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HUMAN RIGHTS AUTHORITY-CHICAGO REGION

REPORT 18-030-9020, 18-030-9022, 18-030-9023 & 18-030-9024
Cook County Department of Corrections – Cermak Health Services

INTRODUCTION

The Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission opened an investigation into similar complaints of potential rights violations in the treatment of four detainees at Cook County Department of Corrections – Cermak Health Services. Cermak provides daily healthcare to all jail detainees, about 2,100 of whom, or one third of the population, receive some level of mental health care. Cermak's on-grounds facility has a maximum capacity of 120 beds for psychiatric treatment, which typically has an 85-90 daily census.

Case 18-030-9020:
The complaint is that a detainee was given continued emergency medication without a filed petition.

Case 18-030-9022:
The complaint is that a detainee was given continued emergency medication without a filed petition and was kept isolated for three days, all without appropriate reason.

Case 18-030-9023:
The complaint is that a detainee was kept isolated, taunted by nursing staff and given emergency involuntary medications for inappropriate reasons.

Case 18-030-9024:
The complaint is that a detainee was given continued emergency involuntary medications without a filed petition.

Substantiated findings would violate protections under the Mental Health Code (405 ILCS. 5).

The Human Rights Authority met with Department of Corrections staff, Cermak hospital staff, Cook County (Stroger) administration and Cermak hospital administration to discuss the care

of these detainees. Relevant policies were reviewed as were the patients' records with proper authorization.

FINDINGS

Case 18-030-9020 - detainee was given continued emergency medication without a filed petition.

This man's chart revealed his escalating behavior for days leading up to a first emergency injection. He was described as increasingly agitated, kicking and banging his door, screaming profanities at the staff and provoking peers, making it risky for a Physician Assistant (PA) to approach him. According to a September 18th entry, the PA wrote of the detainee's challenge to open his cell door so he could "settle" things with the officers and of taking an aggressive stance toward them once they did. He was placed on constant observation and "Out Alone/House Alone" (Alone status) for unpredictable behavior, meaning he was not allowed in the day room or a cell with others, except for staff, for the time being. He refused psychotropic medication.

On Tuesday, September 19th, the detainee was noted to have been up all night displaying the same behaviors. The PA approached him again to find him pacing, muttering to himself and then screaming intermittently at no one. He yelled at the PA that he would kill her as she neared the cell, then he would back off and run toward the door again. Attempts at calming, redirecting him or getting him to take medications failed, and injections of Haldol, Lorazepam and Diphenhydramine were given one time and he was placed into seclusion for two hours according to the records. The corresponding restriction notice included both interventions and stated that he had no preference and refused to have anyone notified.

The charting on Wednesday, September 20th, reflected the detainee's continued aggressions and threats toward a nurse, the PA and other staff, screaming at them to get away, saying he would kill them. He refused to engage with them or cooperate with an exam and any attempt to redirect or deescalate him failed. He refused medications again and was given another round of the same injections one time according to the orders, but he was not placed into seclusion. Alone status remained in place. A restriction notice accompanied the injection, and there were no stated preferences to consider or anyone designated to notify.

Much of the same repeated on Thursday, September 21st. The detainee yelled profanities and similar threats at anyone who approached his cell and he refused any treatment offers. This time he was laughing inappropriately but carried on with saying he would harm anyone who came into the cell. The same one-time medications were given a third day and the Alone status was extended. A restriction notice was completed in the same manner as before.

On Friday, September 22nd, the detainee was seen by a psychiatrist but still refused to engage, this time keeping his blanket over his head and not talking. He grew angry again later that day and tried to hit a nurse, which resulted in more emergency medications and restraints that lasted for a couple hours. A restriction notice was completed that covered both, and again no one was to be notified. The observation statuses were discontinued shortly thereafter and there were no further emergency medications given over the next week. A petition for involuntary treatment was filed two months later following periodic episodes.

We pointed out to Cermak staff that while this detainee's presenting behaviors seemed appropriate for emergency medications, they carried on for four consecutive business days without a petition for involuntary treatment being filed. The chief psychiatrist acknowledged the error and told us that this occurred before they developed a way to ensure compliance with Code timelines. He introduced a new database that tracks emergency medication use and triggers a colored alert when the seventy-two-hour limit approaches or exceeds, and then showed examples of how it works. The HRA was also assured that all nursing and medical staff have been reminded of filing requirements, and regarding general training, all go through Mental Health Code training during first orientation and then have annual refreshers on the Code and policies.

FINDINGS

Case 18-030-9022: a detainee was given continued emergency medication without a filed petition and was kept in isolation for three days, all without appropriate reason.

According to this detainee's record, he rejected all scheduled psychotropics as prescribed and tended to keep to himself, refraining from unit activities prior to the first emergency order. He also needed encouragement to maintain his hygiene as well as nutrition and fluid intake. PRN, or as needed medications had been ordered but were given just a few times with his acceptance.

On Wednesday, August 9th a psychiatrist wrote that he attempted to see his patient but on entering the room, the detainee "began shouting profanities and threatening violence. EM ordered." One-time Haldol, Lorazepam and Diphenhydramine injections were immediately given per the orders and administration records. A nursing entry stated that the detainee was angry about getting the shots, saying they were all now his enemies. The corresponding restriction notice listed aggressive, hostile behavior to justify the emergency medication, and there were no emergency intervention preferences or designated contacts identified.

The same psychiatrist noted on Thursday, August 10th that the detainee quickly became violent on approach that morning, yelling that he was going to kill him. He called security at once, and the same one-time injections were given as the day before. A nurse wrote of the incident that the detainee displayed hostile behavior, made verbal threats toward the doctor

and appeared to have decompensated. There was no restriction notice completed for the forced medication in the record.

A different psychiatrist visited the detainee on Friday, August 11th, and in a report described him as "Floridly psychotic and a danger to self and others. ...has deteriorated severely and would clearly benefit from a psychotropic medication. Emergency medications now." A nurse's note from the same time stated that the detainee was up and about in his room, anxious, but voicing no complaints as the same medications were administered a third time. A restriction notice was not completed.

The record provided no indication that the emergency medications continued beyond the third business day, which would not require a filed petition. There were no orders to seclude or place the detainee on Alone status or to otherwise isolate him, although he did seem to prefer keeping to himself and not engage on the unit according to the documentation.

Cermak acknowledged that for at least two of these incidents, August 9 and 11, there were no supportive documentations for emergency medication and there were missing restriction notices. The staff said that daily reviews of emergency medications and the use of restraints and seclusion are being done, which includes chart reviews. They also informed us that seclusion would be the only type of isolation used, which is typically by a two-hour order, rarely exceeding six hours. The person secluded is observed on camera and nursing and security staff are on-hand at all times should any emergency arise. They described a seclusion room as a cell with special padding on the walls and floors, no bed or sink. The HRA team visited a unit and observed a seclusion room that appeared just as described. It was situated adjacent to a nursing or security desk, on which were several monitor screens, one for the seclusion room.

FINDINGS

Case 18-030-9023: a detainee was kept isolated, taunted by nursing staff and given emergency involuntary medications for inappropriate reasons.

According to the record, the detainee was readmitted into "Cermak Hospital." The detainee had been recently released about twenty (20) days prior. She was seen by psychiatric staff for intake after admission on November 4th and was "somewhat cooperative" during the intake assessment. She was allowed to attend groups and intermingle with other detainees.

On November 6th, she was placed on Alone status due to becoming aggressive with staff and peers, belligerent and refusing to comply with direct orders during a group therapy session with her peers. She remained on Alone status until her eventual discharge from the unit. While being on Alone status she was only allotted on hour per day outside of her holding cell according to consistent nursing notes and entries.

The detainee initially had no prescribed psychotropic medications on the unit, however she did consent to take some medical prescriptions. She refused all medications at times, but on November 18th she was given emergency involuntary medication for the first time. There is a brief note from the attending psychiatrist indicating that the detainee was banging on her cell door and behaving aggressively. The note further maintains she required an emergency medication for her own safety. However, there is no restriction of rights form found in the record to support this issuance.

The record also has another issuance of emergency medication on November 27th. On this date the detainee was swearing at her peers during her hour out. She was then given dinner and refused to allow officers in her cell to collect her dinner tray. The note is written by the social worker who labeled the dinner tray and its' contents, specifically a carton of milk, as contraband. The record has no restriction of rights notice to support this event.

During our interviews, Cermak did acknowledge the missing restriction of rights documentation. The head psychiatrist stated, "the mismatch [missing documentation] of restriction notices are an issue," then reassured the HRA that the process of giving a recipient the notice and explaining that notice is being followed. He then further verified that patients are even given the opportunity of notifying whomever they choose.

The HRA followed these concerns with questions as to what is considered contraband. Cermak informed the HRA that the facility is a jail and there are protocols that must be followed to ensure order and safety. They stated that milk cartons are considered contraband because detainees utilize them as projectile weapons to throw bodily fluids at staff and officers. They stated they typically ask for the items twice and if they are not returned, the person is considered a danger to staff.

FINDINGS

Case 18-030-9024: a detainee was given continued emergency involuntary medications without a filed petition.

The record for this detainee showed four issuances of emergency medications. On July 31st, the detainee allegedly had a physical altercation with another detainee. He was transferred from the general tier to Cermak for physical evaluation and monitoring. A few hours after being transferred to Cermak, the detainee was swinging hands, not following directions and pulling away from officers. The detainee was given emergency involuntary medication and placed in the seclusion room for two hours. There is no restriction of rights notice for this instance or events.

On August 13th, a RN noted that the detainee was "verbally aggressive, agitated and threating". The notes are vague, but the detainee was given emergency medications and placed in seclusion for two hours. There is a restriction of rights notice for this incident,

however it is not descriptive and incorrectly filled out. The notes indicate that the detainee was given medication and placed in seclusion, the restriction of rights notice only recognizes that the detainee was given emergency medication. There was no preference noted on restriction form.

On September 1st, the records indicate that the detainee threw a carton of bodily fluids on the officers and received emergency medications. For this instance, there is a restriction of rights notice, however it is vague and incorrectly filled out. The notes indicate that the detainee was given medication and placed in seclusion, the restriction of rights notice only recognizes that he was placed in seclusion for two hours. There was no preference noted on restriction form.

The final issuance of emergency medication occurred on September 10th, and per the nursing notes the detainee was "aggressive, agitated, yelling, cursing, kicking door and threating staff." The notes also indicate that the detainee was unable to be redirected. That this time, the detainee had a wound on his right arm from banging the door. Emergency medication was given because he was displaying self-harming behavior. There is a restriction of rights form and it is completed correctly for this event, per the form the detainee had no preference.

There were no other instances of involuntary medications as the detainee agreed to take prescribed medications on September 14th. The record detailed that he appeared to take all medication from September 14th until October 2nd. During this timeframe there were no instanced of aggression, however the detainee did start refusing to care for his hygiene. It was discovered that he had several untaken pills in his pocket thus, a petition was filed on October 26th for involuntary medication. The petition was granted on November 17th. From this date until discharge the detainee was completely medication compliant and had no issues with hygiene or behavioral outburst.

During interviews with Cermak staff, the HRA pointed out to Cermak staff that some restriction of rights forms were missing from the record. Cermak mentioned that they recently implemented a new computer system and that the notices are now scanned into the record. They no longer have paper records. Along with the new emergency medication tracking database, they displayed the push reports that are generated and emailed to directorial staff daily.

As with the previous cases the head psychiatrist acknowledged, "the mismatch [missing documentation] of restriction notices are an issue," and then reassured the HRA that the process of giving a recipient the notice and explaining that notice is being followed. He reiterated the annual refresher training on the Mental Health Code and policies.

CONCLUSIONS

Policy Review and Code mandates

The HRA reviewed Cermak's Involuntary Administration of Psychotropic Medications – Emergency Circumstances Policy. This policy details that the facility will at admission attempt to gather a detainee's consent for treatment and administration of psychotropic medication. It furthers that if a detainee refuses the psychiatrist will inform the detainee of the risk associated with medication noncompliance. The psychiatrist will then notify the detainee that the law allows medication in emergency situations. The psychiatrist will clearly define that medication can be used "to prevent serious and imminent physical harm to self or others," which is in line with the Code in 5/2-107.

Section 2-107 also establishes a strict timeframe for allowing the continued use of emergency medication before petitioning for court authority, up to 24 hours provided that the need is determined necessary and is documented in the record, and no more than 72 hours, excluding holidays and weekends, unless a petition is filed and the treatment continues to be necessary.

The policy details that the psychiatrist may "solicit" the detainee's emergency medical treatment preferences. The policy furthers that the preference will be noted in the electronic medical record and communicated to the detainee's guardian or surrogate decision maker. Finally, the policy states that the emergency treatment preference will be followed in emergency situations, "if available and medically appropriate in the psychiatrist's clinical judgement." This is also in line with Code Section 5/2-200 where "If any such circumstances subsequently do arise, the facility shall give due consideration to the preferences of the recipient regarding which form of intervention to use as communicated to the facility by the recipient...."

The policy also covers the fundamental principles of Code Section 5/2-201 as it states that, "[qualified personnel] must execute a Restriction of Rights form for each administration of involuntary psychotropic medication. Copies will be distributed to the patient and/or patient's guardian or authorized decision maker ... a copy of the ... form must be scanned into the patient's electronic chart."

The HRA also reviewed Cermak's Restraint and Seclusion policy. The policy affirms that no restraint is ordered for more than four (4) hours and during the initial two (2) hour period trained personnel will conduct a face-to-face evaluation to determine a need for continued restraint. The policy furthers that the restraint should be employed in a humane and therapeutic manner and that the recipient shall be monitored every fifteen (15) minutes. This policy is in line with the Code's Section 5/2-108.

The Restraint and Seclusion policy also covers Code Section 5/2-109. The policy states seclusion "may only be used as crisis intervention to prevent a mental health patient ... from causing physical harm to himself or physical injury to others." This is in accordance with the

Code where "in no event shall seclusion be utilized to punish or discipline a recipient." Ultimately all requested and received policies meet the mandates set forth in the code.

Under the Mental Health Code, all recipients are to be provided adequate and humane care and services (405 ILCS 5/2-102a). Adequate and humane care and services are defined as those reasonably calculated to prevent further decline in one's clinical condition so that he or she does not present an imminent danger (405 ILCS 5/1-101.2).

Case 18-030-9020 - detainee was given continued emergency medication without a filed petition.

The HRA and Cermak staff agreed that while there were appropriate reasons to give emergency medications, they carried on for four consecutive business days without a petition for involuntary treatment being filed, exceeding the Code's 72-hour limit. A rights violation is substantiated. Cermak has already addressed this issue with their tracking system that was displayed during the site visit.

Case 18-030-9022: a detainee was given continued emergency medication without a filed petition and was kept in isolation for three days, all without appropriate reason.

According to the record, this detainee was given an emergency medication for three consecutive days and only one of them was supported by documentation to prevent serious and imminent physical harm when no less restrictive alternative was available. The other two instances merely described symptoms of mental illness. In addition, two instances were not further justified with required restriction notices. A rights violation is substantiated. There was no evidence that this person was kept in isolation for three days, however, in practical terms, being in a jail cell is rather isolating. Although it was not clear exactly how much time he spent outside his cell, he was not placed on Alone status and all medical and nursing entries noted his preference to avoid others. For lack of more evidence, a violation of the right to adequate and humane care is unsubstantiated.

Case 18-030-9023: a detainee was kept isolated, taunted by nursing staff and given emergency involuntary medications for inappropriate reasons.

This detainee was given emergency medications on two separate occasions. Both instances meet the criteria for providing emergency medications. However, there is the lack of restriction of rights notice for the emergency medication given on November 18th. The code requires that "whenever any rights of a recipient of services ... are restricted, the professional responsible for overseeing ... shall be responsible for promptly giving notice of the restriction..." (405 ILCS 5/2-201). Thus, a rights violation is substantiated for giving medication for inappropriate reasons.

Furthermore, the detainee was placed on Alone status shortly after arriving to the unit. While on this status the detainee was only allowed out of her cell or housing unit for one hour each day. She was also not allowed to interact with the other detainees for the duration of her stay. There were no medical orders for this status in the record.

Cermak maintained throughout the site visit that Alone status is not seclusion. Cermak informed the HRA that there is a seclusion room dedicated for seclusion and monitoring. The HRA reviewed all relevant policies and did not see a policy on what distinguishes Alone status. Thus, the Code defines seclusion as "placement of a recipient alone in a room which he has no means of leaving." The HRA is aware that Cermak is also a jail but, this detainee's Alone status is in direct violation of the Code's right to adequate and humane care and to be free from seclusion without a proper order. The facility calls this Alone status, but she was secluded to a room for 23 hours a day and had no means of leaving. Even if "Alone" status would be considered a behavioral approach, the Code's definition of seclusion (405 ILCS 5/1-126) allows for this only if incorporated into a services plan and imposes limits of not more than 2 hours at one time and 4 hours within 24 hours. This detainee was isolated for her duration in the facility and a rights violation is substantiated.

Finally, in the interview with Cermak, the staff maintained that every detainee is treated with respect. The record does not have any notes or documentation to show that this detainee was taunted or verbally abused. Therefore, a rights violation is unsubstantiated.

Case 18-030-9024: a detainee was given continued emergency involuntary medications without a filed petition.

This detainee was given several emergency medications during his stay on the unit. The notes in the case record justify the issuance of emergency medications. None of the emergency involuntary medication continuances exceeded a consecutive seventy-two-hour (72hr) period. Therefore, a rights violation is unsubstantiated.

RECOMMENDATIONS

Although Cermak developed an emergency medication tracking system and assured that all these related violations were previously corrected, the HRA has no proof that medical, nursing and other appropriate corrections staff were in fact reminded or retrained on meeting the Mental Health Code's exact standard and procedures for them. It is recommended that evidence of reminding or training, either from the time of these discoveries or current, be provided on the following:

1. To administer every emergency medication, medical and nursing entries must descriptively support the need to prevent *serious and imminent physical harm* when no less restrictive alternatives are available (405 ILCS 5/2-107a).

2. Emergency medications may not exceed a 72-hour period, excluding weekends and holidays unless a petition is filed *and* the treatment under subsection a continues to be necessary (405 ILCS 5/2-107d).
3. A restriction of rights notice must accompany every instance of emergency medication and seclusion and include supportive justification for them (405 ILCS 5/2-107; 2-109 and 2-201).

Additionally:

4. Stop the inhumane practice of keeping detainees with mental illness isolated, secluded, or in Alone status in their cells for 23 hours. Formulate a new policy to address relief options for people with mental illness in the jail setting. Policy must contain clear definitions on what distinguishes Alone status from seclusion. Ensure that policy provisions for seclusion meet Code requirements and time limits (405 ILCS 5/2-109) and if "alone" status is a behavioral approach, ensure that the approach is documented in the detainee's service plan and the time limits are consistent with the Code requirements (405 ILCS 5/1-126).

SUGGESTIONS:

1. There should be more effort to show by record how often any detainee with mental illness spends or is offered to spend time out in the common area/day room, particularly if on Alone status.
2. Efforts should also be taken to help the detainee identify emergency treatment preferences and document accordingly.

COMMENT:

Cermak mentioned directives to consider the 72-hour emergency medication limit under 2-107 as cumulative. As advocates we vehemently object to any notion that a recipient will face court proceedings and potential forced treatment for having three separate, unrelated incidents over an extended time, say a year or more during his stay in the facility. The HRA contends that the Code's intention is to limit emergency medications to a "72-hour period" (405 ILCS 5/2-107), meaning consecutive hours, and encourages Cermak to seek more legal advice.

RESPONSE

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

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April 15, 2019

Regina Pessagno, Chair
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Re: HRA Report of Findings on Cases#18-030-9020, 9022, 9023, & 9024

Dear Chairman Pessagno,

This letter is in response to your letter dated March 8, 2019, enclosing the report and findings ("Report") of the Chicago Regional Human Rights Authority ("HRA") pertaining to the above-referenced cases. Cermak Health Services of Cook County ("Cermak) begins by recognizing the fact that the HRA found Cermak's policies to be consistent with the Illinois Mental and Developmental Disabilities Code (the "Mental Health Code"), and that a number of the allegations in the above-referenced cases were found to be unsubstantiated. Additionally, the HRA acknowledges that some of the HRA findings were already remedied by Cermak in advance of the Report.

Accordingly, Cermak's response to the HRA's Report is not intended as a line-by-line refutation or affirmation of the contents of the Report. Rather, this letter is intended to provide additional information or clarification regarding the HRA-substantiated findings identified in the Report.

HRA-Substantiated Finding Regarding Case # 18-030-9020

The complaint to the HRA asserted that, "*detainee was given continued emergency medication without a filed petition.*"

As an initial matter, Cermak notes the HRA's acknowledgement that, upon its own volition, Cermak introduced a database that tracks emergency medication administration and triggers an alert when the 72-hour time frame defined in 2-107 of the Mental Health Code is approaching. Additionally, Cermak re-trained all nursing and medical staff on the Mental Health Code's requirements and specifically, the rights of recipients of mental health services with regard to the administration of emergency medications and associated timeframes.

HRA-Substantiated Finding Regarding Case # 18-030-9022

The complaint to the HRA asserted that, "*detainee was given continued emergency involuntary medications without a filed petition and was kept in isolation for three days, all without appropriate reason.*"

The HRA could not substantiate that the administration of emergency medications to the detainee was not justified by the detainee's symptoms or behaviors or that the administration of emergency medications continued beyond the 72-hour time frame permitted by the Mental Health Code. Additionally, the HRA acknowledged that all medical and nursing notes documented the detainee's preference to avoid others, and further found no evidence to support the assertion that the detainee was kept in isolation for three days. Thus, the HRA's findings are solely centered on a lack of documentation to demonstrate compliance with the Mental Health Code's requirement to complete a restriction notice upon administration of emergency medications or isolation. Cermak already took action before the issuance of the Report to make procedural changes and integration with the electronic medical record system so that restrictions of rights will be part of the medical record and that such notices will be timely documented. Additionally, Cermak has already begun re-training medical staff regarding Code-compliant documentation.

We note the HRA's comment that, "in practical terms, being in a jail cell is rather isolating." While we appreciate that being held in a jail cell requires a detainee to endure a certain amount of solitude, we remind HRA that the detainee is in fact being held by the Cook County Department of Corrections, and that a detainee's housing assignment is a collaborative decision with the Sheriff of Cook County. The Sheriff, as the warden of the jail, has the duty to furnish medical aid for all prisoners held in the county jail. *See,* 730 ILCS 125/2. 55 ILCS 5/3-13003. The Sheriff currently meets this obligation through the operation of Cermak Health Services of Cook County as the medical and mental health services provider in the Cook County Jail. Further, in accordance with state law, the Sheriff is required to receive and confine all persons committed to such jail by any competent authority until discharged by due course of law. *See,* 730 ILCS 125/4. Cermak cannot, on its own, decide the manner of confinement of a detainee at the Jail, regardless of that detainee's mental health status. There is no evidence that Cermak violated any right of the detainee with regard to adequate and humane care.

HRA-Substantiated Findings Regarding Case # 18-030-9023

The complaint to the HRA asserted that, *"detainee was kept isolated, taunted by nursing staff and given emergency involuntary medications for inappropriate reasons."*

First, Cermak reiterates, consistent with the HRA's findings, that the record does not support the allegation that the detainee was taunted or abused in any way.

Second, the allegation that a detainee was kept isolated in violation of the Mental Health Code is not supported by the Cermak record. House Alone status is not a clinical status determined by Cermak. It is a security alert of the Department of Corrections ("Corrections") to maintain the safety of the jail environment consistent with the Sheriff's duty as warden of the jail. In Cook County Jail, an individual, whether or not that individual is a recipient of mental health services, may be placed on House-Alone status by Corrections for any number of reasons related to the safety and security of the individual, other detainees, correctional officers, staff, or others present in the facility. House Alone is a form of protective custody and is implemented for the protection of the detainee. It is not a status applied solely to recipients of mental health services. High profile detainees are frequently placed on House Alone status.

House Alone status differs from therapeutic seclusion ordered by a Cermak psychiatrist. Seclusion as ordered by Cermak medical staff is only ordered for therapeutic reasons. In contrast, House Alone status is a determination made in the discretion of the Department of Corrections. That assertion is supported by Cermak's policies produced to the HRA, which the HRA already concluded satisfied the requirements of the Mental Health Code. Therefore, Cermak disagrees with the HRA's interpretation that House Alone status is a violation of a detainee's right to adequate and humane care by Cermak as it is unrelated to the provision of mental health services it is obligated to provide.

The Report states that in its review of Cermak policies the HRA could not identify any policy that distinguishes therapeutic seclusion from House Alone status. Cermak's policies would not address House Alone status because it is not levied by Cermak. Cermak and Corrections are separate and distinct entities, each with their own duties, obligations, policies, and procedures. As such, Cermak is not in the position to re-define the policy of Corrections, regardless of a detainee's mental health status.

Consistent with its policy, Cermak provides for appropriately documented therapeutic seclusion. Nothing in the Cermak record supports the HRA's statement that the detainee was subjected to therapeutic seclusion by Cermak for 23 hours a day. Likewise, neither Cermak's policy nor practice with regards to therapeutic seclusion calls for detainees receiving mental health services to be isolated for 23 hours per day. In fact, therapeutic seclusion was ordered for the detainee on November 27, 2017, but that order for seclusion did not exceed two hours. The HRA acknowledged in its Report that Cermak had previously informed the HRA that therapeutic seclusion is the only type of segregation used by its clinicians, which is typically a two-hour order. In such cases, the detainee is observed on camera and nursing and security staff are on hand at all times. The HRA

reported that it visited a seclusion room and it appeared as described, with the room being adjacent to the nursing and security desk and with one monitoring screen for each seclusion room.

Cermak acknowledges that its record made reference to the detainee being on House Alone status. However, that reference, in itself, is not evidence that this detainee was actually assigned a House Alone status by Corrections. Moreover, there is no evidence in the Cermak record indicating that Corrections had issued a House Alone alert. Rather, the detainee was given a single-cell bed assignment. Usually, bed-assignments are determined jointly between Corrections and Cermak, but such assignments do not, by themselves, result in restriction of a detainee's access to other detainees. The detainee was provided a single bed-assignment that was the same as other detainees with single-bed assignments.

Single cells are distinctly different from therapeutic seclusion rooms in that unlike therapeutic seclusion rooms, single cells provide for amenities such as a bed, sink, and/or private toilet, while therapeutic seclusion rooms lack such amenities. The Cermak record demonstrates that Cermak only ordered the detainee to a therapeutic seclusion room for a period of two hours. Any further restriction of the detainee was not at the direction of a Cermak clinician and the record does not indicate any further therapeutic seclusion orders by a Cermak psychiatrist or other Cermak provider.

Colloquially within Cermak, this single-cell assignment is sometimes referred to as House Alone status because all detainees with House Alone status have single-cell bed assignments. But not all detainees that have single-cell assignments are placed on House Alone Status by Corrections. While Cermak concedes that reference in its record may have caused some confusion, Corrections keeps its own logs and records with regard to the movement of detainees, and does not rely on or review the Cermak record to restrict the movement of detainees in its custody. Therefore, Cermak respectfully asks that the HRA rescind its finding that House Alone status was a direct violation of Cermak's humane treatment and provision of adequate care and a violation of the Mental Health Code.

Finally, Cermak addresses the allegation that emergency medications were administered for inappropriate reasons. The HRA's finding that a rights violation is substantiated based upon the provision of emergency medication for inappropriate reasons is an inaccurate statement given that the HRA concedes that in both instances where emergency medications where administered to the detainee, Cermak met the criteria for provision of emergency medications.

Similar to the substantive finding in Case # 18-030-9020, the purported violation is more accurately characterized as a lack of documentation to demonstrate compliance with the Mental Health Code's requirement to complete a restriction notice upon administration of emergency medications. The absence of documentation cannot lead to the conclusion that the medications where administered for inappropriate reasons, especially where the HRA acknowledges that the basis for administration met the statutory criteria for emergency medication. The facts presented by the HRA demonstrate that prior to one administration, the detainee was banging on her cell door and behaving aggressively. The second issuance of emergency medication was administered to the detainee after the detainee was observed swearing at her peers and refusing to allow officers in her cell to collect her dinner tray. Ultimately, the finding is nothing more than a documentation error. That has been cured through

the adoption of procedural changes, which now allow for the integration of restriction of rights forms and improved documentation procedures in compliance with the Mental Health Code.

HRA Findings Regarding Case # 18-030-9024

The complaint to the HRA asserted "*a detainee was given emergency involuntary medications without a filed petition.*" Cermak notes, consistent with HRA's findings, that while several emergency medications where administered to this detainee, the notes in the record justify the administrations of emergency medications. None of the administrations exceeded a consecutive seventy-two-hour (72) period. There is no evidence that Cermak violated the Mental Health Code here. Cermak is aware of the requirement that emergency medications may not be administered in excess of a 72-hour consecutive period unless a petition is filed, treatment is necessary, and the tracking system is in place to ensure compliance with this requirement. However, we are also mindful that the intent of the statute is to prevent the use of emergency medications as treatment or creating an artificial break in the consecutive 72-hour period to avoid the filing of treatment petitions.

The HRA's assumption about the manner in which Cermak interprets the statute is unfounded as there is no evidence that Cermak is subjecting detainees to proceedings for involuntary treatment solely based on the number of emergency medications that have been administered. As the HRA is aware, there are many other factors identified in Section 2-107.1 of the Mental Health Code that must be met in order to plead a proper petition. Nevertheless, we appreciate the clarification from the HRA on the consecutive 72-hour period, as that has been a point of discussion with the Legal Advocacy Service.

Cermak acknowledges the notice that the HRA may vote to make any of its findings a part of the public record. However, please be advised that Cermak respectfully requests that the HRA does not make these findings public. However, if the HRA so chooses to make this Report public, Cermak wishes to have these responses/objections made part of the public record as well.

Cermak takes seriously its responsibility to provide quality and humane care to recipients of mental health services within Cook County Jail, while remaining compliant with applicable law. Upon being advised of the complaints, Cermak took proactive steps to not only re-train its staff, buy it also created an alert system to monitor compliance with the administration of emergency medication, and integrated into its electronic medical record the notice of restriction of rights form to improve compliance with documentation requirements set forth in the Mental Health Code. As of the receipt of the HRA's findings, Cermak had also created a tracking tool to assign relevant personnel to review, and in some cases, implement, the recommendations and suggestions made in the Report. Cermak is currently in the process of re-training staff and creating internet-based training modules in its learning management software. Additionally, a number of operational improvements have been made to ensure accurate documentation, monitoring, and reporting about the administration of emergency medications and therapeutic seclusion. Finally, Cermak is confident that its responses or

objections to these findings may persuade the HRA, at least in part, to reconsider one or more of its substantive findings.

Sincerely,
ASA John Power

Enclosures

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