On August 16, 2011, the John Howard Association (JHA) visited the Dwight Reception and Classification (DRC), which serves as the intake, classification and processing center for all adult female offenders in Illinois. The facility is housed within Dwight Correctional Center (Dwight), a maximum-security adult female correctional center. One warden administers both Dwight and DRC and the two facilities share staff.

**Vital Statistics**
- Population: n/a
- Capacity: 404
- Average Annual Cost Per Inmate: n/a
- Average Age: n/a
- Source: DOC

**Key Observations**

- New inmates are sent to DRC Monday through Friday. On average, DRC receives five to 25 inmates per day. Inmates from Cook County jail arrive every Wednesday, and average about 20 to 40 inmates per week.
- DRC must rely upon inmates self-reporting their mental health and medical conditions because the state lacks a reliable system to pass information between county jails, mental health facilities, and the prison system.
- DRC screens all inmates for tuberculosis, but does not routinely screen inmates for other serious infectious diseases, including Hepatitis C and HIV.
- The average length of stay for an inmate at DRC is 90 days, with the exception that inmates sent to DRC for parole violations are generally there for about 60 days.
Executive Summary

The complex process of receiving, identifying, screening, and classifying adult female offenders at the Dwight Reception and Classification Center (DRC) is substantially the same as the process of receiving and classifying adult male offenders at Stateville’s Northern Reception and Classification center (NRC), with some key differences.\(^1\) The most obvious distinction is that there are far fewer female inmates than male inmates in Illinois, making DRC smaller and more logistically manageable.\(^2\)

This is not to suggest that DRC’s challenges are insubstantial. The dramatic increase in the female prison population over the last 20 years, fueled largely by harsher drug sentencing laws, continues to put increased strain on DRC’s ability to safely and reliably screen, classify, and place inmates.\(^3\) A recent study by the Illinois Criminal Justice Information Authority provides some good news, insofar as admissions of female inmates for drug offenses are decreasing in Illinois prisons.\(^4\) However, this same study found that the average age of female inmates has increased along with the number of inmates with children, making this population’s healthcare and social service needs even more complex and demanding.

JHA’s inspection of DRC revealed a clean, orderly and well-maintained facility. We were impressed by the knowledge and dedication of DRC’s administration and staff, who were not only frank and forthcoming about challenges facing the facility, but also vocal about the importance of treating inmates with dignity and compassion. In general, JHA found the living conditions at DRC to be less harsh than at NRC, with inmates being provided with more generous out-of-cell time, recreation, and privileges.\(^5\) During the initial one to two week period while inmates are awaiting medical clearance, however, conditions at

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\(^1\) For a thorough account of the processes underlying reception and classification, see JHA’s July 12, 2011, report on Stateville NRC, available at [http://www.thejha.org/NRC](http://www.thejha.org/NRC).

\(^2\) Per DOC’s 2010 year-end report, 2,900 women, 6.1 percent of the total Illinois prison population, were incarcerated, and 2,751 women were on parole, comprising about 9.8 percent of the total parole population. See [http://www.idoc.state.il.us/subsections/reports/annual_report/FY10%20DOC%20Annual%20Rpt](http://www.idoc.state.il.us/subsections/reports/annual_report/FY10%20DOC%20Annual%20Rpt).


DRC are arguably as difficult and isolating as at NRC because inmates are essentially housed under lockdown with meals served in-cell, no recreation time, minimal out-of-cell time, and very limited privileges, visits, and phone calls.

One feature that likely helps to reduce stress for DRC’s inmates while they are awaiting medical clearance is having access to reliable information about the reception and classification process. JHA was impressed by the thoughtful design of DRC’s Inmate Orientation Manual, which gives inmates thorough, easy to understand information about institutional procedures that might otherwise seem inexplicable. The manual sets out in simple, concrete terms all of the steps in the reception and classification process, what inmates should expect while they are awaiting medical clearance, and the services they will be able to access once they are medically-cleared. Providing inmates with such information at time of intake is vitally important, as this helps to reduce their fear and apprehension and facilitate their adjustment to prison. Studies show that the more personal control an inmate feels over conditions of incarceration, generally the more successful her adjustment to prison life will be.6

At DRC, as at NRC, one of the most pressing problems JHA found was the absence of a reliable, modernized system for transmitting inmates’ medical and mental health records and medications to DRC when inmates are transferred from the county jails. Because inmates’ medications and medical records rarely accompany them to DRC, staff must assume that inmates can and will reliably and accurately report and remember all medications as well as medical and mental health issues. Further, it is the policy of DOC to only accept prescriptions written by doctors at other DOC facilities. Accordingly, even if inmates arrive at DRC with legally valid prescriptions or full bottles of medication, they are required to discard them.

The lack of a reliable system for tracking and transferring inmates’ medical data and medications to reception and classification centers presents a serious risk of harm to inmates’ health and well-being. Self-reporting of medical and mental health diagnoses, treatment, and medications is an unreliable means to ensure that inmates receive continuity of care and uninterrupted medication. Indeed, staff at DRC reported that many inmates cannot remember the names of their medications. Lack of continuity of care in the administration of medications presents particular risks for mentally ill inmates, given that sudden discontinuation of psychotropic medication can have serious and debilitating physical and mental health consequences.7

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7 Potential side effects include anxiety, mania, psychosis, psychiatric relapse and decompensation, seizure, vomiting, nausea, dysphoria, tardive dyskinesia, motor dysfunction, tremor, convulsions, heart palpitations and dramatic rises in blood pressure. See Benjamin J. Sadock M.D., Virginia A. Sadock M.D., Norman Sussman M.D., Kaplan and Sadock’s Pocket Handbook of Psychiatric Drug Treatment (Fourth Edition) (Lippincott Williams & Wilkins 2006).
Standard 23-6.5(a) of the American Bar Association’s Standards on the Treatment of Prisoners provides: “A correctional agency should ensure each prisoner’s continuity of care, including with respect to medication, upon entry into the correctional system, during confinement and transportation, during and after transfer between facilities, and upon release.”

Standard 23-6.5(b) provides: “Prisoners who are determined to be lawfully taking prescription drugs or receiving health care treatment when they enter a correctional facility directly from the community, or when they are transferred between correctional facilities—including facilities operated by different agencies—should be maintained on that course of medication or treatment or its equivalent until a qualified health care professional directs otherwise upon individualized consideration.”

JHA believes that a minimum standard of care requires continuity of care. Without continuity of care, effective diagnosis, management and treatment of inmates’ physical and mental illnesses becomes virtually impossible. In accord with ABA Standards, JHA believes that procedures should be instituted to ensure that inmates’ medical and mental health records and medications accompany them from the county jails to reception and classification centers, and from reception and classification centers to destination facilities. This issue, if left unaddressed, invites serious harm to inmates, as well as court intervention.

Another issue that challenges both the health of inmates and the health of the public is under-screening of inmates for infectious diseases at reception and classification centers, including DRC. At the time of JHA’s visit, DRC screened all inmates for tuberculosis at the time of intake, but did not routinely screen inmates for other serious infectious diseases, including Hepatitis C and HIV. The same practice is followed by DOC’s other reception and classification centers, including NRC.

From a public health perspective, this presents a serious oversight and a lost opportunity. Before their incarceration, most inmates had limited access to health care making them difficult to identify and treat in the general community. For many of the two million men and women incarcerated in the United States, prison thus presents a critical venue to

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9 See, e.g., Plata v. Schwarzenegger, 2005 U.S. Dist. LEXIS 43796 (N.D. Cal. Oct. 3, 2005), where the federal district court found that abbreviated and perfunctory medical screening of inmates and the absence of reliable medical records and medical data tracking in California’s reception and classification centers caused “grave” harm to the inmate population and “virtually guaranteed” inmates would suffer “future injury and death” in “the absence of drastic action.”

provide diagnosis, disease management, education on prevention of transmission, and
treatment to those outside the reach of the conventional healthcare system.\textsuperscript{11} A highly
disproportionate number of inmates suffer from infectious disease compared with the
general public.\textsuperscript{12} About 1.5 percent of the 2.2 million inmates incarcerated in United
States’ prisons and jails have HIV or AIDS, roughly four times the rate of HIV infection
in the general population.\textsuperscript{13} In particular, female inmates have much higher rates of HIV
infection than both the general public and male inmates.\textsuperscript{14} Likewise, the level of Hepatitis
C infection among inmates is between 12 and 31 percent, much higher than the general
population.\textsuperscript{15} Indeed, roughly 29 to 43 percent of all persons infected with Hepatitis C in
the United States pass through the correctional system each year.\textsuperscript{16}

When inmates return to the community, as the vast majority do, but remain undiagnosed
and untreated for communicable diseases, they transmit these conditions into the
community, threatening public health and greatly increasing the burden on the
community’s scarce public health resources.\textsuperscript{17} By contrast, when inmates are effectively
diagnosed and treated in prison, this not only reduces mortality and human suffering, but
protects the public’s health by reducing the rate of disease transmission at great cost-
savings to the state.\textsuperscript{18}

It is hoped that the testing regime in Illinois prisons will soon improve with the recent
passage of legislation, Public Act 097-0323 (effective August 12, 2011), which

\begin{itemize}
  \item \textsuperscript{16} \textit{Ibid}, note 14.
  \item \textsuperscript{17} \textit{Ibid}, note 10, 11, and 12.
  \item \textsuperscript{18} \textit{Ibid}, note 9, p. 38.
\end{itemize}
authorizes DOC to provide free opt-out HIV testing to inmates at the point of intake.\footnote{Public Act 097-0323 amended 730 ILCS 5/3-6-2, 3-8-2, and 3-10-2. Under an opt-out testing regime, patients are given an opportunity to “opt out” of HIV testing, but informed that such testing will occur unless they decline. Studies show an uptake in testing rates where opt-out testing is offered, as opposed to opt-in testing. However, concerns have been raised by some civil rights advocates that opt-out testing runs contrary to the doctrine of voluntary, informed medical consent.}

Subsequent to JHA’s visit to DRC, we spoke with DOC representatives about the implementation of the new opt-out HIV testing laws. They indicated that by the end of Spring 2012, opt-out HIV testing will be provided to all inmates at all DOC reception and classification centers (DRC, NRC, Graham, and Menard) at the time of intake, and, additionally will be offered to inmates prior to their release from prison.


In agreement with these authorities, JHA strongly supports the DOC’s endeavors to institute an expanded opt-out HIV-testing regimen for inmates at the time of intake and prior to their release. In addition, JHA believes that efforts should be made to institute a similar testing procedure to screen inmates for Hepatitis C at the time of intake and prior to their release.

\textbf{Recommendations:}

(1) All DOC receptions and classification centers, including DRC, should provide opt-out HIV and Hepatitis C testing to inmates to protect the health of inmates and the public.

(2) State and county officials must address the absence of a reliable way to track and share inmates’ medical and mental health data and medication histories to ensure continuity of care. The lack of such a system frustrates NRC and DOC efforts to provide inmates with basic, constitutionally required medical and mental health treatment.
(3) Mental health staffing levels and inmate access to psychiatric care should be increased at DRC and all DOC reception and classification centers.

This report examines the following issues: Housing & Living Conditions; and Classification & Screening Process.

**Housing & Living Conditions**

DRC has four housing wings, A, B, C and D. In total, it contains 197 double-bed cells, three handicapped accessible cells, and three multi-occupancy cells. On the date of JHA’s visit, DRC housed roughly 300 inmates, but it has the capacity to house 404 inmates in total.

A typical cell in DRC houses two inmates, and contains a double-bunk bed, a sink, a toilet, a shelving unit and a window. JHA was pleased to see that grievance forms and forms for inmates to request to see their correctional counselors were readily available in the housing units.

The average length of stay for an inmate at DRC is 90 days, with the exception that inmates sent to DRC for parole violations are generally there for about 60 days. Staff reported, however, that when available bed space is short, it may sometimes take four to five months before an inmate is transferred to her parent facility. In cases where inmates require additional medical testing, their stay at DRC may also be lengthened.

New inmates are sent to DRC Monday through Friday. On average, DRC receives five to 25 inmates per day. Inmates from Cook County jail arrive every Wednesday, and average about 20 to 40 inmates per week. Administration indicated that these numbers are lower than they have been in the past.

There is no set time of day for receiving new inmates. Thus, when new inmates arrive at DRC, staff from Dwight must be redirected from their duties to assist in inmate intake at DRC. At the time of JHA’s visit, no inmates were being received and processed through DRC.

Inmates sent to DRC for parole violations are housed separately from other DRC inmates. Likewise, inmates who are sent to DRC for reception and classification are housed separately from Dwight inmates, with the exception of segregation inmates from Dwight and DRC who are held in a consolidated segregation unit. DRC inmates are further separated from inmates who have been medically cleared and inmates who are awaiting medical clearance.

When screening DRC inmates to determine if they are suitable cellmates, the administration considers multiple factors including aggression level, length of sentence, number of prior incarcerations and whether the inmate previously has been designated as “vulnerable” or a “predator.” However, overcrowding and lack of bed space remain
challenges to appropriately assigning inmates as cellmates within DRC and in parent facilities.

As previously noted, the initial one to two week period while an inmate is awaiting medical clearance can be extremely stressful and isolating, as inmates are essentially held in lockdown conditions – with meals served in-cell, no recreation time, minimal out-of-cell time, and very limited privileges, visits, and phone calls. Once an inmate is medically cleared, however, her living conditions improve, as she is moved from initial housing to housing for medically-cleared inmates and allowed substantially more privileges and out-of-cell time.

Specifically, medically-cleared inmates are allowed to spend four to six hours in the dayroom each day, and can make an unlimited number of phone calls during this time. The dayroom schedule rotates according to upper and lower tiers in the housing wings. A single tier, 40 to 50 inmates, is let out at a time for dayroom. Medically-cleared inmates are also permitted one hour of outside recreation/gym time three days a week, and can attend religious services on Sundays. Meals are served to them in the dining hall. In addition, medically-cleared inmates may shop in the commissary one day a week and shower three times a week on alternating days. Clean uniforms are provided to DRC inmates three days a week.

**Classification & Screening Process**

The process of intake, screening and classification has multiple steps and usually takes about four to five hours from the time an inmate arrives at DRC to the time she is placed in housing. On first arriving at DRC, inmates are placed in a holding cell, strip searched, and given a yellow two-piece uniform to wear. Inmates must remove any artificial hair and nails. They are allowed to keep only a minimal amount of personal property, including a bible, a wedding band without stones, and a few personal photos. Inmates must deposit all other personal property with a property officer to be discarded or sent home. They are issued a bag of basic toiletries.

A correctional counselor is assigned to review each inmate’s criminal history and to perform a personal interview to determine the inmate’s offense, sentence, and social and criminal background. Counselors use a standardized questionnaire in interviewing inmates and rely on inmates accurately and reliably self-reporting much information, including the following: whether they are affiliated with a security threat group (i.e. a prison gang); whether they have any enemies in DOC; whether they have any medical or mental concerns or are taking any medications; whether they have been victims of sexual abuse or assault; and whether they are an American citizen or legally in the United States.

Unlike NRC, federal agents from Immigration and Naturalization Services (INS) are not permanently stationed at DRC. Rather, INS is called to DRC on an as-needed basis to investigate an inmate’s immigration status when staff members suspect there may be an issue.
Staff review each inmate’s identification and personal data, including her emergency contacts, aliases, education level, social history, and occupation, and update this information in the Offender Tracking System, a computer database that tracks all adult offenders from the time of reception and classification through release on parole, and through their subsequent discharge from parole or return to state custody. Inmates are classified by security level (minimum, medium, maximum) and escape risk under a standardized scoring system that takes multiple factors into account, including the inmate’s age, offense and length of sentence, outstanding criminal or immigration warrants, escape history, and history of adjustment, social problems and disciplinary issues in and out of DOC. Finally, to determine where an inmate is ultimately sent, staff consider her security designation and escape risk, along with her individual medical, mental health, rehabilitative and substance abuse needs. Once an inmate is classified, she has the right to seek review and reconsideration of her security classification every six months thereafter.

Inmates are asked to self-report their level of education at the time of intake, but DRC does itself not test inmates to determine their educational aptitude. Rather, the Test of Adult Basic Education (TABE), which measures basic education skills, is administered to inmates once they are sent to their parent facility. Because inmates are only at DRC for a relatively short time, no educational programming is offered at DRC.

Inmates are further screened by DRC staff for medical, mental health, and substance abuse issues. As previously noted, medical records and medications rarely accompany inmates from the county jails. Thus, DRC staff must rely on inmates to accurately and reliably self-report their medical conditions and medications. Inmates are not given pregnancy tests at DRC unless they self-report that they might be pregnant. DRC screens all inmates for tuberculosis at the time of intake. In addition, new DOC employees are tested for tuberculosis prior to starting work, and all DOC employees are annually retested for tuberculosis.

At the time of JHA’s visit to DRC, inmates were not being routinely screened for other infectious diseases, like Hepatitis C and HIV. Rather, these tests were ordered on an “as needed” basis, depending upon the inmate’s self-reported medical history and answers to a standardized medical questionnaire. As previously noted, however, DOC is currently in the process of instituting an expanded testing regime that will provide opt-out HIV testing to inmates at DRC and at all reception and classification centers at the time of intake. JHA fully supports DOC’s efforts on this front, and believes that increased testing for infectious diseases, including HIV and Hepatitis C, should be provided to inmates both at the time of intake and prior to their release.

As part of DRC’s screening and classification process, a staff member from Treatment Alternatives for Safe Communities (TASC) also questions each inmate regarding her drug and alcohol history and usage to determine whether substance abuse treatment should be recommended. Mental health staff additionally screens inmates for psychiatric issues at the time of intake. For that purpose, DRC staff ask inmates a series of standardized questions, including: have you ever been treated for mental health or
emotional issues; have you ever been sexually assaulted or abused; do you feel depressed; do you currently feel really stressed out and agitated or “on edge;” have you ever attempted to harm yourself; and are you currently taking or prescribed any medication for mental health or emotional issues. Inmates who indicate that they have been victims of domestic violence or physical or sexual abuse are asked whether they would like to participate in therapy, if available. Inmates are also asked whether they have ever been sexually assaulted or pressured to do sexual favors in a prison or jail setting.

JHA was heartened to see that the medical and mental health screening of female offenders places special emphasis on identifying those who have been victims of domestic violence and emotional, physical and sexual abuse, given statistics showing that the vast majority of this population has suffered such prior abuse and is in need of trauma-based treatment. However, understaffing of mental health professionals and limited resources in DOC parent facilities nevertheless mean that many female offenders who could benefit from psychological treatment to address past traumas cannot access adequate services.

As previously noted, inmates’ medical and mental health records and medications are also rarely transferred to DRC from the county jails. Thus, DRC staff must rely on inmates to accurately and reliably self-report their own physical and psychiatric conditions and medications. Staff indicated that inmates’ family members sometimes help out by contacting DRC and giving them a “heads up” that an inmate is taking medication or has a particular psychiatric or medical issue. In most cases, however, staff must depend on inmates’ memories and self-reports, which are often unreliable.

If an inmate is in mental health crisis and a psychiatrist is on DRC’s premises at the time, the inmate will be evaluated by the psychiatrist that day. If a psychiatrist is not immediately available (an occurrence that is not uncommon, given understaffing) the medical director may evaluate and provide the inmate with medication to “bridge the gap” until the inmate can be evaluated by a psychiatrist. After an inmate’s initial consultation with a psychiatrist, she is generally seen by a psychiatrist every 30 days. In non-emergent situations, it takes between one and three weeks for a DRC inmate to be evaluated by a psychiatrist. Inmates who are taking medications must wait several weeks to be re-evaluated and receive medications.

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23 Because DRC and Dwight share staff, the issue of staffing levels is separately addressed in JHA’s Monitoring Report of Dwight Correctional Center, available at http://www.thejha.org/dwight.
Again, JHA finds the lack of continuity of care in medical and mental health treatment and medication presents an unacceptable risk to inmates’ health and welfare. In particular, the need for adequate mental health staffing and ready access to psychiatric care is even greater at intake because this is a highly stressful period for most inmates. The isolation, lack of activity, shock of new rules and regulations, and loss of personal autonomy in the reception and classification can feel profoundly dehumanizing, alienating, and frightening for inmates. Unsurprisingly given the high levels of stress during this period, studies show that the risk of inmate suicide is heightened during the first 30 days following intake, particularly for inmates with mental disorders or a history of prior suicide attempts.24

Standard 23-6.4 of the American Bar Association’s Standards on the Treatment of Prisoners provides that: “each correctional agency should employ or contract with 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.”25

In accordance with ABA standards, JHA believes that measures should be undertaken to: (1) increase the level of mental health staffing at DRC to ensure that inmates have continuity of care and ready access to psychiatric treatment and medication; and (2) increase cooperation and coordination between county jails, other state medical and mental health providers to ensure that inmates’ medical and mental health records and medications accompany them to reception and classification centers.

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This report was written by Maya Szilak, Director of the Prison Monitoring Project, for the John Howard Association. Maya may be reached at (312) 503-6302 or mszilak@thejha.org.

Contributing to this report were Aviva Futorian, John Howard Association Board President, Alexander Brown, John Howard Association Board Member, and citizen observers: Laurie Joe Reynolds, Juanita Ortiz, Scott Main, Stephanie Tang, and Courtney Widuch.

Since 1901, JHA has provided public oversight of Illinois’ juvenile and adult correctional facilities. Every year, JHA staff and trained volunteers inspect prisons, jails and detention centers throughout the state. Based on these inspections, JHA regularly issues reports that are instrumental in improving prison conditions.

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