E-FILED
Thursday, 17 December, 2020 03:12:09 PM
Clerk, U.S. District Court, ILCD

IN THE UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF ILLINOIS
URBANA DIVISION

DANIEL LEE ROBINSON, Plaintiff, vs JEFF WOOD, in his individual capacity and in his official capacity as Edgar County Sheriff, JAY WILLAMAN, JESSE LEWSADER, EDGAR COUNTY, ILLINOIS, and CITY OF PARIS, ILLINOIS, a municipal corporation, Defendants.	)	Case No. 20-cv-2341 Honorable Colin S. Bruce Magistrate Jonathan E. Hawley

MEMORANDUM IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

I. Introduction

Daniel Lee Robinson (hereinafter "Plaintiff") is a pretrial detainee at the Edgar County Jail (hereinafter "ECJ"), awaiting trial on eight felony and one misdemeanor cases filed in the Circuit Court of Edgar County, Illinois. His most recent uninterrupted incarceration at ECJ began 7/15/20 and continues to date. ECJ has a long history of unabated violations of both state law and the constitutional standards which work to guarantee "the minimal civilized measures of life's necessities". *Farmer v. Brennan*, 511 U.S. 825, 834, 114 S.Ct. 1970 (1990).

In *Board v. Farnham*, 394 F.3d 469 (7th Cir. 2005), the Court discussed claims of inhumane conditions of confinement and deliberate indifference to serious medical conditions claims. Id. at 478.

In the years 2009 -2011, Richard D. Budd was confined in ECJ as a pretrial

detainee. He filed a pro se lawsuit. A copy of the *Budd v. Motley* Complaint, 11-cv-2227 is attached hereto and incorporated herein as Exhibit C. Budd attached news articles documenting the conditions at ECJ. *See* Exhibit C. The Appellate Court vacated, in part, the R.12 dismissal, stating Budd "has stated a valid claim challenging the conditions of his confinement." *Budd v. Motley*, 711 F.3d 840, 842 (7th Cir. 2013).

In 2019-2020, the local media documented the closure of ECJ and the Edgar County Board's reactions and intentions. Copies of news reports are attached hereto and incorporated herein as Exhibit D.

Plaintiff has spent approximately 6 years and seven months of the past 8 years in custody (ECJ, IDOC, Chester MHC), from 10/29/12 to the present, despite having no convictions that passed appellate muster. Plaintiff has a long history of serious mental health diagnoses, dating back at least to April 2013.

In addition, he has medical and dental conditions which have gone untreated.

II. Factual Background

A. Plaintiff's Incarceration and Diagnosed Mental Illnesses

Case No. 2012-CF-186. Plaintiff was arrested in October, 2012, charged with a felony and held in custody at ECJ with a bond of $20,000. Dr. Marks-Frey conducted a fitness evaluation and diagnosed Plaintiff with (1) bi-polar disorder (manic with psychotic features), (2) cyclothymic disorder, (3) intermittent explosive disorder, (4) psychotic disorder due to chronic substance abuse, (5) polysubstance dependence, and (6) antisocial personality disorder and concluded that he "suffers from multiple severe mental illnesses" and "there is very little likelihood that [defendant] will attain fitness within one year, regardless of treatment modality." *People v. Robinson,* 2015 IL App

(4th) 140147-U, ¶ 7, 2015 WL 5050176. Exhibit A is attached hereto and incorporated herein for descriptions of Plaintiff's various mental disorders. After two trials in 2012-CF-186, the appellate court reversed each of the convictions. *Id.; People v. Robinson*, 2019 IL App (4th) 170099-U, 2019 WL 1752572.

On 6/7/20, while in the custody of the Edgar County Sheriff, Plaintiff attempted suicide by cutting his arm and trying to hang himself in a noose and on 6/8/20, he requested, and was granted a furlough to seek mental health treatment at Regional Hospital in Terre Haute, IN, since he was not receiving mental health care or treatment in ECJ.

Plaintiff went to Regional Hospital, and was immediately hospitalized in the psychiatric ward from 6/8/20 to 6/12/20. He was diagnosed with major depressive disorder, recurrent severe psychotic symptoms, ADHD and amphetamine abuse disorder. *See* Exhibit A. He was prescribed Ritalin, Nicoderm patch, Cymbalta, Vistaril and Seroquel. Exhibit B is attached hereto and incorporated herein for descriptions of Plaintiff's various medications. He was indigent and remained unmedicated for a month. He did not return to the jail as ordered and was arrested on 7/15/20, and remains in the custody at ECJ.

Upon arrest on 7/15/20, Plaintiff was properly placed on suicide watch at ECJ, but was taken into court on 7/16/20, without having been evaluated or medicated by any medical/mental health professional. In court, he became irrational and angry; he verbally expressed his frustrations and kicked a free standing podium and was violently taken to the floor and shackled by two officers, Defendant Willaman and Defendant Lewsader, thereby incurring physical injuries to his back and his neck. While in the jail,

he was charged with additional felony charges.

B. Grievances

1. Medical/Medication Grievances

Plaintiff has never been taken to a doctor for the back and neck pain incurred on 7/16/20, despite requests and written grievances.

By 9/15/20, Plaintiff had not been taken to talk with his psychiatrist and was not getting the medications prescribed by physicians.

On 9/16/20, Plaintiff began bleeding from his penis and requested to be taken to a doctor. Beginning 10/1/20, Plaintiff filed grievances on this issue.

On 10/2/20, Plaintiff was taken for a visit with his tele-psych, who prescribed Straterra for control of ADHD. For a month, Defendants refused to pay for Plaintiff's ADHD medication. Without it, Plaintiff became suicidal, manic, paranoid, was unable to control his behavior and acted out at the jail, incurring new felony charges.

Twice, when Plaintiff hurt himself at the jail, he was taken to Horizon Health for examination of his arm and wrist, but when he tried to report his other medical problems (bleeding from penis and continuing back/neck pain) Defendants Wood and Willaman told Plaintiff they were only there for the arm/wrist problem and to shut up about that other stuff.

On 12/3/20, Plaintiff began suffering tooth pain in a chipped tooth with a cavity. He complained and wrote out a medical request form and grievances.

2. Communication with Attorney and Grievance Grievances

ECJ does not supply a non-recorded telephone line for inmates to talk with their attorneys about pending criminal cases. Plaintiff filed grievances about his inability to

speak confidentially with his criminal defense attorney and Sheriff Wood responded: "all phones in jail are recorded J. Wood".

From 10/29/20 to 11/17/20 Plaintiff was denied paper to write grievances or letters.

Plaintiff kept a file of his legal papers, medical papers, and attorney/client communications in his cell. Plaintiff has been confined in an isolation cell, being removed only for showers and to be taken to court, from 10/27/20 to present. On two separate occasions, while absent from his isolation cell, Plaintiff 's file of papers, including confidential letters from his attorney were confiscated by jail officials. He filed grievances.

3. Orientation Manual Grievances

Plaintiff has not been provided a Jail Orientation Manual and has never been provided with printed Grievance Forms. Plaintiff wrote grievances requesting a Jail Orientation Manual.

4. Cleaning/Sanitizing Supplies

On or about 10/5/20, the Edgar County Public Health Department reported that four inmates of the ECJ were confirmed positive for COVID-19 by a lab-confirmed test. Inmates who were COVID-19 positive were not properly segregated from other inmates and, on information and belief, at least one inmate was told by jail staff not to tell the other inmates that he had tested positive. Court records from 11/23/20 show that two inmates of ECJ would not be in court due to having COVID-19.

Despite requesting cleaning/sanitizing supplies, Plaintiff was denied supplies to clean/sanitize his cell, which worried him because of COVID-19. The corrections officers

do not clean/sanitize the cells or common areas, pursuant to IDPH standards.

5. Adequate Heat and Recreation Grievances

The ECJ ventilation system does not work properly; Plaintiff has been subjected to temperatures that were oppressively hot in summer and excessively cold in fall, especially on cold nights when he had no mattress.

From 7/15/20 to the present, Plaintiff has not been allowed any recreational time outside of his cell, despite written grievances.

6. Conditions of Confinement Grievances

The abysmal conditions of confinement at the dungeon-like ECJ have failed the IDOC Inspections for more than 10 years. *See* Complaint (ECF #1) Exhibits A, B and C.

The ECJ conditions are documented in Exhibits (to this memorandum) C and D.

The IDOC Reports for 2018 and 2019 listed specific conditions at ECJ which are below standards. Relevant Excerpts of the 2018 -2019 IDOC Reports are attached hereto and incorporated herein as Exhibit E.

From approximately 10/27/20 – 12/16/20, or longer, Plaintiff's been in a 10' x 10' isolation cell with no seat, bunk or floor mat, furnished only with a jail toilet/sink that has a problem with flushing. He got a floor mat on 11/25/20 and remains in isolation.

Knowing Plaintiff had previously attempted suicide and experienced suicidal/homocidal ideations, Defendants Wood and/or Willaman housed Plaintiff in an isolation cell that had a cracked glass window which was neither made of shatter-proof glass nor protected by a tamper-proof covering. On 11/4/20, Plaintiff, feeling manic, suicidal and otherwise out of control, punched his hand through the cracked glass window in his isolation cell, incurring injury to his hand and arm.

III. Legal Standards

"To obtain a preliminary injunction, a plaintiff must show that: (1) without this relief, it will suffer 'irreparable harm'; (2) 'traditional legal remedies would be inadequate'; and (3) it has some likelihood of prevailing on the merits of its claims." *Speech First, Inc. v. Killeen*, 968 F.3d 628, 637 (7th Cir. 2020) (quoting *Courthouse News Serv. v. Brown*, 908 F.3d 1063, 1068 (7th Cir. 2018)). If a plaintiff makes such a showing, the court proceeds to a balancing analysis, where the court must weigh the harm the denial of the preliminary injunction would cause the plaintiff against the harm to the defendant if the court were to grant it. *Courthouse News Serv.*, 908 F.3d at 1068. This balancing process involves a "sliding scale" approach: the more likely the plaintiff is to win on the merits, the less the balance of harms needs to weigh in his favor, and vice versa. *Ty, Inc. v. Jones Grp., Inc.*, 237 F.3d 891, 895 (7th Cir. 2001). The balancing process also considers the public interest, or the effects the preliminary injunction – and its denial – would have on nonparties. *Speech First, Inc. v. Killeen*, 968 F.3d 628, 637 (7th Cir. 2020), (*as amended on denial of reh'g and reh'g en banc* (Sept. 4, 2020).

In September, 2020, the Seventh Circuit concisely discussed that the analysis of a pretrial detainee's complaints is under an objective reasonableness inquiry:

> We start with the proper scope of the analysis under the more recent objective reasonableness inquiry for pretrial conditions of confinement claims. In *Kingsley v. Hendrickson*, 576 U.S. 389, 135 S.Ct. 2466, 192 L.Ed.2d 416 (2015), the Supreme Court concluded that, when bringing an excessive force claim, a "pretrial detainee must show only that the force purposely or knowingly used against him was objectively unreasonable," rather than demonstrate deliberate indifference. *Id.* at 396–97, 135 S.Ct. 2466. Recognizing "that the Supreme Court has been signaling that courts must pay careful attention to the different status of pretrial detainees," we held in *Miranda v. Cty. of Lake*, 900 F.3d 335 (7th Cir. 2018), that a pretrial detainee's claims of inadequate

medical care also "are subject only to the objective unreasonableness inquiry identified in *Kingsley*." *Id.* at 352. We saw "nothing in the logic the Supreme Court used in *Kingsley*" to support a "dissection of the different types of claims that arise under the Fourteenth Amendment's Due Process Clause." *Id.* We likewise subsequently expanded this holding to encompass conditions of confinement claims under the Fourteenth Amendment Due Process Clause. *Hardeman v. Curran*, 933 F.3d 816, 823 (7th Cir. 2019) (citing *Kingsley*, 576 U.S. at 396–97, 135 S.Ct. 2466). Accordingly, we must analyze Plaintiffs' claim under the objective reasonableness inquiry articulated in *Kingsley*. *Id.*

IV. A Preliminary Injunction Should Issue.

A. Preliminary Injunction Should Issue For Medical/Dental Evaluation/Treatment

1. Irreparable Harm

Irreparable harm is "harm that cannot be prevented or fully rectified by the final judgment after trial." *Roland Mach. Co. v. Dresser Indus., Inc.*, 749 F.2d 380, 386 (7th Cir. 1984). "The moving party must demonstrate that he will likely suffer irreparable harm absent obtaining preliminary injunctive relief. *See Michigan v. U.S. Army Corps of Eng'rs*, 667 F.3d 765, 787 (7th Cir. 2011). This requires more than a mere possibility of harm. *Id.* at 788. It does not, however, require that the harm actually occur before injunctive relief is warranted. *Id.* Nor does it require that the harm be certain to occur before a court may grant relief on the merits. *Id." Whitaker By Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034, 1044–45 (7th Cir. 2017).

Plaintiff first noted blood coming from his penis in mid-September, 2020. The symptom is alarming and could indicate one of a number of abnormal conditions, from a bacterial infection to bladder cancer or prostrate cancer. In a Central District case, the jury awarded $10 million in punitive damages because Wexford ignored an inmate's complaints of painless and visible blood in his urine for months, instead of sending him

for a CT Scan to rule out cancer. *Dean v. Wexford Health Sources, Inc.*, 2020 WL 6255323, *2 (C.D. Ill.).

Plaintiff was taken to the ground by two officers on 7/16/20, which caused immediate pain to his back and neck. Plaintiff has not been evaluated for these injuries.

Plaintiff has tooth pain, stemming from a cracked tooth with a cavity. Plaintiff has not been evaluated for this pain.

Courts within this circuit have granted preliminary injunctive relief to a prison inmate seeking treatment by a specialist for an untreated serious medical need. *See e.g., Foster v. Ghosh*, 4 F.Supp. 3d 974 (N.D. Ill. 2013); *Cade v. Coe*, 2017 WL 4856963 (S.D. Ill.) (granting preliminary injunctive relief ordering Wexford to ensure that plaintiff "is examined and treated by a dermatological specialist within 30 days"); *Johnson v. Obaisi,* 2019 WL 6117582 (N.D. Ill.) (granting preliminary injunctive relief ordering Wexford to cause plaintiff to "be transported to an appropriately qualified specialist physician within the next 45 days for assessment of his lipoma and then report back to the Court" which will "entertain a request for further relief upon review of the specialist's findings"). Such relief is appropriate early in litigation because courts "must not leave litigants to bear pain indefinitely." *Wheeler v. Wexford Health Sources*, 689 F.3d 680, 682 (7th Cir. 2012) (ordering district court to promptly screen the prisoner-plaintiff's complaint and rule on his motion for a preliminary injunction).

2. Traditional Legal Remedies Inadequate

"The absence of an adequate remedy at law is a precondition to any form of equitable relief. The requirement of irreparable harm is needed to take care of the case where although the ultimate relief that the plaintiff is seeking is equitable, implying that he has no adequate remedy at law, he can easily wait till the end of trial to get that relief. (citation to additional authority omitted) Only if he will suffer irreparable harm in the

interim—that is, harm that cannot be prevented or fully rectified by the final judgment after trial—can he get a preliminary injunction. Where the only remedy sought at trial is damages, the two requirements—irreparable harm, and no adequate remedy at law—merge. The question is then whether the plaintiff will be made whole if he prevails on the merits and is awarded damages.

In saying that the plaintiff must show that an award of damages at the end of trial will be inadequate, we do not mean wholly ineffectual; we mean seriously deficient as a remedy for the harm suffered. *Roland Machine Co. v. Dresser Indus., Inc.,* 749 F.2d 380, 386 (7th Cir. 1984)

Here, Plaintiff is and will suffer irreparable harm of pain. "[H]arm is irreparable if it cannot be undone following adjudication and a final determination on the merits of [an] underlying claim." *Foster,* 4 Supp.3d at 983. (internal quotation omitted). "Although Foster also seeks monetary relief in his underlying claim, that cannot adequately compensate for a known risk to his health that could be presently addressed." *Id.* "An untreated painful condition, even though not life threatening, can create an actionable claim under the Eighth Amendment." *Cade v. Coe,* 2017 WL 4856963 at *5 (S.D. Ill.) Additionally, the alarming symptom of having blood seep out of his penis has never been medically evaluated or tests done to rule out cancer or other life-threatening conditions. This uncertainty is causing Plaintiff emotional distress.

3. Likely Success on The Merits

"To succeed in its attempt to preliminarily enjoin GSUSA from interfering with its jurisdiction, Manitou must show that it has a "better than negligible" chance of success on the merits of at least one of its claims. *Ty,* 237 F.3d at 897; *Omega Satellite Prods. Co. v. City of Indianapolis,* 694 F.2d 119, 123 (7th Cir.1982). This is an admittedly low requirement and is simply a threshold question. *Roland Mach.,* 749 F.2d at 387. Only after we clear the threshold inquiries and proceed to the balancing phase of the analysis must we determine how likely Manitou's success must be for us to issue the requested injunction. *Id.*; *see also Ty,* 237 F.3d at 895; *Abbott Labs.,* 971 F.2d at 12." *G.S. of Manitou Council, Inc. v. G.S. of U.S. of Am., Inc.,* 549 F.3d 1079, 1095–96 (7th Cir. 2008).

In *Girl Scouts,* the complaint contained ten causes of action against GSUSA. *Id.*

The Court concluded that, because "Manitou has a better-than-negligible chance of succeeding on the merits . . . on at least one of its causes of action, we need not discuss Manitou's likelihood of success on its remaining nine claims." *Id.*

a) Plaintiff's unabated back and neck pain, his dental pain and the undiagnosed bleeding from his penis are serious medical needs.

"An objectively serious medical need is 'one that has been diagnosed by a physician as mandating treatment or one that is so obvious that even a lay person would easily recognize the necessity for a doctor's attention.' " *Zentmyer v. Kendall Cty., Ill.*, 220 F.3d 805, 810 (7th Cir. 2000) (quoting *Gutierrez v. Peters*, 111 F.3d 1364, 1373 (7th Cir. 1997)).

""A medical condition need not be life-threatening to be serious...." *Gayton*, 593 F.3d at 620. Instead, courts consider various factors, including: (1) whether the failure to treat the condition "could result in further significant injury," *Gutierrez*, 111 F.3d at 1373 (internal quotation marks omitted); (2) whether it was a condition "that a reasonable doctor or patient would find important and worthy of comment or treatment," *Hayes v. Snyder*, 546 F.3d 516, 523 (7th Cir. 2008); (3) whether the condition "significantly affect[ed] an individual's daily activities," *id.*; or (4) whether the condition involves "chronic and substantial pain," *id."* *Parish v. Sheriff of Cook County*, 2019 WL 2297464, at *9 (N.D. Ill. 2019)

In 2005, the Seventh Circuit found plaintiffs' dental complaints, arising out of their pretrial incarceration at ECJ were a serious medical condition:

"At the outset, we reiterate our view that "dental care is one of the most important medical needs of inmates." *See Wynn [v. Southward*, 251 F.3d 588, 593 (7th Cir.2001)], 251 F.3d at 593 (quoting *Ramos v. Lamm*, 639 F.2d 559, 576 (10th Cir.1980)). In addition, a number of other courts have also held that dental pain accompanied by various degrees of attenuated medical harm may constitute an objectively serious medical need." *Board v. Farnham*, 394 F.3d 469, 480 (7th Cir. 2005)

b) Despite knowledge that Plaintiff has been suffering both pain and an unexplained, alarming symptom for months, Defendants failed to provide medical examination/treatment for serious medical conditions.

In *Kingsley v. Hendrickson*, the Supreme Court explained the objective reasonableness analysis:

> *Bell* [*v. Wolfish*, 441 U.S. 520, 540, 547, 99 S.Ct. 1861, 60 L.Ed.2d 447 (1979)] 's focus on "punishment" does not mean that proof of intent (or motive) to punish is required for a pretrial detainee to prevail on a claim that his due process rights were violated. Rather, as *Bell* itself shows (and as our later precedent affirms), a pretrial detainee can prevail by providing only objective evidence that the challenged governmental action is not rationally related to a legitimate governmental objective or that it is excessive in relation to that purpose. *Kingsley v. Hendrickson*, 576 U.S. 389, 398, 135 S. Ct. 2466, 2473–74, 192 L. Ed. 2d 416 (2015).

The Court described the application of the objective reasonableness standard in *Kingsley:* "A court (judge or jury) cannot apply this standard mechanically. Rather, objective reasonableness turns on the facts and circumstances of each particular case." 576 U.S. at 397, 135 S.Ct. 2466.

The ECJ has no medical doctor on staff or contracted to come in for "sick call" regularly, but rely on untrained officers to assess a detainee's medical complaints. Plaintiff made complaints and wrote grievances.

Although Plaintiff was occasionally taken to Horizon Health in Paris, Illinois for mental health "tele-psych" appointments and for the injuries he sustained to his hand and arm, he was restricted from telling the doctor about his other complaints. He was shackled and accompanied by either Defendant Wood or Willaman, who verbally forbid him from voicing his medical complaints to the doctor.

The refusals to take Plaintiff to be evaluated for his back/neck pain, tooth pain and blood from his penis, are not rationally related to a legitimate governmental objective. The sheriff has a statutory obligation to provide medical care for detainees. 730 ILCS 125/17.

In analyzing a pretrial detainee's denial of medical care claims, under the prior Eighth Amendment standard, the Seventh Circuit instructed: "[T]he Eighth Amendment protects a detainee not only from deliberate indifference to his or her *current* serious health problems, but also from deliberate indifference to conditions posing an unreasonable risk of serious damage to *future* health." *Board v. Farnham*, 394 F.3d 469, 479 (7th Cir. 2005)(emphasis in original). Blood coming from Plaintiff's penis, back/neck pain and the pain from a cracked tooth with a cavity (*See Harrison v. Barkley*, 219 F.3d 132, 137 (2d Cir.2000) (tooth cavity presented serious medical condition)) are all conditions that may pose an unreasonable risk of serious damage to Plaintiff 's future health. It has to be determined by professional medical examination, appropriate testing and treatment, if indicated. Objectively, defendants are not qualified to make medical determinations.

In emphasizing that "dental care is one of the most important medical needs of inmates" *Board*, 394 F.3d at 480, Judge Coffey cited a medical text, in footnote 4:

"The risks posed by tooth loss, the most common cause of which is periodontal disease (of which the most common form is known as gingivitis), cannot be underestimated. Such diseases of the mouth are believed to sometimes contribute to coronary atherosclerosis and a myriad of heart problems, as well as bacterial infections such as transient bacteremia or sepsis, all of which are capable of causing death. See Eugene Buaunwald, et al., HARRISON'S PRINCIPLES OF INTERNAL MEDICINE 194-95, 799-800 (15th ed. 2001)." *Board*, at 487, fn 4.

The Court emphasized the importance of a dental exam:

"A basic dental examination is not "an expensive or unconventional treatment," nor is it esoteric or experimental. See *Ralston*, 167 F.3d at 1162. Such examinations are inexpensive and commonly sought immediately to address severe dental pain. Thus, Dr. Butler's refusal to permit Berry such a basic treatment option could be characterized as a "gratuitous cruelty" forbidden by the Eighth Amendment. " *Berry v. Peterman*, 604 F.3d 435, 441 (7th Cir. 2010).

Cutting costs by delaying or refusing to provide outside medical care cannot suffice as a legitimate government objective. Generally, choosing a treatment for a prisoner based on cost and not efficacy may be evidence of deliberate indifference. *Orozco v. Wexford Health Sources*, 2016 WL 7337963, at *4 (S.D. Ill.). "Moreover, lack of financing is not a defense to the failure of a county to provide minimum constitutional standards in its operation of a county jail." *Battle v. Anderson*, 447 F.Supp. 516, 526 (E.D.OK. 1977). The sheriff is statutorily required to furnish, "necessary . . . medical services for all prisoners under his charge." 730 ILCS 125/17.

4. Balance of Harms

"[T]he court weighs the irreparable harm that the moving party would endure without the protection of the preliminary injunction against any irreparable harm the nonmoving party would suffer if the court were to grant the requested relief." *G.S. of Manitou Council, Inc. v. G.S. of U.S. of Am., Inc.*, 549 F.3d 1079, 1096 (7th Cir. 2008). This balancing occurs on a "sliding scale", such that "[t]he more likely the plaintiff is to win, the less heavily need the balance of harms weigh in his favor," and vice versa. *Roland Machine Co. v. Dresser Indus., Inc.*, 749 F.2d 380, 388 (7th Cir. 1984).

As discussed above, the ongoing harm (physical pain and emotional distress) to Plaintiff is substantial, and the likelihood that he will prevail on at least one of his claims passes the required threshold. Defendants will suffer no irreparable harm should the injunction issue. The Sheriff merely has to bear the cost of medical/dental evaluations and necessary treatments - his statutory duty. 730 ILCS 125/17

"Where appropriate, this balancing process should also encompass any effects that granting or denying the preliminary injunction would have on nonparties

(something courts have termed the 'public interest')." *G.S. of Manitou,* 549 F.3d at 1086. The Public Interest favors entry of a preliminary injunction "[b]ecause Illinois taxpayers have a vested interest in ensuring that the constitutional rights of its citizens are protected" *Foster v Ghosh,* 4 F.Supp.3d 974, 984 (7th Cir. 2013).

(B) Preliminary Injunction Should Issue For Private Attorney Phone and Prohibit Confiscation of Legal/Medical Papers.

1. Irreparable Harm

Plaintiff incorporates the Legal Authority as set forth in Section A.1. above.

""The right to . . . consult an attorney is protected by the First Amendment's guarantee of freedom of speech, association and petition . . . [T]he state cannot impede an individual's right to consult with counsel on legal matters." *Denius v. Dunlap,* 209 F.3d 944, 953-54 (7th Cir. 2000)" *Hawkins v. Mitchell,* 756 F.3d 983, 997 (7th Cir. 2014).

ECJ has a policy to record all telephone calls, including attorney-client calls, in which a detainee participates. Plaintiff has eight pending felony cases in Edgar County Circuit Court. He is unwilling to freely discuss his cases, out of fear that Defendants or the State's Attorney may gain information to use against him in this lawsuit and/or in the prosecutions. Plaintiff wrote grievances and Defendant Wood's response was "All phones in jail are recorded. J. Wood". Personal visit is not available due to COVID-19 restrictions. Written communications are an inadequate substitute, where a question-and-answer format is critical.

Twice, Plaintiff's papers, including attorney letters and medical records, were confiscated without explanation. They were eventually returned. Plaintiff has no trust that his confidentiality was respected by the defendants.

In the Southern District, a pretrial detainee's request for private attorney calls was granted: "Defendants **SHALL** permit Plaintiff to speak with his attorney by phone at least once per week for at least thirty minutes without recording or monitoring the phone call." (emphasis in the original) *Brown v. Madison County*, 2008 WL 2625912 at *4 (S.D. Ill.).

"'[A]n inmates right of unfettered access to the courts is as fundamental a right as any other he may hold." *Adams v. Carlson*, 488 F.2d 619,630 (7th Cir.1973) (citing *Ex parte Hull*, 312 U.S. 546, 61 S.Ct. 640, 85 L.Ed. 1034 (1941)). And there is "widespread agreement that communications by post between an inmate and his attorney are sacrosanct, subject only to tests on incoming mail for the presence of contraband which fall short of opening it when the inmate is not present. Oral intercourse has been hedged with similar protection." *Id*. at 631 (citations omitted). Inmates must, therefore, have a reasonable opportunity to seek and receive the assistance of counsel and where a regulation or practice unjustifiably interferes with this right it is invalid." *Procunier v. Martinez* 416 U.S. 396, 419, 94 S.Ct. 1800, 40 L.Ed.2d 224 (1974). Private communication with an attorney is a meaningful part of that access, *Dreher v. Sielaff*, 636 F.2d 1141, 1143 (7th Cir.1980), and the privacy accorded to the attorney-client relationship must exist even in the prison context. *Adams*, 488 at 631." *Id*. at 1.

Plaintiff 's right to unfettered access to the criminal court process by private communications with his attorney about the facts and defenses of his eight pending felony cases is protected by the Sixth Amendment, as well as the First Amendment. "Private communication is a meaningful part of that access" to the courts. *Id*.

Plaintiff was told that no one listens to the recorded attorney phone calls, an argument used by defendants in *Brown*. That argument "defies credulity" and "amounts [to] nothing more than stating that Plaintiff should "just trust us"". *Id*. at *3. "If anything, Defendants' claim" actually "undercuts the necessity" of such recording. *Id*. "[W]hat is the point of taping the calls . . . other than, perhaps, to intimidate detainees from speaking freely over the phone to their attorney. . . " *Id*. Without the requested relief, Mr. Robinson will suffer irreparable harm.

2. Traditional Legal Remedies Inadequate

Plaintiff incorporates the Legal Authority as set forth in Section A.2. above. In Plaintiff 's case, money damages would be seriously deficient, as well as impossible to calculate, if he ends up going to IDOC for 20 or more years due to the inability to prepare defenses by speaking with his attorney.

3. Likely Success on The Merits

Plaintiff incorporates the Legal Authority as set forth in Section A.3. above. "Citation of authority is hardly needed for the proposition that an inmate's right of unfettered access to the courts is as fundamental a right as any other he may hold." *Adams v. Carlson*, 488 F.2d 619, 630 (7th Cir. 1973). "Whether as a vital concomitant of the prisoner's right to petition the bench or as a distinct requirement of his right to effective counsel guaranteed by the Sixth Amendment, a right of access by an inmate to counsel has been perceived by a number of courts." *Id.*

4. Balance of Harms

Plaintiff incorporates the Legal Authority as set forth in Section A.14 above. "[O]ne of the most serious deprivations suffered by a pretrial detainee is the curtailment of his ability to assist in his own defense." *Wolfish v. Levi,* 573 F.2d 118, 133 (2nd Cir. 1978), *rev'd on other grounds, Bell v. Wolfish,* 441 U.S. 520, 99 S.Ct. 1861 (1979).

"Plaintiff's request is a reasonable one. Plaintiff requests a single, unmonitored, thirty minute phone call with his attorney each week. . ." *Brown*, at *3. The defendants' "harm" is that it would cost some money to install another phone line. But, "lack of financing is not a defense to the failure of a county to provide minimum constitutional standards in its operation of a county jail." *Battle v. Anderson,* 447 F.Supp. 516, 526

(E.D.OK. 1977).

Plaintiff requests the Court to order defendants to install a non-recorded telephone line and allow Plaintiff to speak with his attorney at least once a week for at least thirty minutes without recording or monitoring the phone call and to prohibit the confiscation of Plaintiff 's Legal/Medical papers.

(C) Preliminary Injunction Should Issue For Paper Copy of the Edgar County Jail Orientation Manual.

1. Irreparable Harm

Plaintiff incorporates the Legal Authority as set forth in Section A.1. above. The IDOC orientation manual was described as: "Orientation is intended to educate the offender on the "facility's expectations" of them and what each offender can expect in return from the facility's programs and services. (citation to record omitted) The information covered is complex and important. (Id.) It includes topics such as disciplinary rules, grievance procedures, security and emergency procedures, work and educational services, protective custody, etc." *Holmes v. Godinez*, 311 F.R.D. 177, 197 (N.D. Ill. 2015).

Since his incarceration on 7/15/20, Plaintiff has not been given a paper copy of the manual. He remains in an isolation cell where he was placed on disciplinary segregation since 10/29/20. He received no disciplinary hearings or paperwork, justifying his disciplinary placement in isolation. Without a manual, he is unable to challenge this solitary confinement. He wrote grievances on plain paper because he has not been provided with grievance forms, nor with the grievance procedures that should be specified in the orientation manual.

"An inmate is required to exhaust only those administrative remedies available to him. *See* 42 U.S.C. § 1997e(a). The Seventh Circuit has held that administrative remedies become "unavailable" when prison officials fail to respond to inmate grievances. *Lewis v. Washington,* 300 F.3d 829, 833 (7th Cir.2002); *Brengettcy v. Horton,* 423 F.3d 674, 682 (7th Cir.2005). The availability of a remedy does not depend on the rules and regulations as they appear on paper, but on "whether the paper process was in reality open for the prisoner to pursue." *Wilder v. Sutton,* 310 Fed.Appx. 10, 13 (7th Cir.2009). " *Salcedo-Vazquez v. Nwaobasi,* 2014 WL 2580517, at *4 (S.D. Ill.).

Plaintiff has filed grievances in complaint of being housed in an isolation cell since 10/29/20. He recently received an undated "Daniel Robinson's Grievance Request Answers", stating "7. Due to your past history of poor behavior is the main reason you will not be returning to the general population." Thus, the disciplinary punishment is permanent.

If Plaintiff 's written grievances do not comply with ECJ 's Orientation Manual procedures, he should be excused from the PLRA's exhaustion requirement because "paper process" was not, "in reality open for the prisoner to pursue". *Wilder v. Sutton,* 310 Fed.Appx. 10, 13 (7th Cir.2009).

Plaintiff is so heavily medicated that he reportedly "feels like a zombie", "sleepy", "always tired" and he "sleeps most of the day". He is denied such things as a TV, a radio, any human communication except with the guards through the chuckhole, a bed, a bench or table to use for writing or drawing, art materials, outdoor air and sunshine. He was taken to a tele-psych appointment on 12/11/20 and just getting outside into the fresh air and sunshine, while walking from the facility to the squad car, gave him a "new feeling of life" and "an energy that I haven't had for awhile". Plaintiff 's mental and emotional health are suffering irreparable harm by unabated isolation, without being

provided the orientation manual to be able to properly challenge the permanent disciplinary isolation.

2. Traditional Legal Remedies Inadequate

Plaintiff incorporates the Legal Authority as set forth in Section A.2. above. The traditional legal remedy of a damages award, a year or more later, is totally inadequate to remedy the ongoing harm of Plaintiff 's inability to address his permanent disciplinary isolation and other grievance issues.

3. Likely Success on The Merits

Plaintiff incorporates the Legal Authority as set forth in Section A.3. above. The request is simple and easy for the defendants to fulfil. Plaintiff wants to have his own paper copy of the ECJ Orientation Manual.

4. Balance of Harms

Plaintiff incorporates the Legal Authority as set forth in Section A.14 above. Providing the orientation manual to Plaintiff would be favorable to both sides. It is impossible to speculate that any harm could befall the Defendants by letting an inmate know what is expected of him and what he can expect of the facility's programs and services, especially in regards to the imposition of the drastic punishment of being kept permanently in an isolation cell. The ECJ is statutorily required to provide the manual. Ill. Admin. Code tit. 20, §710.50.

The Court should order Defendant Wood to immediately provide Plaintiff a paper copy of the ECJ Orientation Manual.

(D) Preliminary Injunction Should Issue For Cleaning/Sanitizing Supplies.

1. Irreparable Harm

Plaintiff incorporates the Legal Authority as set forth in Section A.1. above. The ECJ is a filthy dungeon, by any reasonable standard. There have been cases of COVID-19 in the jail, in October/November 2020. The air comes through vents that feed the whole building. The broken window goes to another cell area. The cell is filthy. Plaintiff's request for cleaning/sanitizing supplies has been denied for months.

Irreparable harm is exposure to air/surfaces that may be transferring COVID-19, MRSA or other contagious disease to Plaintiff. For instance, MRSA can be spread by communal use of shower soap or razors. A copy of Mayo Clinic on MRSA is attached hereto and incorporated herein as Exhibit H. The courts have recognized (as cited in Section A.1.) that the irreparable harm prong requires more than a mere possibility of harm, but it does not require that the harm be certain to occur before the case goes to trial. The CDC published *Interim Guidance on Management of Coronavirus (COVID-19) in Correctional and Detention Facilities*, (revised 12/3/20), stating, at pp.7-8, that jails should supply various basic cleaning/sanitizing/disinfecting supplies to detainees. CDC Interim Guidance is found at: https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html

2. Traditional Legal Remedies Inadequate

Plaintiff incorporates the Legal Authority as set forth in Section A.2. above. With COVID-19 in the ECJ, there is a known risk to Plaintiff's health. An award after trial cannot adequately compensate Plaintiff, if he contracts COVID-19. In *Foster v.*

Ghosh, 4 F.Supp.3d, 974, 983 (7th Cir. 2013), the appellate court agreed that a later damages award "cannot adequately compensate for a known risk to his health that could be presently addressed." The same reasoning applies to taking reasonable sanitary precautions to attempt to prevent the spread of COVID-19.

3. Likely Success on The Merits

Plaintiff incorporates the Legal Authority as set forth in Section A.3. above.

It seems almost predictable that a jury would find that Plaintiff should have been given this minimum protection, of cleaning/sanitizing supplies, with COVID-19 in ECJ. The Sheriff is statutorily required to "keep and maintain the jail in a clean and healthful condition." 730 ILCS 125/18 and to "see that strict attention is constantly paid to the personal cleanliness of all prisoners confined in the jail." 730 ILCS 125/19.

4. Balance of Harms

Plaintiff incorporates the Legal Authority as set forth in Section A.14 above.

There is no harm to defendants.

(E) Preliminary Injunction For Regular Outdoor Recreation and Adequate Heat

1. Irreparable Harm

Plaintiff incorporates the Legal Authority as set forth in Section A.1. above.

Although ECJ has a yard that is fenced in with chain link fencing and rolled razor wire at the top, it is not used. Since 7/15/20, Plaintiff 's only exposure to fresh air and sunshine has been on infrequent visits to the courthouse or mental health/medical visits, when he got a few minutes outside. Exposure to sunlight has both physical health and mental health benefits.

Vitamin D, gotten mostly from sunlight, is an essential nutrient that the body requires primarily to build strong bones, by maintaining adequate levels of calcium and phosphate. A copy of *Mayo Clinic Q and A: Getting enough vitamin D* is attached hereto and incorporated herein as Exhibit F. Mayo Clinic estimates that 15 minutes a day, three times a week is sufficient. *Id.*

Seasonal affective disorder (SAD) is a form of depression that recurs regularly at certain times of the year, usually beginning in late fall or winter. NAMI *Less Sunlight Means More Blues For Some* is attached hereto and incorporated herein as Exhibit G. Those already experiencing clinical depression or bipolar disorder may see a worsening of their symptoms in winter. *Id.* The symptoms of SAD include depressed mood, loss of energy, increased sleep, anxiety, irritability and difficulty concentrating. *Id.* Low levels of serotonin are associated with depression. Serotonin production is activated by sunlight, so less sunlight in winter could lower serotonin levels, leading to depression. *Id.* Plaintiff's physical, mental and emotional health are suffering irreparable harm by having no ability to get enough fresh air/sunshine.

2. Traditional Legal Remedies Inadequate

Plaintiff incorporates the Legal Authority as set forth in Section A.2. above.

As more thoroughly argued in Section A, above, pain may constitute irreparable injury, and litigants must not be left "to bear pain indefinitely." *Wheeler v. Wexford Health Sources,* 689 F.3d 680, 682 (7th Cir. 2012).

3. Likely Success on The Merits

Plaintiff incorporates the Legal Authority as set forth in Section A.3. above. Plaintiff is likely to succeed in his claim of needing sunshine, recreation and heat, basic

human necessities.

4. Balance of Harms

Plaintiff incorporates the Legal Authority as set forth in Section A.14 above.

Defendants would suffer no harm.

(F) Preliminary Injunction To Close ECJ

1. Irreparable Harm

Plaintiff incorporates the Legal Authority as set forth in Section A.1. above.

The irreparable harm is adequately described in Complaint Exhibits A, B and C. (ECF #1) and Exhibits to this memorandum C, D and E.

2. Traditional Legal Remedies Inadequate

Plaintiff incorporates the Legal Authority as set forth in Section A.2. above.

A damages award after trial cannot compensate present suffering.

3. Likely Success on The Merits

Plaintiff incorporates the Legal Authority as set forth in Section A.3. above.

Plaintiff is likely to succeed on at least one of his claims.

4. Balance of Harms

Plaintiff incorporates the Legal Authority as set forth in Section A.14 above.

Edgar County's Jail has been a disgrace for more than 15 years. The IDOC has found it statutorily inadequate in a number of ways and referred the case to the Attorney General for enforcement. It would serve everyone's interest to force the county to deal with the problem they have neglected.

December 17, 2020

Respectfully Submitted,

DANIEL LEE ROBINSON

By:*/s/ Jude M. Redwood*

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CERTIFICATION

The undersigned certifies that the foregoing Memorandum conforms to the page and type limitations set forth in CDIL-LR 7.1B(4) as it contains 6,911 words (not including the signature block or Certificate of Service), as measured by Microsoft Word program.

/s/ Jude M. Redwood

CERTIFICATE OF SERVICE

I hereby certify that on December 17, 2020, I electronically filed the foregoing *Memorandum in Support of Plaintiff's Motion for Preliminary Injunction* (and Exhibits thereto) with the Clerk of the Court using the ECF system, which will send notification of such filing to all attorneys who have entered appearance in this cause and I have served a paper copy of the aforesaid documents on all unrepresented parties by placing same in a properly addressed envelope and mailing with first class postage affixed, on December 18, 2020, to:

Jeff Wood
c/o Sheriff Dept.
228 N. Central
Paris, IL 61944

Jay Willaman
c/o Sheriff Dept.
228 N. Central
Paris, IL 61944

Jesse Lewsader
c/o Paris Police Dept.
211 W. Washington St.
Paris, IL 61944

August Griffin
County Clerk Office
Edgar County Courthouse
115 W. Court St.
Paris, IL 61944

Brooke Newhart
City Clerk Office
206 S. Central
Paris, IL 61944

/s/ Jude M. Redwood

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E-FILED
Thursday, 17 December, 2020 03:12:09 PM
Clerk, U.S. District Court, ILCD

EXHIBIT A

National Alliance on Mental Illness

ADHD

Attention Deficit Hyperactivity Disorder (ADHD)

Attention deficit hyperactivity disorder (ADHD) is a condition in which characterized by inattention, hyperactivity and impulsivity. ADHD is most commonly diagnosed in young people. An estimated **8.8%** of children aged 4-17 have ADHD. While ADHD is usually diagnosed in childhood, it does not only affect children. An estimated **4.4%** of adults aged 18-44 have ADHD.

With treatment, people with ADHD can be successful in school, work and lead productive lives. Researchers are using new tools such as brain imaging to better understand the condition and to find more effective ways to treat and prevent ADHD.

Symptoms

While some behaviors associated with ADHD are "normal" and not a cause for concern to most people, someone with ADHD will have trouble controlling these behaviors and will show them much more frequently and for longer than 6 months.

Signs of inattention include:

- Becoming easily distracted, and jumping from activity to activity.
- Becoming bored with a task quickly.
- Difficulty focusing attention or completing a single task or activity.
- Trouble completing or turning in homework assignments.
- Losing things such as school supplies or toys.
- Not listening or paying attention when spoken to.
- Daydreaming or wandering with lack of motivation.
- Difficulty processing information quickly.
- Struggling to follow directions.

Signs of hyperactivity include:

- Fidgeting and squirming, having trouble sitting still.
- Non-stop talking.
- Touching or playing with everything.
- Difficulty doing quiet tasks or activities.

Signs of impulsivity include:

- Impatience.
- Acting without regard for consequences, blurting things out.
- Difficulty taking turns, waiting or sharing.
- Interrupting others.

Causes

There are several factors believed to contribute to ADHD:

- **Genetics.** Research shows that genes may be a large contributor to ADHD. ADHD often runs in families and some trends in specific brain areas that contribute to attention.
- **Environmental factors.** Studies show a link between cigarette smoking and alcohol use during pregnancy and children who have ADHD. Exposure to lead as a child has also been shown to increase the likelihood of ADHD in children.

Diagnosis

ADHD occurs in both children and adults, but is most often and diagnosed in childhood. Getting a diagnosis for ADHD can sometimes be difficult because the symptoms of ADHD are similar to typical behavior in most young children. Teachers are often the first to notice ADHD symptoms because they see children in a learning environment with peers every day.

There is no one single test that can diagnose a child with ADHD, so meet with a doctor or mental health professional to gather all the necessary information to make a diagnosis. The goal is to rule out any outside causes for symptoms, such as environmental changes, difficulty in school, medical problems and ensure that a child is otherwise healthy.

Treatment

ADHD is managed and treated in several ways:

- **Medications,** including stimulants, nonstimulants and antidepressants
- Behavioral therapy
- Self-management, education programs and assistance through schools or work or alternative treatment approaches

Related Conditions

Around **two-thirds** of children with ADHD also have another condition. Many adults are also impacted by the symptoms of another condition. Common conditions associated with ADHD include the following.

- Learning disabilities
- Oppositional defiant disorder: refusal to accept directions or authority from adults or others
- Conduct disorder, persistent destructive or violent behaviors
- **Anxiety** and **depression**
- **Obsessive-compulsive disorder**
- **Bipolar disorder**
- Tourette's syndrome
- **Sleep disorders**
- Bed-wetting
- Substance use disorders/ **Dual Diagnosis**

Symptoms from other conditions make treating ADHD more difficult. Talking to a skilled professional to help establish an accurate diagnosis can help increase the effectiveness of treatment.

Contact Us Main 703-524-7600
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HelpLine 800-950-6264
4301 Wilson Blvd., Suite 100 Arlington, VA 22203

MAYO CLINIC

Antisocial personality disorder

Overview

Antisocial personality disorder, sometimes called sociopathy, is a mental disorder in which a person consistently shows no regard for right and wrong and ignores the rights and feelings of others. People with antisocial personality disorder tend to antagonize, manipulate or treat others harshly or with callous indifference. They show no guilt or remorse for their behavior.

Individuals with antisocial personality disorder often violate the law, becoming criminals. They may lie, behave violently or impulsively, and have problems with drug and alcohol use. Because of these characteristics, people with this disorder typically can't fulfill responsibilities related to family, work or school.

Symptoms

Antisocial personality disorder signs and symptoms may include:

- Disregard for right and wrong
- Persistent lying or deceit to exploit others
- Being callous, cynical and disrespectful of others
- Using charm or wit to manipulate others for personal gain or personal pleasure
- Arrogance, a sense of superiority and being extremely opinionated
- Recurring problems with the law, including criminal behavior
- Repeatedly violating the rights of others through intimidation and dishonesty
- Impulsiveness or failure to plan ahead
- Hostility, significant irritability, agitation, aggression or violence
- Lack of empathy for others and lack of remorse about harming others
- Unnecessary risk-taking or dangerous behavior with no regard for the safety of self or others
- Poor or abusive relationships
- Failure to consider the negative consequences of behavior or learn from them
- Being consistently irresponsible and repeatedly failing to fulfill work or financial obligations

Adults with antisocial personality disorder typically show symptoms of conduct disorder before the age of 15. Signs and symptoms of conduct disorder include serious, persistent behavior problems, such as:

- Aggression toward people and animals
- Destruction of property
- Deceitfulness
- Theft
- Serious violation of rules

Although antisocial personality disorder is considered lifelong, in some people, certain symptoms — particularly destructive and criminal behavior — may decrease over time. But it's not clear whether this decrease is a result of aging or an increased awareness of the consequences of antisocial behavior.

When to see a doctor

People with antisocial personality disorder are unlikely to seek help on their own. If you suspect that a friend or family member may have the disorder, you might gently suggest that the person seek help from a mental health professional and offer to help them find one.

Causes

Personality is the combination of thoughts, emotions and behaviors that makes everyone unique. It's the way people view, understand and relate to the outside world, as well as how they see themselves. Personality forms during childhood, shaped through an interaction of inherited tendencies and environmental factors.

The exact cause of antisocial personality disorder isn't known, but:

- Genes may make you vulnerable to developing antisocial personality disorder — and life situations may trigger its development
- Changes in the way the brain functions may have resulted during brain development

Risk factors

Certain factors seem to increase the risk of developing antisocial personality disorder, such as:

- Diagnosis of childhood conduct disorder
- Family history of antisocial personality disorder or other personality disorders or mental health disorders
- Being subjected to abuse or neglect during childhood
- Unstable, violent or chaotic family life during childhood

Men are at greater risk of having antisocial personality disorder than women are.

Complications

Complications, consequences and problems of antisocial personality disorder may include, for example:

- Spouse abuse or child abuse or neglect
- Problems with alcohol or substance use
- Being in jail or prison
- Homicidal or suicidal behaviors
- Having other mental health disorders such as depression or anxiety
- Low social and economic status and homelessness
- Premature death, usually as a result of violence

Prevention

There's no sure way to prevent antisocial personality disorder from developing in those at risk. Because antisocial behavior is thought to have its roots in childhood, parents, teachers and pediatricians may be able to spot early warning signs. It may help to try to identify those most at risk, such as children who show signs of conduct disorder, and then offer early intervention.

By Mayo Clinic Staff

National Alliance on Mental Illness

Bipolar Disorder

Bipolar Disorder

Bipolar disorder is a mental illness that causes dramatic shifts in a person's mood, energy and ability to think clearly. People with bipolar experience high and low moods—known as mania and depression—which differ from the typical ups-and-downs most people experience.

The average age-of-onset is about 25, but it can occur in the teens, or more uncommonly, in childhood. The condition affects men and women equally, with about **2.8%** of the U.S. population diagnosed with bipolar disorder and nearly **83%** of cases classified as severe.

If left untreated, bipolar disorder usually worsens. However, with a good treatment plan including psychotherapy, medications, a healthy lifestyle, a regular schedule and early identification of symptoms, many people live well with the condition.

Symptoms

Symptoms and their severity can vary. A person with bipolar disorder may have distinct manic or depressed states but may also have extended periods—sometimes years—without symptoms. A person can also experience both extremes simultaneously or in rapid sequence.

Severe bipolar episodes of mania or depression may include psychotic symptoms such as hallucinations or delusions. Usually, these psychotic symptoms mirror a person's extreme mood. People with bipolar disorder who have psychotic symptoms can be wrongly diagnosed as having **schizophrenia**.

Mania. To be diagnosed with bipolar disorder, a person must have experienced at least one episode of mania or hypomania. Hypomania is a milder form of mania that doesn't include psychotic episodes. People with hypomania can often function well in social situations or at work. Some people with bipolar disorder will have episodes of mania or hypomania many times throughout their life; others may experience them only rarely.

Although someone with bipolar may find an elevated mood of mania appealing—especially if it occurs after depression—the "high" does not stop at a comfortable or controllable level. Moods can rapidly become more irritable, behavior more unpredictable and judgment more impaired. During periods of mania, people frequently behave impulsively, make reckless decisions and take unusual risks.

Most of the time, people in manic states are unaware of the negative consequences of their actions. With bipolar disorder, **suicide** is an ever-present danger because some people become suicidal even in manic states. Learning from prior episodes what kinds of behavior signals "red flags" of manic behavior can help manage the symptoms of the illness.

Depression. The lows of bipolar depression are often so debilitating that people may be unable to get out of bed. Typically, people experiencing a depressive episode have difficulty falling and staying asleep, while others sleep far more than usual. When people are depressed, even minor decisions such as what to eat for dinner can be overwhelming. They may become obsessed with feelings of loss, personal failure, guilt or helplessness; this negative thinking can lead to thoughts of suicide.

The depressive symptoms that obstruct a person's ability to function must be present nearly every day for a period of at least two weeks for a diagnosis. Depression associated with bipolar disorder may be more difficult to treat and require a customized treatment plan.

Causes

Scientists have not yet discovered a single cause of bipolar disorder. Currently, they believe several factors may contribute, including:

- **Genetics.** The chances of developing bipolar disorder are increased if a child's parents or siblings have the disorder. But the role of genetics is not absolute: A child from a family with a history of bipolar disorder may never develop the disorder. Studies of identical twins have found that, even if one twin develops the disorder, the other may not.
- **Stress**. A stressful event such as a death in the family, an illness, a difficult relationship, divorce or financial problems can trigger a manic or depressive episode. Thus, a person's handling of stress may also play a role in the development of the illness.
- **Brain structure and function**. Brain scans cannot diagnose bipolar disorder, yet researchers have identified subtle differences in the average size or activation of some brain structures in people with bipolar disorder.

Diagnosis

To diagnose bipolar disorder, a doctor may perform a physical examination, conduct an interview and order lab tests. While bipolar disorder cannot be seen on a blood test or body scan, these tests can help rule out other illnesses that can resemble the disorder, such as hyperthyroidism. If no other illnesses (or medicines such as steroids) are causing the symptoms, the doctor may recommend mental health care.

To be diagnosed with bipolar disorder, a person must have experienced at least one episode of mania or hypomania. Mental health care professionals use the Diagnostic and Statistical Manual of Mental Disorders (DSM) to diagnose the "type" of bipolar disorder a person may be experiencing. To determine what type of bipolar disorder a person has, mental health care professionals assess the pattern of symptoms and how impaired the person is during their most severe episodes.

Four Types Of Bipolar Disorder

1. **Bipolar I Disorder** is an illness in which people have experienced one or more episodes of mania. Most people diagnosed with bipolar I will have episodes of both mania and depression, though an episode of depression is not necessary for a diagnosis. To be diagnosed with bipolar I, a person's manic episodes must last at least seven days or be so severe that hospitalization is required.

2. **Bipolar II Disorder** is a subset of bipolar disorder in which people experience depressive episodes shifting back and forth with hypomanic episodes, but never a "full" manic episode.

3. **Cyclothymic Disorder or Cyclothymia** is a chronically unstable mood state in which people experience hypomania and mild depression for at least two years. People with cyclothymia may have brief periods of normal mood, but these periods last less than eight weeks.

4. **Bipolar Disorder, "other specified" and "unspecified"** is when a person does not meet the criteria for bipolar I, II or cyclothymia but has still experienced periods of clinically significant abnormal mood elevation.

Treatment

Bipolar disorder is treated and managed in several ways:

- **Psychotherapy**, such as cognitive behavioral therapy and family-focused therapy.
- **Medications**, such as mood stabilizers, antipsychotic medications and, to a lesser extent, antidepressants.
- **Self-management strategies**, like education and recognition of an episode's early symptoms.
- **Complementary health approaches**, such as aerobic exercise meditation, faith and prayer can support, but not replace, treatment.

The largest research project to assess what treatment methods work for people with bipolar disorder is the **Systematic Treatment Enhancement for Bipolar Disorder**, otherwise known as Step-BD. Step-BD followed over 4,000 people diagnosed with bipolar disorder over time with different treatments.

Related Conditions

People with bipolar disorder can also experience:

- **Anxiety**
- Attention-deficit hyperactivity disorder (**ADHD**)

- Posttraumatic stress disorder (**PTSD**)
- Substance use disorders/**dual diagnosis**

People with bipolar disorder and psychotic symptoms can be wrongly diagnosed with **schizophrenia**. Bipolar disorder **can be also misdiagnosed** as Borderline Personality Disorder (**BPD**).

These other illnesses and misdiagnoses can make it hard to treat bipolar disorder. For example, the antidepressants used to treat OCD and the stimulants used to treat ADHD may worsen symptoms of bipolar disorder and may even trigger a manic episode. If you have more than one condition (called co-occurring disorders), be sure to get a treatment plan that works for you.

Reviewed August 2017

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MAYO CLINIC

Cyclothymia (cyclothymic disorder)

Overview

Cyclothymia (sy-kloe-THIE-me-uh), also called cyclothymic disorder, is a rare mood disorder. Cyclothymia causes emotional ups and downs, but they're not as extreme as those in bipolar I or II disorder.

With cyclothymia, you experience periods when your mood noticeably shifts up and down from your baseline. You may feel on top of the world for a time, followed by a low period when you feel somewhat down. Between these cyclothymic highs and lows, you may feel stable and fine.

Although the highs and lows of cyclothymia are less extreme than those of bipolar disorder, it's critical to seek help managing these symptoms because they can interfere with your ability to function and increase your risk of bipolar I or II disorder.

Treatment options for cyclothymia include talk therapy (psychotherapy), medications and close, ongoing follow-up with your doctor.

Symptoms

Cyclothymia symptoms alternate between emotional highs and lows. The highs of cyclothymia include symptoms of an elevated mood (hypomanic symptoms). The lows consist of mild or moderate depressive symptoms.

Cyclothymia symptoms are similar to those of bipolar I or II disorder, but they're less severe. When you have cyclothymia, you can typically function in your daily life, though not always well. The unpredictable nature of your mood shifts may significantly disrupt your life because you never know how you're going to feel.

Hypomanic symptoms

Signs and symptoms of the highs of cyclothymia may include:

- An exaggerated feeling of happiness or well-being (euphoria)
- Extreme optimism
- Inflated self-esteem
- Talking more than usual

- Poor judgment that can result in risky behavior or unwise choices
- Racing thoughts
- Irritable or agitated behavior
- Excessive physical activity
- Increased drive to perform or achieve goals (sexual, work related or social)
- Decreased need for sleep
- Tendency to be easily distracted
- Inability to concentrate

Depressive symptoms

Signs and symptoms of the lows of cyclothymia may include:

- Feeling sad, hopeless or empty
- Tearfulness
- Irritability, especially in children and teenagers
- Loss of interest in activities once considered enjoyable
- Changes in weight
- Feelings of worthlessness or guilt
- Sleep problems
- Restlessness
- Fatigue or feeling slowed down
- Problems concentrating
- Thinking of death or suicide

When to see a doctor

If you have any symptoms of cyclothymia, seek medical help as soon as possible. Cyclothymia generally doesn't get better on its own. If you're reluctant to seek treatment, work up the courage to confide in someone who can help you take that first step.

If a loved one has symptoms of cyclothymia, talk openly and honestly with that person about your concerns. You can't force someone to seek professional help, but you can offer support and help find a qualified doctor or mental health provider.

Suicidal thoughts

Although suicidal thoughts might occur with cyclothymia, they're more likely to occur if you have bipolar I or II disorder. If you're considering suicide right now:

- Call 911 or your local emergency services number, or go to a hospital emergency department.

- Call a local crisis center or suicide hotline number — in the United States, you can call the National Suicide Prevention Lifeline at 1-800-273-TALK (1-800-273-8255) to reach a trained counselor. Use that same number and press "1" to reach the Veterans Crisis Line.

If you just can't make that call, reach out to someone else — immediately — such as your doctor, mental health provider, family member, friend or someone in your faith community.

Causes

It's not known specifically what causes cyclothymia. As with many mental health disorders, research shows that it may result from a combination of:

- **Heredity,** as cyclothymia tends to run in families
- **Differences in the way the brain works,** such as changes in the brain's neurobiology
- **Environment,** such as traumatic experiences or prolonged periods of stress

Risk factors

Cyclothymia is thought to be relatively rare. But true estimates are hard to pin down because people may be undiagnosed or misdiagnosed as having other mood disorders, such as depression.

Cyclothymia typically starts during the teenage years or young adulthood. It affects about the same number of males and females.

Complications

If you have cyclothymia:

- Not treating it can result in significant emotional problems that affect every area of your life
- There is a high risk of later developing bipolar I or II disorder
- Substance misuse is common
- You may also have an anxiety disorder
- You may be at increased risk of suicidal thoughts and suicide

Prevention

There's no sure way to prevent cyclothymia. However, treatment at the earliest indication of a mental health disorder can help prevent cyclothymia from worsening. Long-term preventive treatment also can help prevent minor symptoms from becoming full-blown episodes of hypomania, mania or major depression.

By Mayo Clinic Staff

National Alliance on Mental Illness

Depression

Depression

Depressive disorder, frequently referred to simply as depression, is more than just feeling sad or going through a rough patch. It's a serious mental health condition that requires understanding and medical care. Left untreated, depression can be devastating for those who have it and their families. Fortunately, with early detection, diagnosis and a treatment plan consisting of medication, psychotherapy and healthy lifestyle choices, many people can and do get better.

Some will only experience one depressive episode in a lifetime, but for most, depressive disorder recurs. Without treatment, episodes may last a few months to several years.

More than **17 million** U.S. adults—over **7%** of the population—had at least one major depressive episode in the past year. People of all ages and all racial, ethnic and socioeconomic backgrounds experience depression, but it does affect some groups more than others.

Symptoms

Depression can present different symptoms, depending on the person. But for most people, depressive disorder changes how they function day-to-day, and typically for more than two weeks. Common symptoms include:

- Changes in sleep
- Changes in appetite
- Lack of concentration
- Loss of energy
- Lack of interest in activities
- Hopelessness or guilty thoughts
- Changes in movement (less activity or agitation)
- Physical aches and pains
- Suicidal thoughts

Causes

Depression does not have a single cause. It can be triggered by a life crisis, physical illness or something else—but it can also occur spontaneously. Scientists believe several factors can contribute to depression:

- **Trauma**. When people experience trauma at an early age, it can cause long-term changes in how their brains respond to fear and stress. These changes may lead to depression.
- **Genetics**. Mood disorders, such as depression, tend to run in families.

- **Life circumstances**. Marital status, relationship changes, financial standing and where a person lives influence whether a person develops depression.
- **Brain changes**. Imaging studies have shown that the frontal lobe of the brain becomes less active when a person is depressed. Depression is also associated with changes in how the pituitary gland and hypothalamus respond to hormone stimulation.
- **Other medical conditions**. People who have a history of sleep disturbances, medical illness, chronic pain, anxiety and attention-deficit hyperactivity disorder (ADHD) are more likely to develop depression. Some medical syndromes (like hypothyroidism) can mimic depressive disorder. Some medications can also cause symptoms of depression.
- **Drug and alcohol misuse**. **21%** of adults with a subtance use disorder also experienced a major depressive episode in 2018. Co-occurring disorders require coordinated treatment for both conditions, as alcohol can worsen depressive symptoms.

Diagnosis

To be diagnosed with depressive disorder, a person must have experienced a depressive episode lasting longer than two weeks. The symptoms of a depressive episode include:

- Loss of interest or loss of pleasure in all activities
- Change in appetite or weight
- Sleep disturbances
- Feeling agitated or feeling slowed down
- Fatigue
- Feelings of low self-worth, guilt or shortcomings
- Difficulty concentrating or making decisions
- Suicidal thoughts or intentions

Treatments

Although depressive disorder can be a devastating illness, it often responds to treatment. The key is to get a specific evaluation and treatment plan. Safety planning is important for individuals who have suicidal thoughts. After an assessment rules out medical and other possible causes, a patient-centered treatment plans can include any or a combination of the following:

- **Psychotherapy** including cognitive behavioral therapy, family-focused therapy and interpersonal therapy.
- **Medications** including antidepressants, mood stabilizers and antipsychotic medications.
- **Exercise** can help with prevention and mild-to-moderate symptoms.
- **Brain stimulation therapies** can be tried if psychotherapy and/or medication are not effective. These include electroconvulsive therapy (ECT) for depressive disorder with psychosis or repetitive transcranial magnetic stimulation (rTMS) for severe depression.
- **Light therapy**, which uses a light box to expose a person to full spectrum light in an effort to regulate the hormone melatonin.
- **Alternative approaches** including acupuncture, meditation, faith and nutrition can be part of a comprehensive treatment plan.

Reviewed August 2017

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Intermittent explosive disorder

Overview

Intermittent explosive disorder involves repeated, sudden episodes of impulsive, aggressive, violent behavior or angry verbal outbursts in which you react grossly out of proportion to the situation. Road rage, domestic abuse, throwing or breaking objects, or other temper tantrums may be signs of intermittent explosive disorder.

These intermittent, explosive outbursts cause you significant distress, negatively impact your relationships, work and school, and they can have legal and financial consequences.

Intermittent explosive disorder is a chronic disorder that can continue for years, although the severity of outbursts may decrease with age. Treatment involves medications and psychotherapy to help you control your aggressive impulses.

Symptoms

Explosive eruptions occur suddenly, with little or no warning, and usually last less than 30 minutes. These episodes may occur frequently or be separated by weeks or months of nonaggression. Less severe verbal outbursts may occur in between episodes of physical aggression. You may be irritable, impulsive, aggressive or chronically angry most of the time.

Aggressive episodes may be preceded or accompanied by:

- Rage
- Irritability
- Increased energy
- Racing thoughts
- Tingling
- Tremors
- Palpitations
- Chest tightness

The explosive verbal and behavioral outbursts are out of proportion to the situation, with no thought to consequences, and can include:

- Temper tantrums
- Tirades
- Heated arguments
- Shouting
- Slapping, shoving or pushing
- Physical fights
- Property damage
- Threatening or assaulting people or animals

You may feel a sense of relief and tiredness after the episode. Later, you may feel remorse, regret or embarrassment.

When to see a doctor

If you recognize your own behavior in the description of intermittent explosive disorder, talk with your doctor about treatment options or ask for a referral to a mental health professional.

Causes

Intermittent explosive disorder can begin in childhood — after the age of 6 years — or during the teenage years. It's more common in younger adults than in older adults. The exact cause of the disorder is unknown, but it's probably caused by a number of environmental and biological factors.

- **Environment.** Most people with this disorder grew up in families where explosive behavior and verbal and physical abuse were common. Being exposed to this type of violence at an early age makes it more likely these children will exhibit these same traits as they mature.
- **Genetics.** There may be a genetic component, causing the disorder to be passed down from parents to children.
- **Differences in how the brain works.** There may be differences in the structure, function and chemistry of the brain in people with intermittent explosive disorder compared to people who don't have the disorder.

Risk factors

These factors increase your risk of developing intermittent explosive disorder:

- **History of physical abuse.** People who were abused as children or experienced multiple traumatic events have an increased risk of intermittent explosive disorder.
- **History of other mental health disorders.** People who have antisocial personality disorder, borderline personality disorder or other disorders that include disruptive behaviors, such as attention-deficit/hyperactivity disorder (ADHD), have an increased risk of also having intermittent explosive disorder.

Complications

People with intermittent explosive disorder have an increased risk of:

- **Impaired interpersonal relationships.** They're often perceived by others as always being angry. They may have frequent verbal fights or there can be physical abuse. These actions can lead to relationship problems, divorce and family stress.
- **Trouble at work, home or school.** Other complications of intermittent explosive disorder may include job loss, school suspension, car accidents, financial problems or trouble with the law.
- **Problems with mood.** Mood disorders such as depression and anxiety often occur with intermittent explosive disorder.
- **Problems with alcohol and other substance use.** Problems with drugs or alcohol often occur along with intermittent explosive disorder.
- **Physical health problems.** Medical conditions are more common and can include, for example, high blood pressure, diabetes, heart disease and stroke, ulcers, and chronic pain.
- **Self-harm.** Intentional injuries or suicide attempts sometimes occur.

Prevention

If you have intermittent explosive disorder, prevention is likely beyond your control unless you get treatment from a professional. Combined with or as part of treatment, these suggestions may help you prevent some incidents from getting out of control:

- **Stick with your treatment.** Attend your therapy sessions, practice your coping skills, and if your doctor has prescribed medication, be sure to take it. Your doctor may suggest maintenance medication to avoid recurrence of explosive episodes.
- **Practice relaxation techniques.** Regular use of deep breathing, relaxing imagery or yoga may help you stay calm.
- **Develop new ways of thinking (cognitive restructuring).** Changing the way you think about a frustrating situation by using rational thoughts, reasonable expectations and logic may improve how you view and react to an event.
- **Use problem-solving.** Make a plan to find a way to solve a frustrating problem. Even if you can't fix the problem right away, having a plan can refocus your energy.
- **Learn ways to improve your communication.** Listen to the message the other person is trying to share, and then think about your best response rather than saying the first thing that pops into your head.
- **Change your environment.** When possible, leave or avoid situations that upset you. Also, scheduling personal time may enable you to better handle an upcoming stressful or frustrating situation.
- **Avoid mood-altering substances.** Don't use alcohol or recreational or illegal drugs.

By Mayo Clinic Staff

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National Alliance on Mental Illness

Smoking

Jump To: **Quitting** | **Infographics & Resources**

Living with a mental illness can be difficult, and some people may turn to smoking as a way to cope with symptoms or handle stressful life events. About **18 million** people with mental illness currently use tobacco products, and adults with mental illness use cigarettes at **higher rates** than those without a mental illness.

People with mental illness or a substance use disorder also smoke more cigarettes. Despite only representing 25% of the U.S. adult population, they consume **40%** of cigarettes sold in the U.S. — smoking **two more packs per month** than people without a mental health condition. People with serious mental illness represent only 6.9% of people who have smoked in the past month, but they consume **8.7%** of all cigarettes sold.

Although it may provide temporary relief from some symptoms, smoking is not a healthy solution for managing mental illness. Nicotine can **alter mood** in a way that covers up symptoms, which reinforces the increased use of tobacco in people with a mental health condition. Smoking tobacco can exacerbate existing mental and physical health challenges in the short term and lead to additional negative outcomes down the road. If you or a loved one smokes, here is what you need to know about smoking and mental illness — including information to help you quit.

Mental And Physical Health Effects

Smoking takes a toll on both your mental and physical health, and the consequences can be severe. In the U.S., people with mental illness who smoke die up to **15 years earlier** than people without mental illness who do not smoke. People with mental illness are **four times** more likely to die prematurely if they smoke cigarettes. Heart disease, cancer and lung disease are the **leading causes of death** for people with mental illness, so it's important to understand how smoking affects your risk for these diseases.

Serious health effects of smoking tobacco include:

- Increased risk of heart attack, stroke and lung cancer
- Coughing and shortness of breath
- Worsened **anxiety, stress and depression**
- Oral health issues, including gum disease and **tooth loss**
- Potential **interactions with psychiatric medications**
    - Smoking tobacco may decrease the effectiveness of some psychiatric medications, and you might need a higher dosage to achieve the same level of therapeutic benefit
- Social isolation, **stigma** and negative self-image

Some of these harmful effects decrease immediately when you stop smoking, and **the improvements add up over time**. Coughing and shortness of breath are reduced in the first month after quitting, risk of heart attack decreases after one year, risk of stroke decreases after five years, and increased risk of lung cancer is dramatically reduced after 10 years.

A number of other benefits are possible when you quit, including more financial freedom, a longer lifespan and a healthier home life.

Vaping And E-Cigarettes

Although some people may believe that vaping is a safe way to use tobacco, this is a dangerous misconception. **E-cigarettes are not harmless**, and complete cessation from all tobacco products is the healthiest choice. Like combustible, or lighted, tobacco products, the liquid in e-cigarettes contains nicotine and can **lead to dependence**.

E-liquids contain additional flavorings and chemical compounds like propylene glycol and glycerol, and research has **not demonstrated** that these compounds are safe to inhale. Because there is little regulatory oversight, e-cigarette products purchased "off the street" may be unsafe due to **adulteration** of these compounds. The overall long-term health effects of e-cigarettes are **also unknown**.

Switching completely to e-cigarettes from combustible tobacco products **may have some health benefit**, but e-cigarettes are **not FDA-approved** tobacco cessation devices.

Youth And Tobacco Use

The use of e-cigarettes is especially common among young people, even those who had never used combustible tobacco products before. In 2018, among young adults ages 18–24, 22.1% of people who currently smoked, 36.5% of people who used to smoke and 4.6% of people who had never smoked **reported using e-cigarettes**.

And in 2020, **3.6 million** middle and high school students reported using e-cigarettes.

However, youth tobacco use is not limited to vaping — 1.15 million middle and high school students **reported smoking cigarettes** in 2019. Research also suggests that, like adults, youth may turn to smoking to cope with the symptoms or stressors associated with mental illness. People aged 12–17 are **2.5 times more likely** to report using cigarettes in the past month if they experienced a major depressive episode in the past year.

Fast Facts

- As many as **70-85% of people with schizophrenia** and as many as **50-70% of people with bipolar disorder** smoke.
- The negative health effects of secondhand smoke have killed about **2.5 million people who do not smoke** since 1964.
- People with serious mental illness who smoke may spend **up to one third of their income** on cigarettes.
- The **average price** for a pack of cigarettes in the U.S. is $6.28. A one pack per day smoker can save $44 per week, $188 per month and $2,292 per year by quitting smoking.

Quitting

Quitting smoking, or smoking cessation, is tough for anyone — and it can be even harder when you have a mental illness. Although tobacco use by adults has decreased in recent years, the rate of reduction is **much lower** among people with mental illness.

About **70%** of people with mental illness who smoke say they want to quit. Quitting is not only possible, but one of the best things you can do for your overall well-being.

Cessation treatments, nicotine replacement therapy and other strategies are **safe, effective and do not increase symptoms** for people with serious mental illness. Also keep in mind that **treating an underlying mental illness** while trying to quit results in the most success for smoking cessation.

How To Quit

There is **no "right" way** to quit and every attempt counts — it can take **multiple** attempts to quit completely.

Having a mental illness is a **risk factor for relapse** to smoking, even for those who have avoided using tobacco for more than a year, so it's important to have a strategy and consider **cessation assistance**.

Try starting with **small steps** such as:

- Setting a quit date
- Buying only one pack of cigarettes at a time so you run out on your quit date
- Throwing away ash trays and lighters and cleaning your car's interior
- Identifying what triggers your urge to smoke
- Finding healthy ways to **distract yourself**, like chewing bubble gum or going for a walk
- Telling someone you're going to quit so they can help you stay accountable

When thinking about your overall strategy for quitting, there are three common options:

- **Cold Turkey**: completely quitting all tobacco and nicotine-containing products at the same time. While some people succeed using this method, most people will need additional support.
- **Nicotine Replacement Therapy (NRT)**: products like gum, patches, lozenges, and prescription nasal sprays or inhalers that deliver measured doses of nicotine to decrease the side effects of withdrawing from tobacco. These products are available "over the counter" to people aged 18 and older and come in a variety of strengths to help decrease nicotine consumption over time.
  - NRT can increase the chances of quitting successfully by **about 50%**.
  - Although NRTs are designed for short-term use, they are safe for long-term use if necessary to prevent a return to smoking.
  - Using more than one NRT at the same time is safe, and can actually **increase success in quitting**.
- Prescription Medications: two medications, varenicline (Chantix®) and bupropion (Zyban® and Wellbutrin®), are approved by the FDA to aid in smoking cessation. They are both **safe to use** for people with mental illness.

- Varenicline **reduces the pleasurable effects** of smoking and possible withdrawal symptoms. People who use varenicline are **three times more likely** to successfully quit compared to those who do not use a cessation medication.
- Bupropion **decreases nicotine cravings** and withdrawal symptoms. People who use bupropion are **two times more likely** to successfully quit compared to those who do not use a cessation medication.

There are some risks associated with cessation products. For example, Bupropion can **interact with MAOIs**, a class of psychiatric medications, and is not appropriate if you are already using Wellbutrin® for psychiatric purposes. It's important to stay in touch with your health care provider and let them know about any **worsening psychiatric symptoms**.

Regardless of which strategy you think is best for you, make sure to talk to your doctor about your desire to quit. Don't wait for your provider to bring it up — research shows that only **62% of psychiatrists** ask about tobacco use and/or advise their patients to stop smoking. Your doctor will answer any questions you have and help you create a personalized quit plan. Visit **Help to Quit** for more information about talking to your doctor when you want to quit smoking.

No-Cost Resources

- Quit Lines
  - 1-800-QUIT-NOW
  - 1-877-44U-QUIT
- Websites
  - **Betobaccofree.gov**
  - **Smokefree.gov**
- SmokefreeTXT Program
  - Text QUIT to 47848
  - Visit **smokefree.gov** for more information

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National Alliance on Mental Illness

Substance Use Disorders

Substance use disorders — the repeated misuse of alcohol and/or drugs — often occur simultaneously in individuals with mental illness, usually to cope with overwhelming symptoms. The combination of these two illnesses has its own term: dual diagnosis, or **co-occurring disorders**. Either disorder (substance use or mental illness) can develop first.

According to the National Survey on Drug Use and Health, **9.2 million** U.S. adults experienced both mental illness and a substance use disorder in 2018.

Symptoms

Because many combinations of dual diagnosis can occur, symptoms vary widely. Mental health clinics are starting to use alcohol and drug **screening tools** to identify people at risk. Symptoms of substance use disorder may include:

- Withdrawal from friends and family
- Sudden changes in behavior
- Engaging in risky behaviors
- Developing a high tolerance and withdrawal symptoms
- Feeling like you need a drug to be able to function

Symptoms of a mental health condition can also vary greatly. **Warnings signs**, such as extreme mood changes, confused thinking or problems concentrating, avoiding friends and social activities and thoughts of suicide, may be reasons to seek help.

Treatment

The best treatment for dual diagnosis is integrated intervention, when a person receives care for both their diagnosed mental illness and substance use disorder. The idea that "I cannot treat your depression because you are also drinking" is outdated — current thinking requires *both* issues be addressed.

You and your treatment provider should understand the ways each condition affects the other and how your treatment can be most effective. Treatment planning will not be the same for everyone, but here are a few common elements:

Detoxification. The first major hurdle that people with a substance use disorder will have to pass is detoxification. Inpatient detoxification is generally more effective than outpatient for initial sobriety and safety. During inpatient detoxification, trained medical staff monitor a person 24/7 for up to seven days. The staff may administer tapering amounts of the substance or its medical alternative to wean a person off and lessen the effects of withdrawal.

Inpatient Rehabilitation. A person experiencing a mental illness and dependent patterns of substance use may benefit from an inpatient rehabilitation center where they can receive medical and mental health care 24/7. These treatment centers provide therapy, support, medication and health services to treat the substance use disorder and its underlying causes.

Psychotherapy is usually a large part of an effective treatment plan. In particular, cognitive behavioral therapy (**CBT**) helps people with dual diagnosis learn how to cope and change ineffective patterns of thinking, which may increase the risk of substance use.

Medications are useful for treating mental illness. **Certain medications** can also help people experiencing substance use disorders ease withdrawal symptoms during the detoxification process.

Supportive Housing, like group homes or sober houses, are residential treatment centers that may help people who are newly sober or trying to avoid relapse. Sober homes have been criticized for offering varying levels of quality care because licensed professionals do not typically run them. Please do some research before making a selection.

Self-Help and Support Groups. Dealing with a dual diagnosis can feel challenging and isolating. Support groups allow members to share frustrations, celebrate successes, find referrals for specialists, find the best community resources and swap recovery tips. They also provide a space for forming healthy friendships filled with encouragement to stay clean. Here are a few groups to check out:

- **Double Trouble in Recovery** is a 12-step fellowship for people managing both a mental illness and substance use disorders.
- **Alcoholics Anonymous** and **Narcotics Anonymous** are 12-step groups for people recovering from alcohol or drug addiction. Be sure to find a group that understands the role of mental health treatment in recovery.
- **Smart Recovery** is a sobriety support group for people with a variety of addictions that is *not* based in faith.

Reviewed May 2020

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The Link Between Psychotic Disorders and Substance Use

January 1, 2007
Emma Barkus, PhD
Volume 24, Issue 1

Relevant Topics

Psychotic disorders are a group of syndromes characterized by positive symptoms, including hallucinations, delusions, and thought disorder; and negative symptoms, including mood symptoms, social withdrawal, and reduced motivation. Cognitive deficits also appear with psychotic disorders. Psychotic disorders rank 22nd in the World Health Organization's list of worldwide causes of disability. This ranking is adjusted for the relatively low lifetime prevalence rate for psychosis; the perceived burden of the disease on those affected with psychotic disorders, as well as their relatives and caregivers, is much higher.

Psychotic disorders are a group of syndromes characterized by positive symptoms, including hallucinations, delusions, and thought disorder; and negative symptoms, including mood symptoms, social withdrawal, and reduced motivation. Cognitive deficits also appear with psychotic disorders. Psychotic disorders rank 22nd in the World Health Organization's list of worldwide causes of disability.[1] This ranking is adjusted for the relatively low lifetime prevalence rate for psychosis; the perceived burden of the disease on those affected with psychotic disorders, as well as their relatives and caregivers, is much higher.[2] Some symptoms are present, albeit in an attenuated form, prior to the onset of a diagnosable disorder. Features of psychotic disorders are detectable in the general population and are referred to as schizotypal traits, representing a normally distributed trait of risk for psychosis.

A recent large study of patients in their first episode of psychosis found a 74% lifetime prevalence of a substance use disorder, with 62% of the sample presenting at baseline with current substance use.[3] Alcohol, nicotine, and cannabis are the predominant substances abused by patients with psychotic disorders.[4] A US epidemiology study reported the risk for substance use as 4.6 fold higher in patients with schizophrenia compared with the general population.[5] Even in Sweden, where there are tight restrictions on the sale of alcohol, patient consumption far exceeds rates reported in the general population.[6]

Relationship with onset

There has been much discussion about the relationship between recreational drug use, psychotic symptoms, and psychotic disorders, particularly with the increasing tolerance for drugs such as cannabis (by society and government). Substance use patterns seem to establish themselves before the onset of psychotic disorders; in a significant proportion of individuals, this may be as little as a month before the first signs of illness.[7] The close temporal proximity of substance use to emerging signs or symptoms of psychotic illness may be an indication for the causal relationship between psychotic disorders and substance use, although this is open for debate.[8]

It is difficult to determine whether those prone to psychosis are self-medicating initial symptoms, or whether they are drawn to substance use by factors unrelated to illness, such as personality traits. In addition, patterns of substance use before onset of illness may be indicative of other risk factors that are associated with lifestyle changes linked to the beginning of deterioration into psychosis and detrimental factors directly related to increased drug use.

There are 2 hypotheses regarding the onset of psychotic disorders that are of interest to researchers and clinicians:

- Drug use triggers psychotic symptoms in those individuals who have an underlying predisposition to psychotic disorders.
- Exposure to recreational drug use is sufficient in itself to lead to these symptoms independent of underlying predisposition.

The NEMESIS project tested these hypotheses in regards to cannabis use. Van Os and colleagues[9] reported that those who displayed a vulnerability to psychotic disorders at baseline were more likely to experience isolated psychotic symptoms after cannabis use. In addition, use of cannabis alone led to the increased likelihood of isolated psychotic symptoms reported at follow-up. Furthermore, one study found higher reports of psychotic-like and psychopathologic experiences from cannabis use (both during the immediate high and during following use) in those individuals with an elevated propensity toward psychosis.[10] These data suggest that cannabis use may trigger an underlying vulnerability to isolated symptoms through an unknown mechanism. There is limited evidence that perhaps in high doses,[11] cannabis in the absence of any vulnerability can lead to isolated psychotic symptoms. However, isolated incidences of psychotic symptoms are not sufficient for a diagnosis of any psychotic disorder, and therefore, there are additional factors that lead to the onset of a psychotic disorder.

The most robust body of evidence for the relationship between the onset of psychotic disorders and drug use comes from the Swedish conscript studies.[12,13] Baseline drug use information was taken at intake to the army for these studies. The authors found that cannabis use, and to a lesser extent amphetamine use, predicted onset of psychotic disorder later in adulthood. The explanatory variable was age at use, with younger age predicting psychotic disorders. This relationship did not exist for other drugs used, such as cocaine. A more recent cohort study in New Zealand confirmed the relationship between cannabis use and the onset of psychotic disorders.[14] This study demonstrated that younger age of first cannabis use predicted younger age of psychotic disorder onset in individuals with the Val/Val genotype for COMT on the Val158Met polymorphism (a gene that codes for the activity level of an enzyme involved in the breakdown of dopamine).

Course of psychosis and substance useThere is conflicting evidence of the effects of substance use on age at psychotic disorder onset. Some studies have found that substance use leads to a younger age at symptom onset and/or diagnosis,[7,15,16] while other studies have found no association.[17] Some investigators have suggested that patients who have an onset related to drug use have a distinct subtype of psychotic disorder. Drug-induced psychosis is still considered diagnostically distinct from psychotic disorders, since in the former, symptoms abate when substance use is discontinued, while symptoms in the latter persist. However, as previously noted, those who experience isolated psychotic symptoms in relation to drug use may have an underlying predisposition to psychosis.

Substance use during the course of psychotic illness may have implications for relapse and may interfere with treatment. Thus, finding predictors of continued use following an initial psychotic episode would identify those patients who may require further interventions and/or close monitoring. The most

consistently reported predictors of continued use are young age and male sex.[15,16,18] Previous studies have reported that young men are significantly more likely to use substances or to use more than one substance; this helps explain why male sex proves to be a significant predictor of continued use.[6] Compared with patients who have just substance use disorder, patients with psychotic disorder and substance dependence are more likely to be using substances after 7 years.[19] This further suggests that those with more severe substance use problems should be identified for targeted interventions concerned with reducing substance use.

However, there is some suggestion that substance use decreases following treatment initiation. Three studies have examined the course of substance use in the early phases of psychotic disorders. Two have shown a marked reduction in substance use during early treatment, compared with that in the pretreatment period.[18,20] A third study found that 1 in 5 patients with psychotic disorders stopped using substances 15 months after their first episode.[21] Those patients who continued use did not increase their baseline use, and very few patients developed substance use behavior after treatment began. Taken together, these studies offer some room for optimism. It seems that a significant proportion of patients with psychotic disorders decrease or discontinue substance use once treatment has been initiated, while those who continue use do not increase their intake.

Exacerbation of symptoms and relapse

The relationship between substance use and symptoms in psychotic disorders is varied. Some studies report a relationship with increased symptoms,[22-24] while others do not.[25-27] However, there appears to be a relationship in those with psychotic disorders between substance use and increased hospitalization and remission,[3,26,28-31] although not all studies report these findings.[32,33] The relationship between remission in patients with psychotic disorders and comorbid substance use can in part be explained by reports of reduced adherence to medication regimens and engagement in services.[3,7,26] One study reported that relapse occurs even when medication adherence has been fully documented (ie, it is not an issue),[34] suggesting the possibility of an interaction between the substances used and antipsychotic medication.

Treatment approaches for substance use

Support for the possibility of an interaction between substances used by patients with psychotic disorders and antipsychotics comes from reports that those with substance use problems have a poorer response to treatment.[4,6] There is an overlap in the neurobiologic networks involved in the development and maintenance of substance use and psychotic disorders.[35] Taken together, these studies suggest that those with comorbid substance use and psychotic disorder may require additional treatment, either in the form of targeted psychological or additional pharmacologic interventions, to address symptoms associated with substance use. There is emerging evidence that this integrated treatment approach is effective in patients with a dual diagnosis.[36] However, psychological interventions are only effective at targeting symptoms that the patient wishes to change.

There is no evidence that typical antipsychotics are particularly effective in treating patients with psychotic disorders and substance use problems; there is even some suggestion that haloperidol use increases tobacco smoking.[37] There is some evidence that the atypical antipsychotic clozapine may reduce substance use in patients with psychotic disorders.[38,39] Alcohol, nicotine, and cannabis use are reported to decrease in response to clozapine treatment; there are some indications that clozapine reduces cocaine cravings and use.[40]

Clozapine has also been reported to be more effective in reducing substance use as compared with risperidone, and it has been reported to be better tolerated, leading to continuation of treatment over 12 months.[41] In addition, patients with comorbid substance use problems and psychotic disorder

respond equally well to clozapine as those who do not have substance use problems.[42] It has been suggested that clozapine reduces substance use through its effects on the dopamine-dependent reward pathways,[43] but this mechanism has yet to be formally tested.

A large-scale prospective randomized controlled trial has not been carried out to test the reduction in substance use in a large sample of patients with psychotic disorders treated with clozapine. Such a trial is needed to substantiate results from smaller studies.

Other atypical antipsychotics have proved to be of interest in treating substance use in patients with psychotic disorders. Risperidone has been reported to reduce cocaine craving and relapse.[44,45] Olanzapine has also been reported to lead to small reductions in substance use and decreased craving for a variety of substances in those with psychotic disorders.[46-48] However, systematic prospective randomized controlled trials have yet to test the efficacy of these drugs in reducing substance use in patients with psychotic disorders.

Conclusions

There appears to be evidence of substance use (at least cannabis use) as a component cause for psychotic disorders. However, it is still unclear whether substance use operates as a causal factor in the absence of underlying biologic vulnerability to psychosis and whether the expression of isolated psychotic symptoms is directly related to clinical psychotic disorders. The evidence for the causal relationship between substance use and psychotic disorders is primarily based on epidemiologic studies; further clinical studies are needed to determine how substance use operates as a risk factor for psychotic disorders. It is possible that this evidence will emerge from the growing numbers of early intervention services worldwide.

According to a recent review, published studies examining the effect of substance use on the course of schizophrenia are drawn from North America, Australia, and a select number of European countries.[6] Therefore, many countries have not contributed to the literature. This is particularly true for developing countries, where the demographic of substance users is likely to be different.

There is a need for more systematic research in this area. In particular, there is a need for systematic large-scale research to examine the causal role of substance use in altering the course of psychotic disorders, where current research is highly conflicting. Focusing on the reasons that patients with psychotic disorders abuse substances (eg, to relieve affective flattening and negative symptoms[7]) may produce information on unmet needs that can be targeted by specifically developed therapies in the future. In addition, the pharmacologic interventions that show promise in treating substance use in those patients with psychotic disorders need to be investigated more systematically to better understand their benefits and their underlying mechanisms.

Dr Barkus is a research fellow in the Neuroscience and Psychiatry Unit, University of Manchester, Manchester, UK. She reports no conflicts of interest concerning the subject matter of this article.

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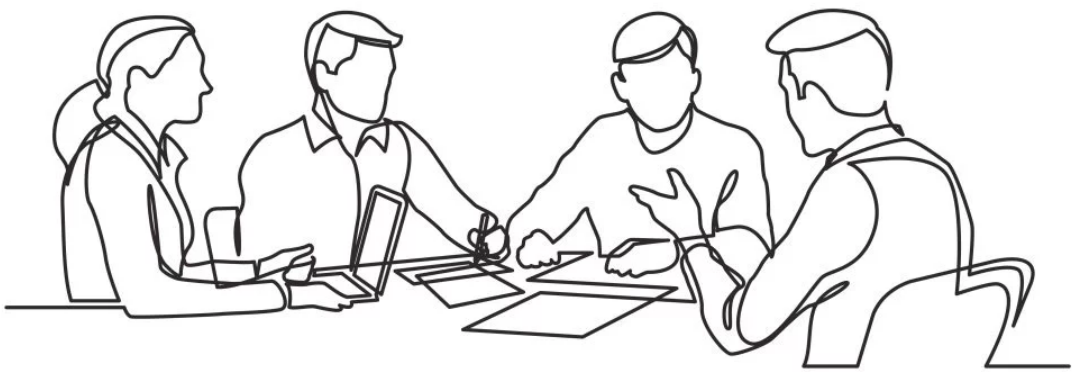
An Inside Look at Depression Treatment Among Patients With Addictive Disorders

December 4, 2020

Cornel N. Stanciu, MD, MRO

Relevant Topics

Are patients with depression and substance use disorder getting an appropriate level of care? Our Journal Club piece investigates.



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Major depressive disorder (MDD) is the leading cause of global disease burden.[1] Between 2018 and 2019 the prevalence of MDD in the United States has continued to increase among all age groups.[2] Patients with these disorders are twice as likely to suffer from a comorbid substance use disorder (SUD) compared with the general population, and the severity of the S6UD parallels that of MDD.[3] The comorbidity poses treatment challenges, and patients have been found to have poor outcomes (eg, increased substance use, more severe disease burden, higher rates of suicide attempts and behaviors), as well as an overall increased mortality.[4]

Table 1. Patients Receiving Antidepressants

	Substance use disorder and major depressive disorder	Major depressive disorder alone
Acute-phase antidepressants	59.4%	66.2%
Continuation-phase antidepressants	36.3%	44.8%

Table 1. Patients Receiving Antidepressants

The tight association between MDD and SUD does not necessarily hint at causation, as substance use can lead to mental health symptoms and conditions; mental illness can lead to self-medicating with substance use; and both conditions may co-occur independently as in the case of overlapping predisposing genetic factors. For patients with the comorbidity treatment gaps exist. 90% of those with SUD do not get MDD treatment, and 55% of those with MDD do not get SUD treatment when addressed independently, while 33% of them get no treatment at all.[2]

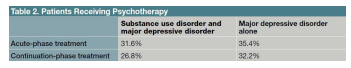

Table 2. Patients Receiving Psychotherapy

	Substance use disorder and major depressive disorder	Major depressive disorder alone
Acute-phase treatment	31.6%	35.4%
Continuation-phase treatment	26.8%	32.2%

Table 2. Patients Receiving Psychotherapy

Both MDD and SUD are in the DSM-5 and hence it is our responsibility to treat them as part of our routine psychiatric practice. Treating depression and substance use independently and in isolation of each other is incongruent with best practices and leads to detrimental outcomes.[5] Guidelines recommend simultaneous and integrated treatment with pharmacotherapy and/or psychotherapy for MDD depending on disease severity.[6,7]

As for how closely these guidelines are followed, no study to date has investigated whether those with the SUD comorbidity receive similar MDD care to those without SUD among the pharmacotherapy and psychotherapy-based treatment modalities, or the degree to which specific SUDs are differentially associated with the receipt of guideline-specific MDD treatment. Coughlin and colleagues[8] attempt to do just that.

Structured Investigation

Question. Do patients with MDD and comorbid SUD receive similar, guideline-concordant, care as those without SUD?

Type of study. Retrospective cohort analysis of 53,034 patients in whom MDD was diagnosed in the 2017 fiscal year in the US Veterans Health Administration (VHA).[8]

Population. The patients were all veterans receiving care through the US Veterans Health Administration system. They all had a diagnosis of depression made in 2017.

Method. Electronic medical record data was reviewed to identify patients from both inpatient and outpatient encounters who were diagnosed with depression using ICD-10 codes and Patient Health Questionnaire (PHQ) screens. The PHQ was required to have been documented within a 30-day window of the depression diagnosis in order to capture active depressive episodes. Exclusionary criteria targeted patients with a past depressive diagnosis or who had received prescription antidepressants (except trazodone) or psychotherapy in the past 12 months prior to the index diagnosis date. Also excluded were those with positive PHQ scores documented between 30 days and 12 months before the index depression diagnosis. Patient with comorbid bipolar disorder, schizophrenia, psychosis, personality disorder or developmental disorders, or those with more than 30 days of inpatient treatment in the last year were also excluded. Patients with comorbid SUD were identified as receiving a SUD diagnosis in the year before the depression diagnosis, as identified using ICD-10 codes meant to capture alcohol, opioid, cannabis, cocaine, stimulants, and other SUDs.

The outcomes measure assessed was adherence to treatment guidelines. For this, the authors used Healthcare Effectiveness Data and Information Set (HEDIS), which is a set of performance measurement tools developed and

maintained by the National Committee for Quality Assurance (NCQA) and widely used to assess where improvements can make a difference. HEIDIS is intended to allow comparisons among various health plans, systems, as well as adherence to national benchmarks and guidelines.

Among patients who received an initial prescription for antidepressants within 90 days of the index, depressive disorders to HEDIS based measures related to pharmacotherapy were applied. These resulted in measurements of adequate acute phase treatment (receipt of an antidepressant prescription within 90 days of diagnosis that provides medication for at least 84 of the 114 days following initial prescription); adequate continuation phase treatment (continuing antidepressant for 180 of the first 231 days following initial script).

Psychotherapy (identified using CPT codes) was also examined using metrics analogous to HEDIS. Here they evaluated both acute phase treatment (psychotherapy sessions that occurred within 90 days of the index depression diagnosis), as well as continuous phase treatment (at least 3 psychotherapy sessions in the 12 weeks following the first session). Additionally, the authors considered the confounding element that psychotherapy could be delivered for both depressive disorders and SUDs hence, in the analysis-only sessions for whichdepressive disorders were the primary diagnosis were included.

The authors also aimed to adjust for patient demographics (age, gender, race, geographical locality, and distance from the VA) and clinical characteristics (comorbid mental health disorders, measured by the Elixhauser score for severity).

Statistical analysis. Sample characteristics across all described covariates were compared between those with and without SUD. Four multivariate logistic regression models were conducted to assess the associations between the presence of a SUD diagnosis and adequate acute and continuous phase antidepressant or psychotherapy treatment. Adjustments for covariates were done for each model.

The authors estimated percentages of those receiving treatment across each of the depression care metrics (those with and without comorbid SUD) as the marginal means of balanced population based on the model. Associations of specific SUDs with depression treatment were examined via the 4 models with each SUD independently analyzed. Authors also descriptively examined the setting where patients with SUD were receiving depression treatment.

Results

Baseline Characteristics

Among the 53,034 participants diagnosed with a new episode of depression during the 2017 fiscal year, 52.9% received antidepressant treatment and 34.9% received psychotherapy within 90 days following diagnosis. Of this cohort, 14.2% had a SUD diagnosis in the year prior to the depression diagnosis.

Patients with SUD comorbidity had more visits in mental health and primary care settings in the year following the depressive diagnosis (average of 14.1 visits [SD 18.1] compared with 10.2 visits [SD 10.9] among those without SUD). Unfortunately, despite this higher opportunity for depression treatment, those with SUD received significantly less guideline-concordant depressive treatment across all metrics.

Before adjusting for covariates, observed rates show acute and continuation-phase antidepressants were provided to 59.4% and 36.3% of those with SUD and MDD versus 66.2% and 44.8% of those with just MDD (**Table 1**). In terms of psychotherapy, 31.6% and 26.8% of those with SUD received acute and continuation-phase treatment respectively, compared to 35.4% and 32.2% of those with just MDD (**Table 2**). For those with SUD, most received treatment in metal health clinics (47% psychotherapy [N = 1117]; 59.1% antidepressants [N

= 2390]); or in primary care/mental health integration clinics (42.7% psychotherapy [N = 1014] and 31.8% antidepressants [N = 1287]). A very small minority received depression treatment in SUD specialty clinics (3.5% psychotherapy [N = 83] and 2.5% antidepressants [N = 102]).

In terms of patient characteristics, those with SUD were slightly younger, male, African American, homeless, and had comorbid psychiatric conditions. Those without SUDs were more likely to be service connected, live in rural areas, and have more comorbid diagnosed medical conditions.

Analysis

Patients with SUD had lower odds of receiving guideline-concordant care, specifically 21% lower odds of receiving acute antidepressant treatment, 13% lower odds of initial psychotherapy treatment, 26% lower odds of adequate continuation of antidepressant, and 19% lower odds of continuation of psychotherapy.

Based on predicted probabilities of receipt of guideline-concordant depression treatment, an estimated 55% of individuals with comorbid SUD, compared with 61% without, received adequate acute antidepressant treatment, and 27% of individuals with comorbid SUD, compared with 29% without, received initial psychotherapy. As for cotinuation of treatment, 33% of individuals with comorbid SUD, compared with 40% without, received adequate continuation of antidepressants, and 22% of individuals with SUD, compared with 25% without, received adequate continuation of psychotherapy.

In terms of specific SUDs, lower quality depression care was evident across all evaluated substance types. Alcohol and cannabis use disorders were associated with significantly lower odds of adequate continuation of antidepressants (adjusted OR 0.81, 95% CI = 0.75, 0.88, $p < 0.001$ and adjusted OR 0.74, 95% CI = 0.63, 0.87, $p < 0.001$ respectively). Alcohol and cocaine use disorders were associated with lower odds of initiation of psychotherapy for depression (adjusted OR 0.86, 95% CI = 0.81, 0.91, $p < 0.001$ and adjusted OR 0.78, 95% CI = 0.66, 0.92, $p < 0.001$ respectively). Alcohol use disorders alone were associated with lower odds of adequate psychotherapy continuation (adjusted OR 0.81, 95% CI = 0.72, 0.90, $p < 0.001$).

There were also several covariates associated with lower odds of guideline-concordant care. These included homelessness, racial and ethnic minority groups, those in rural areas, and those with high psychiatric disease burden living farther away from a health care facility.

The Bottom Line

This retrospective review study of patients in the Veteran Healthcare Administration system points to a treatment gap in the delivery of guideline-concordant care for depression among those with SUD compared with those without it.

Discussion

This study assessed an interesting question: do patients with comorbid MDD and SUD receive different care for depression than those without SUD? Consistent with previous data[9,10] in a large national sample of veteran patients within the VHA system, the authors found that having the comorbid SUD diagnosis is associated with lower quality of depression treatment compared with those without it.[8] After accounting for various demographic, medical, and psychiatric factors, patients with SUD had lower odds of adequate acute phase treatment (21% and 13% lower for antidepressant and psychotherapy, respectively) and lower odds of adequate continuation of treatment (26% and 19% lower for antidepressant and psychotherapy, respectively) for depression. This discrepancy in guideline-concordant care for depression comes despite patients with SUD having higher health care utilization (more visits and medical

encounters) and hence more opportunities for MDD treatment initiation. Knowledge of this treatment gap is important because SUD and MDD affect each other bidirectionally, and the most effective approaches involve concurrent treatment.

There are several limitations to this study. As the authors point out, this sample is limited to veterans in care within the VHA system. The generalization outside this system, and to civilians with various insurance coverages, is unknown. Additionally, the analysis does not include or account for services rendered outside the VHA system, where it is not uncommon for veterans to seek care from.

The diagnosis of MDD as well as SUD is identified here based on ICD-10 codes entered in the electronic health records, which can at times contain errors or not even be entered at all.

There is no mention of how closely providers actually adhere to the use of screening tools such as PHQ-9. It is also necessary to consider that there are other widely available tools that are not accounted for here. It is important to keep in mind that lack of training in the assessment and treatment of complex presentations such as comorbidity leads to inaccurate beliefs and stigmas, an inability to accurately identify co-occurring disorders,[11-13] a lack of awareness of appropriate referral sources,[14,15] and a lack of preparedness to treat co-occurring disorders.[16] The providers caring for these patients are not explicitly defined here as to whether they are highly trained physicians or independently practicing nurse practitioners.[17]

The severity of the MDD is not specifically described here via the use of any objective measure.[8] Because engagement (or refusal) in treatment represents a patient-specific barrier, having a significant MDD severity, which patients with SUD comorbidity do, can lead to low motivation and lack of interest and future outlook, and hence would make it less likely for patients to be interested in and pursue treatment as well as adhere to it.

The sample selection criteria (new diagnosis of depression in fiscal year 2017 and a positive PHQ depression screen 30 days surrounding time of diagnosis) may lead to limits of generalizability of findings to the degree that these criteria may not capture most patients with depression (ie, preexisting diagnosis, noncompletion or adherence with depression screen).

Worthy of mention is that in the context of certain substances (ie, stimulant or cannabis), MDD may have psychotic features and hence require treatment with nontraditional modalities such as antipsychotics, rather than antidepressants. Within the limits of the study design it is also difficult to determine whether the MDD is due substance use or withdrawal.

The primary outcome measures here were based on the HEDIS, which has been criticized in the past for how its individual measures provide a narrow view of health care quality and interventions. There is also a question about whether attainment of their measures actually indicate better outcomes. In this study, the indicators of adequate acute and continuous phases of care (which are most often used measures of the quality of depression care) certainly do not encapsulate all features relevant to high-quality depression care. Nonetheless, HEDIS is part of NCQA's accreditation process and attainment is globally used as incentive for many health plans and Centers for Medicare & Medicaid Services.

The data generated here is consistent with the challenges in treating patients with an SUD comorbidity and it points toward the need to better address the rapidly expanding dual-diagnosis population. From here, next steps towards improvement of delivery of care to this population should include efforts at specifically identifying barriers that account to this gap, whether clinician related, institutional or system.

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What do you think? *Share comments with your colleagues by emailing PTEditor@mmhgroup.com. Comments may be shared online pending review and editing for style.*

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Thursday, 17 December, 2020 03:12:09 PM
Clerk, U.S. District Court, ILCD

EXHIBIT B

National Alliance on Mental Illness

Atomoxetine (Strattera)

Brand name: Strattera®

- Capsules: 10 mg, 18 mg, 25 mg, 40 mg, 60 mg, 80 mg, 100 mg

Generic Name: atomoxetine (AT oh mox e teen)

All FDA black box warnings are at the end of this fact sheet. Please review before taking this medication.

What Is Atomoxetine And What Does It Treat?

Atomoxetine is a prescription medication that is used to treat individuals with attention deficit hyperactivity disorder (ADHD).

Symptoms of ADHD interfere with an individual's ability to function at school or work or in social settings and include:

- Inattention (e.g., making careless mistakes, losing things necessary for tasks)
- Hyperactivity (e.g., inability to sit still)
- Impulsivity (e.g., interrupting or intruding on others)

Hyperactivity is less common in adults. A person may have severe inattention without hyperactivity or impulsivity.

Atomoxetine is used in addition to non-medication treatments to manage ADHD symptoms.

What Is The Most Important Information I Should Know About Atomoxetine?

It may take several weeks before you notice the full benefits of this medication. It is important to continue taking atomoxetine as directed, even if you do not notice immediate improvement.

Are There Specific Concerns About Atomoxetine And Pregnancy?

If you are planning on becoming pregnant, notify your healthcare provider to best manage your medications. People living with ADHD who wish to become pregnant face important decisions. Untreated ADHD has risks for the fetus as well as the mother. It is important to discuss the risks and benefits of treatment with your doctor and caregivers.

Regarding breastfeeding, caution is advised since it is not known if atomoxetine passes into human breast milk.

What Should I Discuss With My Healthcare Provider Before Taking Atomoxetine?

- Symptoms of your condition that bother you the most
- If you have thoughts of suicide or harming yourself
- If you experience side effects from your medications, discuss them with your provider. Some side effects pass with time, but others may require changes in the medication.
- Any other psychiatric or medical problems you have, including heart disease
- All other medications you are currently taking (including over the counter products, herbal and nutritional supplements) and any medication allergies you have
- Other non-medication treatment you are receiving, such as talk therapy or substance abuse treatment. Your provider can explain how these different treatments work with the medication.
- If you are pregnant, plan to become pregnant, or are breast-feeding
- If you drink alcohol or use drugs

How Should I Take Atomoxetine?

Atomoxetine is usually taken one to two times per day with or without food.

The dose usually ranges from 20 mg to 100 mg. Only your health care provider can determine the correct dose for you.

Capsules should be swallowed whole, not crushed or chewed.

Use a calendar, pillbox, alarm clock or cell phone alert to help you remember to take your medication. You may also ask a family member or a friend to remind you or check in with you to be sure you are taking your medication.

What Happens If I Miss A Dose Of Atomoxetine?

If you miss a dose of atomoxetine, take it as soon as you remember, unless it is closer to the time of your next dose. Discuss this with your health care provider. Do not double your next dose or take more than what is prescribed.

What Should I Avoid While Taking Atomoxetine?

Avoid drinking alcohol or using illegal drugs while you are taking this medication. They may decrease the benefits (e.g., worsen your condition) and increase adverse effects (e.g., sedation) of the medication.

What Happens If I Overdose With Atomoxetine?

If an overdose occurs call your doctor or 911. You may need urgent medical care. You may also contact the poison control center at 1-800-222-1222.

A specific treatment to reverse the effects of atomoxetine does not exist.

What Are Possible Side Effects Of Atomoxetine?

Common side effects

- Upset stomach, nausea, vomiting, decreased appetite, constipation, dry mouth, headache
- Feeling sleepy, sluggish or weak during the day, trouble sleeping at night
- Decreased libido or sexual side effects

Rare side effects

- Menstrual cycle changes, urinary retention, hot flushes, sweating, severe fatigue, irritability, or mood swings
- Rarely, a painful prolonged erection has been reported in child, adolescent, and adult males
- Increased heart rate and blood pressure
- Risk of switching to hypomania and mania, particularly in individuals with bipolar disorder

Serious side effects

- Liver toxicity, increased suicidal thoughts, angioedema and cardiovascular complications

Are There Any Risks For Taking Atomoxetine For Long Periods Of Time?

There are no known problems associated with long term use of atomoxetine

What Other Medications May Interact With Atomoxetine?

Atomoxetine should not be taken with or within two weeks of monoamine oxidase inhibitor antidepressants (MAOIs), including phenelzine (Nardil®), Tranylcypromine (Parnate®), selegiline (Emsam®), isocarboxazid (Marplan®), or antibiotic linezolid (Zyvox®). Taking atomoxetine with or within 2 weeks of MAOIs can result in seizures, fever or dangerously high blood pressure that can lead to death.

The following medications may increase the levels and effects of atomoxetine:

- Paroxetine (Paxil®), Fluoxetine (Prozac®), and Quinidine (Quinidex®)

Medications for asthma/difficulty breathing (e.g., albuterol) can increase the risk of high blood pressure and rapid heart rate (tachycardia) when taking atomoxetine.

Because of atomoxetine's possible effect on blood pressure it should be used cautiously with other medications that increase or decrease blood pressure.

How Long Does It Take For Atomoxetine To Work?

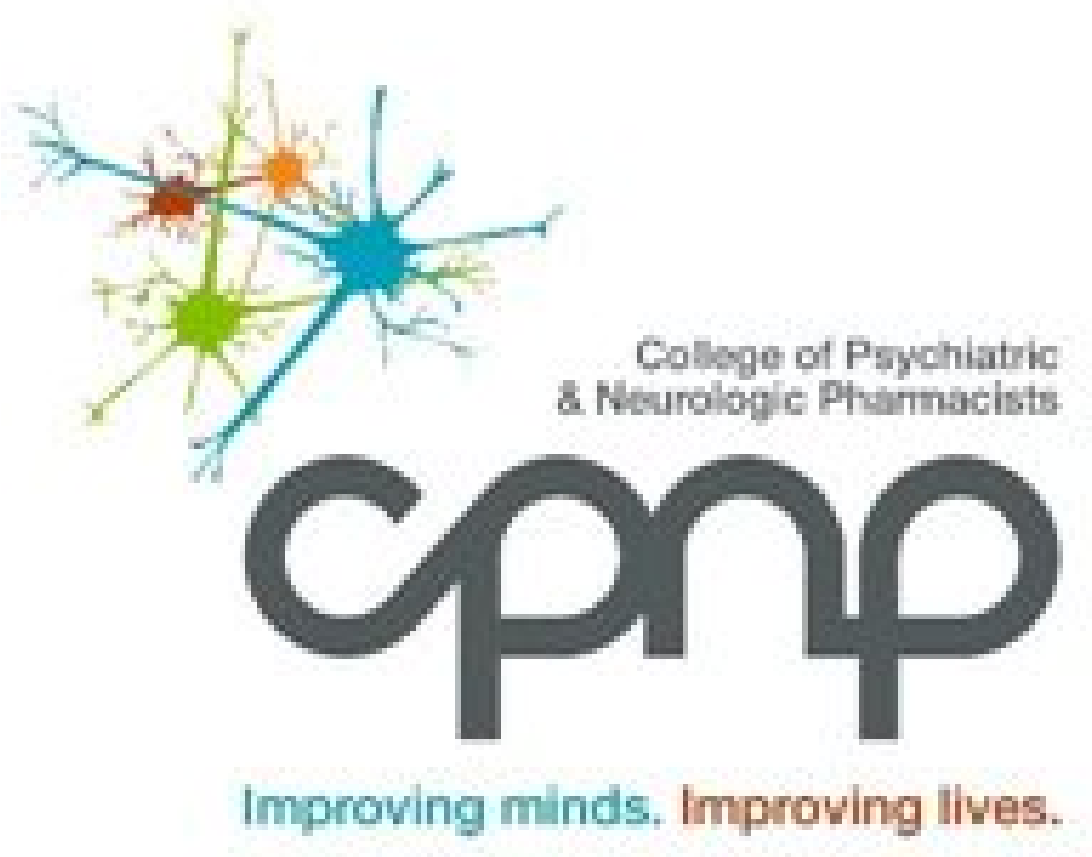
It may take four to eight weeks to get the maximum benefit once the right dose is determined. However, improvements in some symptoms may occur sooner.

Summary Of FDA Black Box Warnings

Suicidal thoughts or actions

- Depression and certain other psychiatric disorders are themselves associated with increases in the risk of suicide.
- In short-term studies, atomoxetine increased the risk of suicidality in children, adolescents and young adults when compared to placebo.
- Patients should be closely monitored for suicidality (suicidal thinking and behavior), worsening of symptoms or changes in behavior.
- Families and caregivers should be advised of the need for close observation and communication with the prescriber.

Provided by



(August 2019)

This information is being provided as a community outreach effort of the College of Psychiatric and Neurologic Pharmacists. This information is for educational and informational purposes only and is not medical advice. This information contains a summary of important points and is not an exhaustive review of information about the medication. Always seek the advice of a physician or other qualified medical professional with any questions you may have regarding medications or medical conditions. Never delay seeking professional medical advice or disregard medical professional advice as a result of any information provided herein. The College of Psychiatric and Neurologic Pharmacists disclaims any and all liability alleged as a result of the information provided herein.

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Cymbalta

GENERIC NAME(S): Duloxetine

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WARNINGS: Antidepressantmedications are used to treat a variety of conditions, including depression and other mental/mood disorders... **Show More**

Uses | Side Effects | Precautions | Interactions | Overdose | Images

Uses

Duloxetine is used to treat depression and anxiety. In addition, duloxetine is used to help relieve nerve pain (peripheral neuropathy) in people with diabetes or ongoing pain due to medical conditions such as arthritis, chronic back pain, or fibromyalgia (a condition that causes widespread pain).

Duloxetine may improve your mood, sleep, appetite, and energy level, and decrease nervousness. It can also decrease pain due to certain medical conditions. Duloxetine is known as a serotonin-norepinephrine reuptake inhibitor (SNRI). This medication works by helping to restore the balance of certain natural substances (serotonin and norepinephrine) in the brain.

How to use Cymbalta

Read the Medication Guide and, if available, the Patient Information Leaflet provided by your pharmacist before you start using duloxetine and each time you get a refill. If you have any questions, ask your doctor or pharmacist.

Take this medication by mouth as directed by your doctor, usually 1 or 2 times a day with or without food. If you have nausea, it may help to take this drug with food. Swallow the capsule whole. Do not crush or chew the capsule or mix the contents with food or liquid. Doing so can release all of the drug at once, increasing the risk of side effects.

taking this medication without consulting your doctor. Some conditions may become worse when this drug is suddenly stopped. Also, you may experience symptoms such as dizziness, confusion, mood swings, headache, tiredness, diarrhea, sleep changes, and brief feelings similar to electric shock. Your dose may need to be gradually decreased to reduce side effects. Report any new or worsening symptoms right away.

Tell your doctor if your condition persists or worsens.

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- disorder characterized by stiff, tender & painful muscles

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Ritalin

GENERIC NAME(S): Methylphenidate Hcl

Read Reviews (310)

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WARNINGS: Misuse or abuse of methylphenidate can result in serious (possibly fatal) heart and blood pressure problems... Show More

Uses Side Effects Precautions Interactions Overdose Images

Uses

This medication is used to treat attention deficit hyperactivity disorder - ADHD. It works by changing the amounts of certain natural substances in the brain. Methylphenidate belongs to a class of drugs known as stimulants. It can help increase your ability to pay attention, stay focused on an activity, and control behavior problems. It may also help you to organize your tasks and improve listening skills.

This medication is also used to treat a certain sleep disorder (narcolepsy).

How to use Ritalin

Read the Medication Guide provided by your pharmacist before you start taking methylphenidate and each time you get a refill. If you have any questions, ask your doctor or pharmacist.

Take this medication by mouth as directed by your doctor, usually 2 or 3 times a day. This medication is best taken 30 to 45 minutes before a meal. However, if you have stomach upset, you may take this medication with or after a meal or snack. Taking this medication late in the day may cause trouble sleeping (insomnia).

Take this medication regularly to get the most benefit from it.

decrease your dose. Also, if you have used it for a long time, do not suddenly stop using this drug without consulting your doctor.

If you suddenly stop using this medication, you may have withdrawal symptoms (such as depression, suicidal thoughts, or other mental/mood changes). To help prevent withdrawal, your doctor may lower your dose slowly. Withdrawal is more likely if you have used methylphenidate for a long time or in high doses. Tell your doctor or pharmacist right away if you have withdrawal.

When used for a long time, this medication may not work as well. Talk with your doctor if this medication stops working well.

Though it helps many people, this medication may sometimes cause addiction. This risk may be higher if you have a substance use disorder (such as overuse of or addiction to drugs/alcohol). Take this medication exactly as prescribed to lower the risk of addiction. Ask your doctor or pharmacist for more details.

Tell your doctor if your condition does not improve or if it worsens.

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Are you taking Ritalin?

Yes No

Psychiatrists in Champaign, IL

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Seroquel

GENERIC NAME(S): Quetiapine

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WARNINGS: There may be a slightly increased risk of serious, possibly fatal side effects (such as stroke, heart failure, fast/irregular heartbeat... **Show More**

Uses Side Effects Precautions Interactions Overdose Images

Uses

This medication is used to treat certain mental/mood conditions (such as schizophrenia, bipolar disorder, sudden episodes of mania or depression associated with bipolar disorder). Quetiapine is known as an anti-psychotic drug (atypical type). It works by helping to restore the balance of certain natural substances (neurotransmitters) in the brain.

This medication can decrease hallucinations and improve your concentration. It helps you to think more clearly and positively about yourself, feel less nervous, and take a more active part in everyday life. It may also improve your mood, sleep, appetite, and energy level. Quetiapine can help prevent severe mood swings or decrease how often mood swings occur.

How to use Seroquel

Read the Medication Guide and, if available, the Patient Information Leaflet provided by your pharmacist before you start using quetiapine and each time you get a refill. If you have any questions, ask your doctor or pharmacist.

Take this medication by mouth as directed by your doctor, usually 2 or 3 times daily with or without food. For the treatment of depression associated with bipolar disorder, take this medication by mouth as directed by your doctor, usually once daily at bedtime.

(including prescription drugs, nonprescription drugs, and herbal products).

To reduce your risk of side effects, your doctor may direct you to start this medication at a low dose and gradually increase your dose. Follow your doctor's instructions carefully. Take this medication regularly to get the most benefit from it. To help you remember, take it at the same times each day.

Do not increase your dose or use this drug more often or for longer than prescribed. Your condition will not improve any faster, and your risk of side effects will increase.

Keep taking this medication even if you feel well. Do not stop taking this medication without consulting your doctor. Some conditions may become worse when this drug is suddenly stopped. Also, you may experience symptoms such as trouble sleeping, nausea, headache, diarrhea, irritability. Your dose may need to be gradually decreased to reduce side effects. Report any new or worsening symptoms right away.

Tell your doctor if your condition persists or worsens.

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Strattera

GENERIC NAME(S): Atomoxetine

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WARNINGS: A small number of people (especially children/teenagers) who take atomoxetine for attention-deficit hyperactivity disorder (ADHD... **Show More**

Uses

Atomoxetine is used to treat attention-deficit hyperactivity disorder (ADHD) as part of a total treatment plan, including psychological, social, and other treatments. It may help to increase the ability to pay attention, concentrate, stay focused, and stop fidgeting. It is thought to work by restoring the balance of certain natural substances (neurotransmitters) in the brain.

How to use Strattera

Read the Medication Guide provided by your pharmacist before you start using atomoxetine and each time you get a refill. If you have any questions, ask your doctor or pharmacist.

Take this medication with or without food as directed by your doctor, usually 1 to 2 times a day. The first dose is usually taken when you wake up in the morning. If a second dose is prescribed, take it as directed by your doctor, usually in the late afternoon/early evening. Taking this medication late in the day may cause trouble sleeping (insomnia).

Swallow the capsules whole. Do not crush, chew, or open the capsules. If the capsule is accidentally opened or broken, avoid contact with the powder and wash away any loose powder as soon as possible with water. If the powder gets in your eyes, flush with plenty of water right away and contact your doctor.

Tell your doctor if your condition does not improve or if it worsens.

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Vistaril

GENERIC NAME(S): Hydroxyzine Pamoate

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Uses

Hydroxyzine is used to treat itching caused by allergies. It is an antihistamine and works by blocking a certain natural substance (histamine) that your body makes during an allergic reaction. Hydroxyzine may also be used short-term to treat anxiety or to help you feel sleepy/relaxed before and after surgery.

How to use Vistaril

Take this medication by mouth with or without food as directed by your doctor, usually three or four times daily.

The dosage is based on your age, medical condition, and response to treatment. In children, the dosage may also be based on weight. Do not increase your dose or take this medication more often than directed.

Tell your doctor if your condition does not improve or if it worsens.

Related Links

What conditions does Vistaril treat?

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Are you taking Vistaril?

Yes No

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- itching

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EXHIBIT C

United States District Court

CENTRAL DISTRICT OF ILLINOIS

Richard D. Budd,

Plaintiff

vs.

Edgar County Sheriff
Edward B. Motley
228. N. Central Ave
Paris Ill. 61944

Defendant(s)

Case No. 11-2227
(The case number will be assigned by the clerk)

(List the full name of ALL plaintiffs and defendants in the caption above. If you need more room, attach a separate caption page in the above format).

COMPLAINT*

Indicate below the federal legal basis for your complaint, if known. This form is designed primarily for pro se prisoners challenging the constitutionality of their conditions of confinement, claims which are often brought under 42 U.S.C. § 1983 (against state, county, or municipal defendants) or in a "Bivens" action (against federal defendants). However, 42 U.S.C. § 1983 and "Bivens" do not cover all prisoners' claims. Many prisoners' legal claims arise from other federal laws. Your particular claim may be based on different or additional sources of federal law. You may adapt this form to your claim or draft your own complaint.

☒ 42 U.S.C. §1983 (state, county or municipal defendants)

☐ Action under *Bivens v. Six Unknown Federal Narcotics Agents*, 403 U.S. 388 (1971)(federal defendants)

☐ Other federal law: _____

☒ Unknown This complaint could fall under a number of claims
Please forward to proper ave.

**Please refer to the instructions when filling out this complaint.* *Prisoners are not required to use this form or to answer all the questions on this form in order to file a complaint. This is not the form to file a habeas corpus petition.*

I. FEDERAL JURISDICTION

Jurisdiction is based on 28 U.S.C. § 1331, a civil action arising under the United States Constitution or other federal law. *(You may assert a different jurisdictional basis, if appropriate).*

II. PARTIES

A. Plaintiff:

Full Name: Richard D. Budd

Prison Identification Number: S11692

Current address: Jacksonville Correctional Institution

2268 E. Morton Ave Jacksonville, IL 62650

For additional plaintiffs, provide the information in the same format as above on a separate page. If there is more than one plaintiff, each plaintiff must sign the Complaint, and each plaintiff is responsible for paying his or her own complete, separate filing fee.

B. Defendants

Defendant #1:

Full Name: Sheriff Edward B. Motley

Current Job Title: Sheriff

Current Work Address 228 N. Central Avenue

Paris IL, [redacted] 61944

Defendant #2:

Full Name: Edgar County Sheriff office

Current Job Title:

Current Work Address 228 N. Central Avenue

Paris IL, 61944

Defendant #3:

Full Name:

Current Job Title: _____

Current Work Address _____

_____

Defendant #4:

Full Name: _____

Current Job Title: _____

Current Work Address _____

_____

Defendant #5:

Full Name: _____

Current Job Title: _____

Current Work Address _____

_____

For additional defendants, provide the information in the same format as above on a separate page.

III. LITIGATION HISTORY

The "three strikes rule" bars a prisoner from bringing a civil action or appeal in forma pauperis in federal court if that prisoner has "on 3 or more occasions, while incarcerated or detained in any facility, brought an action or appeal in a court of the United States that was dismissed on the grounds that it is frivolous, malicious, or fails to state a claim upon which relief may be granted, unless the prisoner is under imminent danger of serious physical injury." 28 U.S.C. § 1915(g).

A. Have you brought any other lawsuits in state or federal court dealing with the same facts involved in this case? Yes ☐ No ☒

If yes, please describe _____

_____

B. Have you brought any other lawsuits in federal court while incarcerated?

Yes ☐ No ☒

C. If your answer to B is yes, how many? _____ Describe the lawsuit(s) below.

1. Name of Case, Court and Docket Number

_____

2. Basic claim made _____

3. Disposition (That is, how did the case end? Was the case dismissed? Was it appealed? Is it still pending?) _____

For additional cases, provide the above information in the same format on a separate page.

IV. EXHAUSTION OF ADMINISTRATIVE REMEDIES

Prisoners must exhaust available administrative remedies before filing an action in federal court about prison conditions. 42 U.S.C. § 1997e(a). You are not required to allege or prove exhaustion of administrative remedies in the complaint. However, your case must be dismissed if the defendants show that you have not exhausted your administrative remedies, or if lack of exhaustion is clear from the complaint and its attachments. You may attach copies of materials relating to exhaustion, such as grievances, appeals, and official responses. These materials are not required to file a complaint, but they may assist the court in understanding your claim.

A. Is there a grievance procedure available at your institution? Yes ☐ No ☒

B. Have you filed a grievance concerning the facts relating to this complaint?

Yes ☒ No ☐

If your answer is no, explain why not wrote one Letter to the Sheriff Begin for help

C. Is the grievance process completed? Yes ☒ No ☐

V. STATEMENT OF CLAIM

Place(s) of the occurrence Paris Edgar County Jail Paris IL 61944

Date(s) of the occurrence 2009, 2010, 2011

State here briefly the FACTS that support your case. Describe what each defendant did to violate your federal rights. You do not need to give any legal arguments or cite cases or statutes. Number each claim in a separate paragraph. Unrelated claims should be raised in a separate civil action.

THE COURT URGES YOU TO USE ONLY THE SPACE PROVIDED. Federal Rule of Civil Procedure 8(a) requires only a "short and plain statement" of your claim showing that you are entitled to relief. It is best to include only the basic, relevant facts, including dates, places, and names.

See Attach copy and Exhibit to this form!

Facts that this is based on a three prong issue of overcrowded jail, deplorable and hazardous conditions regarding medical issues. In Result of Conditions

Fact 1: I was arrested in 2009 and spent 45 days in the Edgar County Jail while some electrical work was being done on the older part of the jail. I was housed upstairs in the older part of the jail more commonly known as the "bird cage" which holds only three people per side. I was housed there with eight other cell mates while repairs were being completed. But repairs continued up until and after my release. I was forced to sleep on the floor under half a table with unsanitary conditions and broken windows that had tape over cracks. The toilets were in such poor condition that you could practically see the floor through the cracks on the toilets.

Fact 2: I had to spend hours waiting for the officer to make his rounds because of the fact that there was only one officer on duty which violates state regulations. State regulations requires that there be two officers on duty.

Fact 3: On September 7, 2010, I was arrested again and was housed in lower part of jail more commonly known as the "bull pen" (which houses twelve inmates/detainees) until December 20, 2010. The conditions were still deplorable, unsanitary, and overcrowded. The toilets were so unsanitary that there was mold and spider webs all over them. Windows were broken allowing the coldness from outside to come in. There was exposed wiring and the heating system did not function at all. I was once again forced to sleep on the floor close to the moldy toilets. The sinks were completely out of order with no running water, neither hot or cold. There was no cleaning supplies made available to us to attempt to clean up our living area. There was water that ran down the walls of the cells from the floor above. The ceiling was in so bad a condition that rust often fell on you without warning. Meals were passed to us through extremely dirty chuck holes. The cells were so overcrowded that there was no room to move around because of the people sleeping on the floor and the floor of the dayroom. The phones that were somewhat operational would shock you while using them. When showers were being used the water would flow out of the shower and onto the dayroom floor were some people had to sleep.

Fact 4: On January 20, 2011, I was arrested for theft and was housed in the lower cell block which has four cells, each with one bunk. This cell block was deplorable and unsanitary that the rust and mold from the toilets covered the wall behind the toilets. The back wall was so rusted that it actually had rust holes. Once again I was forced to sleep on the floor by the toilet. The vents were so caked up with dust that had solidified that they did not allow fresh air to circulate in. We were not given any recreation so we had no chance of getting any fresh air. It was so overcrowded that we asked the officer if he could at least open up our chuck holes for a little fresh air. The air conditioning/heating system was out of order in our part of the cell block but was operational in the officers control area were they sit during their shifts. They were indifferent to the conditions we were subjected to.

Fact 5: After 45 days there I scraped my leg on something or got bit by something and an infection developed. I informed the officer on duty about my situation and was taken to see a nurse. But by the time I was taken to see the nurse my leg was very swollen and all I was given for the swelling was some ice. At no point was I seen by a doctor at the county jail so I was not properly diagnosed. There was a phone call placed to a doctor but that cannot be considered a proper or professional diagnosis. After writing a letter to the sheriff pleading for assistance in getting me to see a doctor, twnety-four hours later an administrative officer by the first name of Shane took me to the hospital. While at the E.R. I

was given a shot for the infection and an ice/hot pack for the swelling.

Fact 6: Two days later I went back to the hospital and was transported in a four wheel drive truck. I was forced to crawl onto the floor of the truck cab and then into the seat unassisted while I was handcuffed and shackled at the ankles. Sheriff Montley and an administrative officer were authorized by the sheriff deputy to transport me to the hospital in this manner.

Fact 7: Still have not been seen by a doctor at the county jail. The jail does not have any type of medical housing. The ice/heat pack I was given was useless to me because there was no officer available to heat it for me so that I could apply it to the affected area. Federal regulations require two officers to be on duty and the county jail did not.

Fact 8: About two days later I was taken back to the hospital per doctors orders so that I could be admitted into the hospital for tests and observation. Since I was still in custody the sheriffs refused to take the handcuffs or the shackles off. It did not matter that I was to have surgery.

Fact 9: The sheriff did not bother to remove the handcuffs or shackles while the doctor operated on my leg. I was not given a chance to put on a hospital gown, they simply pulled down my pants down to my ankles so that the doctor could perform the surgery. I was not given any consideration for my condition whatsoever.

Fact 10: Afterwards the sheriff came to the E.R. with an R.O.R. board. On February 28, 2011, I was given some shots and medication and an MRI of my leg was taken. Blood was also drawn because it was unclear how far or severe the infection had gotten.

Fact 11: Another surgeon comes in on that Saturday and squeezed around the hole in my leg. The doctor also stated that this process would have to be repeated agian every three days or so. Before I was released from the hospital I notified the doctors and nurses of my condition and asked how medical treatment would be administered at the jail since the nurse is only available twice a week and there is no medical doctor at the jail.

Fact 12: The morning of my release from the hospital I became hysterical saying that I would not go back and put my health at risk any further by going back to the county jails hazardous and unsanitary conditions. I still had a hole in my leg because I did not get medical treatment in a timely manner. There is no attending doctor at the county jail and the hazardous conditions at the jail would only further put my health at risk. Judge Garst ordered that I be taken to Charleston Hospital because it had now become a mental issue.

Fact 13: Those hazardous and unsanitary conditions exist to this present day. The proof is in two newspaper articles and a computer printout of Sheriff Motley stating that these conditions are not up to regulations and the standards that were in place when Sheriff Grippus was in position.

Conclusion

Facts and exhibits present proof that I was housed in a jail that is not up to standards, codes, and regulations, was forced to sleep on the floor time and time again, I was in the hospital while I was in custody, and that the sheriff knew about these conditions at the jail, knew that there is no medical housing, no medical staff on site, and knew about the dilapidated and hazardous conditions at the jail. A city council member even stated that he would not dare take a shower in there. The substantive claims herein arise under 42 USC 1983 the Fifth, Eighth, Ninth, and Fourteenth Amendment of the U.S. Constitution. Federal regulations require appropriate officers to inmate ratios, sanitary living conditions, proper transportation of inmates/detainees with medical needs, and provide medical assistance.

Relief

The relief sought is $100 per day spent in the county jail; an additional $100 per day putting me at risk of contracting a disease or a staph infection because of hazardous conditions; $2000 for improper medical transportation to hospital; $4000 for lack of understanding and consideration while undergoing a medical procedure while in custody (did not bother to uncuff me or take shackles off); $2000 for pain, suffering, and for not providing proper timely medical attention; plus all medical costs incurred due to a direct result of hazardous and unsanitary living conditions at the county jail that amount up to $150,000.

Respectfuly Submitted
Richard D. Budd S11692
Richard D. Budd

RELIEF REQUESTED

(State what relief you want from the court.)

JURY DEMAND Yes ☒ No ☐

Signed this 22 day of September, 20 11.

Richard D Budd

(Signature of Plaintiff)

Name of Plaintiff:	Inmate Identification Number:
Richard D. Budd	S11692
Address: Jacksonville CI 2268 E Morton Ave Jacksonville, IL 62650	Telephone Number: ?

are eligi-
ıle. There are
ew causes for de-
ral and very few medi-
tions that are not ac-
ptable. Donors cannot
e taking antibiotics for
infection. Cancer patients
must be one year cancer
free. Heart patients must
be six months symptom
free. Diabetics can do-
nate. It is recommended
that donors have a light
snack before donating.
Do not fast.

Be sure to bring your
picture ID.

The entire process of
donating takes less than
an hour. A cholesterol,
blood pressure, blood
type, and iron check are
included in your dona-
tion.

Indiana Blood Center
is charged with collecting
550 units every day to be
able to supply over 60
Indiana hospitals. Your
donation will save up to
three lives.

wasn't enough
the Clinton Cent

See PARIS on PAGE 2

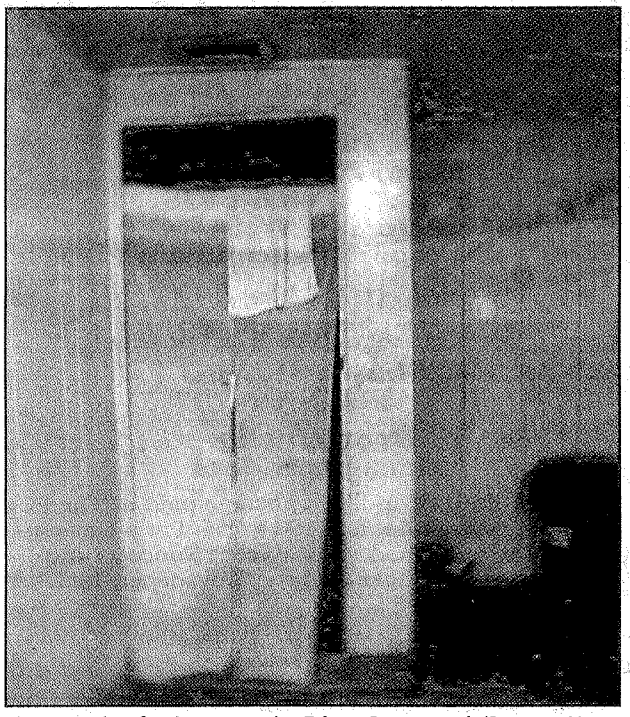
Beacon News

Edgar County Jail could need improvements soon

DEAN CURTIS
dcurtis@parisbeacon.com

PARIS — It's easy to be flippant and cavalier when it comes to how society treats those who are accused of being criminals. And worse things probably are considered for those judged as being a criminal. But if ever there was a place that seemed like it needed a visit from the Health Department, it's the Edgar County Jail.

"It's not that I don't want to fix things or change them, it's just because I can't," Edgar County Sheriff Ed Motley said. "It's always a money issue. Either we can't afford to fix things that need replacing or repair, or it's because we just don't have the budget to add a couple more people as corrections officers."



The outside of a shower at the Edgar County Jail. (Beacon-News Photo by D. Curtis)

Because of the antiquated design of the jail, the two corrections officers on duty only can check on each section of the jail in 30-minute time periods, Motley said."Our patrol cars are the same way," he said. "I pray every day that no one calls in sick because then I don't have to call in a replacement that I can't really afford."

Motley describes the dilemma as a kind of chicken-egg, money-personnel thing where it's hard to tell which issue starts the other one.

A quick tour of some parts of the facility tell an incomplete-but-vivid story.

The visitor's booths on the jail side are remarkably similar. All of them have the same spots of both the once-painted walls and the metal counter part worn off in the exact same places. Hands outstretched above the window and at the bottom of the window and then also at the very worn, shiny rounded edge of the counter.

The jail cell smells like a decades-uncleaned men's gym. Stained mattresses are strewn on the floor. There is an over-abundance of rust everywhere. There's at least a spot of it on almost every surface: the ceiling, the walls, lockers, doors, pipes and, of course, the shower. The inside of the shower in the area visited was a dark red-black color — possibly both a hefty layer of rust as well as black mold.

"There are parts of the jail that, as far as I know, never have been fixed," Motley said. "Some of this stuff obviously has been that way for years, and I have to say that I really don't want an inspection of this anytime soon."

So, what next?

"I'm starting to think it's not a personnel thing," he said. "I know my guys work hard and they're always moving from one part of the jail to another. But when I think about what I could do if I could afford to hire a couple more officers, that would make a big difference."

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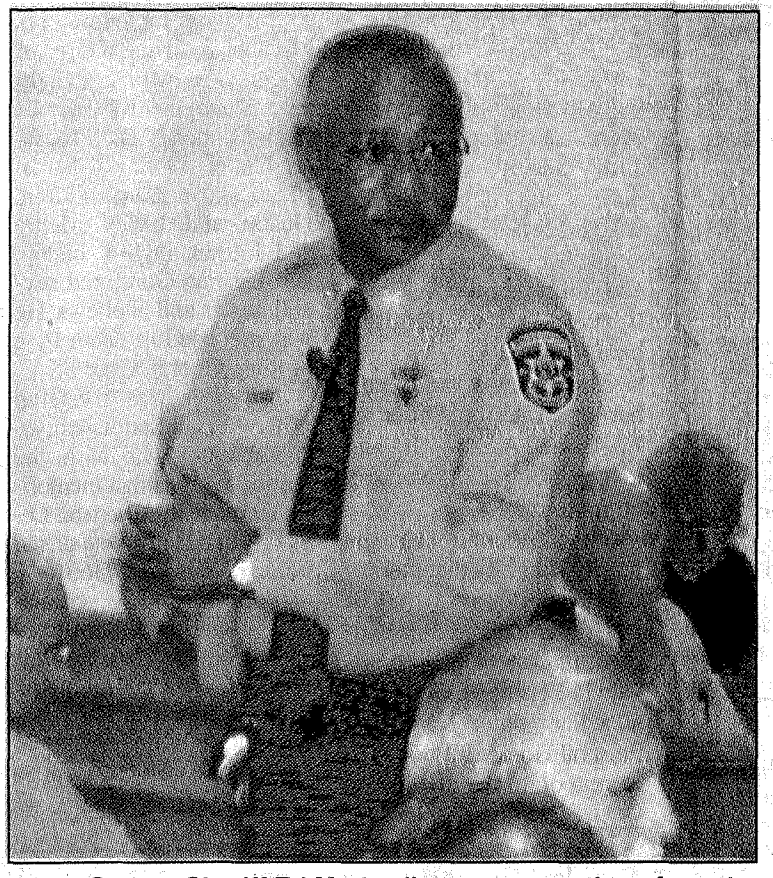
IN THE NEXT ISSUE

News you can use

'Town hall' meeting highlights jail repairs



Edgar County Sheriff Ed Motley listens to questions from the audience at his first "town meeting" to discuss operations of the sheriff's department and issues with the Edgar County Jail. The meeting drew about 50 people to the Chrisman Nazarene Church Thursday evening. (Beacon-News Photo)

NED JENISON
news@parisbeacon.com

CHRISMAN — The physical condition of the Edgar County Jail was the chief discussion topic Thursday night as Edgar County Sheriff Ed Motley hosted his first "town meeting" for citizens. The event drew about 50 county citizens to the Nazarene Church for the 90-minute session, which was highlighted by a video presentation detailing the many condition issues of the jail.

Motley emphasized three points: "I'm not advocating for a new county jail." He added "We must maintain and bring up to acceptable standards the facility we have," and, noting that the county government is facing severe financial strain with 10 percent cuts in the budgets of all departments, "we need to all work together to fix up what we have."

The video illustrated problems of rust and peeling paint in both cell blocks and even the newer administrative addition, broken and inoperative cell locks, antiquated sanitary facilities, broken windows and possible electrical hazards, among others.

Motley emphasized that the main jail and cell block areas, constructed some 130 years ago even before the courthouse, are secure. But they are far from what he considered acceptable standards for housing persons awaiting court hearings, or serving local sentences.

"This is not a new problem. It is one that has faced many previous (sheriff's) administrations," he reminded the audience. A reply suggested that it was the "out of sight, out of mind" situation that has kept this from being a major public issue.

Motley said he has been able to make a few improvements during the first few months of his term. Some sanitary plumbing problems have been corrected. Feeding of inmates has changed from using local fast-food restaurants to a commercial canteen which delivers three meals daily, supervised by a dietician, proving 2500 calories in a balanced menu. Some double-bunk beds are

See JAIL on PAGE 2

Weather

TODAY — Mostly sunny. Highs in the lower 80s. Southeast winds 5 to 10 mph.

TONIGHT — Mostly cloudy. Lows in the lower 60s. Southeast winds 5 to 10 mph.

WEDNESDAY — Partly sunny. Highs in the upper 80s.

WEDNESDAY NIGHT — Partly cloudy. Lows in the upper 60s. Highs in the mid 90s.

THURSDAY — Partly cloudy. Lows in the upper 60s. Highs in the mid 90s.

THURSDAY NIGHT — Mostly clear. Lows in the lower 70s.

FRIDAY — Partly cloudy. Highs in the mid 90s. Lows [illegible] upper 6[illegible]

Playground hockey debut in Kansas

Paris Becon News Aug 30, 1[illegible]

Aug 30, 2011

Paris Beacon News

William Russell Gore

William Russell Gore, 75, of Paris, Ill. passed away at 10:24 a.m. Friday, Aug. 26, 2011 at Paris Community Hospital. He was retired after more than 40 years with Zenith Corporation.

He was born June 5, 1936 in Paris, Ill., the son of the late Clarence Russell and Alvena Ruth (Winans) Gore. He married Rita Christiansen on Dec. 29, 1959 in Copenhagen, Denmark. She preceded him in death Oct. 23, 1991.

Survivors include a son, Michael J. (Tina) Gore, of Rogersville, Mo.; a daughter, Deborah Melby, of Grand Forks, N.D.; a brother, Chuck Gore, of Paris, Ill.; six grandchildren, Dustin and Lacey Melby and Jordun, Dyllin, Juston, and Deanna Gore; and several nieces and nephews. He was preceded in death by a brother, George Gore Sr.

Mr. Gore was a veteran of the United States Army.

For those who wish, the family suggests that memorials be made to American Legion Post #211 or Veterans of Foreign Wars Post #3601.

Following cremation, visitation will be from 2 to 4 p.m. Wednesday, Aug. 31, 2011 at Templeton Funeral Home in Paris. Interment will be private in Vermilion Cemetery at a later date.

Carrie B. Todd

Carrie B. Todd, 95, of Danville, Ill., formerly of Paris, Ill., and Freeport, Ill., passed away at 12:27

JAIL

Continued from page 1

on order to relieve some instances of prisoners sleeping on mattresses on the cell floor.

However to bring the interior of the jail up to minimum current standards is "almost overwhelming," he admitted.

An emphasis on the department's mission statement is leading the public, and adjoining law enforcement agencies, "to recognize that we are now a professional organization."

The sheriff concluded by stating, "My priority is to get the jail cleaned up and livable, however we can, but it will take a long time."

Motley plans to hold a "town meeting" about every six months in various parts of the county to meet his pledge of "running a transparent department."

APARTMENTS

Continued from page 1

Community Hospital.

"This kind of affordable, quality housing is what a lot of people want," she said. "In fact, this has gone so well that there's going to be another development starting up over in Princeton soon. I think it was the city manager of Princeton who was here when Senator Durbin was here and he looked over

New sheriff on mission to make changes

Officials: "Conditions are horrendous, deplorable"

Updated: Monday, 27 Dec 2010, 6:44 PM EST
Published : Monday, 27 Dec 2010, 4:56 PM EST

EDGAR COUNTY, Ill. (WTHI) - The new sheriff in town goes on a mission to make changes.

After only three weeks in office, Edgar County Sheriff Ed Motley gave county officials a grim reminder of the jail's condition.

"When I walked through I said deplorable, the conditions were deplorable," Edgar County Sheriff Ed Motley said.

Sheriff Motley gave the county commissioners a tour behind bars. Officials getting an up close look at what they're dealing with.

"We're aware there's serious problems," Chairman of the County Board James Keller said. "I just saw the showers back there I wouldn't take a shower in that facility whatsoever."

"Yes, they are prisoners, yeah they broke the law, but they're still human beings," Sheriff Motley said. "They still deserve the basics that we have to afford them.

Sheriff Motley said it's not just basic rights, but basic safety.

"I'm keeping doors locked, there were doors that you came through that were unlocked," Sheriff Motley said. "Staff are now getting used to locking the doors and getting buzzed through."

Another concern is the lack of correctional officers on staff for the 28 current inmates. Only one officer is on duty at a time.

The Illinois state statue says there must be at least two officers when there are more than 24 inmates.

Not to mention the exposed wiring and outlets in the cell blocks.

"It becomes a liability for the county and it's one of the safety concerns," Sheriff Motley said.

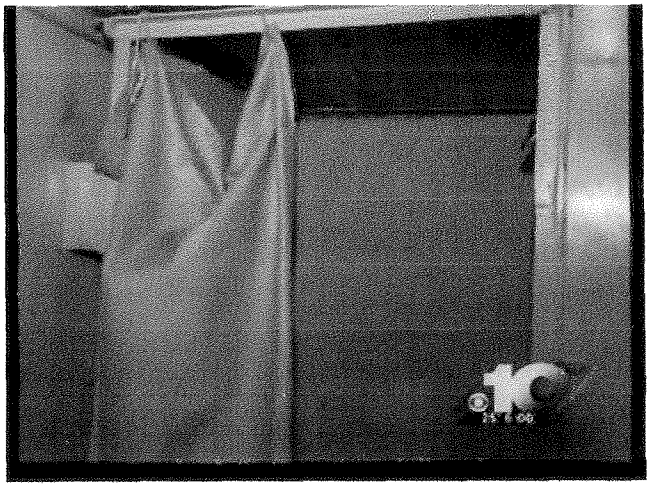
However, the biggest concern is how to fix it.

"There's no funding, there's no funding in the state of Illinois," Keller said. "This county is facing a $200,000 deficit this year "

County officials said they will work with the Sheriff to apply for grant money.

Sheriff Motley said in the meantime the inmates will be put to work to help clean. A change that won't cost the county anything.

His goal is to hire more officers and start renovations by this time next year.



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Edgar County, IL

Judici.com

2010CF160 BUDD, RICHARD D

Date	Entry	Judge
Entered Under: BUDD, RICHARD D		
07/18/2011	Letter from Deft placed on file. Clerk directed to give copy of letter to SA and Mr. Kash.	SLG
07/12/2011	Copy of letter forwarded to SA and Mr. Kash	UNASSIGNED
07/12/2011	Letter from Deft placed on file. Clerk directed to give copy of letter to SA and Mr. Kash.	SLG
04/07/2011	Mr. Kash appointed to represent Mr. Budd because pleadings have been filed within 30 days time to file a motion to withdraw guilty plea is tolled for Mr. Kash to consult with Mr. Budd and amend pleadings if appropriate.	SLG
03/22/2011	On motion of State, Amended Petition to Revoke Probation withdrawn.	SLG
02/28/2011	SA and Ms Bonwell present. Deft FTA and is reported in hospital. Cont to 3/28/11 at 2:00 for status. Status hearing set for 3/28/2011 at 02:00 in courtroom 2.	DWL
02/14/2011	Pre-trial set for 2/28/2011 at 02:00 in courtroom 1.	UNASSIGNED
02/14/2011	Deft present in custody w/Ms. Bonwell, S.A. present. Cont'd. to 2-28-11 at 2 p.m. Deft OTA, remanded to custody.	MLS
01/28/2011	ASA and Ms Bonwell present. Deft present in custody. Amended PTR handed to Deft. Ms Bonwell appt PD on amended PTR. PTR explained Deft denies PTR. Cont to 2/14/11 at 1:30 for PTC. Deft OTA Pre-trial set for 2/14/2011 at 01:30 in courtroom 1.	SLG
01/24/2011	AMENDED PETITION TO REVOKE PROBATION on file.	UNASSIGNED
01/21/2011	Appearance/counsel set for 1/28/2011 at 02:30 in courtroom 1. Ms Bonwell notified	UNASSIGNED
01/20/2011	ASA present. Deft present in custody. PTR handed to Deft in open court. PTR explained. Upon stipulation Ms Bonwell appointed PD. Cont to 1/28/11 at 2:30 for appearance with atty. Deft OTA	DWL
12/28/2010	Petition to Revoke Probation on file.	UNASSIGNED
12/21/2010	Probation Order on file.	UNASSIGNED
12/20/2010	$75.00 bond transferred from case number 2010-CM-000210-D -001. $75.00 bond transferred from case number 2010-CM-000247-D -001. $55.00 bond transferred from case number 2010-CM-000216-D -001. Bond of $55.00 applied on 12/20/2010. Balance due: $600 PSF	UNASSIGNED
12/17/2010	AMENDED INFORMATION ADDING COUNT II CRIMINAL DAMAGE TO PROPERTY on file	UNASSIGNED
12/17/2010	SA present; deft present in custody and w/Ms Bonwell. State moves to have this case heard in December; Ms Bonwell objects. Case remains on the December 21, JT calendar. Deft ordered to be here at 8:30 a.m. that date. Deft present in custody with counsel Ms. Bonwell; S.A. present. Deft. enters a plea of guilty to Count II (Class A). Count I N.P. After an explanation of his rights and the consequences of his plea, he persists therein. Plea of guilty accepted. Judgment on the plea. Waiver of Trial on file. Pursuant to agreement, Deft is sentenced to 2 years' probation under the standard conditions plus that he: 1)serve 105 days ECJ w/credit for 105 days served; 2)have no contact with Pinnell Motel property; 3) pay court costs. Appeal rights explained. Deft remanded to custody of sheriff for release this date.	SLG
12/08/2010	Deft present in custody with counsel Ms. Bonwell; S.A. present. Hearing on Motion for Reduction of bond or to Allow Visitation. Sworn evidence and argument of counsel heard. Deft is granted a furlough from jail December 9, 2010, from 9 a.m. to 4 p.m., to visit with his mother at the home of his sister at 12640 Highway 16, Paris. He is to go directly to that location and directly back to the jail and is not to consume any alcohol or illegal drugs during the furlough	SLG
12/08/2010	Motion for Reduction of Bond or to Allow Visitation placed on file. Pre-trial set for 12/17/2010 at 09:00 in courtroom 1. Copy of docket forwarded to ECJ	UNASSIGNED
11/19/2010	Pre-trial set for 12/08/2010 at 01:30 in courtroom 1.	UNASSIGNED
11/19/2010	SA, Mr. Kash and deft in custody present. All cases continued to 12/8/10 at 1:30 with 09 CF 66	SLG
10/28/2010	ASA and Ms Bonwell present. Deft present in custody. Cont to 11/19/10 at 9:00 for PTC in courtroom 1. Deft OTA Pre-trial set for 11/19/2010 at 09:00 in courtroom 1.	DWL
10/14/2010	ASA and Ms Bonwell present. Deft present in custody. Motion for Reduction of Bond placed on file. Motion heard. Motion is denied. Cont to 10/28/10 at 9:00 for PTC. Deft OTA Pre-trial set for 10/28/2010 at 09:00 in courtroom 2.	DWL
09/28/2010	Pre-trial set for 10/14/2010 at 9:00 in courtroom 2.	UNASSIGNED
09/27/2010	SA present; Deft present in custody and w/Ms Bonwell. Cause called for PH. Court finds probable cause exists. Deft pleads not guilty and requests JT. PT set for 10/14/10 at 9:00 a.m. Deft OTA Deft remanded to custody of sheriff pending posting of bail.	DWL
09/24/2010	Letter from Deft on file. Copy fwd to Mr. Kash and SA w/Proof of Service.	UNASSIGNED
09/20/2010	Subpoena to Officer Matthew McConnell returned served on file.	UNASSIGNED
09/13/2010	ASA Bell present. Deft present in custody. Information handed to Deft in open court. Charge, penalties and rights explained. Upon stipulation Mr Kash appointed PD. Cont to 9/27/10 at 3:00 for PLH Deft OTA Preliminary hrg set for 9/27/2010 at 03:00 in courtroom 2. Mr. Kash notified.	DWL
09/07/2010	Complaint filed on 09/07/2010. COUNT 1 BURGLARY First appearance set for 09/16/2010 at 9:00 in courtroom 2. Bond set by Judge Sullivan over phone at $20,000 (10$)	UNASSIGNED

Edgar County, IL

Judici.com

2011CF12 BUDD, RICHARD D

Entered Under: BUDD, RICHARD D

Date	Entry	Judge
07/18/2011	Letter from Deft placed on file. Clerk directed to give copy of letter to SA and Mr. Kash.	SLG
07/12/2011	Copy of letter forwarded to SA and Mr. Kash	UNASSIGNED
07/12/2011	Letter from Deft placed on file. Clerk directed to give copy of letter to SA and Mr. Kash.	SLG
04/07/2011	Mr. Kash appointed to represent Mr. Budd because pleadings have been filed within 30 days time to file a motion to withdraw guilty plea is tolled for Mr. Kash to consult with Mr. Budd and amend pleadings if appropriate.	SLG
04/07/2011	Motion for Reduction of Sentence with Certificate of Service on file. Letter from Deft on file. Copies forwarded to SA and Mr. Kash. Motion shown to Judge Garst Copy of docket forwarded to Mr. Kash	UNASSIGNED
03/30/2011	DOC mittimus returned served with Seal on file.	UNASSIGNED
03/25/2011	Official Statement of State's Attorney on file. Judgment-Sentence to Illinois Department of Corrections forwarded to Sheriff for transmittal to DOC.	UNASSIGNED
03/23/2011	$135.00 bond transferred from case number 2010-CM-000344-D -001. $90.00 bond transferred from case number 2010-CM-000243-D -001.	UNASSIGNED
03/22/2011	Deft present in custody with counsel Ms. Bonwell; S.A. present. Deft enters pleas of guilty to Count I (Class 4) and Count II (Class 2). After explanation of rights and consequences of plea, he persists therein. Plea of guilty accepted. Judgment on the plea. Waiver of Trial on file. Pursuant to agreement, Deft is sentenced as follows: Count I - 3 yr. DOC w/credit for 86 days; 1 yr. m.s.r. $348.29 restitution for Ken Maloney Count II- 3 yr. DOC w/credit for 86 days; 2 yr. m.s.r. Sentences to be served concurrently with each other and concurrently with 9 CF 66. The credit of 86 days is the total time spent in custody in 09 CF 66 and 11 CF 12. Mittimus to issue. Appeal rights explained. Defendant remanded to custody of sheriff for transportation to DOC. Any bond to be applied to outstanding financial obligations and clerk's fee; balance may be refunded to Deft. State agrees not to file pending escape and criminal damage to government-supported property charges.	SLG
03/15/2011	Preliminary hrg set for 4/04/2011 at 01:30 in courtroom 2. Ms Bonwell notified.	UNASSIGNED
03/14/2011	ASA and deft in custody present. Ms. Bonwell present. Deft handed copy of charges in open court. Charges, penalties and rights explained. Deft requests PD, by stipulation, Ms. Bonwell present. PLH set for 4/4/11 at 1:30 in courtroom #1. Bond $50, 000 (10%)	DWL
03/03/2011	Bail Bond Defendants Own Recognizance on file	UNASSIGNED
03/02/2011	Deft present in custody with counsel Ms. Bonwell; S.A. present. Motion for Recognizance Bond to to Modify Bond on file. Without objection, Deft is granted a $25,000 O.R. bond while he is inpatient at either Paris Community Hospital and any mental health facility he may be referred to, or for inpatient treatment at Hour House in Charleston or Club Soda in Terre Haute. If discharged, voluntarily or involuntarily, from any of those facilities, he is ordered to report directly back to ECJ within 3 hours of discharge. Deft is ordered to keep the sheriff's department advised of his whereabouts at all times.	SLG
02/28/2011	SA Isaf and Ms Bonwell present. Deft NIC and reported in hospital. Cont to 3/28/11 at 2:00 for status. Status hearing set for 3/28/2011 at 02:00 in courtroom 2.	DWL
02/28/2011	Bail Bond Defendants Own Recognizance on file	UNASSIGNED
02/26/2011	Order Modifying Bail on file	UNASSIGNED
02/22/2011	Pro Se Motion to Dismiss on file. Copy forwarded to Ms Bonwell and SA	UNASSIGNED
02/15/2011	Notice of Order filed by Mr Budd. Notice of Indingany filed.	UNASSIGNED
02/14/2011	Pre-trial set for 2/28/2011 at 02:00 in courtroom 1.	UNASSIGNED
02/14/2011	SA present; deft present in custody and w/Ms Bonwell. PH held. Court finds probable cause exists. Deft waives formal arraignment; pleads not guilty and request JT. Hearing cont to 2/28/11 @ 2:00 p.m. Deft OTA. Ms Bonwell makes oral request for deft to have a 1 hr furlough to visit w/his dying mother. Request is granted without objection. Deft may have a one-hour furlough in the next 48 hours to visit with Virgina Budd, if the Sheriff's Dep't. can accommodate the request.	MLS
02/10/2011	Pro Se correspondance from Deft on file regarding civil case	UNASSIGNED
02/03/2011	Subpoena to Officer Nathan Chaplin returned served on file.	UNASSIGNED
01/31/2011	Preliminary hrg set for 2/14/2011 at 01:30 in courtroom 1.	UNASSIGNED
01/28/2011	Deft present in custody with counsel Ms. Bonwell; ASA Bell present. P/H set for 2-14-11 at 1:30 p.m. Deft OTA. Bond modified to allow Deft to be released on a $25,000 recognizance bond if and when a bed becomes available at Hour House in Charleston, IL for inpatient care. Deft must go directly to Hour House. If he leave there for any reason, he is ordererd to return directly to ECJ. He is to keep Ms. Bonwell advised of his contact information.	SLG
01/28/2011	Preliminary hrg set for 2/14/2011 at 01:30 in courtroom 1.	UNASSIGNED
01/27/2011	Pro Se Notice of Inquiry and filing as Indigent person on civil case placed on file per Clerk	UNASSIGNED
01/21/2011	Preliminary hrg set for 1/28/2011 at 02:30 in courtroom 1. Ms Bonwell notified	UNASSIGNED
01/20/2011	ASA Bell present. Deft present in custody. Information handed to Deft in open court. Charge, penalties and rights explained. Upon stipulation Ms Bonwell appointed PD. Cont to 1/28/11 at 2:30 for PLH Bond set at $25,000 (10%) Deft OTA	DWL
01/20/2011	Complaint filed on 01/20/2011. COUNT I CRIMINAL DAMAGE TO PROPERTY; COUNT II AGGRAVATED BATTERY	UNASSIGNED

E-FILED
Thursday, 17 December, 2020 03:12:10 PM
Clerk, U.S. District Court, ILCD

EXHIBIT D

The Prairie Press
Paris Beacon-News

(/)

Costs rack up for housing inmates outside of the county

Posted Monday, January 20, 2020 8:17 am

By GARY HENRY ghenry@prairiepress.net

Efforts to get the Edgar County Jail reopened are ongoing, if not always smoothly.

The one certainty is it is costing the county and that was a topic of conversation during the Monday, Jan. 13, Edgar County Board study session.

“Since the jail shut down, we have spent $44,000 for housing prisoners in three jails during December,” said board member Karl Farnham Jr.

That amount does not include the fuel and wear and tear on vehicles transporting those arrested to other jails for housing and subsequently bringing them back for court appearances.

"On one trip when they went to Coles County they needed three or four squad cars," Farnham stated.

Jail supervisor Jay Willaman confirmed the amount of travel required. He said the sheriff's department recently had 14 people to bring back for court appearances and then returned to the neighboring jails.

"We were doing a lot of running back and forth," said Willaman.

He noted some of that may ease a bit since the department recently acquired a used 10-passenger van for transport duty. Willaman said as of Monday a security cage for inside the van had not been installed. As a result, two officers are required for each trip – one person to drive and the other to provide prisoner surveillance.

The local jail closed Dec. 1 after Illinois County Risk Management, the insurer, refused to continue insurance coverage citing problems with lack of management and improper oversight of policy issues. The Illinois Department of Correction (DOC) also threatened legal action because the jail frequently had only one corrections officer on duty when two are required.

Willaman, a retired DOC official, was hired by the county in November to serve as the jail administrator. His stated goal is to get the 1970s era cellblock back up to standards and operating within three months to the satisfaction of the insurance company and DOC inspectors.

County board members and Willaman discussed progress during the study session. Willaman said without prisoners it has been easier for contractors to work in the building and a welder has fabricated new showers that are ready for installation. His problem is the contractors hired to complete the SmartWATT energy efficiency upgrades on all county buildings are under the impression they are only supposed to work on the newer part of the building and not touch the 19th century portion of the structure.

"I thought the jail came first on the list," said Willaman. "If we don't open the new and old part, we will still be paying for 10 to 15 inmates in other facilities."

He added the plumbing repairs at the jail will likely involve more than just replacing parts as much of the old plumbing is worn out and needs removed before substantive improvements can be made.

"The jail was part of the original scope, and it needs to be done although it has been a mess making decisions," said board member Derrick Lorenzen. "We have a priority in getting our jail open."

Board member Andy Patrick cleared up some of the issues during the Wednesday, Jan. 15 county board meeting. During the interim between the two meetings he talked with subcontractors and representatives of SmartWATT, who are overseeing the changes.

"They are waiting on plumbing parts for the jail," said Patrick. "That's why the revised schedule moved the jail back a bit."

He added SmartWATT asked for clarification about what the county board wants done at the jail where much of the work was removed from the scope of the project after the decision was made to close the building. With Willaman on board and determined to get as much of the building reopened as possible, some of the shelved work needs to get back on the work order.

Patrick added some confusion about the Heating Ventilation Air Conditioning work at the courthouse was also resolved. Apparently, the drawing provided by SmartWATT lacked the building detail the contractor believed necessary. That issue was fixed when Edgar County Clerk and Recorder August Griffin located detailed drawings of the building created in 1968 for a previous remodeling.

"They (the contractor) said it is a difficult building because of the round design," said Patrick, acknowledging some confusion has occurred while expressing confidence in the end product. "It's going to be an efficient, quiet system when it's done."

Griffin announced he is moving the polling place from Carolyn Wenz Elementary School to the nearby First United Methodist Church. He noted this action leaves Memorial School in Paris as the last school in Edgar County serving as a polling place and administrators in Paris Union School District 95 want relieved of that responsibility.

Griffin said it is not a matter of just taking the polling place out of the school.

"The law still says if possible to keep polling places in schools because they are public buildings supported by taxpayers," said Griffin.

Taking the polling place from Memorial School requires finding another building of sufficient size to accommodate multi-precinct voting that is both handicapped accessible and has sufficient parking.

"I'm trying to find something for Memorial," Griffin said, but added there is not time to make the move prior to the March primary.

He emphasized the county incurs a cost of between $4,000 and $5,000 each time a polling center moves because new voter registration cards must be printed and notice of the change must be mailed to every affected voter.

https://www.wandtv.com/news/edgar-county-jail-to-close-inmates-to-be-housed-elsewhere/article_1b468b3c-00ef-11ea-adbb-f38d74dec13b.html

FEATURED

Edgar County Jail to close, inmates to be housed elsewhere

Nov 6, 2019

EDGAR COUNTY, Ill. (WAND) - Outsourcing inmates is now the plan for the Edgar County Jail.

On Monday, Edgar County officials heard back from their insurance company and learned they would not offer a policy to insure the newer part of the jail for housing inmates overnight.

Now, leaders are working on a plan to move forward. WAND News spoke with Edgar County Board Chairman Jeff Voigt to learn more.

"It's going to be hard work. We're going to have to all pull (it) together," he shared. "We have a lot of educating to do of the public and making sure that everybody understands our problem."

Voigt said priority number one is figuring out where to put their current inmates. He said the jail will house 30 inmates on average each day.

He said county leaders are already reaching out to jails and prisons in surrounding counties to see if inmates can go there. Roughly $380,000 will be set aside to cover housing and transportation over the next year.

However, Voigt said this obviously isn't a permanent solution.

"You know the attitude is sometimes, 'Well, they're criminals. So what do they deserve?' They deserve to have a safe, dry, warm or cooled place to be incarcerated that's not going to cause any problems or cause lawsuits," Voigt explained. "We need to have a safe place to have our staff work that doesn't cause them problems."

Voigt said many options are still on the table for the future of the jail, whether it's to renovate what's there, to partially tear down and re-build, or to start over from scratch. He shared that community feedback is encouraged every step of the way.

"We can always look back and say, 'Well, we should've done this, or we should've done that.' But we have the current situation to deal with, and we're going to try to be effective and use tax money and our personnel to our best advantage (for) the people of the county," Voigt said.

Another issue the county is looking to resolve is what will happen to current jail staff once most jail operations end. Voigt said the county is working with the unions on how to still meet their contract obligations. They'll discuss this more in a meeting on Friday.

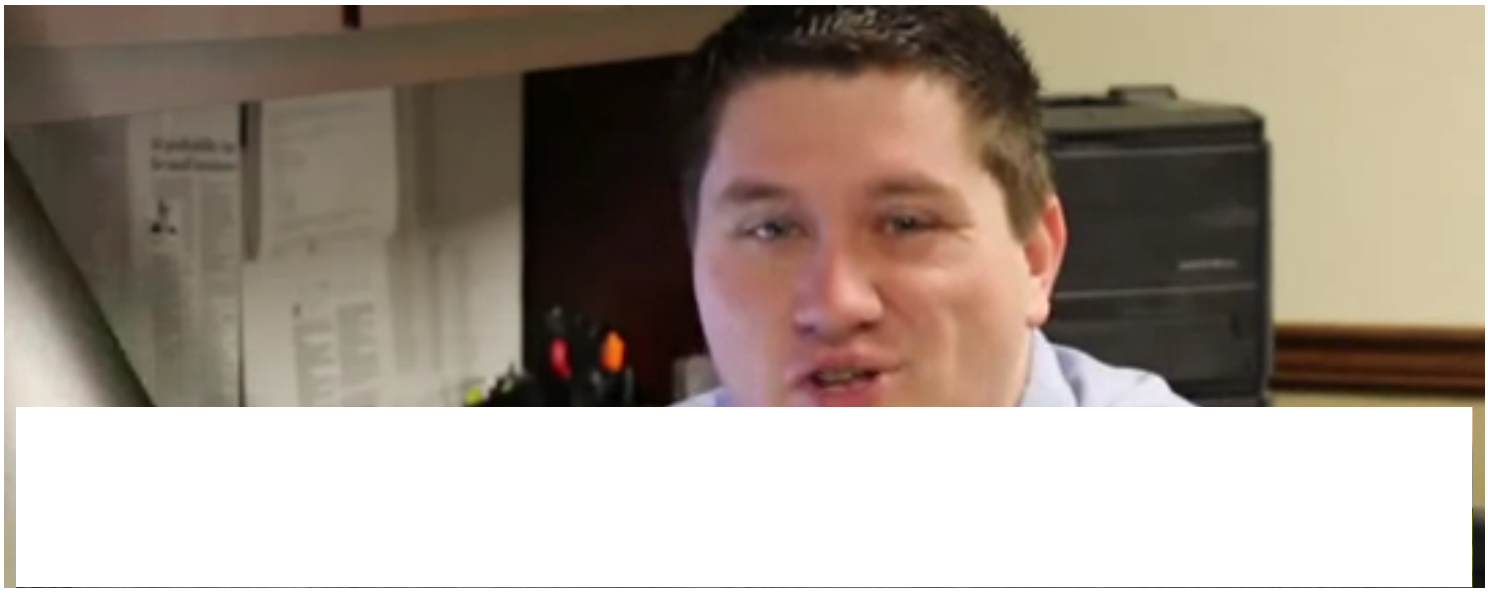
The current facility will be covered under insurance for the next year to continue 9-1-1 operations, other Edgar County Sheriff's Office duties and also to keep prisoners in holding areas temporarily during the day while they await trial.

The last day for the current insurance policy on the whole facility is Nov. 30.

57°

NEWS

Former Edgar County Sheriff says jail improvements needed years ago



57°

Posted: Feb 20, 2020 / 11:32 PM EST / Updated: Feb 20, 2020 / 11:37 PM EST

PARIS, Ill. (WTWO/WAWV) -During a public meeting on Thursday, a former Edgar County sheriff says improvements to jail were needed years ago.

Since the end of 2019, the Edgar County jail has been closed.

To reopen the facility county officials say they need to address issues with the jail's staffing and conditions.

The county is also facing concerns with the number of deputies who serve the community.

"Right now we only have four deputies and few part-timers to cover 24/7 a 600 plus square mile county," said Jeff Voigt, chair of Edgar County Board.

On March 17th, Edgar County voters are being asked to support a referendum that would increase sales taxes by one percent.

That money would allow the county to address the issues they see now, plus look at long-term options for their jail.

"It's something that we need to step up and do as a county to put things right," Voigt said.

On Thursday, a public meeting was held to discuss the referendum.

Among those in the room was former Edgar County Sheriff Edward Motley who in 2012 wrote a memo to county board members which detailed issues within the jail.

"It's not good. I mean it was brought to everybody's attention but I don't know why we didn't continue to work on it," Motley said.

Motley fears that these issues have been put aside for too long.

57°

Since Motley's time as sheriff, leadership of the board has changed and Voigt says regardless of the past Edgar County has to look towards their future.

"To dissect the problems of the past, we missed them for whatever reason people thought at the time, but the opportunity is here and now," Voigt said.

If passed, this sales tax would not impact certain items.

This includes groceries and prescriptions among several others.

County officials say if the referendum does not pass it can be placed on future ballots.

Voigt says that decision has not been made at this time.

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Exhibit E

EXCERPTS FROM IDOC 2018 AND 2019 REPORTS ON EDGAR COUNTY JAIL

"Staff numbers remain insufficient and must be increased. This standard requires at least two security staff members per shift each day." *See* ECF 1-1 page 1 0f 18.

"All areas within the facility are in need of major repair; many of the showers are rusted and or in disrepair. Many of the sinks and/or toilets are in need of repair. The light fixtures are not tamper proof and are easily broken or missing in some areas. Many of the required mirrors are missing. Some minimal repairs have happened since the last inspection but the jail is in need." *See* ECF 1-1 page 7 0f 18.

"Because of the lack of running water and flush toilets in the upper cell block, it is impossible to lock detainees in their individual cells." *See* ECF 1-1 page 8 0f 18.

"Because of understaffing on every shift, the outdoor recreation area is never utilized. If more staff were on duty, detainee movement to the recreation yard could be made possible." *See* ECF 1-1 page 9 0f 18.

"The heating equipment designed to provide heat to the upper left side of the facility does not work and no timetable has been set to repair it." *See* ECF 1-1 page 2 0f 18.

"All areas within the facility are in need of major repair; many of the showers are rusted and or in disrepair. Many of the sinks and/or toilets are in need of repair. The light fixtures are not tamper proof and are easily broken or missing in some areas. Some light fixtures were being held in place with pieces of torn clothing or socks, dangling. Jail staff have hung rope lights on the ceiling in an attempt to provide more light, however, it is still inadequate. Many of the required mirrors are missing. The cell block areas are lined with exposed wiring and some had even been spliced together by the detainees. One cell block had a broken metal fan guard leaning up against the cells within detainees reach. This non-compliance has continued through several inspections, with the fan still leaning within reach of the inmates. A general sweep of the detention areas needs to be performed to remove dangerous and unsafe contraband." *See* ECF 1-1 page 13 0f 18.

"Because of understaffing on every shift, the outdoor recreation area is never utilized. If more staff were on duty, detainee movement to the recreation yard could be made possible." *See* ECF 1-1 page 18 0f 18.

"On the April inspection date the trash cans were over flowing and the catwalk area of the units were littered with trash that the inspector had to step over to conduct the inspection. Staff needs to ensure that trash cans are emptied when full and that the catwalk area is kept clear of trash. The toilets on the unit that housed the female detainees had Kotex stuck around the seat areas of two toilets. This prevents the area from being properly cleaned daily and has the potential to harbor germs and bacteria. Staff needs to ensure that these are removed and that the detainees are NOT allowed to replace them. Shower curtains were moldy and being held in place with pieces of socks or other garments that detainees had torn (sic) into order to held the curtain up." *See* ECF 1-1 page 15 0f 18.

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EXHIBIT F

By Liza Torborg

Mayo Clinic Q and A: Getting enough vitamin D

DEAR MAYO CLINIC: It seems that vitamin D is always in the news. Why is it so important, and does the average person need a vitamin D supplement?

ANSWER: Vitamin D is an essential nutrient that your body requires primarily to build strong bones. It does this by helping your body absorb and maintain adequate levels of two other nutrients important to bone health — calcium and phosphate.

You get most of your vitamin D from sunlight. When ultraviolet (UV) rays hit your skin — particularly midday — it triggers production of vitamin D. People in climates with more sunlight tend to get more exposure than do those in climates with less sunlight.

Certain foods — fortified foods, such as milk and cereal, and fatty fish, such as salmon, tuna and mackerel — also provide vitamin D. Chemical reactions in your liver and kidneys transform vitamin D into forms that your body can use.

In general, adults should consume 600 international units of vitamin D a day. That goes up to 800 international units a day for those over 70. National survey data indicate that most Americans don't get enough vitamin D through their diets. However, the data also indicate that average blood levels of vitamin D are above what's considered necessary for good bone health for most people. This implies that most American adults get enough vitamin D — most likely through sun exposure.

Severe and prolonged vitamin D deficiency (https://www.mayoclinic.org/healthy-lifestyle/nutrition-and-healthy-eating/expert-answers/vitamin-d-deficiency/faq-20058397?mc_id=us&utm_source=newsnetwork&utm_medium=l&utm_content=content&utm_campaign=mayocli is known to cause bone mineralization disorders such as rickets (https://www.mayoclinic.org/diseases-conditions/rickets/symptoms-causes/syc-20351943?mc_id=us&utm_source=newsnetwork&utm_medium=l&utm_content=content&utm_campaign=mayocli in children and osteomalacia (https://www.mayoclinic.org/diseases-conditions/osteomalacia/symptoms-causes/syc-20355514?mc_id=us&utm_source=newsnetwork&utm_medium=l&utm_content=content&utm_campaign=mayocli in adults. Conditions such as these can lead to soft bones, aching muscles, painful movement and fractures. Vitamin D deficiency also may contribute to osteoporosis (https://www.mayoclinic.org/diseases-conditions/osteoporosis/symptoms-causes/syc-20351968?mc_id=us&utm_source=newsnetwork&utm_medium=l&utm_content=content&utm_campaign=mayocli

Although numerous studies have reported results associating vitamin D deficiency with various other diseases and conditions — such as fatigue, depression, chronic pain, heart disease (https://www.mayoclinic.org/diseases-conditions/heart-disease/symptoms-causes/syc-20353118?mc_id=us&utm_source=newsnetwork&utm_medium=l&utm_content=content&utm_campaign=mayocli autoimmune disorders, infections, metabolic issues and cancer — clinical trials of vitamin D supplements in people with these conditions generally have failed to show benefit. This implies that a lack of vitamin D probably isn't causing these conditions. Some experts argue that rather than being a cause of these kinds of illnesses, vitamin D deficiency may be a biological marker for them, signaling the presence of inflammatory processes related to the disease or condition.

Adults who may not get enough vitamin D generally fail to do so due to one or more of these reasons:

- **Chronic condition**
  Conditions that affect your absorption or processing of vitamin D can affect circulating levels of the vitamin. For example, having conditions such as inflammatory bowel disease or celiac disease, or having had bariatric surgery can affect your intestine's ability to absorb vitamin D. Obesity appears to drive down, or perhaps dilute, levels of circulating vitamin D. Chronic kidney or liver problems can interfere with the conversion of vitamin D into its active circulating forms, as can certain drugs, such as anti-convulsants and glucocorticoids.
- **Reduced skin synthesis**
  People with darker skin are at greater risk of vitamin D deficiency because greater amounts of melanin in the skin reduce the skin's ability to produce vitamin D from sunlight. Aging also decreases the efficiency of vitamin D synthesis. Sunscreen, clothing and other UV protective measures that block skin's exposure to the sun not only help prevent skin cancer, but also reduce production of vitamin D.
- **Limited sun exposure**
  People who spend most of their time indoors generally have low levels of vitamin D. The amount of sun exposure needed for adequate vitamin D production is uncertain, but most

estimates are no more than 15 minutes a day between 10 a.m. and 3 p.m., three times a week. However, this sun exposure must be balanced against your risk of skin cancer.

Most healthy American adults have adequate levels of vitamin D. But if you fall into a risk category, talk to your health care provider about whether you need a supplement. Generally, a blood test isn't necessary because taking the recommended amount of vitamin D as a supplement will ensure adequate levels in most people. Even 600 international units a day will correct a deficiency fairly quickly. However, taking too much vitamin D can overly increase your absorption of calcium, leading to problems such as kidney stones and damage to your heart and blood vessels. The National Academy of Medicine recommends an upper limit of 4,000 international units a day to be safe. (adapted from *Mayo Clinic Health Letter*) — ***Dr. Sundeep Khosla (https://www.mayoclinic.org/biographies/khosla-sundeep-m-d/bio-20053638?mc_id=us&utm_source=newsnetwork&utm_medium=l&utm_content=content&utm_campaign=r Endocrinology, Mayo Clinic, Rochester, Minnesota***

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Thursday, 17 December, 2020 03:12:10 PM
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EXHIBIT G

National Alliance on Mental Illness

NAMI News

Less Sunlight Means More Blues For Some

Author: Hisaho Blair - 1/22/2013

Seasonal affective disorder (SAD) is a form of depression that recurs regularly at certain times of the year, usually beginning in late fall or winter and lasting into spring. While the reported incidence of SAD in the general population is four to 10 percent, some studies suggest that up to 20 percent of people in the United States may be affected by a mild form of the disorder. The disease was officially named in the early 1980s, but seasonal depression has been described as early as the days of Hippocrates.

The symptoms of SAD include depressed mood, loss of energy, increased sleep, anxiety, irritability and difficulty concentrating. Many also experience a change in appetite, particularly a craving for carbohydrates, which can lead to weight gain. Some people report a heavy feeling in their arms and legs.

Scientists believe SAD is caused by a biochemical change in the brain, triggered by shorter days and reduced sunlight during the winter. In particular, two chemicals in the brain, serotonin and melatonin, have been linked to changes in mood, energy, and sleep patterns. Low levels of serotonin are associated with depression. Serotonin production is activated by sunlight, so less sunlight in winter could lower serotonin levels, leading to depression. Melatonin regulates sleep and is produced in greater quantities in darkness. Higher melatonin levels could cause sleepiness and lethargy as the days get shorter. The combination of the changes in the levels of serotonin and melatonin could contribute to SAD.

There are various risk factors for the development of SAD. Females are up to four times more likely to be affected than males. Although SAD can affect children, it is reported mostly in people between the ages of 18 and 30, with incidences decreasing with age. Many have a family history of mental illness. Studies have shown that living farther away from the equator increases the occurrence of SAD. Those already experiencing clinical depression or bipolar disorder may see a worsening of their symptoms in winter.

Treatments for SAD include traditional psychotherapy and antidepressant medications. In addition, light therapy, a daily 30-minute exposure to a light box that simulates high-intensity sunlight, has shown promise in treating SAD. Interestingly, the ancient Greeks knew about the power of sunlight. Back in the second century, the physician Aretaeus instructed, “Lethargics are to be laid in the light, and exposed to the rays of the sun for the disease is gloom.”

One theory suggests that SAD is an **evolutionary adaptation** in humans, similar to hibernation in animals. As food gets scarcer and the weather gets colder, animals adapt by storing fat and reducing caloric output. Applied to humans, this could explain the carbohydrate cravings, increased sleep and reduction in energy levels. It could also play a role in reproduction, where it is more beneficial for a female of childbearing age to conserve resources.

While these naturally occurring body changes may have helped our ancestors survive, depression in any form can be serious. Anyone affected by significant symptoms of depression should consult a physician.

*To learn more, **check out NAMI’s fact sheet on seasonal affective disorder** .*

Contact Us Main 703-524-7600
Member Services 888-999-6264
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Thursday, 17 December, 2020 03:12:11 PM
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EXHIBIT H

MAYO CLINIC

MRSA: Protecting student athletes

By Mayo Clinic Staff

Methicillin-resistant Staphylococcus aureus — or MRSA — is a type of highly drug-resistant bacteria that has been a problem in hospital and health care settings for decades. More recently, MRSA has become a problem among otherwise healthy student athletes. Is your child at risk? What can you do to protect against MRSA infection?

MRSA is a type of staph bacteria that has become resistant to the effects of many common antibiotics. This means that the antibiotics that used to kill the bacteria — such as methicillin — no longer work. This makes MRSA infections much more difficult to treat.

MRSA first surfaced in hospitals, where it often caused serious bloodstream infections in people who were sick with other diseases and conditions. Now there are varieties of MRSA that occur in nonhospital settings. These infections typically affect the skin of otherwise healthy individuals — such as student athletes.

An MRSA skin infection looks like a boil, pimple or spider bite that may be:

- Red
- Swollen
- Painful
- Warm to the touch
- Full of pus or fluid
- Accompanied by a fever

These infections most commonly occur at sites where the skin has been broken by cuts or scrapes, or on areas of the skin covered by hair, such as the:

- Back of the neck
- Groin
- Buttock
- Armpit
- Face

MRSA is spread by:

- **Skin-to-skin contact.** MRSA can be transmitted from one person to another through skin-to-skin contact. While MRSA skin infections can occur in participants of many types of sports, they're much more likely to occur in contact sports — such as football, wrestling and rugby.
- **Touching contaminated objects.** If drainage from an MRSA skin infection comes into contact with an object — such as a towel, weight training equipment or a shared jar of ointment — the next person who touches that object may become infected with MRSA bacteria.

Athletic equipment and locker rooms should be regularly cleaned and disinfected. There's no evidence that spraying or fogging rooms or surfaces with disinfectant works any better than just focusing on frequently touched surfaces — such as wrestling mats, weight training equipment and locker room benches.

Schools, coaches and trainers can also:

- Educate student athletes about how to prevent skin infections such as MRSA
- Encourage student athletes to practice good hygiene
- Encourage student athletes to report any suspicious skin infections to the coach
- Refer student athletes who have a suspicious skin infection to a doctor

To help prevent the spread of MRSA infections:

- **Wash your hands.** Use soap and water or an alcohol-based sanitizer. Clean your hands before and after playing sports, using shared weight training equipment, and changing a bandage on a wound.
- **Take showers.** Shower immediately after exercise. Don't share items that touch your bare skin — such as bar soap, razors or towels.
- **Use barriers.** Cover cuts and scrapes with a bandage to keep germs out. Lay a towel down to act as a barrier between your skin and benches in weight rooms, locker rooms, saunas and steam rooms.
- **Wash your clothing and equipment.** Follow the laundering directions for your workout clothing, uniform and equipment. Dry clothes completely in a dryer. Wash your workout clothing and uniform after each use.

Cover the infected area with a clean, dry bandage. Then, go see your doctor. Don't try to treat a skin infection yourself.

It's hard to tell the difference between a skin infection caused by MRSA and a skin infection caused by another type of bacteria. Your doctor can order laboratory tests to determine what kind of bacterial infection you have.

Minor MRSA skin infections usually heal after being drained by your doctor. If the infection doesn't heal well or gets worse, your doctor may prescribe antibiotics that are still effective against MRSA. If the infection is severe, you may need to be hospitalized. In rare cases, MRSA infections can become life-threatening.

While your skin infection is healing, keep it covered with a clean, dry bandage at all times. To avoid spreading MRSA to others, wash your hands often, especially after changing your bandage or touching the infection. Don't share clothing, towels or hygiene products with anyone else. Don't use whirlpools, therapy pools or swimming pools until the infection has healed completely.

The National Athletic Trainers' Association recommends that skin infections be tested for MRSA, and that an athlete who has MRSA should not be allowed to return to play until:

- The athlete has taken an appropriate antibiotic for at least 72 hours
- Drainage from the wound has stopped
- No new lesions have developed in the past 48 hours

Show References

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June 04, 2019

Original article: https://www.mayoclinic.org/diseases-conditions/mrsa/in-depth/mrsa/art-20047876

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