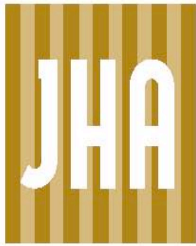

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Unasked Questions, Unintended Consequences: Fifteen Findings and Recommendations on Illinois' Prison Healthcare System

A Special Report by The John Howard Association

Photo Credit: IDOC

JHA's work on healthcare in IDOC is made possible through a generous grant by the Michael Reese Health Trust

The John Howard Association of Illinois (JHA)
Promoting Community Safety Through Cost-Effective Prison Reform

Founded in 1901, JHA is Illinois' only non-partisan prison watchdog. Our mission is to achieve a fair, humane, and cost-effective criminal justice system by promoting adult and juvenile prison reform, leading to successful re-integration and enhanced community safety.

Through our longstanding Prison Monitoring Project and Juvenile Justice Project, JHA staff and trained volunteers regularly tour all facilities in the Illinois Department of Corrections and the Illinois Department of Juvenile Justice. During these tours, monitors are able to observe the challenges faced by both inmates and correctional staff and ensure that policies are implemented in a way that promotes public safety.

Following our visits, JHA issues a written report that focuses on critical matters such as education, medical and mental health care, disciplinary procedures for youth and adults, and the physical condition of the facilities. These widely disseminated reports are read by everyone from lawyers to legislators, wardens to reformers, members of the Governor's office to members of the public at large; they provide essential transparency and oversight to an otherwise overlooked institution and drive safe and cost-effective criminal justice reform.

To read JHA's prison reports and learn more about our work, please visit at our website at http://www.thejha.org.

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The Illinois Department of Corrections (IDOC) is not just an agency of 27 prisons. It is also a healthcare system for nearly 50,000 inmates.

This is an important fact that has profound and under-examined implications for state and local budgets, public safety, and civic health.

The United States Constitution's prohibition against cruel and unusual punishment requires prison officials to provide adequate healthcare for inmates.

Over the past 40 years, as Illinois' inmate population has increased by more than 700 percent, IDOC's constitutional healthcare obligations have become increasingly difficult to fulfill.

As of August 2012, IDOC housed almost 50 percent more inmates than it was designed to hold. Many minimum and medium security facilities housed more than 100 percent beyond their design capacity. These numbers place a nearly impossible demand not only on IDOC's ability to house inmates, but also on its ability to deliver healthcare services. Compared to the general public, inmates have significantly greater healthcare problems, with higher rates of chronic and infectious disease, addiction, and mental illness. The more inmates that IDOC incarcerates, the more sicknesses it must treat.

Apart from overseeing the care of its general population, IDOC also struggles to treat the growing number of inmates with special needs. For instance, over the past decade, Illinois' elderly prison population grew by more than 300 percent, far outstripping increases in other age groups.[1] While exact estimates vary and there is no Illinois-specific data, it is widely accepted that U.S. prisons and jails house more mentally ill people than psychiatric hospitals.[2] Additionally, a 2010 study by the National Center on Addiction and Substance Abuse at Columbia University found that 65 percent of the U.S. prison population meets the DSM IV medical criteria for substance abuse or addiction, though only 11 percent receive treatment.[3]

These special populations and the costs associated with their care stem from decades of choices made by elected officials with the support of the public. Decisions to lengthen sentences, mandate harsher punishments for drug-based offenses, and close public mental health institutions have filled IDOC with inmates who are drug addicted, mentally ill, and growing older. As a consequence, state prisons have become *de facto* hospitals, asylums, drug treatments facilities, and retirement homes.

Faced with unprecedented prison overcrowding, IDOC's healthcare responsibilities put an enormous burden on correctional staff and administrators. In this way, the state of

prison healthcare system directly affects IDOC's ability to promote public safety. With Illinois' fiscal crisis, IDOC has limited resources. The more resources IDOC must devote to healthcare, the less it has to provide inmates with programming that is proven to reduce criminal behavior. For instance, in Fiscal Year 2013, IDOC officials have reported that the agency must devote approximately 98 percent of its funding to basic operations, with less than two percent to spend on rehabilitative programming.

IDOC's healthcare system is not just an issue for the state's prisons. Every year, almost 35,000 inmates leave IDOC to return to their communities. If the prison system is not able to meet its healthcare obligations, cities, counties, and the general public will inevitably pay a higher price when inmates are released, with increased transmissions of infectious diseases, emergency room visits, and higher recidivism rates.

This is not meant as criticism of IDOC's staff and administration. It is a testament to the men and women who staff Illinois' prisons that the system is able to function as well as it does. Moreover, in spite of scarce resources, IDOC is making critical healthcare improvements, including recently partnering with the University of Illinois at Chicago to offer telemedicine clinics for inmates infected with Hepatitis C and HIV and implementing a much-needed electronic medical record keeping system.

The greatest problem facing IDOC's healthcare is not its staff or administration. It is that IDOC's healthcare system was created and is still defined by unasked questions and unintended consequences. When elected officials mandate harsher sentences or shutter community-based mental health programs, their intent is to be tough on crime or save taxpayer money, not to fill prisons with elderly inmates or inmates with special and expensive healthcare needs. As a result, IDOC's healthcare needs are never meaningfully taken into account when elected officials determine the laws, policies, and funding that govern the state's prison system.

Through decades of passing laws and supporting policies that have filled our prisons with an unprecedented number of inmates, we have built a prison healthcare system without asking difficult and yet fundamental questions about what we have created. Where will we find the resources to ensure our prison system can provide constitutionally adequate healthcare? Given Illinois' fiscal crisis, is prison the most cost-effective way to treat people with special healthcare needs? Do we want our prisons to double as hospitals for the mentally ill or the elderly?

Of course, failing to ask these questions is also a way of answering them: we just keep our current system, which will exhaust our resources, strain our prison system, and result in diminishing levels of care of inmates, most of whom will eventually leave IDOC and return to our communities.

The John Howard Association (JHA), Illinois' only non-partisan prison watchdog group, believes that through smart laws and policies and criminal justice reforms that safely

reduce the prison population, we can create a more cost-effective prison healthcare system that makes wise use of our limited resources and balances the needs to provide adequate healthcare and promote public safety.

With the support of the Michael Reese Health Trust and the cooperation of IDOC's staff and administration, JHA concentrated its 2011-12 advocacy and monitoring efforts on the healthcare operations of 12 state prisons. Based on our work, we have issued specific reports on each facility, with particular attention paid to healthcare. These reports, which are fact-checked by IDOC, stem from our research of best-practices, analysis of facility operations, JHA's database of inmate communications (which tracks the more than 3,000 communications we receive each year from inmates and their family members), observations of JHA staff and trained volunteer on monitoring visits, and conversations with IDOC inmates, staff, and administrators.

From our research, monitoring visits, and facility reports, JHA has produced the following 15 findings and recommendations on prison healthcare. As we note, IDOC is already implementing aspects of many of these proposals. JHA intends that our recommendations and advocacy support IDOC's important reforms in these instances. In cases where problems are unresolved, we will use our findings and recommendations to drive cost-effective correctional healthcare reform.

While this report is critical of prison healthcare, JHA agrees with the opinion we often hear from IDOC's healthcare administrators: the vast majority of the prison population receives more and better healthcare services in prison than they have received or could receive in their communities. This is not a reason to be satisfied with our current system. It is a reason to change it. As it stands, communities are not obligated to provide adequate healthcare, while prisons are. This is a symptom of backward priorities. We have created a system where a significant number of Illinois' citizens have to go prison before they receive access to basic healthcare, even though we know that community-based services, including substance abuse and mental health treatment, can help prevent people from going to prison, reduce victimization, keep offenders from recidivating, and do a better job of cost-effectively promoting public health and safety. To reform prison healthcare, we must not only change particular policies and practices inside our prisons, we must change our priorities on the outside as well. We must realize that prison health *is* public health.

Findings and Recommendations

The late act for preserving the health of prisoners requires that an experienced Surgeon . . . be appointed to every jail: a man of repute in his profession. His business is, in the first place, to order the immediate removal of the sick, to the infirmary; and see that they have proper bedding and attendance. Their irons should be taken off; and they should have, not only medicines, but also diet suitable to their condition. He must diligently and daily visit them himself; not leaving them to journeymen and apprentices. He should constantly inculcate the necessity of cleanliness and fresh air; and the danger of crowding prisoners together: and he should recommend, what he cannot enforce. I need not add, that according to the act, he must report to the justices at each quarter-sessions, the state of health of the prisoners under his care.

John Howard, founding father of prison reform, namesake of JHA,
The State of Prisons in England and Wales (1777).

(1) Increase external oversight of correctional healthcare.

JHA finds there is insufficient external oversight of IDOC healthcare services, particularly with respect to services provided under contract by the private vendor, Wexford Health Sources (Wexford). In 2011, Wexford negotiated a 10-year contract to provide healthcare services to all 27 IDOC facilities at the cost of $1.36 billion to the state. While administrators in individual IDOC facilities are charged with performing quality improvement reviews and monitoring the delivery of healthcare services, they do not have the resources to perform comprehensive quality control monitoring and financial auditing of services under the contract. The Office of the Illinois Auditor General, the entity that typically performs such comprehensive public financial audits, does not audit the Wexford contract.

To ensure cost-containment and the timely delivery of adequate healthcare, JHA recommends that the Illinois Governor and General Assembly appoint an independent performance audit review task force to assess IDOC's oversight of healthcare services, the cost and quality of services provided by Wexford, and the adequacy of correctional healthcare planning, and present and publish a report of its findings for legislative and public scrutiny.

(2) Improve medical records and data collection and sharing to allow greater continuity of care between county and state correctional facilities, and promote the implementation of data-based correctional healthcare policies and planning.

During its 2011-12 monitoring, JHA found that IDOC's existing medical records/data sharing systems are inadequate to ensure continuity of healthcare, particularly for inmates entering the state's prison system from county jails. It should be noted IDOC will pilot an

electronic medical records program in fall of 2012, with plans of expanding the program system-wide in spring of 2013. This new system will constitute an enormous improvement from the current paper-based system and should result in better care and significant cost-savings. For instance, the use of an electronic medical records program in Texas' prisons has saved that state's taxpayers an estimated $1 billion over the past 10 years and improved the quality of healthcare for inmates. Instituting an electronic medical records program in Illinois will also enable IDOC to identify and track key areas of correctional healthcare utilization in relation to the population's age, ethnicity, race, and gender, and to better plan for the healthcare needs of special populations.

While IDOC's new electronic medical records system will help improve care within state correctional facilities, it will not address significant problems that arise when inmates are transferred from county to state custody. For instance, there is currently no electronic system that allows IDOC to access medical records from county jails or hospitals. Most often, the only medical information IDOC officials have when inmates enter state custody is what inmates self-report. As such, even if county medical personnel have diagnosed an inmate with an illness and prescribed him or her medication, IDOC will have no way of verifying this when the inmate enters state custody. If the inmate tells IDOC's medical staff that he or she is taking medication, IDOC's policy is to offer "bridge" medication until they can make their own assessment so as to prevent potential abuses. While this is a reasonable policy given the existing state of affairs, it illustrates the need for reform and a reliable record sharing system that will allow medical histories to follow inmates from county to state custody, reduce duplicative medical work, and ensure continuity of care and timely delivery of services.

IDOC is currently working to interface with the University of Illinois at Chicago (which provides HIV and Hepatitis C management to IDOC inmates) and Cermak Hospital (which provides healthcare services to the approximately 10,000 detainees housed in the Cook County Department of Corrections and the Department of Community Supervision and Intervention) to share electronic medical data. The prospect of data sharing between separate agencies raises legal and confidentiality challenges. However, IDOC is confident that these issues can be addressed and worked through.

JHA recommends that IDOC, in partnership with county jails and hospitals and government health agencies, continue to work towards creating an integrated electronic medical records system that will allow the prison agency to access and share information with their county counterparts. A potential model for such a system can be found in the Jail Data Link, a successful Illinois program that allows county jails to access and share information with the state's mental health system.[4]

Consistent with the American Bar Association's Standards on the Treatment of Prisoners regarding continuity of care, JHA also recommends that IDOC modify its existing

policies to recognize and continue medication and healthcare treatment prescribed to inmates by licensed healthcare providers prior to their transfer to IDOC, unless and until a qualified healthcare professional directs otherwise upon individualized consideration.[5]

JHA further recommends that the Illinois Governor and General Assembly implement a permanent, reliable, centralized system for data collection, auditing, and analysis of inmate healthcare services to assist policy makers, legislators and IDOC administrators in the current and future management of correctional healthcare, particularly with special populations such as the mentally ill and the elderly.

(3) Increase availability of substance abuse treatment within IDOC facilities and as an alternative to incarceration.

JHA finds that IDOC facilities lack sufficient space, staffing, and funding to provide substance abuse treatment to all the inmates who need and would benefit from such treatment. Further, incarceration is overused as a primary means to manage drug and non-violent offenders, whose criminal behavior is driven by untreated substance abuse and addiction and mental health disorders. This comes at great cost to taxpayers and has little positive impact on recidivism or public safety.

JHA recommends that the Illinois Governor and General Assembly prioritize funding drug abuse treatment within IDOC facilities, given the evidence that providing such treatment greatly reduces recidivism, crime rates, and the cost to taxpayers. JHA further adopts recommendations previously set forth by both the Center for Health and Justice at TASC and Chicago Metropolis Strategies, including that the Illinois Governor and General Assembly: (1) expand the use of community-based treatment, drug courts and mental health courts as alternatives to incarceration; (2) roll back statutory provisions that limit access to treatment alternatives; and (3) require that a fiscal and community impact analysis be conducted for any proposed penalty enhancements for drug crimes.[6]

(4) Increase the availability of medical and therapeutic diets for chronic disease management and special populations, including female and elderly prisoners. Identify challenges and strategies for improving menus and access to therapeutic diets, and increasing nutritional counseling and education for inmates.

JHA finds that that inmates with special dietary needs, such as diabetics, have limited or, at best, inconsistent access to medical diets depending upon the facility where they reside. JHA also finds that while IDOC menus comply with minimal daily caloric and nutritional standards, the quality and palatability of food is generally poor, but varies between facilities. As inmates generally and understandably dislike the food provided in daily meals, many rely on the commissary to feed themselves and choose foods that are high in fat, sugar, and salt. JHA further finds a general lack of nutritional education and counseling for inmates, and noticeable evidence of obesity among female populations.

JHA recommends that IDOC, in line with best practices and minimum standards of care, analyze its correctional menus and work with food vendors to institute an affordable, palatable "heart-healthy" therapeutic meal option (reduced sodium, high fiber, low fat and sugar, with an emphasis on fruits and vegetables) to be made available to inmates system-wide, along with nutritional counseling and education on obesity and the relationship between diet and chronic disease.[7] IDOC indicated that overall it has switched to a "heart healthy" type diet in menu planning. JHA commends this effort, and encourages IDOC to work with vendors and dieticians to review and improve the quality of food provided to inmates.

JHA notes that IDOC provides low carbohydrates and concentrated sweets to diabetics who have difficulty controlling their eating patterns. To improve upon this policy, JHA recommends that IDOC work to institute the American Diabetes Association (ADA) proposed protocols for management of diabetes in correctional institutions, which include diabetic menu-planning and providing inmates with nutritional information and education to assist them with self-management of their disease.[8]

JHA further recommends that the Illinois Governor and General Assembly, in line with sound fiscal and public policy, provide IDOC with the requisite funding, staffing and flexibility needed to implement dietary analysis and reforms. Because good nutrition greatly reduces the risk for many chronic diseases, including heart disease, hypertension and stroke, promoting therapeutic dietary changes is a key step in preventing and managing chronic diseases (particularly the hypertensive/cardio-vascular diseases that are endemic to prison populations) and thereby reducing correctional healthcare costs.[9] In addition, there is emerging evidence indicating that improving the nutrition of prisoners' diets with the inclusion of increased vitamin, minerals and essential fatty acids can have a profound impact on antisocial behavior, improve morale, and reduce violence and depression amongst inmates.[10]

Finally, JHA observes that mismanagement of correctional diets can have serious health and fiscal consequences. Accordingly, JHA urges IDOC to use caution and careful planning in implementing its newly-initiated "brunch" program which reduces the number of daily meals provided to inmates from three to two on weekends.[11] Significantly, the Correctional Institution Inspection Committee, the entity charged with monitoring Ohio's prison system, found use of a similar brunch program created serious medical issues for some inmates and ultimately increased medical costs because inmates were unable to readily digest medications due to lack of adequate food in their stomachs on days that "brunch" was served.[12]

(5) Abolish the fee-for-services inmate medical co-payment program. Alternatively, reassess and modify the existing medical co-payment program to conform to the recommendations of the National Commission on Correctional Health Care to insure that inmates' access to care is not impeded.

JHA finds that IDOC's existing $5 fee-for-services inmate co-payment program unduly restricts inmates' access to healthcare and disproportionately penalizes and discourages indigent inmates from receiving necessary healthcare services, thereby jeopardizing the health of inmates, staff, and the public and increasing public healthcare costs long term.

To be clear, IDOC's policy is to not charge inmates co-payments for the treatment of significant chronic conditions, referrals for follow-up care that are requested by medical providers, emergency care, MRSA-related infection or any IDOC mandated healthcare service. Further, 730 ILCS 5/3-6-2 (2012), the statute that regulates inmate co-payments, contains an exception providing that "[a] committed person who is indigent is exempt from the $5 co-payment and is entitled to receive medical or dental services on the same basis as a committed person who is financially able to afford the co-payment."[13]

However, JHA found discrepancies between policy and practice at facilities. Inmates at every facility we visited reported inconsistencies in how co-payments are actually implemented and administered. Numerous inmates reported being charged multiple, multilevel co-pays to obtain necessary follow-up care or medication refills for chronic conditions. Inmates also reported unpredictability and lack of uniformity regarding which chronic health conditions and treatments require copayments and which are exempted. Some inmates reported that, as a prerequisite to being referred to a doctor for examination, they must first be seen by a nurse on sick call three times. Inmates indicated they are charged separate $5 co-pays for each of these visits, even where the reason for their return visit is misdiagnosis or ineffectual treatment. Inmates also reported their ability to timely access medical care was frustrated by the practice of staff refusing to address more than one medical issue per $5 visit. Thus, inmates suffering from multiple medical problems commonly put off treatment until medical conditions become serious and more difficult and costly to treat.

Finally, the reality is that when inmates have to choose between seeking medical attention or ordering food and toiletries from a commissary, many will choose the later.[14] This can lead to inmates foregoing treatment for minor medical problems, which, in turn, become major illnesses that entail substantially higher costs for the agency.[15]

JHA, in agreement with the National Commission on Correctional Health Care (NCCHC), therefore opposes the fee-for-services inmate medical co-payments program and recommends that the Illinois General Assembly abolish the statutory provision, 730 ILCS 5/3-6-2, that authorizes the program in Illinois.[16]

Alternatively, JHA recommends that the Illinois Governor and General Assembly, in collaboration with IDOC: (1) reassess and modify the existing inmate medical co-payment program to conform with the 10 guidelines set forth by the NCCHC to minimize impediments to inmates' access to care; and (2) perform data collection and analysis to determine whether infection levels and other adverse outcome indicators, including incidents of delayed diagnosis and treatment of serious medical problems within facilities, are either consistent with or lower than the levels before implementation of the

2012 legislation that increased the amount of inmates' medical co-payments from $2 to $5.[17]

(6) Increase bi-lingual staff and improve access to services, particularly healthcare services, for Spanish-speaking inmates.

JHA finds a great need for more bilingual Spanish-speaking staff, including healthcare staff, at IDOC facilities, particularly facilities that serve as temporary places of detention for inmates awaiting transfer to Immigration and Customs Enforcement (ICE) centers for deportation proceedings. Lack of access to Spanish-speaking staff isolates Spanish-dominant inmates and prevents them from being able to use basic services, including healthcare services. In the absence of bilingual staff, bilingual inmates are often used as translators for Spanish-dominant inmates in communications with staff and administrators that demand confidentiality and reliability, such as medical consultations, grievance procedures, and disciplinary actions. These practices run contrary to minimum standards of care.[18] However, IDOC is to be commended for making significant strides this year towards improving access for Spanish-speaking inmates by making grievance forms, orientation manuals, and informational health fliers available to inmates in Spanish.

In accord with best correctional and healthcare practices, JHA additionally recommends that the Illinois General Assembly and Governor, in partnership with IDOC: (1) undertake a study to identify and determine the number of non-English speaking inmates in IDOC's population, the number of bilingual staff at each facility, and the ideal number of bilingual staff needed at each facility needed to provide access to services, based on the size of the non-English speaking population; (2) implement a program to recruit and retain staff who reflect the cultural and linguistic diversity of the prison populations being served, including bilingual healthcare staff; and (3) develop and implement a strategic plan to provide culturally and linguistically appropriate services to groups of non-English speakers who are significantly represented in the prison population, particularly Spanish-dominant speakers.

(7) Institute opt-out HIV and Hepatitis C testing at IDOC reception and classification centers, provide HIV and Hepatitis C treatment to more inmates during their incarceration, and facilitate greater continuity of care for these conditions upon inmates' reentry to the community.

JHA finds that IDOC has a strong Peer Education Program for HIV and other sexually transmitted diseases. As of the publication of this report, IDOC is in the process of implementing opt-out HIV testing at reception and classification centers in accordance with 2011 legislation authorizing this testing regime.[19] This will mark an improvement from current policy, which is to offer all inmates HIV testing on admission to their parent facility and prior to discharge, as well as offer additional HIV testing every six months if the inmate requests it or his or her doctor feels it is medically necessary.

JHA commends IDOC for this action and recommends that IDOC continue to implement and monitor the use of opt-out HIV testing at all reception and classification centers, and coordinate efforts with county jails to prevent unnecessary expense from redundant retesting of inmates for HIV. JHA further recommends that the Illinois Governor and General Assembly fund implementation of opt-out HIV testing at IDOC reception and classification centers.

To date, opt-out Hepatitis C has not been authorized or implemented at IDOC reception and classification centers. Currently, inmates are referred for Hepatitis C testing only on an individualized basis if they report having risk factors for the disease. Inmates who are identified with Hepatitis C, who otherwise would be appropriate candidates for treatment during incarceration, are often excluded from Hepatitis C treatment due to medical protocols that defer treatment if an inmate is likely to be released within 12 months before treatment can be completed. IDOC allows exceptions to this protocol on a case-by-case basis.

The clinical reasons for not offering opt-out testing and deferring treatment for inmates with less than a year to serve include: (1) a relatively small percentage of Hepatitis C infected patients go on to have significant disease from the infection; (2) it takes between 20-30 years from infection to develop those problems; (3) Hepatitis C treatment requires regular monitoring to identify potentially serious side effects; and (4) partial Hepatitis C treatment may select out resistant organisms and may not be beneficial to the inmate-patient. IDOC also noted that when Hepatitis C treatment cannot be completed in prison, the inmate must often "start from scratch" with the treatment upon release, even if resistance has not developed.

Despite these reasons, there are strong arguments for providing more robust and consistent Hepatitis C testing and treatment for inmates. Undiagnosed Hepatitis C infection among the prison population presents a serious threat to public health and invariably results in greater rates of infection and increased mortality among inmates and the general public, and increased public health costs. Untreated Hepatitis C exacts a high toll on the public health, today killing more Americans than HIV. Some states, like New York, have been successful in modifying correctional treatment protocols and extending treatment to more inmates by connecting newly-released inmates to "medical homes" for ongoing Hepatitis C treatment and monitoring, thereby allowing treatment to be initiated during incarceration without regard to an inmate's length of stay in prison. Improving Hepatitis C diagnosis, access to treatment, and prevention services for the prison population is a proven public health/disease-control strategy that benefits the community by reducing rates of disease transmission and reducing public health costs.[20]

The Centers for Disease Control (CDC) recently recommended that all baby boomers (*i.e.* those born between 1945 and 1965), be tested for Hepatitis C.[21] Public health and medical experts likewise have called for increased testing and treatment of Hepatitis C among the prison population as the best means to curtail the Hepatitis C epidemic in the United States.[22] IDOC is aware of these recommendations, but indicated that a large

percentage of the population is already tested for Hepatitis C under existing CDC guidelines, which recommend that correctional facilities provide Hepatitis C testing at intake to inmates who report a history of risk factors, especially intravenous drug use.[23]

The problem with risk-based Hepatitis C testing, however, is that this method has been shown to underestimate the prevalence of Hepatitis C in correctional settings and limit the opportunity for diagnosis and treatment.[24] For instance, a study of the Rhode Island Department of Corrections found that most inmates who were Hepatitis C infected would not have been tested and identified under the CDC guidelines for risk-based testing.[25] "One factor contributing to this underestimation is that self-reporting of injection drug use requires inmates to disclose illegal and stigmatized behaviors within the correctional setting. The timing and context of the screening itself may prevent many injection drug users from discussing incriminating behaviors."[26] Testing only those inmates with reported risk behaviors also reinforces the stigma of Hepatitis C and drug use that may have led to incarceration and further marginalize these individuals.[27]

For these reasons, JHA recommends that: (1) the Governor and General Assembly, in cooperation with IDOC, initiate a pilot opt-out Hepatitis C testing program at county jails/IDOC's reception and classification centers, at least with respect to inmates born between 1945 and 1965; and (2) that IDOC, in partnership with the General Assembly and Governor, county jails, public health agencies and hospitals, and the division of parole, devise a pilot program to provide ongoing access to Hepatitis C treatment and continuity of care to newly-released inmates and modify treatment protocols to allow the initiation of Hepatitis C treatment by more inmates during incarceration regardless of their length of stay. Developing a plan now to broaden Hepatitis C testing and continuity of treatment to inmates during and subsequent to their incarceration is critical, given that implementation of the Affordable Care Act in 2014 will eventually finance post-release care for people who receive a Hepatitis C diagnosis while they are in prison.

(8) Reassess and increase staffing levels of physicians, nurses, psychiatrists, mental health professionals, dental staff, optometrists and security and clerical staff as needed to ensure that inmates receive timely access to quality healthcare, including routine and preventative healthcare, and implement a strategic plan to timely fill staff vacancies.

JHA finds the quality of healthcare services and the ability of inmates to timely access healthcare treatment varies greatly among facilities depending upon available resources, the size and healthcare needs of the population, and inmate-to-healthcare staff ratios. Overall, however, JHA finds that healthcare resources and staffing are inadequate to meet minimum standards of care throughout IDOC. In particular, systemic nursing shortages prevent inmates from timely accessing sick call and necessary healthcare services. However, lack of adequate medical staffing and resources in all areas—medical, mental health, dental, vision—threaten serious harm by delaying diagnosis and treatment and inviting medical error. Inadequate medical staffing levels also contribute to staff burnout and turnover, which, in turn, help perpetuate chronic understaffing throughout IDOC.

Compounding these problems, vacancies for healthcare staffing positions, both through the state and the private contractor, Wexford, frequently remain unfilled for long periods of time. To ensure adequate access to healthcare, sufficient security and clerical staffing also must be maintained to allow the safe delivery of healthcare services in a secure setting and facilitate the timely maintenance and transmission of medical records and data.

Minimum standards of care dictate that correctional authorities employ a sufficient number of qualified medical, dental, and mental health professionals at each correctional facility to render preventive, routine, urgent, and emergency health care in a timely manner consistent with accepted health care practice and standards.[28] The Eighth Amendment of the U.S. Constitution likewise requires the government to provide inmates with adequate medical and mental health care.[29]

To rectify systemic deficiencies in the delivery of healthcare services to IDOC inmates, prevent harm to inmates, staff and the public, satisfy the constitutional duty to provide adequate medical care, and foreclose civil litigation, JHA recommends that the Illinois Governor and General Assembly, in partnership with IDOC and Wexford: (1) comprehensively assess the healthcare needs, utilization of services, delays in service, staffing levels and adverse outcomes at each facility, and increase minimum medical staffing levels to address identified inadequacies and meet minimum standards of care; and (2) develop and implement a strategic plan to increase medical staffing levels and recruitment and ensure that medical staff vacancies are filled on a timely basis.

(9) Continue to explore and implement safe alternatives to long-term segregation and abandon segregation to punish mentally ill inmates.

JHA finds that a significant number of inmates in disciplinary segregation throughout IDOC are taking psychotropic medications and diagnosed with serious mental illnesses. JHA finds that a substantial number of inmates housed in long-term isolation exhibit signs of mental illness. An increasing body of data, literature, studies, and research establish that long-term isolation can have severely detrimental effects on inmates' physical and mental health, and is particularly hazardous for inmates with preexisting mental illness.[30]

In line with the United Nations' and the American Bar Association's standards on the treatment of prisoners and expert medical authorities, JHA recommends that the long-term solitary confinement and use of long-term isolation for mentally-ill inmates should be banned altogether and a *per se* prohibition placed on holding inmates at Tamms Correctional Center who have a history of mental illness or self-harm.[31] To this end, JHA commends IDOC for taking action on this issue and working with the Vera Institute of Justice to decrease its use of long-term segregation.

(10) Ensure that female inmates receive gender-based programming grounded in evidence-based best practices.

JHA finds that IDOC's Women Division has made significant progress in creating and sustaining programming that focuses on the needs and issues that bring women into the criminal justice system. The vast majority of female inmates come from backgrounds of serious trauma and physical, sexual or emotional abuse. Female inmates also have substantially higher rates of mental illness, self-injuring behaviors, and drug abuse than male inmates. Approximately 80 percent are also mothers, and many were the sole parent-providers for their children prior to their incarceration. IDOC is working to address these issues through gender-specific programming, including several initiatives that facilitate strengthening relationships between mothers and their children, such as the Moms and Babies program at Decatur Correctional Center that enables specially-screened pregnant inmate to deliver and care for their child while they are incarcerated. In line with JHA's recommendations, IDOC confirmed its commitment to hiring more female correctional officers.

To build upon this progress, JHA recommends that IDOC require that female prisoners be "attended and supervised only by woman officers."[32] In accord with best correctional practices, JHA further advises that: (1) all staff assigned to work with female populations (including all cadets and staff in training) be screened to ensure they are sympathetic and open to working with female inmates; and (2) that all staff assigned to work with female inmates be given gender-sensitive specific training to ensure knowledge of and sensitivity to female inmates' special issues and needs, including issues of prior trauma, cross-gender supervision issues, the role of security staff, and the importance of using gender-responsive strategies when working with female populations.[33]

(11) Study Illinois' growing elderly inmate population with an eye toward proposing safe, cost-effective approaches to their care in prison and potential alternatives to incarceration.

JHA finds that Illinois' elderly inmates represent the fastest growing segment of prisoners.[34] Over the past decade, Illinois' elderly prison population grew by more than 300 percent. It is unclear how Illinois will pay for the housing, treatment, and medical care of this growing elderly inmate population. Indeed, it is unclear how Illinois can currently pay for elderly inmates' housing and care today, which is conservatively estimated to cost $428 million a year, about a third of IDOC's budget.[35] Estimates place the average cost of incarcerating an elderly inmate between $60,000 to $70,000 per year, compared to the $27,000 per year it costs on average to house a general population inmate.[36] Because the federal government generally does not pay for state inmates' medical care, these costs are borne almost entirely by Illinois taxpayers.[37]

While IDOC has long recognized that the rise in the elderly population presents a burgeoning fiscal and healthcare crisis, it is constrained from addressing the issue head-on by limited budgets, overcrowding, understaffing, scarce resources, and the lack of

political will to tackle this difficult issue.[38] Indeed, in 2010, IDOC proposed construction of a 448-bed geriatric prison to address the needs posed by this population.[39] With the state's ongoing fiscal hardships, this proposal has since stalled. Likewise, legislative efforts aimed at allowing earlier release for long-term elderly prisoners have repeatedly failed to obtain requisite support.[40]

To ensure that IDOC is positioned to address the needs of its aging population, JHA supports recommendations set out in recent studies by the Vera Institute of Justice, Human Rights Watch, and the Prison Reform Trust on the treatment and care of elderly prisoners, including that: (1) elected officials should support an analysis of the factors contributing to the growth of the elderly prison population and existing sentencing and parole policies, including geriatric release mechanisms, to determine whether modifications could be made to reduce the population of elderly prisoners without appreciable risk to public safety; (2) IDOC should provide training for correctional officers working with older persons, including training on physical and mental conditions of elderly inmates; and (3) IDOC facilities should implement a regular process for consulting with elderly inmates by holding elderly inmate forum/focus group meetings on a recurring basis to enlighten staff and administrators on the issues, problems, and assistance required by older inmates.[41]

(12) Export Dixon Correctional Center's Hospice Program to other facilities.

While all of IDOC's facilities house aging inmates, Dixon Correctional Center is Illinois' *de facto* special population prison for male inmates, with a special unit for elderly prisoners. Dixon is also home to one of the most innovative and successful correctional hospice/adult-care programs in the country.

Given the exponential growth of the elderly prison population and the rising cost of correctional healthcare, JHA recommends that elected officials establish a commission to study the projected hospice/adult-care needs of this growing elderly population and the feasibility of expanding and importing Dixon's outstanding hospice/adult-care program to other facilities in the state.

(13) Continue and explore expanding telemedicine and telepsychiatry.

JHA finds that IDOC has made innovative and cost-effective use of telemedicine and telepsychiatry. Telemedicine clinics, in collaboration with the University of Illinois at Chicago, are provided to qualifying inmates with HIV and Hepatitis C, depending on the time remaining on their sentence. Wexford offers telepsychiatry in some facilities. While JHA heard some complaints from IDOC staff about problems scheduling visits, we noted overall broad-based support for this technology from inmates, staff, and healthcare professionals.

Given the success of telemedicine and telepsychiatry, JHA recommends that IDOC explore expanding their use. In particular, telemedicine clinics seem ideally situated to oversee care of physical therapy, diabetes, and hypertension.

(14) Assess and improve IDOC grievance system.

JHA finds IDOC's grievance system to be flawed and unreliable. JHA has received multiple reports from inmates of grievances being lost, not responded to or even acknowledged. An inmate grievance system is a fundamental element of a functional prison system. "When inmates view the system as credible, they can also serve as a source of intelligence to staff regarding potential security breaches in addition to excessive force or other staff misconduct. Not only should the grievance system be readily available and easily accessible to all inmates, it should also allow prisoners to file their grievances in a secure and confidential manner without threat of reprisal, and have them answered by staff that performs its responsibilities in a responsive and prompt manner."[42]

In our discussions with staff and administration, JHA has not uncovered a uniform, consistent system or policy in IDOC to ensure that grievances, once turned over by a prisoner to the facility, are logged, docketed and recorded as having been filed. This is problematic, given that: (1) the Illinois Administrative Code, which governs the grievance process, places time limits on filing a grievance;[43] and (2) the Prison Litigation Reform Act of 1995 ("PLRA") makes exhaustion of administrative remedies under the grievance system mandatory prerequisite for a prisoner to bring a claim over prison conditions in Federal Court.[44]

Lack of reliability, credibility and consistency in the Illinois prison grievance system are not new problems, but were noted by JHA and the Illinois Bar Foundation decades ago in studies conducted on the grievance systems in Cook County Jail, Stateville Correctional Center and Vienna Correctional Center.[45]

To rectify these longstanding issues, JHA recommends that the Illinois Governor and General Assembly, in cooperation with IDOC, appoint an ombudsmen panel, including at least one independent medical professional and one mental health professional, to: (1) study, review and audit prisoner grievances and the grievance systems at each individual facility; (2) identify problems and sources of unreliability or inconsistency in the existing grievance system and make recommendations for improvement; and (3) formulate and present a plan to the General Assembly for instituting a permanent prison ombudsman program to provide independent, external oversight and regular review of inmate claims and grievances.[46]

(15) Prepare to enroll all inmates in Medicaid in 2014.

In 2014, the Affordable Care Act (ACA) will make people under 65 years of age with income below 133 percent of the federal poverty level eligible for Medicaid. Once this

change is in effect, virtually all inmates will become Medicaid eligible once they leave prison. This change in federal law will create an enormous opportunity for state and local governments to establish much-needed continuity of care for inmates as they leave prison. Providing inmates with access to medical and mental health care post-release promises to greatly reduce recidivism, cut costs at the local level, and save lives, as inmates leaving prison are at high risk of death due to the current lack of supportive services.[47]

As approximately 35,000 inmates leave and enter IDOC every year, this effort will require extraordinary coordination among and between state and local agencies. JHA finds that promising work is already being accomplished on this front, as the Illinois Department of Healthcare and Family Services recently issued a new policy that jail detainees who are currently Medicaid eligible shall retain their Medicaid-eligibility rather than having it terminated or suspended prior to conviction. This initiative is not only commendable improvement in itself, but also provides a potential template for working with increased populations under the changes in Medicaid eligibility forthcoming under the ACA.[48]

As Illinois gets ready to implement the ACA, JHA recommends that IDOC, the Illinois Department of Healthcare and Family Services, and Illinois Department of Human Services in collaboration with local governments, service providers, and advocates develop a strategic plan to ensure that inmates are pre-enrolled to receive Medicaid healthcare coverage and care upon exiting prison.

Methodology and Acknowledgements

In summer of 2011, JHA, with the generous support of a grant from the Michael Reese Health Trust, embarked on a project to examine the state of healthcare in IDOC. We selected 12 diverse facilities to visit and study which, together, form a representative cross-section of IDOC's healthcare system. The facilities include all of the state's maximum-security facilities (Menard Correctional Center, Stateville Correctional Center, Pontiac Correctional Center, and Dwight Correctional Center); the state's only supermax facility (Tamms Correctional Center); several facilities that serve special populations (Dixon Correctional Center, Illinois special population prison for male inmates, and Sheridan Correctional Center, one of Illinois' drug-treatment prisons); several medium and minimum security facilities (Vienna Correctional Center, Lincoln Correctional Center, and Pinckneyville Correctional Center), and two of the state's Reception and Classification Centers.

On monitoring visits to the 12 facilities, JHA staff and trained citizen volunteers inspected physical conditions and interviewed inmates, staff, and administrators. We focused particular time and attention on interviewing prison healthcare staff and administrators, as well as inmates receiving healthcare treatment. With the cooperation of facility and healthcare administrators, we also gathered objective statistical data regarding staffing, healthcare services, and the incidence of disease among the

populations. We additionally conducted confidential, in-depth interviews with a cross-section of inmates who communicated with JHA by mail or phone about healthcare problems. The knowledge and information we gained from the totality of these methods forms the basis of our healthcare findings and policy recommendations.

John Maki, the Executive Director of JHA, and Maya Szilak, the Director of JHA's Adult Prison Monitoring Program, led the project. To ensure that JHA's study and research addressed healthcare authoritatively, JHA formed a task force of healthcare experts and clinicians to advise us on the project. JHA is indebted to the following task force members for their contributions and advice: Alexander Brown, Linda Emanuel, Dan Cooper, John Fallon, Robyn Golden, Thomas K. Kenemore, Patricia O'Brien, Elena Quintana, Taryn Roch, Melissa Kraus Schwarz, and Kathie Kane-Willis.

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JHA also thanks the many citizen volunteers who contributed to the project with dedication, focus, and hard work on the facility visits. They include: Samantha Arauz, Rick Artwick, Lindsay Bostwick, Megan Brady, Alexander Brown, Phil Carrigan, Allison Dussias, Sandra Fernbach, Aviva Futorian, Pamela Gretza, Robyn Inaba,

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This report would not have been possible without IDOC's openness and cooperation in allowing JHA access to facilities and healthcare data. JHA thanks IDOC Director, S.A. Godinez, and Medical Director, Louis Shicker, for their assistance and steadfast support of this project. JHA is also especially thankful to the medical administrators of the 12 IDOC facilities we visited, who expended considerable time and effort completing exhaustive questionnaires about healthcare operations that were essential to JHA's understanding. We further thank IDOC's staff, particularly healthcare staff, who were patient and generous with their time and knowledge in answering JHA's many questions.

Finally, JHA thanks the thousands of inmates and inmates' family members who contributed to this report and honored JHA with the gift of candidly sharing their personal experiences.

JHA's work on healthcare in IDOC is made possible through a generous grant by the Michael Reese Health Trust.

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[1] *See Minutes of the Illinois Department of Corrections Adult Advisory Board Meeting (*July 26, 2010), p.2, available at: http://www2.illinois.gov/idoc/aboutus/advisoryboard/Documents/20100726_Advisory_Board_Minutes.pdf.

[2] *See* International Association for Correctional and Forensic Psychology, *Standards for Psychology Services in Jails, Prisons, Correctional Facilities, and Agencies*, Journal of Criminal Justice and Behavior, Vol. 37, No. 7, 749-808, p. 754. (July 2010), available at: http://cjb.sagepub.com/content/37/7/749.full.pdf+html.

[3] *See* National Center on Addiction and Substance Abuse at Columbia University, *Behind Bars II: Substance Abuse and America's Prison Population* (February 2010), available at: http://www.casacolumbia.org/articlefiles/575-report2010behindbars2.pdf.

[4] For further information on the Jail Data Link system, see the Illinois Department of Human Services homepage discussing the program, available at: https://sisonline.dhs.state.il.us/jaillink/home.asp. In addition, see David Gruenenfelder, *Evaluation of the Jail Data Link Program Prepared for the Illinois Criminal Justice Information Authority*, Institute for Legal, Legislative and Policy Studies Center for State Policy and Leadership, University of Illinois at Springfield, 1-113 (May 2009), available at: http://www.icjia.state.il.us/public/pdf/ResearchReports/Jail%20Data%20Link%20Final%20Report%20May%202009.pdf.

[5] *American Bar Association (ABA) Standards on Treatment of Prisoners,* Standard 23-6.5, Continuity of Care, available at: http://www.americanbar.org/publications/criminal_justice_section_archive/crimjust_standards_treatmentprisoners.html#23-6.5.

[6] *See* Lisa Braude, Melody M. Heaps, Pamela Rodriguez, and Tim Whitney, Center for Health and Justice at TASC, *No Entry: Improving Public Safety through Cost-Effective Alternatives to Incarceration in Illinois*, 1-32 (May 2007), available at: http://www.centerforhealthandjustice.org/IllinoisNoEntry_Final.pdf; Metropolis 2020, *Position Paper: Alternatives to Incarceration*, 1-19, available at: http://www.chicagometropolis2020.org/documents/AlternativestoIncarcerationPaper.pdf.

[7] *See* Federal Bureau of Prisons, *Inmate Information Handbook: Food Service* 1-91, p. 16 (January 2012), available at: www.bop.gov/locations/institutions/spg/SPG_aohandbook.pdf. *See also ABA Standards*

on Treatment of Prisoners, Standard 23-3.4(b), which dictates that correctional authorities "[m]ake appropriate accommodations for prisoners with special dietary needs for reasons of health or age***," available at: http://www.americanbar.org/publications/criminal_justice_section_archive/crimjust_standards_treatmentprisoners.html#23-3.4.

[8] *See* American Diabetes Association Position Statement*: Diabetes Management in Correctional Institutions*, Diabetes Care, Volume 33, Supplement 1, 575-81, (January 2010), available at: http://care.diabetesjournals.org/content/33/Supplement_1/S75.full.pdf+html.

[9] *See, e.g.,* Barbara Wakeen, T*urning Lemons Into (Sugar-Free) Lemonade: How Food Budgets Cuts Can Improve Diets*, National Commission on Correctional Healthcare, CorrectCare, (Summer 2008), available at: http://www.ncchc.org/pubs/CC/food_budgets.html; Arlene J. Spark, *Nutrition in Public Health: Principles, Policies, and Practice*, 1-552, p. 230-36, CRC Press (May 2007).

[10] *See* C. Bernard Gesch, Sean Hammond, Sarah Hampson, Anita Eves. Martin Crowder*, Influence of Supplementary Vitamins, Minerals and Essential Fatty Acids on the Antisocial Behaviour of Young Adult Prisoners,* British Journal of Psychiatry, 22-18 (2002), available at: http://bjp.rcpsych.org/content/181/1/22.full.pdf+html; Ap Zaalberg, Henk Nijman, Erik Bulten, Luwe Stroosma, Cees van der Staak, *Effects of Nutritional Supplements on Aggression, Rule-Breaking, and Psychopathology Among Young Adult Prisoners*, Aggressive Behavior, Volume 36, 117–126 (2010), available at: http://onlinelibrary.wiley.com/doi/10.1002/ab.20335/abstract.

[11] *See, e.g.,* Chicago Sun-Times *"Illinois Prisons' Cost-cutting Plan: Give Prisoners Brunch on Weekends,*" (April 20, 2012), available at: http://www.suntimes.com/news/metro/12024375-418/illinois-prisons-cost-cutting-plan-give-prisoners-bruncn-on-weekends.html.

[12] Adam Jackson, *Evaluation of Correctional Food Services: A Correctional Institution Inspection Committee Summary and Evaluation of DRC Food Services*, 1-20, p. 13 (2010), available at: www.ciic.state.oh.us/download-document/332-evaluation-of-correctional-food-services.html.

[13] "Indigent" under the statute means "[a] committed person who has $20 or less in his or her Inmate Trust Fund at the time of such services and for the 30 days prior to such services." *See* 730 ILCS 5/3-6-2, available at: http://www.ilga.gov/legislation/ilcs/fulltext.asp?DocName=073000050K3-6-2.

[14] *See* Lt. Sean McGillen, *Research Paper: The Financial Impact of Inmate Healthcare: Maintaining a Cost Effective and Efficient System*, 1-14, p. 2 (cataloged March 28, 2011), available at: http://nicic.gov/Library/024920.

[15] National Commission on Correctional Heath Care, *Position Statement: Charging Inmates a Fee for Health Care Services* (October 2005), available at: http://www.ncchc.org/resources/statements/healthfees.html.

[16] *Ibid*., note 15.

[17] *See* Public Act 097-0562, effective date January 1, 2012, which amended 730 ILCS 5/3-6-2 by increasing inmates' medical co-payments from $2 to $5, available at: http://www.ilga.gov/legislation/publicacts/fulltext.asp?Name=097-0562.

[18] *See ABA Standards on Treatment of Prisoners*, Standard 23-7.2(f), which provides, in relevant part: "[C]orrectional authorities should make reasonable attempts to communicate effectively with prisoners who do not read, speak, or understand English. This requirement includes: (i) to the extent practicable, the translation of official documents typically provided to prisoners into a language understood by each prisoner who receives them; (ii) staff who can interpret at all times in any language understood by a significant number of non-English-speaking prisoners; and (iii) necessary interpretive services during disciplinary proceedings or other hearings, for processes by which a prisoner may lodge a complaint about staff misconduct or concerns about safety, and during provision of health care," available at: http://www.americanbar.org/publications/criminal_justice_section_archive/crimjust_standards_treatmentprisoners.html#23-7.2. *See also* U.S. Department of Health and Human Services, Office of Minority Health, *Final Report: National Standards for Culturally and Linguistically Appropriate Services in Health Care,* 1-109 (March 2001), available at: http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf; Laurie M. Anderson, Susan C. Scrimshaw, Mindy T. Fullilove, Jonathan E. Fielding, Jacques Normand, and the Task Force on Community Preventive Services, *Culturally Competent Healthcare Systems: A Systematic Review*, American Journal of Preventative Medicine, Volume 24, Issue 3S, 68-79 (2003), available at: http://www.wrha.mb.ca/osd/files/soc-AJPM-evrev-healthcare-systems.pdf.

[19] Specifically, Public Act 097-0323 (effective August 12, 2011), amended 730 ILCS 5/3-6-2, 3-8-2, and 3-10-2, authorized county jails and IDOC to provide opt-out HIV testing to inmates, available at: http://www.ilga.gov/legislation/PublicActs/fulltext.asp?Name=097-0323.

[20] *See* Duncan Smith-Rohrberg Maru, Robert Douglas Bruce, Sanjay Basu, and Frederick L. Altice, *Clinical Outcomes of Hepatitis C Treatment in a Prison Setting: Feasibility and Effectiveness for Challenging Treatment Populations*, Clinical Infectious Diseases, Volume 47, Issue 7, 952-961, p. 952 (October 2008), available at: http://www.ncbi.nlm.nih.gov/pubmed/18715156; *See, e.g.,* Tan JA, Joseph TA, Saab S., *Treating Hepatitis C in the Prison Population is Cost-saving*, Hepatology, Volume 48, Issue 5, 1387-95 (2008); Harvey J. Alter and T. Jake Liang, *Hepatitis C: The End of the*

Beginning and Possibly the Beginning of the End, Annals of Internal Medicine, Volume 156, Issue 4 317-18 (February 21, 2012), available at: http://annals.org/article.aspx?volume=156&issue=4&page=317; Anne C. Spaulding and David L. Thomas, *Screening for HCV Infection in Jails*, Journal of the American Medical Association, Volume 307, Issue 12, 1259-60 (March 2012) available at: http://app.jamanetwork.com/ama.jama/307/12/10_1001-jama_2012_374.html.

[21] CDC, *Recommendations for the Identification of Chronic Hepatitis C Virus Infection Among Persons Born During 1945–1965*, Morbidity and Mortality Weekly Reports (August 17, 2012), available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6104a1.htm?s_cid=rr6104a1_w.

[22] *See* Anne C. Spaulding and David L. Thomas, *Screening for HCV Infection in Jails*, Journal of the American Medical Association (March 26, 2012), available at: http://www.natap.org/2012/HCV/032812_02.htm; *Hepatitis News:Jail Screening Could Impede Hep C's Spread* (April 5, 2012), available at: http://www.hepmag.com/articles/Correctional_System_Screening_2501_22202.shtml.

[23] *See* CDC: *Correctional Facilities and Viral Hepatitis*, available at: http://www.cdc.gov/hepatitis/Settings/corrections.htm.

[24] Grace E. Macalino, Darpun Dhawan, and Josiah D. Rich, *Missed Opportunity: Hepatitis C Screening of Prisoners*, American Journal of Public Health, 1739–1740 (October 2005), available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1449429/

[25] *Ibid*., note 24.

[26] *Ibid*., note 24.

[27] *Ibid*., note 24.

[28] *ABA Standards on Treatment of Prisoners,* Standard 23-6.4, Qualified Health Care Staff, available at: http://www.americanbar.org/publications/criminal_justice_section_archive/crimjust_standards_treatmentprisoners.html#23-6.4.

[29] *See Estelle v. Gamble*, 429 U.S. 97 (1976) available at: http://www.law.cornell.edu/supct/html/historics/USSC_CR_0429_0097_ZO.html; *Brown v. Plata*, 563 U.S.__(2011), available at: http://www.law.cornell.edu/supct/html/09-1233.ZS.html.

[30] Documented physiological effects of long-term isolation include: gastro-intestinal, cardiovascular and genitourinary malfunctions; hypertension; migraine headaches;

profound fatigue; heart palpitations; diaphoresis (sudden excessive sweating); insomnia; back and joint pain; deterioration of eyesight; weight loss; lethargy; weakness; diarrhea; tremors; and aggravation of preexisting medical conditions. Documented psychological effects include: anxiety; panic attacks; major depression; poor impulse control; outbursts of physical and verbal violence against others, self and objects; cognitive disturbances, memory loss, disorientation; perceptual distortions, hypersensitivity to noises and smells; disorientation in time and space; depersonalization and derealisation; hallucinations affecting all five senses: visual, auditory, tactile, olfactory and gustatory (*e.g.* hallucinations of objects or people appearing in the cell, or hearing voices when no-one is actually speaking); paranoia; psychosis, persecutory ideation; psychotic episodes; and aggravation of preexisting mental illness. In addition, a direct link has been found between long-term isolation and self-harm, auto-aggression, self-mutilation, and suicide among inmates. *See* Hans Toch, *Men in Crisis: Human Breakdowns in Prison*, 1-342, p.40 (Transaction Publishers, 2007); Sharon Shalev, *A Sourcebook on Solitary Confinement, The Health Effects of Solitary Confinem*ent, Manheim Centre for Criminology London School of Economics and Politics, 1-98, p. 21 (October 2008), available at: http://solitaryconfinement.org/uploads/sourcebook_web.pdf; Craig Haney, *Mental Health Issues in Long-Term Solitary and Supermax Confinement*, Crime & Delinquency, Vol. 49, No. 1, p. 124-156 (January 2003); Lorna A. Rhodes, *Pathological Effects of the Supermaximum Prison*, American Journal of Public Health 95(10), 1692–1695 (October 2005), available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1449421; Terry A. Kupers, *What To Do With the Survivors? Coping With the Long-Term Effects of Isolated Confinement*, Criminal Justice and Behavior, Vol. 35, No. 8, 1005-1016 (August 2008), available at: http://cjb.sagepub.com/content/35/8/1005.abstract; Human Rights Watch, *Ill-Equipped: U.S. Prisons and Offenders with Mental Illness*, 1-214, p. 145-185 (2003) available at: http://www.hrw.org/sites/default/files/reports/usa1003.pdf; Stuart Grassian, *Psychiatric Effects of Solitary Confinement*, 326 Washington University Journal of Law & Policy, Vol. 22:325, 325-380 (2006), available at: http://law.wustl.edu/journal/22/p325grassian.pdf; Jeffrey L. Metzner and Jamie Fellner, *Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics*, The Journal of the American Academy of Psychiatry and the Law, Volume 38, Number 1, (March 2010); and *The Istanbul Statement on The Use and Effects of Solitary Confinement*, International Psychological Trauma Symposium (December 9, 2007), available at: http://www.univie.ac.at/bimtor/dateien/topic8_istanbul_statement_effects_solconfinment.pdf.

[31] Consistent with prevailing scientific, psychological, sociological and medical evidence, solitary confinement has largely been abandoned in Europe and is widely viewed as a form of cruel, inhuman and degrading treatment that violates international human rights conventions. The UN Special Rapporteur of the Human Rights Council on Torture has specifically held that solitary confinement "can amount to torture;" that "solitary confinement should be used only in very exceptional circumstances, as a last resort, for as

short a time as possible;" and that "prolonged solitary confinement, in excess of 15 days, should be subject to an absolute prohibition."*Interim Report of the Special Rapporteur of the Human Rights Council on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (August 2011), 1-27, p.23, available at: http://solitaryconfinement.org/uploads/SpecRapTortureAug2011.pdf. *See also* United Nations News Centre, "*Solitary Confinement Should be Banned in Most Cases, UN Expert Says*" (October 8, 2011) available at: http://www.un.org/apps/news/story.asp?NewsID=40097; Elizabeth Vasiliades, *Solitary Confinement and International Human Rights: Why the U.S. Prison System Fails Global Standards*, American University International Law Review, Volume 21, Issue 1, 71-98 (2005). Likewise, in recognition of the deleterious effects of long-term isolation, the American Bar Association's standards call for severe restrictions on its use. *See ABA Standards on Treatment of Prisoners,* Standards 23.2-1, *et seq.,* available at: http://www.americanbar.org/publications/criminal_justice_section_archive/crimjust_standards_treatmentprisoners.html.

[32] United Nations Congress on the Prevention of Crime and the Treatment of Offenders, *Standard Minimum Rules for the Treatment of Prisoners*, Rule 53(3), available at: http://www2.ohchr.org/english/law/treatmentprisoners.htm. As Rule 53 notes, this requirement "does not, however, preclude male members of the staff, particularly doctors and teachers, from carrying out their professional duties in institutions or parts of institutions set aside for women."

[33] U.S. Department of Justice, National Institute of Corrections, *Prison Staffing Analysis: A Training Manual With Staffing Considerations for Special Populations*, 1-233, p. 115-117 (December 2008), available at: http://www.asca.net/system/assets/attachments/2086/staffing_analysis-1-3.pdf?1296162143.

[34] *See* Carrie Abner, *Graying Prisons: States Face Challenges of an Aging Inmate Population*, The Council of State Governments, available at http://www.csg.org/knowledgecenter/docs/sn0611GrayingPrisons.pdf; Human Rights Watch, *US Number of Aging Prisoners Soaring: Corrections Officials Ill-Prepared to Run Geriatric Facilities* (January 27, 2012), available at: http://www.hrw.org/news/2012/01/26/us-number-aging-prisoners-soaring.

[35] *Ibid.,* note 1.

[36] U.S. Department of Justice, National Institute of Corrections, *Correctional Health Care: Addressing the Needs of Elderly, Chronically Ill, and Terminally Ill Inmates,* p.44 (February 2004), available at: http://static.nicic.gov/Library/018735.pdf.

[37] Significantly, in exception to the general rule precluding federal reimbursement of states for inmate medical care, a 1997 ruling by the Federal Department of Health and

Human Services held that inmates who are otherwise eligible for Medicaid effectively lose their inmate status and obtain "inpatient status" when they are admitted to a hospital for 24 hours or more, in which event Medicaid reimbursement funds are available to the state. *See* December 12, 1997, *Letter from Director of Disabled and Elderly Health Programs Group Center for Medicaid and State Operations to all Associate Regional Administrators regarding Clarification of Medicaid Coverage Policy for inmates of a Public Institution*, available at: http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251618397983&ssbinary=true. Under the Patient Protection and Affordable Care Act ("ACA"), Medicaid coverage will greatly expand in 2014, such that virtually all state inmates could be eligible for Medicaid coverage for inpatient hospital stays. To collect Medicaid reimbursements for these inmates, however, a state must actually bill Medicaid, which many states neglect to do. *See, e.g.,* Sandra Yin "Failing *to Bill Medicaid for Inmate Care Costs State [of North Carolina] Millions*," Fierce Healthcare News Letter (August 25, 2010), available at: http://www.fiercehealthcare.com/story/failing-bill-medicaid-inmate-care-costs-state-millions/2010-08-25; Mal Leary, "*State [of Maine] Considers Putting Prisoners on Medicaid*," Capitol News Service (November 27, 2011), available at: http://bangordailynews.com/2011/11/27/news/state/corrections-commissioner-exploring-medicaid-for-some-prisoners/; The Crime Report, "*State Prison Inmates Could Get Medicaid Hospital Coverage in 2014*" (October 18, 2011), available at: http://www.thecrimereport.org/archive/2011-10-medicaid-prisoners.

The Illinois Department of Health and Family Services (DHFS) ostensibly has a practice of billing Medicaid for inmate inpatient hospital stays already. *See DHFS Chapter H-200, Policy and Procedures for Hospital Services, H-254.7,* "Claims for Illinois Department of Corrections (IDOC) and Illinois Department of Juvenile Justice (IDJJ) Inmates," available at: www.hfs.illinois.gov/assets/h200.pdf. With the slated expansion of Medicaid under the ACA in 2014, however, new legislation was introduced this last year, Senate Bill 3175: The Medicaid Billing for Inmate Inpatient Hospital and Professional Services Act, which was aimed at reducing correctional healthcare costs by requiring hospitals and other medical service providers to bill Federal Medicaid for eligible inmate inpatient hospital stays. *See 97th Illinois General Assembly, Senate Bill 3175*, available at: http://www.ilga.gov/legislation/BillStatus.asp?DocTypeID=SB&DocNum=3175&GAID=11&SessionID=84&LegID=64107. The legislation languished in assignments and never passed into law, and JHA is unaware of any current efforts to renew the legislation.

[38] *See ,e.g.,* Jessica Pupovac, "*Guarding Grandpa: Illinois is Spending Money it Doesn't Have To Keep Convicts Who Can Barely Walk Behind Bars*," The Chicago Reader (January 6, 2011),

available at: http://www.chicagoreader.com/chicago/illinois-prisons-budget-elderly-old-inmates/Content?oid=3013140.

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[39] *See Minutes of the Illinois Department of Corrections Adult Advisory Board Meeting (*July 26, 2010), p.2, available at: http://www2.illinois.gov/idoc/aboutus/advisoryboard/Documents/20100726_Advisory_Board_Minutes.pdf.

[40] For instance, HB 4154 would have allowed prisoners who served 25 consecutive years, reached age 50, and demonstrated genuine, consistent behavior change over a period of years, to apply to the original sentencing courts for a sentence adjustment. However, like prior legislative efforts to this effect, was defeated. *See* 97th Illinois General Assembly, Bill Status HB 4154, available at: http://www.ilga.gov/legislation/BillStatus.asp?DocNum=4154&GAID=9&DocTypeID=HB&LegId=34373&SessionID=51.

[41] *See* Tina Chiu, *It's About Time: Aging Prisoners, Increasing Costs, and Geriatric Release* , Vera Institute of Justice (April 2010), 1-16, p. 11-12, available at http://www.vera.org/download?file=2973/its-about-time-aging-prisoners-increasing-costs-and-geriatric-release.pdf; Human Rights Watch*, Old Behind Bars: The Aging Prison Population in the United States*, 1-110, p. 13 (January 27, 2012), available at: http://www.hrw.org/sites/default/files/reports/usprisons0112webwcover_0.pdf; Francesca Cooney with Julia Braggins, *Doing Time: Good Practice with Older People in Prison*, Prison Reform Trust, 1-87, p.14 (2010), available at: http://www.prisonreformtrust.org.uk/Portals/0/Documents/doing%20time%20good%20practice%20with%20older%20peop,.pdf.

[42] *See* Ashley M. Belich, Note: *Dobbey v. Illinois Department of Corrections: A Small Piece of a Growing Policy Puzzle*, 5 Seventh Circuit Review 272, p. 301-302 (2009), available at: http://www.kentlaw.iit.edu/Documents/Academic%20Programs/7CR/v5-1/belich.pdf.

[43] *See* Title 20 Illinois Administrative Code, Section 504.810, "Filing of Grievances," available at: http://www.ilga.gov/commission/jcar/admincode/020/020005040F08100R.html.

[44] *See* 42 U.S.C. § 1997e (2000), available at: http://www.law.cornell.edu/uscode/text/42/1997e.

[45] *See Ibid.,* note 42, p. 297-306.

[46] *See* Van Swearingen, *Imprisoning Rights: The Failure of Negotiated Governance in the Prison Inmate Grievance Process*, California Law Review Volume 96, Issue 5, Article 5, 1353-1382 (October 31, 2008), available at: http://scholarship.law.berkeley.edu/cgi/viewcontent.cgi?article=1165&context=californialawreview.

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[47] *See* Ingrid A. Binswanger, Marc F. Stern, Richard A. Deyo, Patrick J. Heagerty, Allen Cheadle, Joann G. Elmore, and Thomas D. Koepsell, *Release from Prison — A High Risk of Death for Former Inmates*, New England Journal of Medicine, Volume 356,157-165, (January 11, 2007), available at: http://www.nejm.org/doi/full/10.1056/NEJMsa064115#t=articleTop.

[48] *See* Illinois Department of Healthcare and Family Services, MR #12.19, *Medical Benefits for Persons in an Illinois Jail*, available at: http://www.dhs.state.il.us/page.aspx?item=56511.