COUNTY BOARD AGENDA - STUDY SESSION
RE: Jail Issues

County of Champaign, Urbana, Illinois
Tuesday, January 31, 2012 – 6:00 p.m.

Lyle Shields Meeting Room, Brookens Administrative Center
1776 East Washington Street, Urbana, Illinois

Page Number

I. Call To Order

II. Roll Call

III. Approval of Agenda

IV. Public Participation

V. Structural Analysis of Downtown Correctional Center

a. Report provided by John Frauenhoffer 1-2
b. Q&A with John Frauenhoffer

VI. Facilities Overview – Pre-Built Expandability of Satellite Jail 3

VII. Sheriff's Report – Operational Issues & Trend Analysis Regarding Future Needs 4-22

VIII. Next Steps for County Board

a. Project Recognition: Decision to Replace Beds at Downtown Correctional Center through Expansion of Satellite Jail *(Straw Vote)*
b. Establish Jail Planning Project Team
c. Issue RFP to Hire Consultant Team to Conduct Needs assessment & Pre-Design Planning

IX. Adjournment

FRAUENHOFFER AND ASSOCIATES
A Division of Engineering Resource Associates, Inc.
Consulting Engineers, Scientists & Surveyors

October 2011

Structural Evaluation for Remodeling Considerations Champaign County Downtown Correctional Center Urbana

Purpose

The purpose of this investigation is to answer two questions:

1. Can the lower level of the facility be gutted to allow for a full remodel?

2. Is vertical expansion of the existing building structurally feasible?

Summary

1. **The partition walls in the lower level can be demolished.**

2. **The existing building was not designed for vertical expansion.** However, it is structurally feasible to construct an independent steel frame bearing upon spread footings cast inside and outside of the facility to support new floors. There is an extra cost burden for an independent structural frame.

Evaluation

The downtown Correctional Center is a two–story structure. The lower level was cast slab-on-grade. Below the floor slab are primarily rectangular and square footings supporting steel columns. The upper level is supported by steel beams and girders, spanning between the steel columns. The roof is supported by steel beams and girders of much lighter construction reflecting the lower load requirements for roofs as compared to correctional center floors. **The interior masonry walls do not support the first floor or the roof and can be demolished, except in the jail cells in the northeast and northwest corners of the facility.** Removal of the jail cells in these two corners will require the shoring of the floor slab and the jail cell walls above. Hence, an operationally efficient floor plan allowing supervision of a greater number of inmates from a single station can be achieved.

The downtown Correctional Center was not designed for vertical expansion. However, vertical expansion is feasible with the construction of an independent steel frame designed to support new floors and a new roof. Independent footings would be constructed to accept the new columns. Locations of the new foundations and columns would be determined based upon a new lower level floor plan and based upon avoiding the existing footings.

At the County's option, new columns can be constructed inside or outside of the existing perimeter foundation walls. Interior construction of new columns and footings conceals the structure and is more costly. Exterior construction is less expensive and frees the new design of the constraints of the lower level perimeter plan, allowing additional floor space per floor. Four girder lines could be constructed at Column Lines A.6, C, D.3, and F. A fifth column line would be constructed north of the north exterior wall. Interior girder lines would consist of double W40's and beams spanning between girders would consist of W24's.

Any construction inside of the facility will impact inmate housing. Construction operations would require phasing, allowing for inmate transfer out of sections of the facility and then securement of those sections for construction operations. In concert with correctional center management, phasing will require vacating portions of the building, completing structural additions within those portions, and having the new floor plan construction ready for occupancy prior to the next phase proceeding.

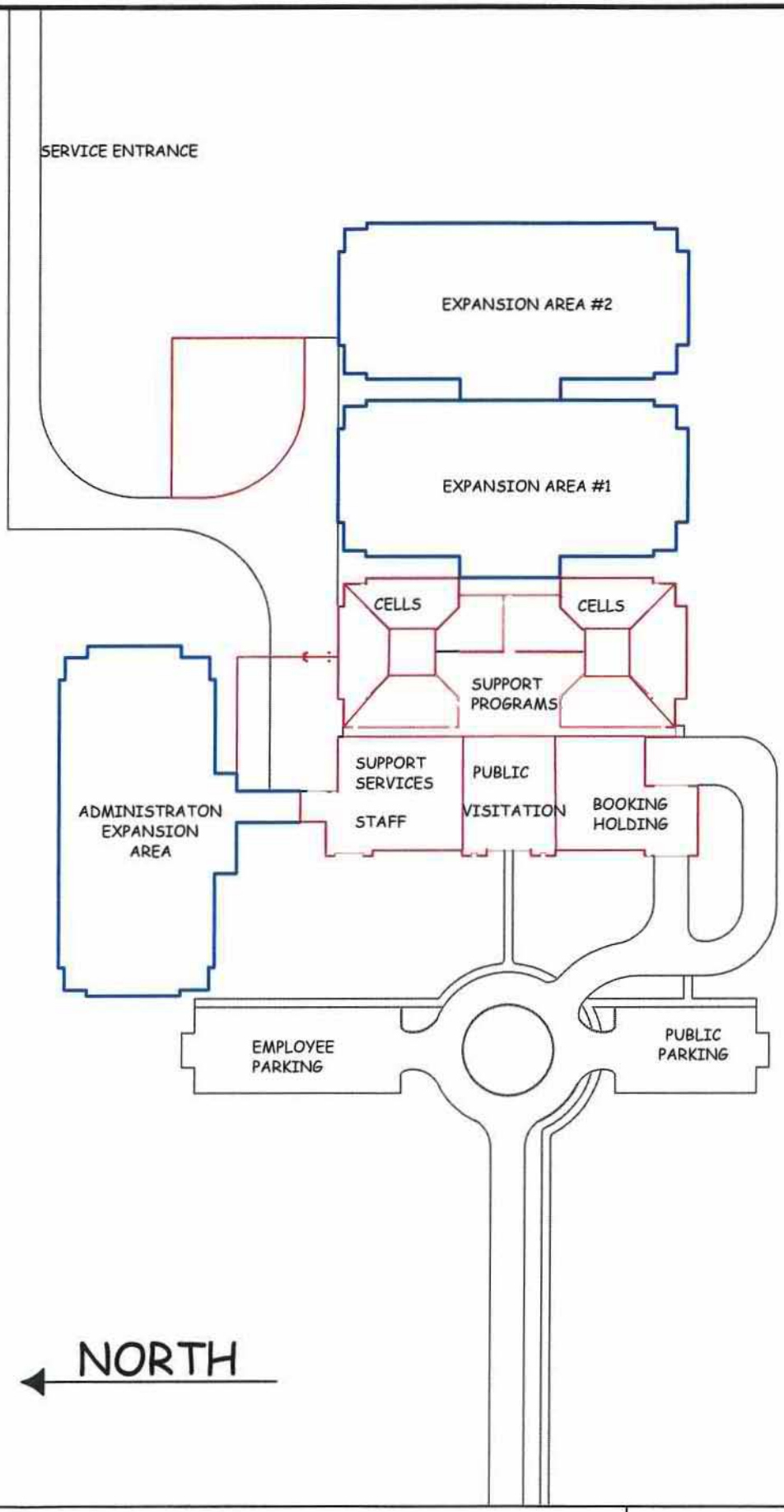
The exterior masonry walls are load-bearing, carrying floor and roof loads. The upper level jail cell floors are cast into the concrete block wythe of the exterior walls. The exterior walls are cavity walls with 2 inches of rigid board insulation in the cavity. The thermal resistance of the cavity wall will vary depending upon the insulation manufacturer. The thermal resistance of the insulation is likely approximately R-10. Unless upgraded during a roof replacement, the roof insulation is likely approximately R-15. A modern remodel would include increased thermal resistance in the walls and the roof.

Future expansion for the facility was considered by the Architect. Two locations are shown on the plans, including jail cell expansion to the north and office expansion to the southeast. The space to the north is currently fenced as a secure outside refuge area in case of fire.

Further, there are additional opportunities for expansion of the building to the east. The independent steel frame designed to carry additional floors above the existing facility can be extended east, allowing for covered parking. Expansion to the east would allow for the construction of a new mechanical plant on the east side of the facility, removing it from the center of the correctional facility, and allowing for direct construction and future maintenance access. The use of modern mechanical equipment will reduce energy costs.

Over the kitchen is a roof at the level of the first floor. Remodeling of the building would allow for this area to be usable correctional space. Reinforcement of the roof framing will be required.

Exterior yard walls and retaining walls are in poor condition. Wind driven rain intrusion and freeze-thaw damage are deteriorating the walls. Any yard or retaining walls remaining as exterior walls require masonry rehabilitation and re-flashing.



ADULT DETENTION FACILITY
502 S. LIERMAN AVENUE
URBANA, ILLINOIS

Not to Scale

DATE: 1-13-12

A-1

SHERIFF DAN WALSH
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Dear Board Member:

This is my report to you concerning the downtown jail and remodeling/expansion of the satellite jail. Many of the facts contained herein you have already heard from me or others. I have tried to be concise and yet be sure you have the facts you need to make a decision at this point.

I have spent some effort to explain our inmate medical and mental health situation because it is becoming a bigger problem every year and I think it is important that you and the public know this. Deb Busey invited me to speak to the "Justice & Social Services Committee" on March 13, I accepted primarily to tell you about these same problems (we can probably cancel that meeting).

I have tried to cover many of the areas of interest that you and public might have, but I am sure there may be many other questions you might have that I or one of my staff or the medical/mental health professional present may be able to answer.

I am likewise sure there will be questions now and that will come up during any "exploratory process" that cannot be answered without further "research."

As you consider these matters, please keep in mind that building jail space is much different than most County and commercial construction projects. Most sheriffs have never built a jail and most architects have never designed one. As we proceed we will need the services of jail planners and jail architects who have considerable experience in matters such as ours. We will also use the resources of the Department of Justice National Institute of Corrections (NIC) as much as possible. We only get one chance to get it right and it is generally more economical to properly plan and design than it is to change things after initial contract for construction is bid.

My recommendations are at the end of the report.

Sincerely,

Dan Walsh
Sheriff

DJW:tss

What About the Downtown Jail?

The downtown jail was built in 1980 and has a maximum of 131 bed spaces (this includes 18 dormitory spaces that would only be used as an absolute last resort because of the difficulties of supervision and major humidity problem.) The satellite began operating in 1996 and now has 182 maximum bed spaces (This was after we had 30 additional beds added in 2003 when our population was exceeding the existing capacity). Since about 2003 or 2004 I have been telling you, the press and the public that it was "antiquated" and of an older design that makes it very difficult to efficiently monitor prisoners. You have received reports from Alan Reinhart describing the problems associated with the physical plant and the structure and the costs to repair and replace. A couple of years ago when you decided to replace the chiller—which was necessary to continue to occupy the building—I think I compared it to replacing a flat tire on a very old car (necessary to keep the car running, but doesn't really add to its mechanical life or value—only a short range bandage.)

The building still has considerable problems with providing uniform comfortable heat and air conditioning along with excess humidity and the associated paint, mold and other related problems. This adversely affects both your employees and inmates. I will not repeat our "critter" issues.

Many of your have toured the buildings and seen the videos. I could go on for pages, but what you saw in your tours and the video explains the stark contrast between the facilities much better than I can do in writing. The design of the satellite is much more conducive to the efficient and safer monitoring of the prisoners and it also does not have the instant depressing affect on staff and inmates as does the downtown facility.

Should the downtown facility be remodeled? I am not an architect or engineer, but I suspect with enough money you can certainly do almost anything in terms of construction. While at the National Institute of Corrections attending new jail construction issue classes with many subject matter experts, it was clear that the costs to remodel an existing jail structure almost always exceeds that of building new, especially when you do not have new land acquisition costs. A maximum security jail is not a stud and drywall building. This is a steel and concrete structure and remodeling will be a huge undertaking. I have met several times with Engineer Frauenhoffer and while he could not give me excess costs (remodeling downtown vs. adding on at the satellite) either in terms of price per square foot or percentages, he made it clear that he would not recommend that unless: there is a very good reason to keep the downtown facility in its present location. There is no such reason.

Should downtown be remodeled, we would have to board those prisoners (1/24/12: 53 inmates, includes 17 females) in other counties (assume about $60.00 per day each plus expenses) and then transport them to and from court, etc. - all at considerable expense, including overtime.

A consolidation of all jail functions at the satellite would offer some operational benefits, such as:

1. Laundry, food and other items would not have to be regularly (food 3 times per day) transported between facilities.

2. Medical and mental health facilities would be consolidated and the professionals would not have to travel between the jails.

3. The master control function (electronic control of each facility) could be consolidated. This may not totally free up a controller (normally a civilian, but sometimes staffed by an officer) but would give more flexibility and may substantially free up a person on the night shift.

4. All officers would be at one site which would be beneficial for training, supervision of personnel, efficiency of briefings, and provide additional officers in the event of a critical incident.

Proximity Issues (downtown and courthouse)

We do not walk prisoners across Main Street to the courthouse. All prisoners are transported by vehicle and taken into the secure sally port and ultimately into the holding cells and secure hallways in the courthouse. My clerical staff does make several trips back and forth to the courthouse during the business day to pick up hard copy and sometimes original documents which are required for various activities. Things are changing and I believe the time is near when electronic copies will suffice for many of the computer and recordation entries we have to make in various law enforcement data systems.

I and some members of command would be inconvenienced by a move of the office functions away from downtown because there are frequent meetings at the courthouse. This is a very minor inconvenience and not really worth any further consideration.

The only real drawback to a move would be in the event of a major "critical event" at the courthouse. Presently there are usually some CCSO command staff and frequently investigators and deputies at the office who can usually respond across the street in a minute or two. This response time would obviously be longer if office operations were moved to the satellite site. However there is a well trained, on-site Court Security unit that can solve or at least contain almost any crisis.

Office Functions

I am told that to keep office type operations in the downtown facility that the entire building would need to be maintained and HVAC systems would need to be operated, maintained and repaired/replaced as necessary. This would seem to be very expensive in

terms of ongoing expenditures including routine utilities with minimal benefit for the office. Relative to building jail capacity, constructing office space will be less expensive.

Consolidating the office and only jail will enhance CCSO command staff's ability to observe and manage jail functions and, I think, it will improve the contact and communication between the Corrections Division and the Law Enforcement Division. It will, during business hours, provide additional available personnel who would be on site in the event of critical incident in the jail.

The present office has some significant functional drawbacks:

1. There is a huge lack of properly secure and ventilated evidence storage space. We presently have evidence secured in multiple locations, some with an entry that is only 3 feet tall. Some areas have almost no ventilation (very bad for preserving damp marijuana or blood soaked items and not good for the health of our staff.)

2. We have insufficient conference room and meeting room space. Sometimes meetings with witnesses, victims, etc. have to be held in rooms that are also used for employee lunches and/or storage.

3. We have no training room.

4. We do have some exercise equipment, but it is seldom used as it had to be moved back into the mechanical room areas of the jail.

5. Some of the employee areas of the downtown facility are just as depressing as the jail areas and need major cosmetic repair work. (broken, missing tiles, mold, deteriorating walls, mal-functioning devices).

As we have begun these jail discussions, one of the frequent questions I am asked is: how much additional jail capacity will we need in the next 10, 15 or 20 years. While there are consultants you can hire to make predictions based upon historical data, I can tell you that these mid to long rage predictions as simply educated guesses which do incorporate historical data.

There are several factors that have a large impact on jail (and prison) populations and they are well beyond the control of the Sheriff. Some of the main ones are as follows.

<u>Legislative changes to Laws</u>

Passing more laws with criminal sanctions, increasing existing criminal penalties, imposing or increasing mandatory minimum jail (prison) sentences, and limiting the use of alternative [to jail] sentences can all have a huge affect on jail populations. No one can accurately predict what the legislature will do in years to come. While one could

logically argue that the current lack of tax revenue might reduce the legislature's tendency to impose more jail or prison sanctions, some politicians still have a get tough on crime, or certain crimes, as part of their political agenda (in making this statement I intend to express no opinion as to any particular law or penalty.)

California, which is in a budget crunch much like our state, has changed some laws to require that county jails hold more prisoners that were previously sent to the state prison system.

Judicial Action

In 2011 the second district appellate court in People v. Horsman (406 Ill.App.3d.984) decided that a judge or sheriff could not use Electronic Home Detention (EHD) for mandatory minimum jail sentences. Many traffic offenses carry such mandatory minimum sentences which keep increasing as one commits further similar offenses. While this decision does not seem to be universally followed, it has reduced our EHD population from about 40-50 to about 20 or thereabouts. In other words this action quickly added about 20-25 in house inmates.

Senator Frerichs recently called me and he will be introducing legislation that, if passed and signed into law will again allow Sheriffs to use EHD in most situations.

Efficiency of the system and the priorities/concerns of the key decision makers in the Champaign County criminal justice system

These factors have a large impact on our jail population. When I first took office in 2002 our prisoner numbers were then approaching and exceeding our capacity. At that time the States Attorney in office felt that it was his job to put people in jail and he had no concern over CCSO's limited resources or bed space. In general he felt that it was the County Board's responsibility to provide the Sheriff with sufficient resources, despite the County's then-deteriorating revenues, to house whatever number of prisoners the system generated. The then-presiding judge gave us some assistance, but it was not a high priority. Prisoners sat for long periods of time awaiting resolution of their cases, bonds were often set high even on non-violent crimes and resources were never a sentencing concern.

After this, some of the decision makers changed, Judge Difanis became the presiding judge and States Attorney Rietz was elected. Judge Difanis was very concerned about our limited resources and even asked that a copy of our jail population counts be sent directly to him every morning. States Attorney Rietz was also concerned with the County's financial condition and its inability to increase resources devoted to the Sheriff. Public Defender Rosenbaum and Court Services Director Joe Gordon also became involved in the process and in numerous meetings to discuss how to partially solve the resource/jail population issues. All these key players worked hard with the Sheriff's Office to reduce the jail population. Case backlog was substantially reduced, cases were ordered to move more expeditiously thru the system, judges were encouraged to consider

jail resources when setting bonds and sentences, assistant PD's and SA's were directed by their bosses to move cases and both the judges and the states attorneys now regularly work with the Sheriff to quickly resolve cases (when they can—sometimes this is not possible) where there are severe medical and/or mental health issues which cause a huge drain on the Sheriff's Office resources (both personnel and money.)

Should the key players or their concern for County/Sheriff resources change, there could be a large increase in our jail population. This change could easily develop within one to two months of simple inattention to the necessity of quickly resolving cases.

Society's and the Community's attitude towards criminal activity

I believe that society, and especially the local community (including family and peers) can have an impact on criminal activity and therefore jail population. Having said that, the only concrete thing I can point to is the reduction in DUI behavior and resulting injuries over the last 10-15 years. This, of course leads to less jail sentences for DUI. Anecdotally I would suggest that our local community is becoming more violent with more shootings and armed robberies. This will ultimately result in more prison sentences, but that means more time spent in the local jail awaiting case resolution--- more severe cases take longer to be resolved for a variety of reasons.

General population trends in Champaign County

In the last ten years census statistics show the County's population has increased by about 12%. Over the last 50 years it has increased by 53%. I think it reasonable to assume that trend will continue and therefore one might expect an increase in jail population to mirror the general population trends, even if all other factors remain constant. Using this factor alone, I would assume that if we are planning for 15years into the future, we should increase capacity by at least 15% that would be 46 beds. If you are only looking at 10 years, then we are talking about 31 beds.

Census stats for Champaign County: 2010----------201,081
2000----------179,669
1960----------132,436

Jail Statistics

Please see Lt. Robert Cravens, who many of you met in the tours, narrative and statistics from 1994 to present (Exhibits E & F). Note the large increases in medical and mental health watches in the last year alone. I am happy to report that our (CCSO's only) serious crime statistics have remained relatively flat the last 3 years.

In the News:

January 19, 2012 - Governor Quinn's Active Care Transition Plan – Rebalancing Plan: In reading the Governor's press release it seems to concentrate on closing larger mental health institutions (Tinley Park and Jacksonville) and placing the residents who have mental health or developmental disabilities into community based programs. This process is designed to provide residents a better quality of care at lesser cost to the state. I do not believe this will have any noticeable affect on our jail. It does not increase treatment bed space; it does not at all deal with our residents who are found unfit and awaiting bed space in DHS. I hope I am wrong, but it may result in more work for local police and sheriffs as these folks walk away from local facilities and interact with the public.

January 20-21, 2012 - Press info released concerning non-violent offenders and drug treatment. WCIA TV – January 25, 2012, 10:00 p.m. news – Reporter Steve Staeger: Since Meritorious Good Time (MGT) was abolished in December 2009 there have been discussions about reinstating some form of it. If some type of early release program (such as MGT) is reinstated it will reduce Illinois DOC populations, but because of the recidivism factor it may somewhat increase county jail populations.

Separately Representative Reboletti has been discussing a bill to use ankle bracelets and halfway houses for first or second time substance abuses that have been sentenced to DOC. These discussions have, in part, been initiated because of Illinois prison population and Illinois' lack of resources.

Champaign County Judges, States Attorney and Public Defender have frequently used probation and similar rehabilitation programs for such drug offenders (note CCSO uses EHD and separately participates with Drug Court Supervision – ¼ FTE Deputy).

While Judge Ford's "Drug Court" is a great program with success, overall with these programs there is a significant failure and recidivism rate.

If the State program for these does not change the underlying criminality but only deals with initial sentencing options, it may initially reduce Illinois DOC population, but it will at least temporarily increase county jail populations because some of these people in local treatment facilities will "walk away" and commit crimes and if serious, new county charges may be filed as opposed to simply sending them back to DOC.

Can we rent excess new capacity to the Fed's?

Probably. The U.S Marshal's Service (USMS) which holds pre-trial federal prisoners and contracts with 3 local counties (Ford, DeWitt and Macon) to hold between 50 and 120 prisoners. The Bureau of Prisoners, which contracts with a half-way house in Champaign often "piggybacks" off the USMS contracts to temporarily house sentenced prisoners who violate half-way house rules and laws. The USMS pays generally between $55-$65 per prisoner per day (the price, in large part, is based upon our costs) and reimburses for some additional costs (transport, medical and hospital bills, hospital

officers, etc.). There is an application and inspection process, but if entered into, the contract can be somewhat flexible (i.e. if we need the space in several years).

I have talked with the USMS and they are interested in pursuing discussions if we have excess capacity (for awhile) as we offer the best proximity to the US District Court (Urbana) and a quality medical program that they desire.

What do we need in a partial new facility? (Medical and mental health issues are growing)

If the Board indicates a willingness to proceed then key members of the Sheriff's jail operations (command, mental health and medical providers) will need to meet with experienced jail planners and architects.

Our present buildings have significant limitations on where we can house the people with the most needs. Those with significant and acute mental health and medical problems must be housed in the book-in area as there is no other space that allows separation from all others, regular repeated monitoring and attention, special bed arrangements, and at least some electrical outlet access. Inmates with these problems often need at least two of these conditions and some need all four. We should consider building separate housing units for people with these problems. I would like to consider cells that have a lot more visibility (glass?) and also easier access for both medical and mental health providers and some of the medical equipment that is becoming more and more necessary as our inmates have increased medical and mental health needs. Over the years I have been in office, our jail, like most others in the country, has experienced a huge increase in the numbers of prisoners with severe medical problems and mental health issues. It is very common for us to have multiple prisoners who exhibit active suicidal thoughts or behaviors, and sometimes another one who throws or even eats his own fecal material. It is almost rare that we do not have several inmates waiting weeks and weeks for placement in DHS because of their mental issues. Sometimes we have difficulty finding room for the next jail intakes because the book-in area is so full of the above described inmates.

Please see the attached narratives from our head nurse, Susan Swain RN (Exhibit A) and Harmony Goorley, our Mental Health Director (Exhibit B). I have asked them to prepare a brief summary of their issues of January 23, 2012, a fairly typical day (mental health - Exhibit C) (medical – Exhibit D).

Our problems with prisoners' medical and mental health issues have been growing each year. Last year we spent $566,000 on inmate medical and mental health care.

We should also consider adding negative pressure cells/isolation cells to deal with those who have airborne contagious diseases.

As part of any expansion at the satellite we will need to consider adding some dormitory like bed space or other less secure housing as opposed to maximum security housing. This is often cheaper to build and could offer well behaved inmates who are not security

risks some more amenities. This option could, in turn, offer incentives for inmates not to misbehave.

A remodeled facility would allow more options. Presently we have to keep the bulk of the female population at the downtown facility. An expanded satellite for female housing, including those with special needs and would likely allow more program opportunities for female inmates.

Jail facts to keep in mind as you consider the issues

Unlike many states, Illinois has minimum jail standards that we must follow and these sometimes get into some detail such as number of calories or temperature of water. (No we cannot house prisoners like they do in Arizona.)

Males and females must have housing units that are separated by sight and sound.

Illinois standards as well as Federal statutory and case law require that we provide a certain standard of both medical and mental health care to our inmates.

Just because you have an open bed does not mean it can be used. For a variety of of reasons inmates must be separated, sometimes segregated and classified. Issues include (i.e. separation may be required, from all or just from some other inmates):

Sex
Sentenced or awaiting trial
Nature /seriousness of the crime
Danger to others
Danger to self
General behavior
Gang or group affiliations
Medical conditions
Mental Health Issues
Overt or potential threat from other inmates
Developmental issues
Age/ youthful appearance or demeanor
Separation of co-defendants/co-conspirators
Gender related issues, besides simple original anatomy

In general, because of these separation requirements, a jail that is at about 80% of usable bed capacity is a FULL jail.

Recommendations

I do recommend we engage a qualified and well experienced jail planner (and possibly architect) to begin an intelligent and informed decision making process, with the goal of

closing the downtown facility and moving both the inmate and all Sheriff's Office functions to the satellite.

Now comes the part I have stressed over the most – it's like predicting the next number on the roulette wheel. While some will not criticize me for suggesting we build too big and years down the road others will criticize me for suggesting too small (for future needs), I do suggest we considered adding about 40 or so beds (depending upon design). I believe this would probably be sufficient for somewhere between 5-10 years, if the County maintains its current Criminal Justice system attitudes and efficiency.

I realize that the County does not have unlimited resources, but I would hope we approach this project with the goal of having it properly fulfill our needs for at least a few years and not be at lower capacity or know it will have functional/structural problems (recall Board member Moser's discussion about the cost cutting measures as downtown was designed and built).

If we build on at the satellite, whether it only replicates downtown capacity or add beds, we will need to add (some are obvious):

Inmate housing – including specialized needs to include provisions for medical and mental health care

Inmate recreation – multi-purpose rooms, library, employee storage and break areas

Additional maintenance tool, equipment and storage – preferably outside of the secure area

Visitation area

Master Control – redesign and/or additional control area

Parking for correctional staff, visitors, other CCSO staff including patrol vehicles

Office and related space including secure and "moist" evidence storage

Laundry and related storage – probably need to add equipment and some dry storage (this is a close question)

Kitchen – operation and storage areas are likely sufficient even to add 40. Equipment is wearing out – its 15 yrs old so it will need to be replaced in any event. "Small goods" will need to be increased some if we add capacity.

Inmate Commissary Storage – likely sufficient even if we add 40

Inmate Personal Property Storage – likely sufficient even if we add 40, but may need redesigned.

While I have been told the satellite facility was designed so that inmate housing pods could be added, I have no idea as to the difficulty of modifying existing components (electrical, plumbing, HVAC, cameras, controls, etc.) to efficiently accommodate additional inmate and office demand.

Once decisions are made, if we anticipate excess capacity for a period of time, I would engage in preliminary, and later more detailed, discussions with the USMS for a contract to house federal prisoners to help the County defray costs (and this would be of some benefit both to the federal government and local federal inmates and their families).

What about the downtown real estate if we move all operations to the satellite? Good question – obviously if the economy was good and it was just a vacant lot, it would be very valuable. Unfortunately neither of those conditions exists. Engineers and real estate experts need to be consulted, but I do believe the structure likely needs to be demolished as I suspect it would ultimately cost a lot more just to maintain its water tight integrity.

I am very certain (and have been for years) when I tell you that the downtown facility is inadequate for both inmate and office needs.

I am also confident when I suggest that it will be more economical to build and result in more efficient operations in the long run to build-out at the satellite and not remodel the downtown.

I am far from confident in making predictions as to long term future jail needs for many of the reasons already stated. I do believe that the current make up and attitude of the principals in the Champaign County Criminal Justice system has significantly reduced our jail population. I know many other counties do not have such concerted efforts to make the entire system efficient. At the risk of being repetitive, a change in this attitude could quickly add more than 40 prisoners to our population.

If we truly want to be sure we have capacity for 10 or 15 years down the road, then we should certainly consider much more than 40 additional beds.

I look forward to our discussions on Tuesday evening.

Respectfully Submitted,

Dan Walsh

Sheriff Dan Walsh

Atch: Exhibits A-F

1/26/2012

Over the past five years, the acuity of our medical patients has escalated significantly. We are housing patients with more severe disabilities as well as more debilitating illnesses. We have cared for patients with all types of Cancer, Heart Disease, Autoimmune Diseases, Diabetes, COPD, and Hypertension. The number of patients with HIV has grown more rapidly than any other aliment and the diseases and conditions that accompany HIV have grown at the same accelerated rate. We have cared for patients with pacemakers and defibrillators. Several of our patients have suffered strokes and have impaired gaits and speech. We have patients that are on Oxygen twenty four hours a day and wear C-Paps. Many of our patients have Co Morbidities in that they have several of these conditions that they are battling. We have had several gunshot wound patients that have been released from the hospital that would have normally been taken to a Skilled Nursing Care facility to have extensive dressing changes and therapy that come to us instead. Our patients include Para and Quadriplegics, who are new amputees that require wheelchairs, difficult and detailed dressing changes, and are incontinent of bowel and bladder. At one time, approximately a month ago, we had three cells in booking occupied with hospital beds for patients that required that them. We recently had to purchase 2 Oxygen concentrators for patient's that live on Oxygen full time. We have housed patients that are dying.

The sheer number of medical patients, of all types had risen in the past five years. The poor economy and the lack of medical resources throughout our community have caused people to go without healthcare which in turn, causes their conditions to deteriorate. Some have indicated to us that they break the law in order to come to jail to obtain the healthcare that they are unable to receive at home. Some do not have homes and have been banned from shelters and local hospitals. The average of our patients has risen and we are housing patients that are in their 70's and 80's.

All of these patients I have described would be considered vulnerable in some form or other. Some are elderly, some immune suppressed, some have wounds that are at risk for infection, and some are malnourished and have addictions to alcohol and illegal substances. Many of our patients have to be housed alone in booking to accommodate their hospital beds, walkers, Oxygen concentrators, and wheelchairs. These patients often times become depressed form the isolation if they do not already suffer from other psychiatric issues. Due to the increase in numbers and the acuity of our patients, and considering the medical supplies and apparatuses that they require, additional housing to accommodate our medical/mental patients would certainly advantageous.

EXHIBIT A

I would also like to see a medical/mental health unit. The severely mentally ill offender may be particularly vulnerable to the exploitation of other inmates for a variety of reasons. At times we see developmental delayed individuals incarcerated. The severity of cognitive handicaps varies yet typically limits one's ability to protect himself in this environment. These inmates may present as eager to please and/or threat-sensitive, yielding them easy targets of exploitation (i.e. commissary, sexual contact, etc). These inmates may also present with reduced frustration tolerance leading to impulsive and unpredictable behavior requiring closer monitoring. Another group of serious mentally ill offenders that I see are those suffering from dementia. Similarly to the inmate with mental retardation, these inmates are more easily exploited. The normal age of an inmate is on the rise, adding medical complication to already fragile cognitive and emotional states.

The mentally ill population also consists of offenders with thought disorders. This type of inmate may present with extreme paranoia and misinterpret benign encounters with others as threatening leading to an increased likelihood for violence. A correctional environment may lead to a sense of paranoia even within the non-mentally ill offender yet can be so exacerbated with those struggling with psychosis leading to an increased suicide risk as well as homicide risk. This again requires closer observation to ensure safety.

We see a growing number of veterans incarcerated with symptoms of stress disorders. These inmates tend to present as hyper-vigilant and threat-sensitive as well. They tend to isolate and/or engage in interpersonal conflicts with others. A sense of constant anxiety and/or re-experiencing traumatic, violent memories may serve to increase one's homicide and/or suicide risk. They may benefit from closer monitoring and easier access to mental health staff to engage in frequent stress management activities.

The seriously mentally ill offender tends to be easily manipulated by others. They may be coaxed into giving their meds to non-mentally ill offenders as these individuals enjoy the sedative effects of most psychiatric meds. On the other hand, the stigma of taking "crazy" meds may lead one to refuse meds that keep him stable enough to be housed with others. When mentally ill offenders refuse meds, they are more likely to require individual housing. Long-term segregated housing increases one's suicide risk.

A medical/mental health unit may provide a greater sense of safety within this population. When a mentally ill individual's sense of safety is compromised, depressive, psychotic, and anxiety-related symptoms tend to become exacerbated. This type of unit would foster rehabilitation and treatment of symptoms, hopefully reducing one's likelihood to recidivate once they are released from our custody.

EXHIBIT B

Most Acute Mental Health Inmates from Monday, Jan. 23, 2012
(Requiring closer observation, frequent Mental Health assessments, medications, and/or special housing)

INMATE #

1. Diagnosed Bipolar D/O and acutely suicidal
2. Acute psychosis and acutely suicidal
3. Diagnosed PTSD and depressed
4. Anxiety Disorder, needs persistent monitoring
5. Acutely psychotic, must be housed alone
6. Acutely homicidal and suicidal
7. Diagnosed Schizoaffective Disorder, acutely psychotic with self-harming tendencies, must be housed alone, awaiting transfer to Dept. of Human Services (DHS)
8. On Suicide watch, Diagnosed Schizophrenia
9. Needs persistent monitoring due to self-harm while in custody
10. Delusional and paranoid, DHS Remand
11. History of command hallucinations telling him to kill himself
12. Dementia symptoms
13. Anxiety symptoms with debilitating threat-sensitivity
14. Delusional and paranoid
15. History of psychosis, DHS Remand
16. Depressed and threat-sensitive
17. Delusional with hallucinations
18. Diagnosed Bipolar Disorder and acutely depressed
19. Depressed with recent suicidal thoughts
20. Diagnosed PTSD
21. Manic
22. Depressed
23. Hears voices
24. Depressed

EXHIBIT C-1

25. History of psychosis, DHS Remand
26. Diagnosed Anxiety and Depression
27. Diagnosed Bipolar Disorder
28. History of psychotic symptoms with recent suicide attempt
29. Diagnosed PTSD
30. Poor adjustment to jail leading to symptoms of anxiety
31. Diagnosed PTSD with current symptoms of depression
32. Delusional, debilitating paranoia with hallucinations, awaiting DHS transfer
33. Diagnosed Schizophrenia, pending DHS transfer
34. History of depression and ADHD
35. Diagnosed Anxiety Disorder
36. History of severe and aggressive mood swings, DHS Remand
37. Diagnosed Bipolar Disorder and Schizophrenia
38. Diagnosed Anxiety Disorder
39. History of hallucinations and depression
40. Diagnosed Anxiety Disorder and Depression
41. Diagnosed Adjustment Disorder with depressed mood
42. Grieving death of relative in past week
43. Diagnosed Bipolar Disorder
44. History of depressive symptoms
45. Diagnosed ADHD with severe behavioral problems
46. History of depression with suicide attempts
47. Depressive symptoms (due to chronic illness)
48. Diagnosed Bipolar Disorder with hallucinations
49. Diagnosed ADHD with 3 suicide attempts while in prison
50. Diagnosed Bipolar Disorder
51. Step-down from Suicide Watch
52. Hears voices
53. Acutely Psychotic

EXHIBIT C-2

Most Acute Medical Patients that require daily medication, close monitoring, and special Housing. Most of these patients require multiple medications, multiple times daily. The Diabetic patients require twice daily blood sugar checks, as well as, twice daily insulin administration and a special diet.

Patient 1) Drinks Alcohol daily and experiences W/D
Patient 2) High Blood Pressure, Dementia.
Patient 3) Is Elderly has High Blood Pressure, Heart Disease, and High Cholesterol
Patient 4) Drinks Alcohol daily and experiences W/D.
Patient 5) Diagnosed with Hernia and has chronic pain associated with the Hernia
Patient 6) Diagnosed with both Diabetes and Arthritis.
Patient 7) History of 2 Heart Attacks, 2 Strokes, has 2 stents in his heart and a implanted Defibrillator. Patient takes blood thinners and his blood needs to be checked weekly.
Patient 8) Has had major jaw reconstruction from a gunshot wound. Has chronic pain associated with the reconstruction.
Patient 9) Diagnosed with severe seizures and been hospitalized several days for the Seizures.
Patient 10) Has had kidney removed as a result of a Gun Shot Wound. Patient came to us drains still implanted from the surgery to remove his kidney.
Patient 11) Diagnosed with Diabetes, High Blood Pressure, and Heart Disease. Patient Has drug addiction and suffers from W/D.
Patient 12) Patient has debilitating Arthritis.
Patient 13) Has chronic back pain associated with a motor vehicle accident.
Patient 14) Diagnosed with Diabetes and is Elderly.
Patient 15) Is Elderly and has chronic pain associated with degenerative disc disease.
Patient 16) Diagnosed with Seizures and High Blood Pressure.
Patient 17) Diagnosed Seizures and chronic back pain associated with a motor vehicle Accident.
Patient 18) Diagnosed Viral Infection.
Patient 19) Diagnosed Diabetes and High Blood Pressure. Prescribed a C-pap to wear at night in order to prevent his airway from collapsing. Diagnosed with Elevated Cholesterol.
Patient 20) Is a narcotic addict with chronic back pain and Gerd.
Patient 21) Diagnosed with High Blood Pressure.
Patient 22) Diagnosed with severe Seizures.
Patient 23) Diagnosed with severe COPD and is on Oxygen 3L all fulltime.
Patient 24) Has had knee surgery and wears a supportive brace at all times.
Patient 25) Has had two Heart Attacks.
Patient 26) Diagnosed with HIV.
Patient 27) Diagnosed with High Blood Pressure.
Patient 28) Diagnosed with High Blood Pressure and Diabetes.
Patient 29) Diagnosed with Gerd, impaired ability to swallow following a stabbing, and chronic pain associated with a motor vehicle accident.
Patient 30) Diagnosed with Congestive Heart Failure.

EXHIBIT D-1

Patient 31) Diagnosed with Diabetes.
Patient 32) Diagnosed with Diabetes.
Patient 33) Is a Heroin Addict and is experiencing W/D
Patient 34) Diagnosed with Peptic Ulcers.
Patient 35) Diagnosed with High Blood Pressure.
Patient 36) Diagnosed with High Blood Pressure.
Patient 37) Diagnosed with Seizures
Patient 38) Diagnosed with High Blood Pressure
Patient 39) Diagnosed with High Blood Pressure and High Cholesterol.
Patient 40) Diagnosed with High Blood Pressure.
Patient 41) Diagnosed with High Blood Pressure.

Sheriff, this is what our medical roster looked like this past Monday 1-23-2012. Upon reviewing it, I believe that this is a fair representation of a "typical" day, medically speaking, in regards to most of the conditions we assess and treat. However, I noticed that presently, we are housing only one patient with HIV. This does not represent the amount of patients with this condition that we normally house. During the final months of 2011, we had up to 5 patients with HIV that were administered medication up to twice daily with a cost of between $2000.00 and $3000.00 a month per each patient. These patients need close observation as they manifest multiple other health problems which can become life threatening quite quickly. We had one patient in 2011 that was admitted to the hospital for a potentially fatal HIV related infection.

EXHIBIT D-2

Champaign County Jail Population

Through various statistical reports and reports generated from the Jail Information System (JIS) I have been able to gather some population numbers as far back as 1994 which allows us to review the changes throughout the years. When you review the spreadsheet any areas left blank are a result of information that cannot be farmed off the JIS system that was in use at the time. I continue to work with the Information Technology (IT) staff to obtain this information.

The population over the past 18 years rises and falls with no real trends to see. Changes in population, policing strategies and changes in other areas of the judicial system have a large affect on our population and cannot be easily predicted.

Looking at the past decade we were at our lowest Average Daily Population (ADP) in 2011. Despite this and efforts to close down our downtown jail we still have to maintain 2 facilities in order to properly house and classify our inmates. Currently at the downtown jail we house our female inmates, a portion of our sentenced and high security males along with inmates that are on either mental health or medical watch. The 18 year study of the female population indicates that on average we have 27 women in custody. For this time period the average yearly population low was 18 in 2009 and the high was 57 in 2004.

Our largest population increase is amongst those on mental health and medical watches. Although I only have 3 years of data for both, the increase is considerable enough that we have been forced to change the classification of entire housing units in order to accommodate the special needs population. They also consume a majority of our booking cells which were designed for new intake and not mental health/medical housing.

Electronic Home Detention (EHD) – The EHD average daily population (ADP) decreased by 21% in 2011 while the number of inmates sentenced to the correctional center increased by 18%. The EHD population decreased from a high of 59 in January of 2010 to a low of 11 in January 2011. The high EHD ADP of 41 in 2010 would be equal to 2 or possibly 3 housing units if the inmates were housed within the correctional facility. This is due to gender separation and some that require special needs housing, furthermore stretching our housing resources in that area.

EXHIBIT E

YEAR	Yearly ADP	Male ADP	Female ADP	Downtown ADP(131)	Satellite ADP(182)	EHD ADP	SENTENCED ADP	Non-Sentenced ADP	Pre-Arraign ADP (booking)	Intakes per year	Average Days in Jail	Average Length Sentence	Average Sentence actual stay	MALE Average Sentence actual stay	FEMALE Average Sentence actual stay	Mental Health Watches	Medical Watches
1994	156.00	175.00	19.00							6534							
1995	158.00	177.00	19.00							7302							
1996	184.00	205.00	21.00							7912							
1997	238.00	215.00	22.00				65.00	167.00		8534							
1998	286.00	258.00	28.00				104.00	186.00		9101							
1999	291.00	258.00	34.00				117.00	185.00		8931							
2000	254.00	283.00	29.00				114.00	188.00		9472							
2001	293.00	259.00	35.00				79.00	179.00		9868							
2002	303.00	269.00	34.00				94.00	213.00		10141							
2003	288.00	256.00	32.00				76.00	213.00		10292							
2004	335.00	298.00	57.00				55.00	282.00		9627							
2005	259.70	230.00	29.70	101.48	158.23	38.27	46.74	207	13.78	8973	13.08	71	40	40	38		
2006	229.69	208.54	21.14	83.30	146.38	53.79	37.59	196.35	15.53	9016	12.11	66	40	41	36		
2007	256.96	230.91	26.05	98.16	158.80	39.31	56.10	198.21	16.08	9329	12.31	61	32	32	32		
2008	252.02	227.39	24.63	101.19	150.84	13.88	45.35	206.24	15.96	9288	11.66	71	31	32	30		
2009	244.96	226.67	18.29	87.50	157.46	23.64	44.02	201.64	14.92	8756	12.18	68	32	32	30	146	12
2010	225.75	206.43	19.31	45.04	180.71	41.29	40.57	184.10	13.24	7795	12.95	76	38	38	39	294	34
2011	223.58	202.67	20.90	40.41	183.17	32.90	49.30	175.12	12.86	7719	11.32	77	39	38	42	654	134
2012																	
Yearly Average	248.81	232.53	27.22	79.58	162.23	34.73	68.25	198.78	14.62	8810.56	12.23	70.00	36.00	36.14	35.29	364.67	60.00

EXHIBIT F