The detainee was eventually transferred to a state-operated mental health facility.

The HRA concluded with questions regarding the private medical provider. The administrator stated that the provider has been used by the jail for some time. In the past, a community mental health provider served the jail. Jail staff would take detainees to the mental health center's psychiatrist who had an office in town; however, the psychiatrist no longer has a local office and evaluations were delayed. The private agency conducts evaluations and physicals. During the course of the investigation, the Authority learned of recent contacts between the community mental health agency and the jail.

The administrator explained that detainees can file complaints about conditions. A complaint form is available to detainees to write out concerns or detainees can report concerns directly to the jail administrator. The administrator reported that he had not received any complaints from the detainee involved in the HRA case.

Jail Tour

As part of the investigation, the HRA team toured the jail. The HRA noted the cells used for suicide watch. One cell was by an office from which staff could observe the detainees; however, the HRA noted that there was an area of the cell that could not be seen from the window. The administrator stated that visual checks are also done by opening the cell door; notes are made of visual checks. For all other cells, detainees can be observed from the cell window. The team examined the holding cell that is sometimes used for suicide watch; the holding cell has a concrete bench. The cots were also viewed; the cots are plastic and molded to fit the shape of a body. The team also examined the exercise area and a private room that could be used for meeting with a counselor.

Record Review

With consent, the HRA examined the record of a detainee with mental health needs. A screening form was completed on the detainee that included questions regarding a detainee's

medical, medication and mental health needs. The screening form questioned the detainee's suicide risk, disability needs, aggression toward others, ability to understand instructions, and need for separation from others. One question even stated the following: "Do you understand that you may request a health care provider at any time you are here?" For the detainee under review, the screening indicated that the detainee had a serious medical condition, took medication for both physical and mental health needs, had a serious mental health condition, had attempted suicide in the past and was currently considering suicide. The intake date was listed as 04-05-09. The form included signature lines for the detainee and booking officer; however, the form was unsigned although the officer identification number was listed at the top of the form.

A release form, dated 12-29-08, indicated that the detainee had several charges related to burglary, criminal trespassing, criminal damage to property and disorderly conduct; his initial intake/arrest date was 09-26-08. In addition, the form stated that the detainee had a mental illness but was not considered a suicide risk or violent at the time of release; he was released to a state-operated mental health facility. A separate release form, dated 06-25-09, indicated an intake/arrest date of 04-05-09 and a release to the Department of Corrections; the form continued to indicate the detainee's mental illness.

Notes of the detainee's stay at Henry County jail were reviewed. A note on 10-03-08 indicated that the inmate was on suicide watch and during rounds, the inmate stopped guards "…and said that he was going crazy in that block and that he needed his medication. [Staff] asked what medication he needed and he stated Lithium, Lorezepam and several others. [Staff] further inquired if he had spoken to the nurse concerning these medications. He said he had. [Staff] advised him that a new med request would be put in. He stated that he was not going to see her and that he wanted out of the block because he was hearing voices and that he feared people were out to hurt him. [Staff] advised him for the time being he would be locked in his cell until it could be decided where, if any place he could be moved….When [staff] sent to retrieve inmate's…tray … he was standing there with a pencil up to his eye and stated 'Do you want to see me kill myself,' 'Do you want to see me stab myself in the eye.' The cell door was then opened and [staff] removed the pencil from [inmate's] hand while [other staff] retained his arms. Inmate…was then escorted to the drunk tank and placed on suicide watch. A med request was placed for inmate…to be evaluated by medical staff." Another note dated 05-12-09 indicated that the inmate "…stated that he was suicidal and that he was hearing voices." He was placed on suicide watch. A medical note was documented on 05-26-09 which states that the inmate saw the nurse after having a bout of diarrhea.

The detainee's medication record states that he received the following medications: Lithium 300 mg twice per day; Zyprexa 5 mg in the morning and 10 mg in the evening; Lorazepam 1mg twice per day, Trazodone 100mg in the evening and Nitroglycerin as needed. According to the May and June 2009 medication records, the detainee received most of his medication, most of the time. During the May - June 2009 time frame, the detainee missed 3 doses of lithium, 1 dose of Zyprexa, 7 doses of Lorazepam, and 2 doses of Trazadone. It is unclear as to the reason for the missed doses. The detainee never accessed the Nitroglycerin. Medication records from April 2009 indicated that no dosages were missed during the month. Medication records from December 2008 indicated that the recipient was taking Chlorpromazine 100 mg twice per day, Fluoxetine 20mg per day, Trazadone 100mg per day Ibuprofen, Haldol

5mg twice per day and Benadryl 50 mg twice per day; the Chlorpromazine was discontinued for 3 days in December and it does not appear that Haldol was given at all. The medication form for October 2008 indicated that an order for Chlorpomazine 25 mg twice per day began October 14th and was given only about 8 times for the reminder of the month; a new order for Chlorpromazine at 50 mg twice per day was order 10-29-08 but was not taken by the detainee during the month. An order for Fluoxetene was dated 10-29-08 but was not taken in October 2008.

The HRA examined medical progress notes. A physician's note dated 10-11-08 questioned the inmate's medication but ordered the Thorazine at 25mg twice per day. A thought disorder diagnosis is noted along with the inmate's statements that he felt unstable but was unsure of suicidal thoughts. On 10-17-08, a nurse contacted a mental health center requesting information about the detainee's most recent medication list. A physician note dated 10-29-08 is difficult to read but Thorazine was increased and Prozac was added. And, another physician note dated 11-26-08 increases the Thorazine dosage again and adds Trazadone. On 05-12-09, the physician noted a medication evaluation and the need to call another physician regarding the medication, Zyprexa. A call was made to the other physician. And, a physician's note dated 05-29-09 indicated discussion with the detainee about suicidal ideation and intent.

Inmate Medical Request forms were reviewed. A form dated 09-26-08 indicated that the inmate reported that he had a Bi-Polar Disorder but had no medication; staff secured a release for community mental health center. A form dated 10-03-08 stated that the inmate reported that he was going crazy, needed his medication and feared that persons were out to get him. On 12-23-08 the inmate requested to see the nurse about his medication stating that the Thorazine is upsetting his stomach; the Thorazine was discontinued and Haldol was ordered. A 05-12-09 request form stated that the inmate reported hearing voices and suicidal thoughts; he was placed on suicide watch and examined by the physician. On 05-18-09, the inmate reported symptoms of diarrhea after meals and discussed social isolation while on suicide watch and wanted to return to the general population.

Additional record documents were reviewed. According to the record, the detainee signed a refusal of medical treatment form each time he was offered a physical exam upon entry into the jail and then when he returned after a stay at a state-operated facility. The HRA found releases signed by the detainee allowing a prior psychiatric hospital unit to release detainee information to the jail. The initial release was signed in October 2008 but was resubmitted, at the hospital's request, because the hospital did not find that the release met confidentiality requirements. The hospital provided the jail with information about the detainee's medications; those medications included, Lithium 600mg twice per day, Lorazepam 1mg three times per day, Seroquel 100 mg in a.m. and 300mg at night, Buspirone 20 mg twice per day, Fluoxetine 40 mg per day and Benztropine 1 mg twice per day. Also reviewed were physician Medical Notification forms; there were 3 such forms for the detainee, and all three were related to the detainee's complaints of chest pain for which aspirin, Benadryl and/or ibuprofen was ordered.

With regard to the inmate's status while at the jail, record information states that he was arrested in September 2008 and in a preliminary hearing a fitness exam was ordered. He was later found unfit to stand trial and remanded to the Illinois Department of Human Services. In

April 2009, he returned to the jail from a state-operated mental health facility after having been found fit to stand trial.

Additional Documents

The HRA examined additional materials related to the complaints, including training materials that guide the jail's activities related to individuals with mental illness and a complaint form. The jail provided staff training information entitled, "Mental Health and Suicide Prevention Training for Illinois County Jails." The training identifies the rights retained by a detainee which include: voting, speech, religion, freedom from excessive force, food, shelter, clothing, protections from harm, medical care, mental health services and freedom from discrimination. Various disorders are described as well as warning signs related to mental instability. Intervention techniques are listed as follows: awareness, engagement, non-judgmental approach, open ended questions, specific questions, reports to mental health/medical staff, and assistance with medication compliance. Treatment options are listed as medication, counseling and linkage to community mental health treatment. The information concludes with a discussion of suicide risks, screening and approaches. Approaches identified were similar to approaches to be used for mental health interventions as described above.

The complaint form simply allows the inmate to document and then sign and date a complaint.

Information regarding the contracted medical provider was also reviewed. The provider is described as an agency that serves correctional facilities with a range of services including medical, pharmaceutical and behavioral health services. The behavioral health services reference on-call availability of mental health professionals.

The Authority requested policies specific to suicide watch, medical services, mental health services and inmate grievances. Inmate rules as posted on the jail's internet site include a statement that "prescription medication is accepted only if current and in original container."

Contact with Illinois Department of Human Services Official

The HRA contacted a representative of the Department of Human Services to inquire about the provision of community mental health services in county jails. The HRA was informed that the Department is involved in a project entitled, Mental Health and Justice, designed to evaluate and increase resources to individual with mental illness who encounter the criminal justice system. The representative stated that many community mental health agencies have some type of contract that at least provides crisis services to jails. And, many community mental health providers are willing to see inmates on a routine basis if the inmate had been a client of the community mental health center.

MANDATES

Regulations that govern jails (20 Il. Admin. Code 701) state in Section 701.90 under the heading of "Medical and Mental Health Care" that "All jails shall provide a competent medical authority to ensure that the following documented medical and mental health services are available: 1) Collection and diagnosis of complaints. 2) Treatment of ailments. 3) Prescription of

medications and special diets. 4) Arrangements for hospitalization. 5) Liaison with community medical facilities and resources. 6) Environmental health inspections. 7) Supervision of special treatment programs, as for alcohol and other drug dependent detainees. 8) Administration of medications….Professional mental health services may be secured through linkage agreements with local and regional providers or independent contracts. Linkage agreements and credentials of independent contractors shall be documented…A written record shall be maintained, as part of the detainee's personal file, of all treatment and medication prescribed, including the date and hour such treatment and medication is administered…Annually, mental health professionals shall provide training to all jail officers and other personnel primarily assigned to correctional duties on suicide prevention and mental health issues….Psychotropic medicines shall not be used as a disciplinary device or control measure."

The County Jail Act (730 ILCS 125) also addresses jail requirements. Section 125/5 addresses the cost of maintaining prisoners and states that "… all costs of maintaining persons committed for violations of Illinois law, shall be the responsibility of the county…all costs of maintaining persons committed under any ordinance or resolution of a unit of local governments, including medical costs, is the responsibility of the local government enacting the ordinance or resolution, and arresting the person."

With regard to the separation of prisoners, the County Jail Act states in Section 125/11 that the jail is to separate debtors and witnesses from other prisoners, male and female prisoners, minors from those convicted of a felony or other infamous crime and those charged from those convicted of crime.

Section 125/17 of the County Jail Act addresses inmate bedding, clothing, fuel, and medical aid. This Section states the following: "The Warden of the jail shall furnish necessary bedding, clothing, fuel and medical services for all prisoners under his charge, and keep an accurate account of the same. When services that result in qualified medical expenses are required by any person held in custody, the county, private hospital, physician or any public agency which provides such services shall be entitled to obtain reimbursement from the county for the cost of such services….To the extent that such person is reasonably able to pay for such care, including reimbursement from any insurance program or from other medical benefit programs available to such person, he or she shall reimburse the county or arresting authority. If such person has already been determined eligible for medical assistance under the Illinois Public Aid Code…at the time the person is detained, the cost of such services, to the extent such cost exceeds $500, shall be reimbursed by the Department of Healthcare and Family Services under that Code….The sheriff or his or her designee may cause an application for medical assistance under the Illinois Public Aide Code to be completed for an arrestee who is a hospital inpatient….When medical expenses are required by any person held in custody, the county shall be entitled to obtain reimbursement from the County Jail Medical Costs Fund to the extent moneys are available from the Fund. To the extent that the person is reasonably able to pay for that care, including reimbursement from any insurance program or from other medical benefit programs available to the person, he or she shall reimburse the county." In a 1996 opinion, the Attorney General stated that "Although counties may seek reimbursement and initiate a civil action to recover costs of medical services, they do not possess the power to authorize a sheriff to

seize a prisoner's commissary account to reimburse the county for medical expenses incurred on the prisoner's behalf [1996 Op.Atty.Gen. No. 96-014]."

Finally, Section 125/20 of the County Jail Act, states that "The cost and expense of keeping, maintaining and furnishing the jail of each county, and of keeping and maintaining the prisoner thereof, except as otherwise provided by law, shall be paid from the county treasury….The county board may require convicted persons confined in its jail to reimburse the county for the expenses incurred by their incarceration to the extent of their ability to pay for such expenses. The warden of the jail shall establish by regulation criteria for a reasonable deduction from money credited to any account of an inmate to defray the costs to the county for an inmate's medical care"

CONCLUSIONS

Complaint #1: A detainee with mental health needs did not receive needed mental health treatment, including medications and physician/nursing care.

The HRA found that the detainee whose file was reviewed received medication, suicide watch precautions and access to physician and nursing services. The provision of medication, nursing contacts and physician contacts were all documented. And, nursing/physician contacts were made in response to the recipient's voiced mental health and medical concerns. A screening form was completed; however, it was not signed by either the detainee or the staff person who completed the form. There was some question as to the timeliness of medication pursuits; it appeared that medication was not pursued for several days after detention and after the detainee voiced concerns. And, when medication was ordered, the medication was not consistent with the medication the individual had been taking when in the community although the medication orders were eventually changed to reflect medication he had previously taken. The HRA noted that, occasionally, the detainee missed doses of medication although the reasons for the missed doses were not documented. Training materials indicated staff training on mental health issues and suicide risks. The HRA noted that the jail administrator referenced take down procedures using force versus any crisis intervention/prevention models. The HRA also noted that a Department of Human Services official cited the availability of community mental health agencies to provide mental health services.

Mandates that govern county jails require the provision of mental health and medical care to inmates to review, diagnose and treat ailments/complaints, including medication treatment. The jail can enlist linkage agreements with medical and mental health providers to ensure medical and mental health care.

Based on its findings, the HRA does not substantiate the allegation that a detainee with mental health needs did not receive mental health care, medication or nursing/physician services. However, the Authority would like to take this opportunity to offer the following suggestions:

1. Secure detainee and staff signatures on screening forms.

2. Pursue contacts with prior mental health providers as soon as possible upon detention to facilitate the continuation of mental health care and treatment, including the provision of appropriate medications.

3. Document the reasons for missed medication doses.

4. Consider the use of crisis intervention/prevention models when addressing the behavior of detainees with mental health needs.

5. To maximize mental health expertise and to facilitate a continuum of mental health services after detention or release for an inmate, consider pursuing a linkage agreement with the area community mental health provider for the provision of mental health services at the jail.

6. Consider the development of a policy to address inmate mental health and medical needs.

7. To confirm inmate consent and that medication was not forced or used for disciplinary purposes, secure signed consent forms for the administration of psychotropic medication

Complaint #2: Three individuals on suicide watch and whose conditions were unstable were subjected to unsafe and uncomfortable conditions.

According to the complaint, a detainee was placed on suicide watch with two other individuals whose conditions were unstable and was forced to sleep without a mattress.

The jail administrator acknowledged that a detainee on suicide watch may have been placed with other individuals on suicide watch depending on the availability of a single cell. He also acknowledged that there may have been gaps in the provision of a mattress but that the gap would have only been for a few days versus a few months. At the same time, the HRA found documented evidence of 15 minute checks of the detainee when he was on suicide watch and referrals to the physician and nurse when placed on suicide watch.

Regulations that govern jails require appropriate bedding. Regulations address the separation of inmates in certain circumstances and although individuals on suicide watch are not specifically listed, the underlying reason for the separation is safety. The 15 minute checks would allay some concerns related to safety.

Based on the administrator's report that individuals on suicide watch were sometimes placed in the same cell and without mattresses, the HRA substantiates a rights violation related to unsafe and uncomfortable conditions while a detainee was on suicide watch and recommends the following:

1. **Ensure the provision of adequate bedding consistent with jail regulations.**

2. **Ensure the provision of safety for inmates on suicide watch.**

The HRA also makes the following suggestion:

Consider the development of a policy on suicide watch to guide staff in suicide precautions.

Complaint #3: Detainees are required to pay $20 to see a physician, $10 to see a nurse and pay fees to access needed medication.

The jail administrator acknowledged that inmates may sometimes be charged fees for services although record information provided to the Authority did not confirm that fees were charged to the detainee in this case. Regardless, the inmate appeared to receive needed medications and access to medical care.

Jail regulations appear to allow jails to assign fees for medical services under certain circumstances.

Due to the lack of documented evidence that the inmate was inappropriately charged fees for medical services, the allowance of fees in certain situations as per jail regulations, and evidence that the detainee received medical care, the HRA does not substantiate the allegation.

The Authority does suggest that the jail document any fees collected from inmates and consider the development of a policy to guide fee collection.