E-FILED
Tuesday, 28 May, 2019 03:19:04 PM
Clerk, U.S. District Court, ILCD

IN THE UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF ILLINOIS

PEORIA DIVISION

ASHOOR RASHO et al.,	)	
	)	No. 1:07-CV-1298-MMM-JEH
Plaintiffs,	)	
	)	
	)	Judge Michael M. Mihm
vs.	)	
	)	Magistrate Judge Jonathan E. Hawley
	)	
DIRECTOR JOHN R. BALDWIN, et al.,	)	
	)	
Defendants	)	

THIRD ANNUAL REPORT OF MONITOR PABLO STEWART, MD

TABLE OF CONTENTS

BACKGROUND

IDOC: IDOC consists of 29 adult correctional facilities. Among these are four maximum security facilities (including a facility for women), and two additional facilities for women. Four of the facilities have Reception and Classification units where inmates are received into IDOC. Three of the facilities, Logan, Joliet and Dixon, have Residential Treatment Units. The Joliet Treatment Center began receiving offenders on October 4, 2017 and as of April 1, 2019 the census was 126. The RTU at Pontiac is not operating as of the submission of this report although it does have the beginnings of a program with approximately 40 residents. The Amended Settlement Agreement states that the RTU at Pontiac is to open no later than July 6, 2018[1]. All facilities have crisis care beds as well as having some form of segregation, including administrative detention, disciplinary segregation, and investigative status.

Settlement: The original Settlement Agreement was filed with the Court on January 21, 2016. The Amended Settlement Agreement ("Settlement") was approved May 23, 2016. It covers a range of practices affecting inmates with mental illness or serious mental illness:

- Policies and procedures
- Intake screening
- Medication continuity on arrival
- Referrals
- Mental health evaluations
- Crisis Intervention Team
- Licensure
- Inmate orientation
- Treatment plans and updates
- Psychiatric evaluations
- Follow-up after discharge from specialized treatment settings
- Staffing plans and hiring
- Bed, programming, and office space for residential treatment units, inpatient facilities, and crisis beds
- Administrative staffing
- Medication administration, documentation, evaluations, lab work, side effects monitoring, informed consent, non-compliance follow-up
- Enforced medication
- Housing assignment notice and recommendations
- Treatment, housing conditions, and out-of-cell time in segregation and investigative status
- Review of segregation terms length
- Suicide prevention
- Restraints for mental health purposes
- Mental health care records and forms
- Confidentiality
- Change of Seriously Mentally Ill designation

[1] Id page 12, section X(b)ii(B)

- Staff training
- Nondiscrimination in program participation
- Records and medication continuity on inter-facility transfers
- Use of force and verbal abuse
- Mental health input into discipline
- Continuous quality improvement
- Terms of monitoring this Settlement
- IDOC reporting

Deadlines: Deadlines in the Settlement range from immediate to the year 2020; this report calculates many deadlines from the Amended Settlement Agreement approval date of May 23, 2016. A number of deadlines on critical issues were contingent upon, and calculated from, the state budget approval date of July 6, 2017. The team reviewed each provision of the Settlement per the specific deadlines identified in the Settlement. Of note, there are many provisions for which the deadline is "as agreed upon" between the parties but for which the monitoring team did not receive a schedule of specific agreed-upon dates. For these particular issues, the assigned compliance ratings reflect the current status of the issues.

The following table lists the requirements in order of their deadlines to be accomplished. Of the 39 items with deadlines on or before May 22, 2019, 24 have reached Substantial Compliance. Ratings are also indicated for those items to be accomplished "in a reasonable time," in the event that it is determined that a reasonable time is now at hand. A more detailed summary of the compliance status of all Settlement Agreement provisions can be found in the body of the report.

Amended Settlement Agreement provision	**Timeline**	**Substantial Compliance?**
Crisis Beds are to be outside Control Units (except Pontiac)	May 2016	Partial
Regional Director hires	June 2016	Yes
State employee at each facility to supervise State clinical staff, monitor and approve vendor staff	June 2016	Partial
Architectural plans to Monitor	July 2016	Yes
12 Mental Health Forms in use	July 2016	Yes
Treating mental health professionals[2] disclose information to patient	July 2016	Partial
Medical Records and medication transferred with patient	August 2016	Yes
Intergovernmental Agreement with Department of Health Services	August 2016	Yes
Medication delivery, recording, side effects monitoring, lab work, patient informed, non-compliance follow-up	August 2016	Partial

[2] Referred to throughout the Settlement Agreement and this report as MHP

Propose any amendment to Staffing Plan	August 2016	Original requirement-n/a
Any objections to proposed amended Staffing Plan	October 2016	Original requirement-n/a
All policies/procedures/ADs specified in Settlement Agreement – drafts to Plaintiffs and Monitor	November 2016 (unless otherwise specified)	Partial
Confidentiality: records, mental health information, policies and training	November 2016	Partial
Behavior Treatment Program pilot	November 2016	Partial
Quality Improvement Manager hire	February 2017	Yes
Review Committees for SMI Disciplinary Segregation terms	February 2017	Yes
Mentally ill Control Unit residents >60 days receive 8 hours out of cell time weekly	May 2016-May 2017	Partial
Inmate Orientation policy and procedure	May 2017	Yes
Crisis beds at Pontiac moved to protective custody	May 2017	No
Suicide Prevention measures	May 2017	Partial
Physical Restraints measures	May 2017	Some institutions
Staff Training plan and program developed	May 2017	Yes
Discipline: policies related to self-injury	May 2017	Partial
Mental health staff Training plan and program developed	May 2017	Yes
Transfers: consults and notification	May 2017	Yes
Mentally ill Control Unit residents >60 days receive 12 hours out of cell time weekly	May 2017-May 2018	No
Staffing: quarterly hiring reports, meeting targets	Quarterly from October 2017 on	No
Mental health referrals and evaluations	November 2017	Partial
Staffing to run RTU at Joliet	November 2017	No
Central office staff hires for policies and recordkeeping	November 2017	Yes
RTU Programming and Office Space	January 2018	Partial
Staffing hires – Dixon, Pontiac, Logan	January-July 2018	No
RTU Bed Space	January-October 2018	Partial
Inpatient Bed Space construction	January-November 2018	Yes
Screening conducted with sound privacy	May 2018	Yes
Training for all State and vendor staff with inmate contact	May 2018	Yes
Mentally ill Control Unit residents >60 days receive 16 hours out of cell time weekly	June 2018-May 2019	No
MHP review within 48 hours after Investigative Status/Temporary Confinement placement	July 2018	Some institutions
Inpatient Facility – transfer ownership and expand, policies	November 2018	Partial

Mentally ill Control Unit residents >60 days receive 20 hours out of cell time weekly	June 2019-May 2020	Not due
Segregation and Temporary Confinement for mentally ill: housing decisions, MHP review, treatment and out-of-cell requirements	May 2020	Not due
Develop plans for inpatient care that can be implemented after necessary appropriations	After IGA is signed	Yes
Screening on arrival at reception	Reasonable time	Yes
Psychotropic medications continued on arrival, reviewed, and related documentation	Reasonable time	Yes
Inmate Orientation	Reasonable time	Yes
Treatment Plans	Reasonable time	Partial
Psychiatry Review frequency	Reasonable time	Partial
Follow-up after Specialized Treatment Settings	Reasonable time	Partial
Enforced Medication	Reasonable time	Some institutions
SMI Housing Assignment information and consultation	Reasonable time	Yes
Change of SMI designation only by treatment team (or treating MHP before teams are operating)	Reasonable time	Yes
Mental illness does not prevent access to prison programs	Reasonable time	Yes
Use of Force and Verbal Abuse	Reasonable time	Some institutions
Discipline system conforms to AD 05.12.103	Reasonable time	Partial
Discipline in RTU or inpatient is carried out in a mental health treatment context	Reasonable time	Yes
Quality Improvement Program implemented	Reasonable time	Yes

METHODOLOGY / MONITORING ACTIVITIES

This report was prepared and submitted by Pablo Stewart, MD, Virginia Morrison, JD, Reena Kapoor, MD, and Miranda Gibson, MA.

To accomplish the monitoring obligations, the monitoring team sought information in a variety of ways. The monitoring team conducted 37 site visits of 19 different IDOC facilities, where interviews of administrators, staff, and offenders were conducted. While on site, the monitoring team would meet with the administrative and clinical leadership of the facility and then tour the facility. The tour would include observing general population units, segregated housing units, crisis care units, infirmary areas including medical records and restraint rooms, working spaces for the clinical staff, group therapy areas (if present), as well as any other area associated with the provision of mental health services. The monitoring team also toured the Residential Treatment Units at Logan, Joliet and Dixon. The Monitor personally inspected the Mental Health Unit at Pontiac on six separate occasions. The team also requested and analyzed systemwide data, and a sampling of health care or master file records, as to some requirements.

Centralia 7/20/18 Dr. Stewart and Ms. Gibson	Danville 2/13/19 Ms. Gibson	Decatur 4/2/19 Ms. Gibson	Dixon 2/7-2/8/19 Dr. Kapoor
East Moline 4/8/19 Ms. Gibson	Elgin 1/16/19 Dr. Stewart	Graham 7/16-7/17/18 Ms. Morrison 2/22/19 Dr. Stewart and Ms. Gibson	Illinois River 7/23/18 Dr. Kapoor 3/4-3/6/19 Ms. Morrison
Jacksonville 12/23/18 Ms. Gibson	Joliet 10/22/18 Dr. Kapoor 12/28/18 & 3/22/19 Dr. Stewart	Lawrence 7/19/18 Dr. Stewart and Ms. Gibson	Logan 6/27/18 & 12/27/18 Dr. Stewart and Ms. Gibson
Menard 6/25/18, 10/17/18 & 1/8/19 Dr. Stewart and Ms. Gibson	Pinckneyville 10/16/18 Dr. Stewart and Ms. Gibson	Pontiac 6/26/18, 10/18/18, 12/28/18 & 3/22/19 Dr. Stewart 6/12/18 & 9/11-9/12/18 Dr. Stewart and Ms. Gibson 1/22/19-1/24/19 Ms. Morrison	Robinson 3/6/19 Ms. Gibson
Shawnee 7/23/18 Ms. Gibson	Stateville 6/25-6/26/18 (proper) Dr. Kapoor 10/11-10/12/18 (NRC) Ms. Morrison 3/21/19 (NRC) Dr. Stewart and Ms. Gibson	Vandalia 11/27/18 Ms. Gibson	Vienna 8/6-8/8/18 Ms. Morrison
Western 7/18-7/20/18 Ms. Morrison 1/28/19 Dr. Stewart and Ms. Gibson			

EXECUTIVE SUMMARY

As reported in the midyear report, there has been a tremendous amount of litigation during the reporting period. The Court issued a Preliminary Injunction on May 25, 2018 which was followed by a Permanent Injunction on December 20, 2018. It is my understanding that the staffing provisions of the Permanent Injunction have been appealed to the 7th Circuit. The Monitoring Team completed its own staffing analysis and submitted it to parties and the Court on April 24, 2019

The Monitoring Team conducted 37 site visits to 19 different IDOC facilities during the reporting period. Hundreds of charts were reviewed, hundreds of IDOC staff were interviewed as well as hundreds of mentally ill offenders interviewed. I feel that the data set from which the opinions in this report are based is especially robust. I also meet with IDOC's executive staff, including the Director, on two separate occasions during the reporting period. Finally, I have instituted the rating of "partial compliance" to more accurately reflect the progress that IDOC has made in meeting the requirements of the Settlement Agreement. Of note, I have also met with counsel for the plaintiffs' several times during the reporting period.

As we close out the 3rd year of the Settlement Agreement, I can definitely state that IDOC has greatly improved its ability to care for mentally ill offenders. As documented in the body of this report, the following areas were found to be in Substantial Compliance:

- IV: Initial (Intake) Mental Health Services: Screening
- VI: Mental Health Services Orientation
- XIV: Housing Assignments
- XVIII: Medical Records
- XX: Change of SMI Designation
- XXI: Staff Training
- XXII: Participation in Prison Programs
- XXIII: Transfer of Seriously Mentally Ill Offenders From Facility to Facility
- XXVII: Continuous Quality Improvement Program
- XXVII: Monitoring
- XXVIII Reporting and Recordkeeping

A major problem that is preventing IDOC from being substantially compliant with the entire Settlement Agreement is staffing. Inadequate number of mental health staff prevents IDOC from being substantially compliant with the following areas:

- V: Mental Health Evaluations and Referrals
- VII: Treatment Plan and Continuing Review
- VIII: Transition from Specialized Treatment Settings
- IX: Additional Mental Health Staff
- XI: Administrative Staffing
- XII: Medication
- XV: Segregation

- XIX: Confidentiality
- XXIV: Use of Force and Verbal Abuse
- XXV: Discipline of Seriously Mentally Ill Offenders

Although staffing is a major problem preventing full compliance, IDOC still has much work to do with Mental Health Evaluations and Referrals, Treatment Planning, Medication, Segregation, Confidentiality, Use of Force and Discipline. Please refer to the individual sections of the report to see the actual status of each of these sections that was not found in substantial compliance.

I look forward to continuing cooperation from IDOC in achieving the goal of meeting the requirements of the entire Settlement Agreement.

A summary of compliance findings follows:

Requirement	Compliance Status
IV: INITIAL (INTAKE) MENTAL HEALTH SERVICES: SCREENING	Overall: Substantial compliance Subfindings supporting overall finding:
(IV)(a), (b), (c), (d), (e), (f), (g)	Substantial compliance
V: MENTAL HEALTH EVALUATION AND REFERRALS	Overall: Partial compliance Subfindings supporting overall finding:
(V)(a) (V)(b), (c), (d), (e) (V)(f), (V)(g) (V)(h), (i) (V)(j)	Partial compliance Substantial compliance Non-compliance Partial compliance Substantial compliance Partial compliance
VI: MENTAL HEALTH SERVICES ORIENTATION	Overall: Substantial compliance Subfindings supporting overall finding:
(VI)(a), (b)	Substantial compliance
VII: TREATMENT PLAN AND CONTINUING REVIEW	Overall: Partial compliance Subfindings supporting overall finding:

Requirement	Compliance Status
(VII)(a), (b), (c), (d) (VII)(e)	Partial compliance Substantial compliance
VIII: TRANSITION FROM SPECIALIZED TREATMENT SETTINGS (VIII)(a) (VIII)(b)(i), (b)(ii)	Overall: Partial compliance Subfindings supporting overall finding: Substantial compliance Partial compliance
IX: ADDITIONAL MENTAL HEALTH STAFF (IX)(a), (b) (IX)(c) (IX)(d), (e) (IX)(f)	Overall: Non-compliance Subfindings supporting overall finding: Non-compliance No rating Substantial compliance No rating
X: BED/TREATMENT SPACE (X)(a) (X)(b)(i), (ii) (X)(c)(i), (ii) (X)(d) (X)(e) (X)(f) (X)(g) (X)(h) (X)(i)	Overall: Partial compliance Subfindings supporting overall finding: Substantial compliance Substantial compliance Substantial compliance Non-compliance Partial compliance Partial compliance Partial compliance Partial compliance Substantial compliance
XI: ADMINISTRATIVE STAFFING (XI)(a), (b) (XI)(c), (XI)(d)	Overall: Partial compliance Subfindings supporting overall finding: Substantial compliance Partial compliance Substantial compliance
XII: MEDICATION	Overall: Partial compliance

Requirement	Compliance Status
	Subfindings supporting overall finding:
(XII)(a)	Substantial compliance
(XII)(b)	Non-compliance
(XII)(c)(i)	Partial compliance
(XII)(c)(ii), (iii), (iv)	Partial compliance
(XII)(v)	Substantial compliance
(XII)(vi)	Partial compliance
XIII: OFFENDER ENFORCED MEDICATION	Finding: Substantial Compliance for 15 institutions Partial compliance for remaining institutions
XIV: HOUSING ASSIGNMENTS	Overall: Substantial compliance
	Subfindings supporting overall finding:
(XIV)(a), (b), (c)	Substantial compliance
XV: SEGREGATION	Overall: Partial compliance
	Subfindings supporting overall finding:
(XV)(a)(i)	Substantial compliance
(XV)(a)(ii)	Partial compliance
(XV)(a)(iii)	Partial compliance
(XV)(a)(iv)	Substantial compliance in 18 institutions; partial compliance in the rest.
(XV)(a)(v),	Non-compliant
(XV)(a)(vi),	Partial compliance
(XV)(vi)(sic)	Non-compliance
(XV)(a)(vii)	Substantial compliance
(XV)(b)(i),(ii), (iii), (iv) (v), (vi)	Substantial compliance
(XV)(c)(i)	Partial compliance
(XV)(c)(ii)	Substantial compliance
(XV)(c)(iii)	Partial compliance
(XV)(c)(iv)	Non-compliance
(XV)(c)(v)	Substantial compliance
(XV)(c)(sic)	Non-compliance
(XV)(d)	No rating

Requirement	Compliance Status
XVI: SUICIDE PREVENTION	Overall: Partial compliance
	Subfindings supporting overall finding:
(XVI)(a), (b)	Partial compliance
XVII: PHYSICAL RESTRAINTS FOR MENTAL HEALTH PURPOSES	Overall: Partial compliance
	Subfindings supporting overall finding:
(XVII)(a)	Substantial compliance as to 14 institutions; partial compliance as to the rest of the institutions
(XVII)(b),(c)	Substantial compliance
(XVII)(d)	Noncompliance
XVIII: MEDICAL RECORDS	Overall: Substantial compliance
(XVIII)(a), (b)	Subfindings supporting overall finding: Substantial compliance
XIX: CONFIDENTIALITY	Overall: Partial compliance
	Subfindings supporting overall finding:
(XIX)(a)	Substantial compliance
(XIX)(b)	Substantial compliance
(XIX)(c), (d)	Partial compliance
XX: CHANGE OF SMI DESIGNATION	Finding: Substantial compliance
XXI: STAFF TRAINING	Overall: Substantial compliance
	Subfindings supporting overall finding:
(XXI)(a), (b), (c)	Substantial compliance
XXII: PARTICIPATION IN PRISON PROGRAMS	Finding: Substantial compliance
XXIII: TRANSFER OF SERIOUSLY MENTALLY ILL OFFENDERS FROM	Overall: Substantial compliance

Requirement	Compliance Status
FACILITY TO FACILITY (XXIII)(a), (b), (c)	Subfindings supporting overall finding: Substantial compliance
XXIV: USE OF FORCE AND VERBAL ABUSE	Finding: Partial compliance
XXV: DISCIPLINE OF SERIOUSLY MENTALLY ILL OFFENDERS (XXV)(a) (XXV)(b) (XXV)(c) (XXV)(d)	Overall: Partial compliance Subfindings supporting overall finding: Partial compliance Partial compliance Substantial compliance Partial compliance
XXVI: CONTINUOUS QUALITY IMPROVEMENT PROGRAM (XXVI)(a), (b)	Overall: Substantial compliance Subfindings supporting overall finding: Substantial compliance
XXVII: MONITORING	Finding: Substantial compliance
XXVIII: REPORTING AND RECORDKEEPING	Finding: Substantial compliance

DETAILED FINDINGS

This Section details the Monitor's findings for each provision of the Settlement.

Overall structure: This Section is organized along the same structure as the Settlement; each major section below corresponds with a substantive section of the Settlement. That said, the Settlement includes provisions that appear multiple times across different sections. The Monitor attempts in this report to address each substantive requirement in that section of the Settlement where it appears.

Compliance with specific provisions of policies or law incorporated by reference: Unlike the Settlement itself, the report lays out the specific provisions of the various Administrative Directives ("ADs"), administrative code ("Code"), or the Mental Health Standard Operating Protocol Manual ("Manual" or "SOP Manual") that are incorporated by reference in the Settlement. This significantly lengthens the report, but it is critical that the monitoring team evaluates these substantive requirements, especially given that many of them are central to providing the kind of treatment, out-of-cell opportunities, conditions, and protection from harm contemplated in the Settlement. For example, it is in the ADs and the Manual that one finds

detailed requirements on suicide prevention, including crisis placement, crisis intervention teams, and suicide reviews. However, the team will apply the compliance/partial compliance/non-compliance rating only to the provision of the Settlement, not to individual provisions of ADs or the Manual or Code incorporated by reference. In this way, IDOC may be out of compliance with one or two provisions of the cited AD, for example, but, depending on the severity (including the importance of the particular provision of the AD) or how widespread that non-compliance is, nonetheless may be in substantial compliance with the provision of the Settlement.

Compliance ratings: In all previous reports, the team applied the "Substantial Compliance" and "Non-compliance" ratings for each provision, as specified in the Settlement. In actual fact, these may mask IDOC's true performance in meeting the requirements of the Settlement Agreement. In practice, IDOC has made substantial progress on a number of requirements. This progress possibly could be more accurately described as "partially compliant." The terms of the Settlement, however, only allow for the use of "Substantial Compliance" and "Non-compliance." After discussions with counsel for the defendants and plaintiffs, "Partial Compliance" will be utilized in this report. "Partial Compliance" is defined as making substantial progress on a particular requirement without fully meeting the rigorous obligations of the Amended Settlement Agreement.

Section II (t) of the Amended Settlement Agreement defines "Substantial Compliance" as follows: The Defendants will be in substantial compliance with the terms of this Settlement Agreement if they perform its essential, material components even in the absence of strict compliance with the exact terms of the Agreement. Substantial compliance shall refer to instances in which any violations are minor or occasional and are neither systemic nor serious. Substantial compliance can be found for obligations imposed under this Settlement Agreement either IDOC-wide or at specific facilities. For the purposes of this report, most compliance ratings will be IDOC-wide. This was done because the changes to the mental health delivery system contemplated in the Settlement represent a major shift in both the clinical care provided to the offenders and the overall culture of the IDOC. As the monitor of this seismic shift for IDOC, I continue to feel that it is more appropriate to consider system-wide compliance prior to evaluating the compliance of specific facilities. Most Settlement Agreement provisions are complex with many factors to fulfill, so the substantial compliance findings are in the minority but are growing. It is important to note that during the first three years of monitoring the Settlement Agreement, IDOC has improved the overall quality of psychiatric and mental health services offered to the offender population. IDOC still has a long way to go to fully meet the requirements of the Settlement Agreement especially in terms of staffing.

IV: INITIAL (INTAKE) MENTAL HEALTH SERVICES: SCREENING

IDOC is in substantial compliance with this section. Mental health screenings are occurring within the designated time frame, they are being performed by MHPs utilizing the proper forms, and unlicensed clinicians are being properly supervised. Mental health screenings occur in confidential settings. Policies and Procedures have been developed to ensure that offenders prescribed psychotropic medications continue to receive their medications. The Monitoring team has observed that psychotropic medications are being properly continued. The mental health screenings are a comprehensive review of the offenders' mental health history. The Monitoring team will not be reviewing this requirement going forward unless specifically asked by the Court or parties.

(IV)(a): Specific requirement: All persons sentenced to the custody of IDOC shall receive mental health screening upon admission to the prison system. Absent an emergency which requires acting sooner, this screening will ordinarily take place within twenty-four (24) hours of reception (*see* "Components of Mental Health Services" at pg. 5 in the IDOC Mental Health Protocol Manual (incorporated by reference into IDOC Administrative Directive 04.04.101(II)(E)(2)), but in any event no later than forty-eight (48) hours after reception, as required by IDOC Administrative Directive 04.04.100 (II)(G)(2)(b) (*see also* IDOC Administrative Directive 05.07.101).

Findings: During the reporting period, the monitoring team conducted nine separate site visits at the four Reception and Classification Centers operated by IDOC. That is, two visits each for Graham, Logan and NRC and three visits to Menard. In all sites visited, the monitoring team observed that "all persons sentenced to the custody of IDOC shall receive mental health screening upon admission to the prison system." These screenings were occurring within 24 hours of arrival at a reception center. IDOC is in substantial compliance with this specific requirement.

(IV)(b): Specific requirement: The mental health screening conducted upon admission to IDOC shall be conducted by a Mental Health Professional [MHP][3] and shall use IDOC Form 0372 (Mental Health Screening). In those instances where a mental health screening is performed by an unlicensed mental health employee, said mental health employee will be supervised by a licensed MHP no fewer than four hours per month. This exception for unlicensed mental health employees applies only to those mental health employees currently working in IDOC and grandfathered in prior to this Settlement.

Findings: The monitoring team has observed at all reception centers that mental health screenings are conducted by a Mental Health Professional. In those cases where a mental health screening is performed by an unlicensed mental health employee, the monitoring team found that these employees are properly supervised by a licensed MHP. IDOC is in substantial compliance with this specific requirement.

[3] The Settlement uses MHP to indicate Mental Health Professional. This report adopts that convention as well.

(IV)(c): Specific requirement: Offenders transferred from a receiving and classification facility who have been screened and referred for further mental health services shall be administered the Evaluation of Suicide Potential, IDOC Form 0379, but need not be administered the mental health screening form again.

Findings: The monitoring team noted that this requirement is being met at all IDOC facilities audited. IDOC is in substantial compliance with this specific requirement.

(IV)(d): Specific requirements: In order to encourage full and frank disclosure from offenders being screened, mental health screening shall take place in the most private space available at the receiving and classification facilities. Within two (2) years of the approval of this Settlement Agreement, IDOC will ensure that mental health screening at all receiving and classification facilities takes place only in spaces that ensure sound confidentiality.

Findings: The monitoring team has previously determined that all reception centers conduct screenings with sound confidentiality. This finding was confirmed during the current reporting period. IDOC is in substantial compliance with this specific requirement.

(IV)(e): Specific requirement: IDOC shall develop policies and procedures to ensure that an offender who has a current prescription for psychotropic medication is able to continue receiving medication without interruption upon transfer to IDOC custody.

Findings: IDOC has developed policies and procedures to ensure that an offender who has a current prescription for psychotropic medication is able to continue receiving medication without interruption upon transfer to IDOC custody. IDOC is in substantial compliance with this specific requirement.

(IV)(f): Specific requirement: Following transfer to IDOC custody, an offender's prescription for psychotropic medication shall be reviewed by a licensed physician or psychiatrist and modified only if deemed clinically appropriate. Any change in psychotropic medication, along with the reason for the change, shall be documented in the offender's medical record. The psychiatrist or other physician, or nurse practitioner acting within the scope of their license, must also document on the offender's chart the date and time at which they discussed with the offender the reason for the change, what the new medication is expected to do, what alternative treatments are available, and what, in general, are the side effects of the new medication, and answered any questions the offender had before starting the medication.

Findings: As reported previously, IDOC has been generally meeting this requirement. That is, in the majority of the cases reviewed, IDOC is meeting this requirement. A minority of cases reviewed revealed that medications were modified without adequate documentation that the offender was given the opportunity to ask questions of the prescribers. As this was found in only a small number of cases, IDOC will be found in substantial compliance with this specific requirement.

(IV)(g): Specific requirement: Screening will include identifying neurodevelopmental disabilities, suicidal ideation or intent, current or past self-injurious behavior, the presence or history of symptoms of mental illness, current or past use of psychotropic medications, or the presence of conditions that require immediate intervention, in addition to the information required

to be documented on IDOC Form 0372 (Mental Health Screening). The screening process shall also include review of the records which accompany the offender.

Findings: IDOC is in substantial compliance with this requirement.

V: MENTAL HEALTH EVALUATION AND REFERRALS

Summary: A persistent backlog exists for the timely completion of mental health evaluations and the majority of the backlogged cases are greater than 14 days late. Also, due to the tremendous workload and limited number of staff at NRC, mental health evaluations are generally not occurring. A Policy and Procedure has been created which addresses referrals and the proper forms are being utilized.

Gatekeeping by the custody staff regarding the use of the Crisis Intervention remains an issue. The Director and Chief of Operations assured the Monitor that they will personally address this issue.

Due to the ongoing presence of a backlog for timely completion of mental health evaluations and the question of gatekeeping, IDOC will receive a rating of partial compliance.

(V)(a): Specific requirement: Mental health evaluation, or an appropriate alternative response in case of emergency, shall be timely provided as required by IDOC Administrative Directives 04.04.100 and 04.04.101.

Findings: IDOC has improved greatly over the course of the Settlement Agreement in regards to this requirement. A review of recent backlog data suggests that IDOC continues to struggle with fully meeting this requirement:

3/22/19	262 mental health evaluations backlogged	135 within 1-14 days late
3/29/19	292 mental health evaluations backlogged	118 within 1-14 days late
4/5/19	287 mental health evaluations backlogged	124 within 1-14 days late
4/12/19	313 mental health evaluations backlogged	135 within 1-14 days late

The data doesn't allow for a more comprehensive understanding of exactly what percentage of the total mental health evaluations this backlog represents. Also, in this particular sample, 60% of the backlogged cases are greater than 14 days late.

Finally, it is important to note that mental health evaluations are not routinely completed at the NRC. This is due to their tremendous workload of new intakes and having to house a large number of offenders on writs. While workload may make this understandable, it is a significant compliance issue. IDOC's April Quarterly Report states that offenders stay at the NRC for an

average of 18 days if they do not have pending court or medical matters. What it does not say is that those exceptions involve hundreds of people.

In a visit during this monitoring period, the team analyzed caseload lengths of stay for the population onsite at the time. Using IDOC's data and applying very conservative measures,[4] 169 people had been at NRC longer than the stated average that week, and staff said there was nothing unusual about the population at the time. Over a year's time, of course, this total would multiply. Staff appropriately attempted to prioritize higher acuity patients for evaluations, to mitigate these circumstances, but were only successful in a slight majority of such cases onsite at the time.

IDOC will receive a rating of "partial compliance" for this requirement. A rating of substantial compliance will be assigned when IDOC can demonstrate that the mental health backlog represents less than 15% of the total mental health evaluations and that the majority of these cases are in the 14 days or less category.

(V)(b): Specific requirement: Referral may be made by staff and documented on IDOC Forms 0387 and 0434 or by self-referral by the offender.

Findings: The monitoring team observed that referrals are made by staff and offenders and are documented on the appropriate forms. IDOC is found to be in substantial compliance with this requirement.

(V)(c): Specific requirement: IDOC shall ensure that the referral procedures contained in IDOC AD 04.04.100, section II (G)(4)(a) and (b) for offender self-referral are created and implemented in a timely fashion in each facility.

Section II (G)(4)(a) and (b) provide:

Referrals for mental health services may be initiated through staff, credible outside sources such as family members, other offenders or self-reporting.

(a) To ensure proper handling of requests from credible outside sources, the Department shall ensure mail room staff and facility operators, gatehouse staff and other staff who may come in contact with family members, visitors or other interested persons are aware of procedures for receiving and addressing inquiries regarding referrals for mental health services. Additionally, the contact information and procedures by which outside sources may refer offenders for mental health services shall be provided on the Department's website.

(b)The Chief Administrative Officer of each facility shall ensure a procedure for referring offenders for mental health services is established.

(1) Referrals from staff shall:

[4] The team reviewed the Mental Health Database maintained by NRC staff. Calculating from the date a patient is added to the caseload, the team included those patients onsite and on the caseload 3 weeks or more—not the 2-week requirement—to allow for short delays in evaluation practice, filing, and/or data entry. Thus, the 169 total is reached using these more flexible criteria.

(a) Be initiated on the Mental Health Services Referral, DOC 0387;
(b) Be submitted to the facility's Office of Mental Health Management through the chain of command; and
(c) Include a copy of the Incident Report, DOC 0434, if applicable.

(2) The facility Crisis Intervention Team shall be contacted immediately for offenders with serious or urgent mental health problems, as evidenced by a sudden or rapid change in the offender's behavior or behavior that may endanger themselves or others, if not treated immediately.

(c) Procedures for self-referrals by offenders for mental health services shall be provided in the offender handbook. The offender will be encouraged to submit their requests on the Offender Request, DOC 0286.

Findings: As previously reported, IDOC has established the required referrals procedures and has been found to be in substantial compliance with this requirement in previous reports. They continue to be found in substantial compliance.

(V)(d): Specific requirement: In addition to those persons identified by the screening process described in Section IV, *above*, any offender who is transferred into the custody of IDOC with a known previous history of mental illness as reflected in that offender's medical records or as self-reported by the offender shall automatically be referred for services which will include a mental health evaluation and/or referral.

Findings: The monitoring team inspected all four of IDOC's Reception Centers during the current reporting period. The team observed that this requirement was being met. As reported in V(a), above, mental health evaluations are not routinely being completed at the NRC. Referrals are being made, however, which fulfills the requirements of this subsection. IDOC will receive a rating of substantial compliance.

(V)(e): Specific requirement: IDOC shall develop a policy and procedure by which other sources with credible information (including other offenders or family members) may refer an offender for a mental health evaluation. The policy and procedure shall include a record-keeping mechanism for requests, which shall record who made the request and the result of the referral.

Findings: As previously reported, IDOC has developed the required policy and procedure, 04.04.100 and it is being implemented throughout the Department. This policy contains a section, II.G.4, which outlines the record-keeping mechanism for requests. Section II.G.4(d) states "All referrals shall be documented in the offenders medical file and shall include the date and source of the referral and the resulting referral action, such as scheduled to see appropriate mental health professional." This record-keeping mechanism technically fulfills the requirement of V(e) so the Department will receive a rating of substantial compliance. IDOC, however, is strongly encouraged to maintain a centralized referral tracking system at each facility. This would allow for an effective means of following each referral to ensure that they receive the proper follow up. Without a system, it is impossible for internal or external auditors to determine whether referrals are receiving a response in a reasonable time, or if some are inadvertently overlooked, creating a risk to patient care.

(V)(f): Specific requirement: Evaluations resulting from a referral for routine mental health services shall be completed within fourteen (14) days from the date of the referral.

Findings: As reported in V(a), IDOC still struggles to meet the 14-day requirement for completing mental health evaluations. In an eight-week period, 2/22-4/12/19, the Department had a total backlog of mental health evaluations of 2,305. Among this backlog, 54% of the mental health evaluations were more than 14 days late. This means that slightly over half of the offenders who received a referral for a mental health evaluation were waiting more than 28 days for this evaluation to be completed.

The most recent IDOC Quarterly Report also offered commentary on this issue.[5] That report offered that, on a particular recent date, the backlog represented 2% of the mental health population, and suggests that the issue is concentrated at a minority of institutions, as 22 facilities reportedly had an evaluation backlog of five or fewer persons.

IDOC will receive a rating of non-compliance for this subsection.

(V)(g): Specific requirement: As required by IDOC AD 04.04.100, section II (G)(4)(a)(2), the facility Crisis Intervention Team shall be contacted immediately for offenders with serious or urgent mental health problems.

Findings: IDOC has made some improvement regarding this requirement but struggles to achieve substantial compliance. During the current reporting period, numerous reliable complaints were received from plaintiffs' counsel about custody staff acting as gatekeepers. This issue was also noted by the monitoring team at numerous facilities throughout IDOC. It is impossible, however, to determine exactly how widespread a problem is this gatekeeping.

The Monitor and Assistant Monitor Ms. Gibson met with IDOC executive staff on 4/4/19. This gatekeeping issue was discussed at length during this meeting. The Director and Chief of Operations stated unequivocally that gatekeeping is an unacceptable practice. They assured Ms. Gibson and I that they will personally look into this issue. Several IDOC quarterly reports, including the most recent, describe formal investigations IDOC has undertaken for this issue, and the systemwide distribution of two memos during the monitoring period reminding staff of the obligations of this subsection. As complaints on this issue frequently emanate from Pontiac, IDOC offered that 1,403 crisis team contacts at Pontiac in 2018 supports the institution's position that gatekeeping is not occurring.

IDOC will receive a rating of partial compliance for this subsection.

(V)(h): Specific requirement: The results of a mental health evaluation shall be recorded on IDOC Form 0374 (Mental Health Evaluation). These documents shall be included as part of the offender's mental health record as required by IDOC AD 04.04.100, section II (G)(3).

[5] The report comments on backlogs on a single date, March 22, so is not completely parallel to the two-month period discussed herein, but provides some context.

Findings: IDOC is in substantial compliance with this requirement.

(V)(i): Specific requirement: Mental health evaluations shall be performed only by mental health professionals. In those instances where an evaluation is performed by an unlicensed mental health employee, said mental health employee will have obtained at least a Master's degree in Psychology, Counseling, Social Work or similar degree program or have a Ph.D./Psy.D. and said mental health employee will be supervised by a licensed MHP no fewer than four hours per month. This exception for unlicensed mental health employees applies only to those mental health employees currently working in IDOC and grandfathered in prior to this Settlement. Further, a licensed MHP will review, and if the evaluation is satisfactory, sign off on any evaluation performed by an unlicensed mental health employee within seven (7) days after the evaluation has been completed. If the evaluation is not satisfactory, it shall be redone by a licensed MHP.

Findings: IDOC is in substantial compliance with this requirement.

(V)(j): Specific requirements: The provisions of this Section shall be fully implemented no later than eighteen (18) months after the approval of this Settlement Agreement.

Findings: Due to the enduring presence of a backlog of mental health evaluations and the unresolved issue of gatekeeping by custody staff in regards to the Crisis Intervention Team, IDOC will receive a rating of partial compliance for this requirement.

VI: MENTAL HEALTH SERVICES ORIENTATION

Summary: IDOC has been found to be in substantial compliance with this requirement since the First Annual Report. This requirement will not be monitored after submission of the Third Annual Report.

(VI)(a): Specific requirement: In addition to information regarding self-referrals to be included in the offender handbook as required by IDOC AD 04.04.100, § II (G)(4)(b), information regarding access to mental health care shall be incorporated as part of every offender's initial reception and orientation to IDOC facilities. The basic objective of such orientation is to describe the available mental health services and how an offender may obtain access to such services.

Findings: IDOC is in substantial compliance with this requirement.

(VI)(b): Specific requirement: IDOC shall develop and implement a written policy and procedure concerning such orientation no later than one (1) year after approval of this Settlement Agreement.

Findings: IDOC is in substantial compliance with this requirement.

VII: TREATMENT PLAN AND CONTINUING REVIEW

Summary: Significant backlogs exist for the timely completion of treatment plans. Improvements were noted in the completion of treatment plans when an offender is placed on crisis watch. Treatment plans, however, are not routinely being completed upon entrance to segregation or updated properly. Problems also remain regarding timely psychiatric follow up visits. Although there has been some improvement in the quality of treatment planning, overall much work needs to occur to fully meet the rigorous requirements of this section of the Settlement Agreement. Of note, Form 0284 has gone through many iterations. As such, it is not consistently being implemented. This results in treatment plans often being completed by the MHP or the psychiatric provider.

(VII)(a): Specific requirement: As required by IDOC AD 04.04.101, section (II)(F)(2)(c)(4), any offender requiring on-going outpatient, inpatient or residential mental health services shall have a mental health treatment plan. Such plans will be prepared collectively by the offender's treating mental health team.

Findings: Treatment planning backlogs still plague the Department. As of 5/24/19, there were 440 backlogged treatment plans within IDOC with the majority of them, 62%, being greater than 30 days late. Of note, the backlog at Pontiac was 107 and at Illinois River 105. Regardless of how one defines collectively, significant numbers of treatment plans only being prepared by MHP or psychiatric providers were discovered during site visits. Menard, Stateville NRC, Western, Vandalia and Danville were facilities where this was noted.

The RTUs at Logan and Joliet demonstrated true multidisciplinary treatment planning. The STC at Dixon also utilized multidisciplinary treatment planning but not the RTU located in X-house.

As for crisis watch treatment plans, the monitoring team reviewed them during each site visit, and also studied a systemwide sample.[6] In all crisis watches in that study, the patient had a documented treatment plan at some point during the watch (though not necessarily at each required point in the watch); there was only one watch with no apparent treatment plan.

[6] The sample was drawn from all 26 institutions that had crisis watches in February 2019. The sample consisted of all crisis watches, or a sample reportedly chosen by random selection method, depending on the number of watches at an institution. An additional set was provided to demonstrate updates during lengths of stay longer than one week. The total was 147 watches; since most patients had more than one treatment plan during the watch, 299 plans were reviewed.

In the study, in terms of plans being prepared collectively, it bears discussing separately the treatment plans due at different stages. On admission, there was only an indication of any kind of joint process in 10% of the treatment plans. This improved where weekly updates took place for longer term placements; here, 59% of the plans showed multidisciplinary contributions and most of those appeared to be a joint meeting. Most of IDOC's efforts on crisis watch plans have been directed at discharge plans and results are evident. Here, descriptions and/or the timing of signatures show that 57% clearly were, or likely were, discussed in a joint meeting in person or by phone. Another 20% appear to have been prepared by one discipline and reviewed by another, consistent with IDOC's plans but contrary to the Monitor's views on appropriate treatment planning. For the final 23%, however, there was still no indication of more than one discipline being involved with the treatment plan.

Other aspects of process and content of crisis watch treatment plans were also of concern, and will be discussed in the sections that follow.

As noted above, backlogs are a concern with treatment plans. The most recent IDOC Quarterly Report offers that, on a recent date, backlogged treatment plans affected less than 5% of the mental health population. It noted that backlogs are most highly concentrated at two institutions and that more than half of facilities have no backlog. It reported that the majority of backlogged evaluations are overdue by 30 days or less, which is not accurate, but did not include what percentage this reflects[7] nor the length of delay for the minority of cases.

(VII)(b): Specific requirement: The plan shall be recorded on IDOC Form 0284 (Mental Health Treatment Plan), or its equivalent and requires, among other things, entry of treatment goals, frequency and duration of intervention/treatment activities, and staff responsible for treatment activities. Reviews of the treatment plan shall also be recorded on form 0284 or its equivalent.

Findings: IDOC Form 0284 has gone through many iterations throughout the life of the Settlement Agreement. As such, the Monitoring Team encountered the use of several different forms during the current reporting period.

The overall assessment of the status of treatment planning within the Department is that the Monitoring Team has noted some improvement but more work is needed to meet the requirements of this subsection. There still exists treatment plans created only by the psychiatric provider which only list medications. Similarly, MHP-only treatment plans were noted in which no reference was made to medication management. The Monitoring Team did encounter well-prepared treatment plans at the RTUs at Logan and Joliet as well as the STC at Dixon. Of note, these are relatively well staffed facilities. This demonstrates that if the Department was appropriately staffed, good quality, multidisciplinary treatment plans could be the norm.

As for crisis watch treatment plans, clinicians do, for the most part, use a form formatted to call for goals, frequency and duration of treatment activities, and the staff responsible. Rarely in the systemwide sample, staff instead offered a progress note to demonstrate their treatment

[7] It could be significant to an assessment of compliance whether "majority" refers to 51%, 99%, or anywhere within that range.

planning. In that study, Illinois River and Jacksonville seemed to have the strongest practice. Hill, Sheridan, and Vandalia showed the greatest need to improve.

IDOC training has emphasized the need to complete these fields and the monitoring team observes some improvement in this regard. The greatest improvement is evident in recording patients' **problems and goals**: in the systemwide study, 34% of the plans captured these well.[8] Another 22% were adequate but had minimal content and minimal tailoring to the patient. Fully 23% were insufficient. These reflected issues such as missing a key problem of the patient's, omitting goals altogether, content that appeared unrelated to the patient, and boilerplate that would not appear to assist in treating the patient.[9]

The **interventions** described in the plans lagged much further behind. Here, only 12% in the study capture these well, and another 9% were adequate. The vast majority were insufficient. This principally took the form of naming the *Rasho*-required contacts but not discussing what treatment would take place during them. Some omitted one or more of the problems that led to the crisis watch, contained content inapplicable to that patient, or omitted interventions altogether.

(VII)(c): Specific requirement: Treatment plans shall be reviewed and updated for offenders designated as receiving outpatient level of care services annually, or sooner when clinically indicated (e.g., when level of care changes).

Findings: IDOC continues to show improvement in this area. A rating of substantial compliance will be given for VII(c).

Specific requirement: Where the IDOC provides crisis or inpatient care to an SMI offender, treatment plans shall be reviewed and updated upon entrance and thereafter once weekly, or more frequently if clinically indicated, and upon discharge.

Findings: In the above-referenced systemwide study, 95% of the monitored records had a treatment plan update upon entrance. The sample included 43 patients who were in crisis watch long enough for weekly updates; only 35% of their records demonstrated all the weekly updates required. Where there was noncompliance, it was about evenly divided between cases with updates in some weeks but not others (often the number of misses exceeded the number completed) and cases where there appeared to be no updates at all. Staff assert that they routinely complete these reviews but do not always document it. On discharge, the sample provided updated treatment plans for 86% of the patients who had been released from crisis watch.

A chart review of the inpatient facility at Elgin revealed that 100% of the inpatients met this requirement.

---

[8] This includes clearly tailored problems and goals, and instances where the language is standardized but clearly fits the patient's situation and would be helpful in reducing his or her acute symptoms sufficient to discharge to less intensive care.

[9] These percentages do not add to 100% because, in the remaining subset, a plan was required but the monitoring team received no indication that one was completed; for example, a patient might have a plan on admission but not on discharge.

Specific requirement: For those offenders receiving RTU care, treatment plans shall be reviewed and updated upon entrance and thereafter no less than every two (2) months, or more frequently if clinically indicated, and upon discharge.

Findings: As reported above, the RTUs at Logan, Joliet and the STC at Dixon are meeting this requirement. The RTU located in the X-house at Dixon is not meeting this requirement.

Specific requirement: For mentally ill offenders on segregation status, treatment plans shall be reviewed and updated within seven (7) days of placement on segregation status and thereafter monthly or more frequently if clinically indicated.

Findings: The monitoring team conducted a multi-site chart review[10] of 80 mentally ill offenders assigned to segregated housing. Only 21 of the 80 charts reviewed (26%) confirmed that treatment plans were reviewed and updated within seven days of placement on segregation status.

In addition to this data-driven analysis, Dr. Kapoor reported that at Dixon, treatment plans are not updated upon entry into segregation for any offender. Illinois River had the best practice, with an updated plan in essentially all reviewed cases, but these were completed late, between two and three weeks after placement.

The monthly reviews and updates were assessed with a much smaller cohort because many fewer mentally ill patients in the sample remained in segregation longer than 30 days. Among the 16 relevant charts, *none* had their treatment plans reviewed and updated on a monthly basis, though a few had one or two updates.[11]

(VII)(d): Specific requirement: Offenders who have been prescribed psychotropic medications shall be evaluated by a psychiatrist at least every thirty (30) days, subject to the following:

(i) For offenders at the outpatient level of care, once stability has been observed and documented in the offender's medical record by the attending psychiatrist, consideration for an extension of follow-up appointments to more than a thirty (30) day period may be considered, with no follow-up appointment to exceed ninety (90) days.

(ii) For offenders at a residential level of care, once stability has been observed and documented in the offender's medical record by the attending psychiatrist, consideration for an extension of follow-up appointments to more than a thirty (30) day period may be considered, with no extension to exceed sixty (60) days.

(iii) Offenders receiving inpatient care shall be evaluated by a psychiatrist at least every thirty (30) days with no extension of the follow-up appointments.

[10] Graham, Western, Decatur, Stateville NRC, Danville, East Moline, Pontiac, Robinson, Vandalia, Vienna, and Illinois River.

[11] Relevant charts were included from Graham, Illinois River, Pontiac, Stateville-NRC, and Western Illinois

Findings: The monitoring team conducted a data-driven analysis of the frequency of psychiatry contacts in general population. This consisted of chart reviews for 138 mentally ill offenders from 10 facilities[12] who were prescribed psychotropic medication. A review of the medication practices at Dixon was also conducted and will be described later. Only 74 of the 138 charts reviewed demonstrated that the time parameters were being met. Examples of the problems encountered:

- 90-day follow ups were scheduled without patient stability documented in the medical record
- 60-day follow up was scheduled without patient stability documented in the medical record
- 55-day follow up scheduled for a patient started on a new medication
- 30-day follow ups were planned but completed weeks late

The most recent IDOC Quarterly Report offers that the backlog for psychiatry contacts, measured on a recent date, represented a single-digit percentage of the total mental health population. It is unknown what percentage of the *psychiatry* caseload—which is significantly smaller--this constitutes. As of 5/24/19, the psychiatric backlog was 668 out of a total caseload of 9790. This equates to a backlog of 6.82%. The backlog is able to measure the timeliness of the most recent contact, but is not designed to fully answer about the pattern of contacts described under this requirement. Nevertheless, the backlog has undeniably decreased through concerted efforts by IDOC leadership.

In addition, the monitoring team reviewed the frequency of psychiatry contact in crisis watch. Based on a sample of 664 crisis watches in 2019 drawn from across all institutions, 87% saw a psychiatric provider within one week and nearly all others were seen by the 30-day point. Only 5% had no psychiatry contact during their admission. This analysis did not capture patients who remained in crisis watch for multiple months, so is silent as to whether those patients were seen at least every 30 days.

(VII)(e): Specific requirement: Upon each clinical contact with an SMI offender, the MHP shall record a progress note in that offender's mental health records reflecting future steps to be taken as to that offender based on the MHP's observations and clinical judgment during the clinical contact.

Findings: As previously reported, the Monitoring Team has reviewed thousands of progress notes written by MHPs after a clinical contact. There is not a method to accurately measure IDOC's performance with this requirement. As such, they will receive a rating of substantial compliance given the ubiquitous nature of MHP progress notes.

[12] Elgin, Western, Graham, Menard, Pinckneyville, Logan, Pontiac, Illinois River, Vienna, and Stateville-NRC and Stateville proper.

VIII: TRANSITION OF OFFENDERS FROM SPECIALIZED TREATMENT SETTINGS

MHPs are involved in the transfer of offenders to general population units from a "specialized treatment setting." Five-day follow ups as occurring when an offender is discharged from a crisis watch. The 30-day follow ups, however, are not occurring due to staffing shortages.

(VIII)(a): Specific requirement: SMI offenders shall only be returned to general population from a specialized treatment setting with the approval of either the treating MHP or, once established, with the approval of the multidisciplinary treatment team. The Settlement provides a definition of "Specialized Treatment Setting": Housing in a crisis bed, residential treatment unit, or inpatient mental health setting.

Findings: IDOC is meeting the requirements of VIII(a). It is not clear, however, to what extent multidisciplinary treatment teams are involved in this process with the exception of Joliet, Logan and the STC at Dixon.

(VIII)(b)(i): Specific requirement: For offenders transitioning from Crisis placement, there will be a five (5) working day follow-up period during which the treating MHP will assess the offender's stability on a daily basis since coming off Crisis watch. This assessment may be performed at cell front, using a form, which will be specifically designed for this purpose by IDOC and approved by the Monitor.

Findings: A data driven analysis of nine facilities[13] was conducted. A total of 49 charts were reviewed. Five (5) working day follow ups occurred in 37 of the 49 charts reviewed. This equates to 76% completion rate. Consistent with other requirements, IDOC will receive a rating of partial compliance until such time that they can demonstrate a completion rate of at least 85%.

Specific requirement: This five-day assessment process will be in addition to IDOC's current procedure for crisis transition, which IDOC will continue to follow. This procedure requires an MHP to conduct an Evaluation of Suicide Potential (IDOC Form 0379) on the offender within seven (7) calendar days of discontinuation from crisis watch, and thereafter on a monthly basis for at least six (6) months. Findings shall be documented in the offender's medical record.

Findings: The same chart review referenced above looked at this particular requirement. 36 of the 49 charts reviewed showed evidence of seven (7) day follow ups where the Evaluation of Suicide Potential was administered. This equates to 73% completion rate. Partial compliance will be given until this completion rate is at least 85%.

The Monitoring Team was not able to conduct a similar analysis for the monthly follow ups for at least six (6) months. As discussed with IDOC executive staff, my opinion as Monitor is that this six (6) month follow up is clinically unnecessary. I have encouraged IDOC staff to request a modification of the Settlement Agreement for this particular requirement.

[13] East Moline, Menard, NRC, Western, Vandalia, Robinson, Danville, Decatur and Graham.

(VIII)(b)(ii): Specific requirement: Offenders returned to general population or to an outpatient level of care setting from a specialized/residential treatment facility shall be reviewed by an MHP within 30 days to assess the progress of the treatment goals. The IDOC Form 0284 shall be reviewed annually thereafter, unless otherwise clinically indicated (e.g., change in level of care) as required by IDOC AD 04.04.101, section (F)(2)(c)(4)(c).

Findings: Due to staffing shortages within the Department, this requirement is not consistently being met.

IX: ADDITIONAL MENTAL HEALTH STAFF

Summary: Substantial and problematic vacancies remain in multiple disciplines at Dixon, Logan, and Pontiac well past the Agreement-specified deadlines. This is also the case for Joliet, though to a lesser degree. With targets having been missed, this issue is being litigated and is not in the negotiation process.

IDOC does provide quarterly hiring progress reports, as required, and to the monitoring team's knowledge, MHPs are dedicated solely to the provision of the mental health services mandated by this Settlement Agreement.

(IX)(a): Specific requirement: The Approved Remedial Plan identifies additional staff needed for the operation of IDOC's outpatient and RTU settings. The necessary funding to pay for this hiring is dependent upon additional appropriations. Consequently, IDOC will cause to be hired the appropriate staff no later than the following dates: Dixon Correctional Center and Logan Correctional Center – 6 months from the budget contingent approval date; Pontiac Correctional Center – 12 months from the budget contingent approval date.

Findings: All staffing levels are current as of 3/22/19:

- Dixon:
  - Mental Health Training Director 1.00 FTE vacant
  - Mental Health Unit Director 3.00 FTEs vacant
  - Post-Doc Psychologist 1.00 FTE vacant
  - Pre-Doc Psychologist 2.00 FTEs vacant
  - Staff Psychologist 0.975 FTE vacant
  - QMHP 3.00 FTEs vacant
  - Recreational Therapist 1.00 FTE vacant
  - BHT 2.00 FTEs vacant
  - Psychiatrist 4.50 FTEs vacant
- Logan:
  - Mental Health Unit Director 3.00 FTEs vacant
  - Post-Doc Psychologist 2.00 FTEs vacant
  - Staff Psychologist 1.00 FTE vacant
  - QMHP 6.00 FTEs vacant
  - Recreational Therapist 1.00 FTE vacant
  - RN-Mental Health 3.00 FTEs vacant

- Psychiatrist 3.287 FTEs vacant
- Pontiac:
  - Mental Health Unit Director 3.00 FTEs vacant
  - Post-Doc Psychologist 2.00 FTEs vacant
  - Staff Psychologist 2.00 FTEs vacant
  - QMHP 4.00 FTEs vacant
  - BHT 1.00 FTE vacant
  - Psychiatrist 3.1 FTEs vacant

The deadline for Dixon and Logan meeting their staffing requirements was February 6, 2018. Pontiac's deadline was July 6, 2018. Of note, the staffing levels for psychiatrists is especially problematic. That is, Dixon only has 5.50 of 10.00 psychiatrists, Logan has 6.713 of 10.00 psychiatrists and Pontiac has 2.90 of 6.00 psychiatrists. IDOC is clearly non-compliant with this requirement.

(IX)(b): Specific requirement: The Approved Remedial Plan also identified the staff IDOC preliminarily determined to be necessary in order to open and operate the RTU to be located at the former IYC Joliet. IDOC will cause to be hired the appropriate staff no later than eighteen (18) months from the approval of the Settlement Agreement.

Findings: All staffing levels are current as of 3/22/19:

- Joliet:
  - Mental Health Unit Director 1.00 FTE vacant[14]
  - Post-Doc Psychologist 1.00 FTE vacant
  - QMHP 1.00 FTE vacant
  - BHT 1.00 FTE vacant
  - RN-Mental Health 3.00 FTEs vacant
  - Psychiatrist 1.50 FTEs vacant

The deadline for Joliet to meet their staffing requirements was November 22, 2017. The IDOC Quarterly Report issued in April indicates that Joliet staffing is at "nearly 80%" for its state positions and is silent as to Wexford positions. IDOC is non-compliant with this requirement.

(IX)(c): Specific provision: Defendants will have three (3) months from the approval of the Settlement Agreement to propose an amendment to the staffing plan. The Monitor and Plaintiffs shall have forty-five (45) days following the submission of the revised staffing plan to state whether they have an objection to the proposed revisions and provide data to support the objections. Following receipt of any objection and supporting data, the parties will either accept the Monitor's and/or Plaintiffs' suggestions or the issue will be resolved through the dispute resolution process.

Findings: As noted in previous reports, the Defendants did not opt to propose a staffing plan amendment within the three-month deadline.

[14] Position hired, start date 4/1/19

(IX)(d): Specific requirement: To the extent the positions listed on Exhibits A and B of the Approved Remedial Plan are to be filled by Mental Health Professionals, these positions shall be allocated solely to the provision of the mental health services mandated by this Settlement Agreement.

Findings: IDOC is in substantial compliance with this requirement.

(IX)(e): Specific requirement: In accordance with its obligations in Section XXVIII, *infra*, IDOC will include quarterly hiring progress reports related to the additional mental health staff identified in the Approved Remedial Plan. Where a target may not have been met, the Monitor will review the reasons for failure to meet the target and, if necessary, propose reasonable techniques by which to achieve the hiring goals as well as supporting data to justify why these techniques should be utilized.

Findings: IDOC provides quarterly hiring progress reports related to the additional mental health staff identified in the approved Remedial Plan. As Monitor, I have regularly met with IDOC staff to discuss their staffing shortfalls. The first formal meeting to discuss staffing took place at IDOC headquarters on June 26, 2017. The Director, Chiefs Lindsay and Hinton participated in this meeting as well as representatives from Wexford. At this meeting, I made several concrete recommendations on how to increase staffing. These recommendations included utilizing primary care physicians and advanced practice nurses to provide psychiatric care. At this meeting I also authorized the increased use of telepsychiatry. More recently, I met with the executive staff of IDOC on January 30, 2019. Staffing was one of the primary topics of this meeting. Finally, I have proposed holding a "staffing summit" where several days can be dedicated to addressing the serious staffing problems facing IDOC. As will be discussed more fully in section XXVII, I have requested the addition of a staffing expert to the Monitoring team.

IDOC will receive a rating of substantial compliance for this requirement. **(IX)(f): Specific requirement:** In the event that IDOC has not achieved a staffing target, then, after notice to counsel for Plaintiffs, any necessary time extensions shall be negotiated by the parties. All such extensions shall require the written agreement of counsel for Plaintiffs. This provision is in addition to any mechanism for dispute resolution set out in Section XXIX.

Findings: As there is currently litigation regarding staffing, IDOC will receive a rating of "no rating" for this requirement.

X: BED/TREATMENT SPACE

Summary: IDOC has met, and often exceeded, all construction requirements for RTU beds and programming space; it is making them available at two institutions but availability falls far short in two other institutions. As to delivering therapeutic services, two RTUs are meeting the requirements specified in this section; two other RTUs are unable to do so, principally because of understaffing.

As to inpatient care, IDOC has an intergovernmental agreement in place and 44 beds are available, with a substantial portion of them in use. IDOC also reports that groundbreaking for a new facility took place in March 2019.

IDOC facilities have established crisis beds as required and they are in use throughout the system. For the most part, patients are not housed in control units when receiving crisis care, though more remains to demonstrate whether this requirement is met. In terms of aggressive mental health treatment to reduce acute symptoms and stabilize the patient, IDOC has put significant work into improving this treatment. Daily MHP meetings are often more substantive than when observed in the past, but a significant number still resemble an assessment alone. IDOC increased psychiatry contacts, with a great majority of these patients being seen within one week. Treatment planning did not do much to support the required level of treatment; nearly every patient received a new treatment plan on admission, but the content remained limited and approaches did not appear to change for patients with extended stays. Multidisciplinary treatment planning improved, particularly on discharge.

For a substantial number of patients, the care is not serving to stabilize them within 10 days or effect a transfer to a more intensive care setting. Hundreds of cases exceeded the expected 10 days—some for several months--and few were referred to RTU or inpatient care.

(X)(a): Specific requirement: The Approved Remedial Plan identified four facilities at which IDOC would perform renovations, upgrades, and retrofits to create bed/treatment space for SMI offenders requiring residential levels of care: (i) Dixon Correctional Center (male offenders only); (ii) Pontiac Correctional Center (male offenders only); (iii) Logan Correctional Center (female offenders only); and (iv) the former IYC Joliet facility (male offenders only). The necessary funding to complete this construction is dependent upon additional appropriations.

Findings: IDOC is in substantial compliance with this requirement.

(X)(b): RTU beds for male offenders

(i): Specific requirement: Approximately 1,150 units of RTU bed space for male offenders have been identified.

Findings: IDOC has identified 1257 units of RTU bed space for male offenders. This number was provided to the Monitor during the Executive staff meeting on 4/4/19. IDOC is in substantial compliance.

(ii): Specific requirement: IDOC will perform the necessary construction to make its RTU beds available at the following facilities on the following schedule:

(A) RTU beds and programming space for approximately 626 male offenders at Dixon CC no later than six (6) months after the budget contingent approval date. Additional construction to increase treatment and administrative office space will be completed within twelve (12) months after the budget contingent approval date;
(B) RTU beds and programming space for 169 male offenders at Pontiac CC no later than twelve (12) months after the budget contingent approval date; and
(C) RTU beds and programming space for at least 360 male offenders at IYC-Joliet no later than fifteen (15) months after the budget contingent approval date.

Findings:

- Dixon-RTU bed count of 648. 537 beds are currently filled.
- Pontiac-RTU bed count of 187. 41 beds are filled with offenders assigned to the RTU level of care. Of note, the actual RTU is not operating. IDOC officials are unable to provide the monitoring team with an official opening date because of staffing recruitment difficulties.
- Joliet-RTU bed count of 422. 126 beds are currently filled.

Although deadlines have not been consistently met, IDOC is exceeding the requirement for construction for RTU beds and programming space. This is important progress.

An essential component of this requirement, however, is to "make its RTU beds available." This has not been achieved. Neither Pontiac nor Joliet has ever filled more than a fraction of those beds. While there is no obligation to keep units at full occupancy, and there are natural fluctuations in demand, Pontiac has fewer than 25% of the beds filled and cannot expand in the foreseeable future. Joliet has been open a year and a half and, to the Monitor's knowledge, the current occupancy—35% of the requirement—is the highest level reached to date. IDOC could certainly be in compliance with some number of beds unfilled; Dixon is an example of that, with fluctuating numbers but a substantial percentage of beds filled. But at Joliet and Pontiac, the distance between the required number and these minimal occupancy levels is too great. It cannot be said that the required number of beds is being made available there.

Neither are the beds going unfilled for lack of demand. The monitoring team analyzed nine months of referrals to higher level of care; almost 40% of them[15] waited more than 1 month for a bed and some waited as long as 4.5 months. As described in section (X)(f), an additional 88 people were not referred and should have been, and that number might approach 500 on closer inspection of relevant patients' circumstances. It cannot be said that IDOC is making these RTU beds available but there is simply no need for them.

Dixon is in substantial compliance with this requirement; Pontiac and Joliet are in partial compliance. The Monitor urges IDOC to examine and address the barriers to making more of these RTU beds available as there is substantial indication of unmet need for this treatment.

[15] Where timing could be discerned

(X)(c): RTU beds for female offenders

(i): Specific requirement: IDOC has identified RTU bed and programming space for 108 female offenders at Logan CC.

Findings: IDOC has identified RTU bed and programming space for 146 female offenders at Logan CC. This includes the beds in the "Acute Crisis Care Unit." IDOC is in substantial compliance with this requirement.

(ii): Specific requirement: IDOC will perform the necessary construction to make these 108 RTU beds available on the following schedule:

(A) RTU beds and programming space for 80 female offenders no later than six (6) months after the budget contingent approval date; and
(B) RTU beds and programming space for an additional 28 female offenders no later than twelve (12) months after the budget contingent approval date.

Findings:

(A) The deadline for creating RTU beds and programming space for 80 female offenders was February 6, 2018. This requirement has been met.
(B) The deadline for creating RTU beds and programming space for an additional 28 female offenders was July 6, 2018. This requirement has been met.

IDOC is in substantial compliance with the requirements of this section.

(X)(d): Specific requirements: The facilities and services available in association with the RTU beds provided for in subsections (b) and (c), *above*, shall in all respects comply with the requirements set forth in the section titled "IDOC Mental Health Units," subsections 2 and 3, in the IDOC Mental Health Protocol Manual (incorporated by reference into IDOC AD 04.04.101, section II (E)(2)). All RTU units shall have sufficient beds and program space for all offenders in need of residential level of care services, including the provision to each RTU offender of a minimum of ten (10) hours of structured therapeutic activities per week and a minimum of ten (10) hours of unstructured out of cell activities per week. To the extent that IDOC maintains an RTU in segregation units (e.g., Pontiac) these provisions shall apply regardless of whether the RTU bed is within or outside of a segregation unit.

Findings:

- **Dixon RTU:** The requirements of (X)(d) are not being met at the Dixon RTU. Dr. Kapoor has made six site visits to Dixon over the life of the Settlement Agreement. Her most recent visit occurred on February 7 & 8, 2019. Based on her experience and expertise, she is in a unique position to report on the status of RTU-level treatment at Dixon. Dr. Kapoor noted that short-staffing—particularly of psychiatrists—and high staff turnover remain significant problems at Dixon. Because of inadequate staffing, Dixon has had to choose parts of the Settlement Agreement on which to focus its efforts, recognizing that full

compliance is impossible at current staffing levels. Accordingly, as the facility has tried to comply with the requirements for Segregation and Crisis Watch, **programming in RTU settings has decreased substantially.** Many of the front-line mental health professionals resented the directive from IDOC to focus on offenders in segregation, feeling that their sickest patients (those in the RTU) were being neglected in order to care for a few chronically problematic offenders. Overall, even the most dedicated mental health professionals were growing frustrated with both IDOC leadership and the *Rasho* litigation, believing that little improvement in care was being made.

The most recent IDOC Quarterly Report indicates that Dixon is able to offer far more than the required 10 hours of unstructured out of cell activities, citing 48.5 hours per week. As to structured therapeutic activity, the report states that one unit is offered more than the required amount (15 hours) while the other is offered half of the required hours. The monitoring team has not reviewed this data.

- **Pontiac RTU:** The monitoring team made seven site visits to Pontiac over the reporting period. As noted above, the RTU has not officially opened as of May 13, 2019. 187 RTU bed spaces have been identified and, as of April 4, 2019, there are 41 offenders housed there who have been designated RTU-level of care. As with Dixon, Pontiac suffers from being significantly understaffed. This understaffing prevents Pontiac from fulfilling the requirements of (X)(d).

- **Logan RTU:** The monitoring team conducted site visits of Logan, including the RTU, on 6/27/18 & 12/27/18. This facility is clearly meeting the requirements of (X)(d). The most recent IDOC Quarterly Report indicates that Logan is able to offer 40 hours per week of unstructured out of cell activities and 13 hours of structured therapeutic activity, more than is required.

- **Joliet RTU:** The monitoring team made three site visits to Joliet over the course of the reporting period. This facility is clearly meeting the requirements of (X)(d). The most recent IDOC Quarterly Report indicates that Joliet is able to offer 15 hours per week of unstructured out of cell activities and 15 hours of structured therapeutic activity, more than is required.

(X)(e): Inpatient beds

Specific requirement: Within three (3) months of the approval date of this Settlement Agreement, IDOC shall enter into an intergovernmental agreement ('IGA') with the Illinois Department of Human Services ('DHS') to secure at least 22 beds for female offenders and at least 22 beds for male offenders in an existing DHS-owned mental health facility. The necessary funding to complete this construction is dependent upon additional appropriations. Consequently, IDOC will perform the construction and improvements to make at least 22 beds available for

female offenders within nine (9) months of the budget approval contingent date and to make at least 22 beds available for male offenders within sixteen (16) months of the budget contingent approval date. Within thirty (30) months of the approval of this Settlement Agreement, IDOC will transition to assuming control or ownership of said facility and provide approximately sixty (60) additional beds and programming space for separate housing of male and female offenders in need of an inpatient level of care. During that transition period, IDOC shall consult closely with the Monitor and IDOC's own retained mental health expert to develop any additional policies and procedures and design programming and treatment space that is appropriate for a forensic hospital. After the IGA is signed, IDOC will continue to develop plans for inpatient care that can be implemented after necessary appropriations.

Findings: This requirement contains several sub-requirements:

- Within three (3) months of the approval of this Settlement Agreement, IDOC shall enter into an intergovernmental agreement ('IGA') with the Illinois Department of Human Services ('DHS') to secure at least 22 beds for female offenders and at least 22 beds for male offenders in an existing DHS-owned mental health facility. IDOC is in substantial compliance with this sub-requirement.
- Consequently, IDOC will perform the construction and improvements to make at least 22 beds available for female offenders within nine (9) months of the budget approval contingent date and to make at least 22 beds available for male offenders within sixteen (16) months of the budget contingent approval date. The facility has been in use since April 2018 and IDOC reports occupancy as 33 as of April 2019. IDOC indicates that staffing is at more than 90% of state positions for this facility; the April Quarterly Report is silent as to any Wexford positions. IDOC is in substantial compliance with this sub-requirement.
- Within thirty (30) months of the approval of this Settlement Agreement, IDOC will transition to assuming control or ownership of said facility and provide approximately sixty (60) additional beds and programming space for separate housing of male and female offenders in need of an inpatient level of care. IDOC has begun to meet this sub-requirement, having broken ground in March 2019 for a facility to be located on the Joliet Treatment Center campus. This is not within the required period of performance, but is a useful step. Non-compliance.
- Finally, Dr. Puga has been meeting with the Monitor to develop policies and procedures related to inpatient level of care.

IDOC is in substantial compliance with this requirement.

(X)(f): Crisis beds

Specific requirement: IDOC shall also ensure that each facility has crisis beds which comply with IDOC Administrative Directive 04.04.102, § II(F)(2), IDOC Administrative Directive 04.04.100, § II(G)(4)(b), and IDOC Administrative Directive 04.04.102. These beds shall not be located in Control Units with the exception of Pontiac CC, in which case such cells will be relocated to the protective custody unit no later than twelve (12) months after approval of the Settlement Agreement. To the extent that, as of the approval of this Settlement Agreement, offenders are placed in crisis beds located in a Control Unit (excluding Pontiac CC), they will be

moved to a crisis bed in general population within the facility, to an infirmary setting within the facility, or, if no such placement is available, transferred to another facility which has an appropriate crisis bed available.

Findings: IDOC facilities have established crisis beds as required. Logs indicated that eight institutions housed patients in segregation cells during a crisis watch during this monitoring year; leaving aside Pontiac, however, it appeared that this occurred very rarely.[16] Such placements are permitted in exigent circumstances and for three days or less. Assessing for those criteria, the length of stay commonly met that criterion, but exceeded the permitted length in 34% of the relevant watches. Lincoln employed a segregation cell in almost half of its crisis watches, and Stateville proper did so in 10% of its watches, indicating there is ongoing demand for more crisis cells than are available in those facilities, raising a question as to whether this is truly exigent use. Both of these percentages show improvement in recent months, however, and Robinson appears to have resolved its similar issue.

Examining Pontiac separately, it initially had the highest usage, housing 197 crisis watches[17] in the segregation unit during the initial months of this monitoring year. After ceasing to use that unit for segregation in September 2018, however, it appears that Pontiac has resolved the longstanding issue of housing crisis watches in a control unit, a significant accomplishment. The Settlement Agreement language calls for the beds to be in protective custody instead; that is not the case. This requirement specifically states "These beds shall not be located in Control Units with the exception of Pontiac CC, in which case such cells will be relocated to the protective custody unit no later than twelve (12) months after approval of the Settlement Agreement." This is an example of how IDOC should move to modify the Settlement Agreement or actually move all crisis beds to protective custody.

All in all, there is improvement on this requirement. When all reporting IDOC facilities can provide housing information as called for on IDOC's crisis watch logs, and the current level of performance is sustained systemwide for one year, this requirement can be found in substantial compliance. With the current amount of data, IDOC has demonstrated partial compliance.

Specific requirement: Section II (e) of the Settlement Agreement states in part: Crisis beds are available within the prison for short-term (generally no longer than ten (10) days unless clinically indicated and approved by either a Mental Health Professional or the Regional Mental Health Administrator) aggressive mental health intervention designed to reduce the acute, presenting symptoms and stabilize the offender prior to transfer to a more or less intensive care setting.

Findings: Logs show that all institutions except two—Kewanee and Murphysboro—had crisis watches during the monitoring year.

In terms of aggressive mental health treatment to reduce acute symptoms and stabilize the

[16] This analysis is based on eight months of crisis watch logs provided by IDOC. Placements marked as being in segregation cells were 1% of the total crisis watches. With a large number of entries where housing was not indicated, however, one cannot discern whether this is all of the segregation placements.

[17] The analysis in the Mid-Year Report has been updated based on new information.

patient, IDOC clinicians continue their practice of daily MHP meetings with the patient, and IDOC leadership has strongly encouraged that these be longer interactions so that more substantial treatment can take place. During the monitoring team's visits, the team observed contacts ranging from 5 to 40 minutes, though most typically they followed IDOC's directive of 20 minutes or more. The content of the contacts varied quite a bit; some provided therapeutic guidance to work through the issues underlying the crisis watch admission, but many still resembled an assessment alone.

IDOC has also brought attention to increasing psychiatry contacts during crisis watch, a welcome addition. The monitoring team reviewed a sample of 664 crisis watches from a two-month period in 2019 that was drawn from across all institutions. In that sample, 40% of patients saw a psychiatric provider by the day after admission, the standard the Monitor would expect for a crisis setting. Another 47% were seen within one week. There was especially good practice at Centralia, Decatur, Dixon, Robinson, Sheridan, and Stateville-NRC. On the other hand, at some institutions,[18] that contact appeared only to occur at the discharge decision, so did not seemingly affect the course of care in crisis watch. Other patients appeared to be housed for multiple weeks before a psychiatry contact.[19] Five percent had no psychiatry contact during their admission.

Treatment planning did not do much to support the provision of aggressive mental health treatment to reduce acute symptoms and stabilize the patients. IDOC has put significant work into treatment planning in the last year and improvement is evident, but there is further to go. The monitoring team reviewed treatment plans during each site visit. Additionally, the team conducted a systemwide study of 299 recent crisis watch treatment plans. It revealed that nearly every patient received a new treatment plan on admission, but these were not decided by a multidisciplinary team, a minority identified patient-specific problems and goals, and, for treatment, nearly all merely named the standard number of contacts but said nothing about what the treatment would be or how the clinician and patient would move toward meeting the goals. Multidisciplinary engagement in treatment planning improved to over half in those crisis watches lasting more than one week, though documents had the same content problems—indeed, the approaches did not appear to change over time, nor to respond to the fact that the patient had been in this acute setting for weeks or months--and were generated much less often than required. For a detailed discussion, please see section VII, above.

Additionally, logs suggest that, for a substantial number of patients, the care is not serving to stabilize them within 10 days or effecting a transfer to a more intensive care setting. Crisis watch logs indicate that 13% of crisis watches exceeded the expected 10 days.[20] While all such cases were authorized by a Mental Health Professional in the relevant charts reviewed, these hundreds of cases suggest a substantial unmet need for a higher level of care, whether by failing to recognize the need or by failing to make available the needed beds.

---

[18] This was particularly evident at East Moline, Hill, Shawnee, and Taylorville.

[19] These two points, however, may reflect a difficulty with data and may not always be accurate. Additionally, there was a large, additional set of records NOT included in this analysis because dates could not be discerned. Thus, this analysis reflects a snapshot of a substantial number of crisis watches, but results might shift, positively or negatively, with a more complete data set.

[20] This analysis is based on a review of eight months of crisis watch logs from all IDOC institutions, exempting Elgin from the 10-day expectation. It excludes those entries where length of stay could not be discerned.

Most disturbing were the 114 people who stayed in crisis watch one month or more. This practice was widespread, occurring at 14 institutions, though it was most prevalent at Dixon, Stateville, Pontiac, and Lawrence. Shockingly, among that group, 11 patients were in this setting for 3 months to more than 1 year. These occurred principally at Dixon, but also at Pontiac, Pinckneyville, and Stateville. Yet few were referred to a higher level of care.[21] Those referrals can be summarized as:

Length of stay	Number of people	Referred to higher level of care
11-29 days	472	65
1 – 3 months	103	24
3 months - >1 year	11	2

There is also an indication that this is *not* fully explained as a deliberate judgment that a higher level of care is not needed. In a complementary study of treatment plans in crisis watches exceeding 10 days, only 19% contained any documented consideration of another level of care.[22]

It appears, at minimum, 88 people needed a higher level of care and did not receive it, and the number potentially approaches 500.[23]

Although some improvement occurred over the reporting period, IDOC will receive a rating of non-compliance for this very important section of the Settlement Agreement.

(X)(g): Specific requirement: IDOC shall also ensure that each RTU facility has adequate space for group therapy sessions; private clinical meetings between offenders and Mental Health Professionals; private initial mental health screenings; and such other therapeutic or evaluative mental health encounters as are called for by this Settlement Agreement and IDOC's own ADs, forms, and policies and procedures. IDOC shall also ensure that each RTU facility has adequate office space for the administrative and mental health staff required by this Settlement Agreement .

Findings: The RTUs at Dixon, Logan and the JTC are in substantial compliance with this requirement.

The RTU at Pontiac has at least 10 treatment spaces whose configuration allows them to be used efficiently for 1:1 and group contacts. Custody staff said they presently can run five spaces concurrently, and programming schedules show structured activity being offered seven days per

[21] According to the monitoring team's review of eight months of logs from all institutions showing referrals to RTU and Elgin.

[22] This is a portion of the systemwide study of crisis watch treatment plans described in section VII above. Among the 26 patients with stays exceeding 10 days and for whom a treatment plan update was provided, only 19% made any mention of other levels of care. Progress notes were not part of this review, so this figure is not definitive, but it serves as one part of the picture.

[23] For patients in crisis watch 11 days or more, one expects at least consideration of whether a higher level of care is needed. Patients with multiple crisis watches also warrant this consideration under some circumstances; the monitoring team did not undertake this analysis.

week, for a total of 4.5 to 6 hours per week for most patients. All spaces are well constructed for sound privacy. The unit, however, is not fully operational. Only after it is fully operational, with a complete complement of mental health staff and mentally ill offenders can it be determined if it meets this requirement. IDOC will receive a rating of partial compliance for this subsection.

(X)(h): Specific requirement: The treatment and other space required by subsections (d)-(g), *above*, shall be completely available no later than six (6) months after the work completion dates identified in subsection (a), *above*, for the four facilities identified there, and for any other residential treatment or outpatient facilities at which it is determined that modifications are needed no later than December 2017**.**

Findings: The RTUs at Logan, Dixon and the JTC are meeting this requirement. The RTU at Pontiac is not fully operational. Therefore, IDOC will receive a rating of partial compliance for this subsection.

(X)(i): Specific requirement: Within forty-five (45) days of the selection of the Monitor, IDOC will submit to the Monitor descriptions and architectural plans, if being used, in sufficient detail to enable the Monitor to determine whether construction undertaken pursuant to this section complies with the previously approved Remedial Plan. If, having reviewed these descriptions and plans, the Monitor concludes that the space allocations in any or all facilities under this Settlement Agreement are not consistent with the Remedial Plan, the Monitor shall so inform IDOC and Plaintiffs' counsel, and IDOC shall have thirty (30) days to propose additional measures that address the Monitor's concerns.

Findings: IDOC has been in substantial compliance with this requirement for the life of the Settlement Agreement.

XI: ADMINISTRATIVE STAFFING

Summary: IDOC is meeting the requirements of this section in the areas of Regional Directors, Statewide Quality Improvement Manager, and Central Office Staff. Currently there are five facilities that have vacancies for Clinical Supervisors. The overall rating for this section is partial compliance due to the Clinical Supervisor vacancies.

(XI)(a): Regional Directors

Specific requirement: Within thirty (30) days after the approval of this Settlement Agreement, to the extent it has not already done so, IDOC will hire two regional directors who are licensed psychologists or psychiatrists to assist the IDOC Chief of Mental Health Services.

Findings: IDOC has been in substantial compliance with this requirement throughout the life of the Settlement Agreement.

(XI)(b): Statewide Quality Improvement Manager

Specific requirement: IDOC will also create a position for a statewide Quality Improvement Manager (the QI Manager). In addition to the other responsibilities assigned to the QI Manager in this Settlement Agreement, the QI Manager or one or more qualified designees shall have the responsibility for monitoring the provision of mental health services performed within IDOC by state or vendor employees and the performance of any vendor(s) under the vendor contract(s). This position shall be filled only by a State, not vendor, employee, and shall be filled no later than nine (9) months after the approval of the Settlement Agreement.

Findings: IDOC is in substantial compliance with this requirement.

(XI)(c): Clinical supervisors

Specific requirement: Within thirty (30) days after approval of this Settlement Agreement, IDOC shall also designate at least one qualified state employee at each IDOC-operated facility encompassed by this Settlement Agreement to provide supervision and assessment of the State clinical staff and monitoring and approval of the vendor staff involved in the delivery of mental health services. The employee shall be a PSA-8K, Clinical Psychologist, Social Worker IV or appropriately licensed mental health professional. If the designated employee leaves the facility and the position has not yet been filled, IDOC may designate an interim holder of this position who may be a member either of IDOC or vendor staff.

Findings: At the time of the submission of this report, there existed five clinical supervisor vacancies:

- Danville PSA-8k
- East Moline Social Worker IV
- Menard PSA-8k
- Pontiac Social Worker IV
- Stateville NRC PSA-8k

IDOC is in partial compliance with this requirement.

(XI)(d): Central office staff

Specific requirement: IDOC shall hire ten (10) central office staff (*i.e.*, non-facility-specific staff including the positions mentioned in (a)-(d), above) to implement the policies and record-keeping requirements of this Settlement Agreement. These positions will be filled no later than eighteen (18) months after the approval of this Settlement Agreement.

Findings: IDOC is in substantial compliance with this requirement.

XII: MEDICATION

Summary: The monitoring team found that IDOC medical staff are contemporaneously recording medication administration and contacts with medical staff as to medications. A review of the psychiatric backlog and a data driven analysis regarding the frequency of medication follow up visits reveals that IDOC still does not meet the requirements of the Settlement Agreement concerning proper frequency of medication follow up visits. IDOC has made progress in assuring that prescribed medications are actually being delivered and taken by the offenders. Similarly, IDOC is making progress regarding the charting of medication side effects, the use of standard protocols for ascertaining side effects, providing explanations to the offenders regarding their prescribed medications and addressing medication non-compliance.

(XII)(a): Specific requirement: In accordance with the provisions of IDOC AD 04.03.100, section II (E)(4)(d)(1), no later than ninety (90) days after the approval of this Settlement Agreement, medical staff shall record contemporaneously on offender medical records all medications administered and all offender contacts with medical staff as to medications. With respect to offenders taking psychotropic medications, "contemporaneously" means that the medication, the amount of the medication, and whether the offender took it or refused it will be recorded at the time the medication is delivered, either on a temporary record from which information is subsequently transferred to a permanent record located elsewhere, or in the permanent record at the time of delivery.

Findings: IDOC has been consistently meeting this requirement since the midyear report of 11/22/17.

(XII)(b): Specific requirement: Within ninety (90) days after the approval of this Settlement Agreement, IDOC shall also comply with the provisions of IDOC AD 04.04.101, section II (F)(5), except that under no circumstances shall a SMI offender who has a new prescription for psychotropic medication be evaluated as provided therein fewer than two (2) times within the first sixty (60) days after the offender has started on the new medication(s).

AD 04.04.101, section II (F)(5) provides: Offenders who are prescribed psychotropic medication shall be evaluated by a psychiatrist at least every 30 days, subject to the following:

(a) For offenders in the outpatient level of care, once stability has been observed and documented in the offender's medical record by the attending psychiatrist, consideration for the extension of follow-up appointments may be considered, with no follow up appointment to exceed 90 days.
(b) For offenders at a Special/Residential Treatment Unit level of care, once stability has been observed and documented in the offender's medical record by the attending psychiatrist, consideration for an extension of follow-up appointments may be considered with no extension to exceed 60 days.

Findings: The psychiatric backlog data must be taken into consideration when evaluating IDOC's performance regarding this requirement. At the beginning of the reporting period, 6/1/18, the psychiatric backlog was 1265. At that time, the largest backlogs existed at Dixon (134), Menard (172), Pontiac (138), Shawnee (155), Stateville (113) and Western (98). IDOC has made progress in reducing the backlog over the reporting period. As of 5/10/19, the backlog was 680. Some facilities had no backlog.[24] Other facilities had significant backlogs: Dixon, 223 of 897 cases (25%); Robinson, 120 of 273 cases (44%); and Vienna, 67 of 194 cases (35%).

Overall, this backlog of 680 represents 7% of the total psychiatric caseload. Although a backlog of 680 is significantly preferable to one of 1265, it remains an unacceptable figure given the critical nature of timely psychiatric follow up. This is especially true at Dixon given their large number of RTU-level offenders.

Backlog, however, is only one indication of IDOC's performance regarding this requirement. The monitoring team conducted a data-driven analysis of the requirements of Section XII, throughout the reporting period. This consisted of chart reviews for 138 mentally ill offenders from 10 facilities[25] who were prescribed psychotropic medication. A review of the medication practices at Dixon was also conducted and will be described later. This analysis revealed that regarding the specific requirements of XII(b), only 74 of the 138 charts reviewed demonstrated that the time parameters were being met. Examples of the problems encountered:

- 90-day follow ups were scheduled without patient stability documented in the medical record.
- 60-day follow up was scheduled without patient stability documented in the medical record.
- 55-day follow up scheduled for a patient started on a new medication.

Given the problems associated with the psychiatric backlog and that only 54% of the reviewed charts demonstrated timely psychiatric follow up, a rating of non-compliance will be assigned for XII(b).

(XII)(c): Specific requirement: In addition to these requirements, within ninety (90) days after the approval of this Settlement Agreement, IDOC shall accomplish the following:

(i): Specific requirement: The timely administration or taking of medication by the offenders, so that there is a reasonable assurance that prescribed psychotropic medications are actually being delivered to and taken by the offenders as prescribed;

Findings: As Monitor, I have been very critical of IDOC's lack of progress regarding this specific requirement in the past.[26] Since this midyear report, however, IDOC has made a concerted effort to address this critical issue. These endeavors include:

---

[24] Big Muddy, Centralia, Danville, East Moline, Elgin, Jacksonville, JTC, Kewanee, Menard, Murphysboro, Sheridan and Taylorville.

[25] Elgin, Western, Graham, Menard, Pinckneyville, Logan, Pontiac, Illinois River, Vienna, and Stateville-NRC and Stateville proper.

[26] Midyear Report, dated 11/30/18, page 48.

- IDOC reports that facilities actively identify those mentally ill offenders who have a history of "cheeking" medication. Hill is offered as an example of such a facility and a robust procedure is described. The monitoring team looks forward to learning about other facilities undertaking similar practices.
- Using better lighting to inspect the mouths of offenders in restricted housing settings. Almost half of institutions report upgrading in-cell lighting and/or using flashlights.
- Pulling patients out of their cells—either on to the tier, in a holding cell, at an officer's desk, or in the health care unit or other pill window--where they can be better observed while taking their medications. Seven institutions have instituted this as routine practice, and another seven employ this method when necessary.
- Illinois River and Shawnee utilize a "crush and float" method of medication administration.
- Changing the formulary to address this issue (i.e. introducing oral-disintegrating tablets of the antipsychotic and mood stabilizer, Zyprexa; moving to daily dosing of certain medications.)

Nine institutions report using the normal procedures, without enhancements, and the belief that that is sufficient in their circumstances.

All of these changes, however, are not without challenges. In an email to Chief Lindsay on 4/19/19, plaintiffs' counsel reported that on a recent site visit to Menard "We received many concerns from Class Members that their psychiatric medications on order for 'crush and float' are passed out already crushed with no assurance to them that the crushed medications are in fact their own prescribed medications." The monitoring team has received similar concerns from mentally ill offenders while touring facilities during the current reporting period.

Reena Kapoor, M.D. conducted her sixth visit to Dixon on February 7th & 8th, 2019. She noted that hoarding and misappropriation of medications is a problem at Dixon, contributing indirectly to the suicide of an offender in 2018. As one method to manage this issue, Dixon reports it has replaced metal screens with plexiglass in its segregation units, a valuable change that should greatly improve visibility during cellside medication administration.

The efforts of IDOC to address this very difficult issue are duly noted and appreciated. A rating of partial compliance will be assigned for this subsection.

(ii): Specific requirement: The regular charting of medication efficacy and side effects, including both subjective side effects reported by the patient, such as agitation, sleeplessness, and suicidal ideation, and objective side effects, such as tardive dyskinesia [sic], high blood pressure, and liver function decline;

Findings: As reported in the midyear report of 11/30/18, IDOC has been making steady progress in meeting the requirements of this subsection. Aggregating three studies the monitoring team conducted, 94 of the 150 charts reviewed (63%) were satisfying the requirements of this subsection. A significant subset of the cases falling short did chart efficacy, so were partially compliant. A rating of partial compliance will be assigned for this current report. IDOC can expect

to receive a rating of substantial compliance for XII(c)(ii) when they can demonstrate a compliance rate of 85%.

(iii): Specific requirement: Adherence to standard protocols for ascertaining side effects, including client interviews, blood tests, blood pressure monitoring, and neurological evaluation;

(iv): Specific requirement: The timely performance of lab work for these side effects and timely reporting on results;

There is significant overlap with XII(c)(iii) and (iv). Aggregating three sets of monitoring team analyses, charts demonstrated that 99 of the 149 charts reviewed (66%) were meeting the requirements of these two subsections. This 66% compliance finding is an improvement over previous reviews. A partial compliance rating will be assigned for both of these subsections. Again, IDOC can expect to receive a rating of substantial compliance for XII(c)(iii) & (iv) when they can demonstrate a compliance rate of 85%.

(v): Specific requirement: That offenders for whom psychotropic drugs are prescribed receive timely explanation from the prescribing psychiatrist about what the medication is expected to do, what alternative treatments are available, and what, in general, are the side effects of the medication; and have an opportunity to ask questions about this information before they begin taking the medication.

Findings: As reported in the midyear report of 11/30/18, IDOC remains in substantial compliance with this requirement. Again, this rating is based on a box being checked on the psychiatric progress note form. I encourage IDOC to better document the degree to which the psychiatric provider is explaining the medication management of a given mentally ill offender.

(vi): Specific requirement: That offenders, including offenders in a Control Unit, who experience medication Non-Compliance, as defined herein, are visited by an MHP. If, after discussing the reasons for the offender's Medication Non-Compliance said Non-Compliance remains unresolved, the MHP shall refer the offender to a psychiatrist.

Findings: As reported in the midyear report of 11/30/18, IDOC was found to be in substantial compliance with this requirement based on evidence of psychiatry considering the patient's compliance/non-compliance with his or her medication regimen. In a more recent, multi-site chart review, however, only 62% of the charts referenced this.

To the monitoring team's knowledge, IDOC does not maintain a system that would allow staff or monitors to identify the population of patients who have been noncompliant with their medication. While medication adherence is one subject of the monitoring team's chart reviews, the cohort on which to make an assessment remains small as they are encountered by chance.[27] Among those reviews, however, only 23% were fully compliant with the terms of this Settlement Agreement requirement. Deficiencies tended to be concentrated at the nursing referral step; referrals either were not made, were made late, or progress notes suggested the possibility that a

[27] This analysis is based on 22 charts, the only charts evidencing nonadherence to medication regimen for stretches of 3 days or more, per IDOC policy, during the monitoring period. These were the only such charts in a multi-site review of 188 charts.

referral was made but it is unclear whether that took place. Charts also raised a question when progress notes show patients telling clinicians that they had been refusing medication but MARs show the patient receiving medication at that time.

Once mental health staff was aware of a referral, response tended to meet required timeframes; there were only a few exceptions where response was late or the MHP does not appear to have referred the patient to psychiatry when it was warranted.

To remain consistent with previous ratings, IDOC will be found to be in partial compliance with this requirement. Again, a compliance rate of 85% will earn IDOC a substantial compliance rating. Additionally, the monitoring team and IDOC will need to collaborate on methods to identify the relevant population so that the Monitor and the Court may have confidence in the sufficiency of studies.

XIII: OFFENDER ENFORCED MEDICATION

Summary: There appeared to be an increase in the number of patients subject to enforced medication. In the records reviewed, IDOC personnel followed the required notice and hearing procedures. However, in 67% of reviewed cases, a decision to enforce medication was made when the record did not reflect that the standard had been met.

Previously, 15 institutions have been found in substantial compliance, and that finding remains in place.

Specific requirements: IDOC shall ensure that its policy and practice as to involuntary administration of psychotropic medication continues to fully comply with 20 Ill. Admin. Code § 415.70. The cited provision of the Administrative Code is lengthy and includes numerous detailed provisions:

a) Administration of Psychotropic Medication

1) Psychotropic medication shall not be administered to any offender against his or her will or without the consent of the parent or guardian of a minor who is under the age of 18, unless: A) A psychiatrist, or in the absence of a psychiatrist a physician, has determined that: i) The offender suffers from a mental illness or mental disorder; and ii) The medication is in the medical interest of the offender; and iii) The offender is either gravely disabled or poses a likelihood of serious harm to self or others; and

B) The administration of such medication has been approved by the Treatment Review Committee after a hearing (see subsection (b) of this Section). However, no such approval or hearing shall be required when the medication is administered in an emergency situation. An emergency situation exists whenever the required determinations listed in subsection (a)(1)(A) of this Section have been made and a psychiatrist, or in the absence of a psychiatrist a physician, has determined that the offender poses an imminent threat of serious

physical harm to self or others. In all emergency situations, the procedures set forth in subsection (e) of this Section shall be followed.

2) Whenever a physician orders the administration of psychotropic medication to an offender against the person's will, the physician shall document in the offender's medical file the facts and underlying reasons supporting the determination that the standards in subsection (a)(1) of this Section have been met and: A) The Chief Administrative Officer shall be notified as soon as practicable; and B) Unless the medication was administered in an emergency situation, the Chairperson of the Treatment Review Committee shall be notified in writing within three days.

b) Treatment Review Committee Procedures

The Treatment Review Committee shall be comprised of two members appointed by the Chief Administrative Officer, both of whom shall be mental health professionals and one of whom shall be a physician. One member shall serve as Chairperson of the Committee. Neither of the Committee members may be involved in the current decision to order the medication. The members of the Committee shall have completed a training program in the procedural and mental health issues involved that has been approved by the Agency Medical Director.

1) The Chief Administrative Officer shall designate a member of the program staff not involved in the current decision to order medication to assist the offender. The staff assistant shall have completed a training program in the procedural and mental health issues involved that has been approved by the Agency Medical Director.

2)The offender and staff assistant shall receive written notification of the time and place of the hearing at least 24 hours prior to the hearing. The notification shall include the tentative diagnosis and the reasons why the medical staff believes the medication is necessary. The staff assistant shall meet with the offender prior to the hearing to discuss the procedural and mental health issues involved.

3) The offender shall have the right to attend the hearing unless the Committee determines that it is likely that the person's attendance would subject the person to substantial risk of serious physical or emotional harm or pose a threat to the safety of others. If such a determination is made, the facts and underlying reasons supporting the determination shall be documented in the offender's medical file. The staff assistant shall appear at the hearing whether or not the offender appears.

4) The documentation in the medical file referred to in subsection (a)(2) of this Section shall be reviewed by the Committee and the Committee may request the physician's personal appearance at the hearing.

5) Prior to the hearing, witnesses identified by the offender and the staff assistant may be interviewed by the staff assistant after consultation with the offender as to appropriate questions to ask. Any such questions shall be asked by the staff assistant unless cumulative, irrelevant, or a threat to the safety of individuals or the security of the facility.

6) Prior to the hearing, the offender and the staff assistant may request in writing that witnesses be interviewed by the Committee and may submit written questions for witnesses to the Chairperson of the Committee. These questions shall be asked by the Committee unless cumulative, irrelevant, or a threat to the safety of

individuals or the security of the facility. If any witness is not interviewed, a written reason shall be provided.

7) Prior to the hearing, the offender and the staff assistant may request in writing that witnesses appear at the hearing. Any such request shall include an explanation of what the witnesses would state. Reasonable efforts shall be made to have such witnesses present at the hearing, unless their testimony or presence would be cumulative, irrelevant, or a threat to the safety of individuals or the security of the facility, or for other reasons including, but not limited to, unavailability of the witness or matters relating to institutional order. In the event requested witnesses are unavailable to appear at the hearing but are otherwise available, they shall be interviewed by the Committee as provided for in subsections (b)(6) and (9) of this Section.

8) At the hearing, the offender and the staff assistant may make statements and present documents that are relevant to the proceedings. The staff assistant may direct relevant questions to any witnesses appearing at the hearing. The offender may request that the staff assistant direct relevant questions to any witnesses appearing at the hearing and the staff assistant shall ask such questions unless cumulative, irrelevant, or a threat to the safety of individuals or the security of the facility.

9) The Committee shall make such investigation as it deems necessary. The staff assistant shall be informed of any investigation conducted by the Committee and shall be permitted to direct relevant questions to any witnesses interviewed by the Committee. The staff assistant shall consult with the offender regarding any statements made by witnesses interviewed by the Committee and shall comply with requests by the offender to direct relevant questions to such witnesses unless cumulative, irrelevant, or a threat to the safety of individuals or the security of the facility.

10) The Committee shall consider all relevant information and material that has been presented in deciding whether to approve administration of the medication.

11) A written decision shall be prepared and signed by all members of the Committee that contains a summary of the hearing and the reasons for approving or disapproving the administration of the medication. Copies of the decision shall be given to the offender, the staff assistant, and the Chief Administrative Officer. Any decision by the Committee to approve involuntary administration of psychotropic medication must be unanimous. The Chief Administrative Officer shall direct staff to comply with the decision of the Committee.

12) If the Committee approves administration of the medication, the offender shall be advised of the opportunity to appeal the decision to the Agency Medical Director by filing a written appeal with the Chairperson within five days after the offender's receipt of the written decision.

c) Review by Agency Medical Director

1) If the offender appeals the Treatment Review Committee’s decision, staff shall continue to administer the medication as ordered by the physician and approved by

the Committee while awaiting the Agency Medical Director's decision on the appeal.

2) The Chairperson of the Committee shall promptly forward the written notice of appeal to the Agency Medical Director or a physician designated by the Agency Medical Director.

3) Within five working days after receipt of the written notice of appeal, the Agency Medical Director shall: A) Review the Committee's decision, make such further investigation as deemed necessary, and submit a written decision to the Chief Administrative Officer; and B) Provide a copy of the written decision to the offender, the staff assistant, and the Chairperson of the Committee.

4) The Chief Administrative Officer shall direct staff to comply with the decision of the Agency Medical Director.

d) Periodic Review of Medication

1) Whenever any offender has been involuntarily receiving psychotropic medication continuously or on a regular basis for a period of six months, the administration of such medication shall, upon the offender's written request, be reviewed by the Treatment Review Committee in accordance with the procedures enumerated in subsections (b) and (c) of this Section. Every six months thereafter, for so long as the involuntary medication continues on a regular basis, the offender shall have the right to a review hearing upon written request.

2) Every offender who is involuntarily receiving psychotropic medication shall be evaluated by a psychiatrist at least every 30 days, and the psychiatrist shall document in the offender's medical file the basis for the decision to continue the medication.

e) Emergency Procedures

Subsequent to the involuntary administration of psychotropic medication in an emergency situation:

1) The basis for the decision to administer the medication shall be documented in the offender's medical file and a copy of the documentation shall be given to the offender and to the Agency Medical Director for review.

2) A mental health professional shall meet with the offender to discuss the reasons why the medication was administered and to give the offender an opportunity to express any concerns he or she may have regarding the medication.

f) Copies of all notifications and written decisions shall be placed in the offender's medical file.

g) Grievances

An offender may submit a grievance concerning the involuntary administration of psychotropic medication directly to the Administrative Review Board in accordance with 20 Ill. Adm. Code 504.Subpart F. In considering the grievance, the Board shall confer with the Agency Medical Director.

Findings: In the past, IDOC has provided documentation concerning staff at each institution who have been trained to serve on hearing committees, and the April Quarterly Report notes additional training provided in April 2018 and April 2019.

It appears there are substantially more people subject to enforced medication—258--than in previous monitoring periods.[28] Logs show 118 new decisions issued since the Second Annual Report. The monitoring team reviewed 10% of the new decisions drawn from half of the institutions issuing them. In all cases, documents indicated that IDOC followed the prescribed procedures: the patient was issued a written notice; a staff assistant was assigned;[29] a hearing was convened with the correct mental health disciplines; and a hearing record was issued, specifying the basis for the decision. The patient appeared, or the hearing record noted that he or she was given the option and refused. There were notes concerning whether the patient wished to call witnesses; none were requested in the documents reviewed.

While procedures were followed, the central purpose of this protection was only fulfilled in 33% of the cases reviewed. While the hearing personnel considered a substantial amount of clinical information, and it reflected clearly sick patients, in the large majority of cases, it did not describe someone gravely disabled nor at substantial risk on inflicting serious harm to him- or herself or others, any more than the risk posed by a great number of other IDOC patients. While medicating these patients would be very desirable, it is a serious matter to remove a patient's right to bodily integrity, and too often the committees did so where the record did not demonstrate that the standard had been met.

During previous monitoring periods, the team found 15 institutions to be in substantial compliance with this requirement. No contrary information has come to the team's attention, so I find that those institutions continue to be in substantial compliance.

XIV: HOUSING ASSIGNMENTS

Summary: IDOC has been in substantial compliance with the requirements of this section since the midyear report of 11/22/17. The Monitoring team will not be reporting on this section in future reports.

(XIV)(a): Specific requirements: Cell assignments for SMI offenders shall be based on the recommendations of the appropriate security staff. However, notice shall be made to members of the SMI offender's mental health treatment team within twenty-four (24) hours of a new or changed cell assignment. It is expected that MHPs will monitor the location of each SMI offender on their caseload. IDOC will require MHPs to alert security staff of their concerns regarding SMI offender housing assignments and related contraindications. In all instances, an SMI offender's housing assignment shall serve both the security needs of the respective facility and the treatment needs of the offender.

Findings: IDOC is in substantial compliance with this requirement.

---

[28] It is unclear, however, whether the method of reporting contributes to this impression. If the reporting is consistent, there was a 38% increase over previous monitoring periods.

[29] In a few instances, it appeared that a different staff assistant served notice—and presumably prepared the patient—than the one who participated in the hearing a short time later.

(XIV)(b): Specific requirement: For those offenders who have served fifteen (15) days or longer in Administrative Detention or Disciplinary Segregation, an MHP who is a member of the SMI offender's mental health treatment team shall be consulted regarding post-segregation housing recommendations pursuant to Section XVIII (a)(v)(F), *below*.

Findings: IDOC is in substantial compliance with this requirement.

(XIV)(c): Specific requirement: If security staff rejects a housing recommendation made by an MHP as to an SMI offender, the security staff representative shall state in writing the recommendation made by the MHP and the factual basis for rejection of the MHP recommendation.

Findings: IDOC is in substantial compliance with this requirement.

XV: SEGREGATION

Summary: IDOC appropriately considers classification concerns and confers with Mental Health staff before double-celling mentally ill prisoners. Documents do not demonstrate that existing treatment plans are continued after segregation placement. There have been great improvements in MHPs assessing patients within 48 hours of placement, a high-risk time. It is impressive that, in recent months, 81% of reviewed placements systemwide were compliant and fully 18 institutions are in substantial compliance on this important function.

A minority of treatment plans are updated at the first week and monthly thereafter. Systems are well-established to provide weekly rounds, but documentation suggested periodic lapses. As for out-of-cell time, there has been incremental improvement in the amount of structured time offered. However, approximately 30% of patients in segregation were not offered 16 hours per week of out-of-cell time. Then, with a very high recorded refusal rate, the percent who actually receive that amount of time is in the single digits.

There have been improvements in the physical conditions in segregation units, particularly at Pontiac. More improvement to the segregation units is needed throughout the Department if substantial compliance is to be achieved.

XV(a)(i): Specific requirement: Prior to housing two offenders in a cell, the respective Lieutenant or above shall comply with Administrative Directive 05.03.107 which requires an offender review that shall consider compatibility contraindications such as difference in age or physical size; security threat group affiliation; projected release dates; security issues; medical or mental health concerns; history of violence with cell mates; reason for segregation or protective custody placement; racial issues; and significant negative life changes, such as additional time to serve, loss of spouse or children, etc. The respective security staff shall consult with the mentally ill offender's treatment team regarding the appropriateness of such placement in accordance with Section XVII of this Settlement Agreement.

Of note, AD 05.03.107 provides: The Chief Administrative Officer of each facility with segregation and protective custody units designed to double cell offenders shall develop a written policy that includes, but is not limited to, the following for routine segregation and protective custody placement:

- Segregation placement
- PC placement
- Documentation
- Review of documentation and final determination
- Compatibility contraindications
- Review with other inmates
- Upon determination to double-cell:
    - Documentation

  - Suitability review following placement
  - Documentation upon release
- Documentation and Reassessment for disciplinary report

Findings: IDOC continues to meet the requirements of this subsection. A rating of substantial compliance will be assigned.

XV(a)(ii): Specific Requirement: Standards for living conditions and status-appropriate privileges shall be afforded in accordance with 20 Ill. Admin. Code §§ 504.620, 504.630 and 504.670. Section 504.620 is detailed and covers a number of issues regarding conditions in segregation: double celling, secure fastening of the bed, clean bedding, running water, lighting, placement above ground with adequate heat and ventilation, food passage and visual observation, use of restraints inside the cell, cleaning materials, showers and shaves, toiletries, clothing and laundry, dentures, glasses and other hygienic items, property and commissary, food, visits, medical, chaplain and correctional counselor visits, programs, exercise, phone calls, mail privileges and reading materials. Section 504.630 provides for the same conditions and services in investigatory status as in segregation status. Section 504.670 addresses recreation, including requiring five hours of recreation for inmates who have spent 90 or more days in segregation, yard restrictions, and related documentation.

Findings: IDOC continues to struggle with this particular requirement. Overall, the segregated housing units within the Department do not meet the requirements of this subsection. Of note, however, IDOC has implemented some of the recommendations of the Monitor regarding the use of segregated housing. The offenders previously placed in the North House at Pontiac have been transferred and the facility has been refurbished. Hopefully, with new leadership looking at this critical issue, improvements regarding the use of segregated housing will continue to occur. The Monitor and his staff remain very willing to work with the Department in addressing this issue, especially regarding the placement of mentally ill offenders in segregated housing units.

XV(a)(iii): Specific requirement: Mentally ill offenders in segregation shall continue to receive, at a minimum, the treatment specified in their Individual Treatment Plan (ITP). Treating MHPs and the Warden shall coordinate to ensure that mentally ill offenders receive the services required by their ITP.

Findings: The Quarterly report of 4/23/19 states on page 19 “The Department continues to work to ensure that this mandate is fulfilled.” I completely agree with this statement in that the Department recognizes that more work needs to occur to fully meet the requirements of this subsection. For example, the most recent backlog data regarding treatment planning is as follows:

• 4/19/19	545 Department wide	161 at Pontiac
• 4/26/19	604 Department wide	156 at Pontiac
• 5/3/19	528 Department wide	142 at Pontiac
• 5/10/19	457 Department wide	136 at Pontiac
• 5/17/19	463 Department wide	123 at Pontiac
• 5/24/19	440 Department wide	107 at Pontiac

This data suggests that at Pontiac, a significant number of mentally ill offenders, many of whom are placed in segregated housing, are either without a treatment plan or an updated treatment plan.

In a six-institution study, only 22% of the patients placed in segregation clearly had their treatment plans continued on entry.[30] More specifically, among those institutions, a chart review of treatment plans at Pontiac revealed that in most of the 13 charts reviewed, it could not be discerned if the treatment plan was being continued while the offender was in segregation. This was due to the fact that the treatment plan was vague in its treatment recommendations or that the treatment only included MHP contacts every 60-90 days and that time had not passed. In the handful of charts where a determination could be made, three did not continue the full treatment plan and only one did. Similar findings were encountered in a chart review of mentally ill offenders housed in segregation at Illinois River. The ITP was generally not continued when an offender was transferred to segregated housing. For example, relevant treatment plans called for MHP contact every 60-90 days, but there were no documented contacts for these offenders for three to four months. In a few instances, there was no treatment plan in the chart with which to make an assessment.

These findings from Pontiac and Illinois River, however, are consistent with those encountered by the monitoring team throughout the Department during the current reporting period. Given the totality of the data regarding this requirement, IDOC will be assigned a rating of partial compliance.

XV (a)(iv): Specific requirement: An MHP shall review any mentally ill offender no later than forty-eight (48) hours after initial placement in Administrative Detention or Disciplinary Segregation. Such review shall be documented.

Findings: The Department has brought attention to this important requirement and substantial improvement is evident. To accomplish this, IDOC has reported reconfiguring staff schedules; considering alternative staffing for the task; and incorporating this requirement in a major policy document, Departmental Rule 504, to reinforce its importance.

The monitoring team's first analysis in the monitoring period, conducted in June and July 2018, found a compliance rate of 27% in the 92 charts examined. However, analyzing a more recent and larger sample found compliance had jumped to 81%, an impressive accomplishment.[31] Where practice was noncompliant, most often the screening was completed but it was late—half of those only one day late and the others completed within a week after the deadline. Dixon and

[30] This is drawn from site visits to Graham, Pontiac, Illinois River, Stateville-NRC, Vienna, and Western Illinois. Among a larger sample of mentally ill segregation patients, 27 had a treatment plan in place before entering segregation and served as the basis for this analysis.

[31] The team reviewed two additional snapshots, one in November 2018 and one in February 2019. The sample totaled 308 new Segregation placements; these concentrate on SMI patients and were drawn from 23 institutions, exempting only those that had no such placements and one facility that appeared to misunderstand the request. Both the date of placement and the next mental health paperwork were provided for each person in the sample. For some institutions, all such placements were included; where there were large numbers of placements, IDOC provided a subset reportedly using random selection method. It is not practical to determine the total number of mental health caseload patients placed in segregation in a given period, so some relevant measurements are not included, but this does provide a substantial sample of overall practice.

Hill had the greatest difficulty with timely screening; Pinckneyville and Pontiac also had late screenings, but their practice was much improved by the February review. There was no evidence of screening in 6% of the segregation placements in the systemwide sample.

The following institutions have shown consistent, strong practice on this requirement, or have not have mental health patients in segregation for an extended period, and are found to be in substantial compliance: Big Muddy, Centralia, Danville, Decatur, East Moline, Graham, Jacksonville, Kewanee, Logan, Murphysboro, Robinson, Shawnee, Sheridan, Stateville and Stateville-NRC, Southwestern, Vandalia, Vienna, and Western Illinois.

XV (a)(v): Specific requirement: As set forth in Section VII(c) above, an MHP shall review and update the treatment plans (form 284) of all offenders on segregation status within seven (7) days of placement on segregation status and thereafter monthly or more frequently if clinically indicated.

Findings: The Quarterly report of 4/23/19 states "These provisions have been implemented although, due to staffing issues, are not occurring at all required times." This statement is consistent with the findings of the monitoring team throughout the Department during the current reporting period. The monitoring team conducted a multi-site chart review[32] of 80 mentally ill offenders assigned to segregated housing. Only 21 of the 80 charts reviewed (26%) confirmed that treatment plans were reviewed and updated within seven days of placement on segregation status.

In addition to this data-driven analysis, Dr. Kapoor reported that at Dixon, treatment plans are not updated upon entry into segregation for any offender. Illinois River had the best practice, with an updated plan in essentially all reviewed cases, but these were completed late, between two and three weeks after placement.

The monthly reviews and updates were assessed with a much smaller cohort because many fewer mentally ill patients in the sample remained in segregation longer than 30 days. Among the 16 relevant charts, *none* had their treatment plans reviewed and updated on a monthly basis, though a few had one or two updates.[33]

XV(a)(vi): Specific requirement: IDOC will ensure that mentally ill offenders who are in Administrative Detention or disciplinary segregation for periods of sixteen (16) days or more receive care that includes, at a minimum:

A) Continuation of their ITP, with enhanced therapy as necessary to protect from decompensation that may be associated with segregation.
B) Rounds in every section of each segregated housing unit, at least once every seven (7) calendar days, by an MHP, documented on IDOC Form 0380.
C) Pharmacological treatment (if applicable).
D) Supportive counseling by an MHP as indicated in the ITP
E) Participation in multidisciplinary team meetings once teams have been established.

[32] Graham, Western, Decatur, Stateville NRC, Danville, East Moline, Pontiac, Robinson, Vandalia, Vienna, and Illinois River.
[33] Relevant charts were included from Graham, Illinois River, Pontiac, Stateville-NRC, and Western Illinois

F) MHP or mental health treatment team recommendation for post-segregation housing.
G) Documentation of clinical contacts in the medical record.
H) Weekly unstructured out-of-cell time, which may include time for showers or yard time, of an amount equivalent to the out-of-cell time afforded to all segregation offenders at the relevant facility, unless more unstructured out-of-cell time is indicated by the offender's ITP. Instances where mentally ill offenders in segregation refuse out-of-cell unstructured time shall be appropriately documented and made available to the offender's mental health treatment team.

Findings:

Continuation of ITP with enhanced therapy as necessary to protect from decompensation that may be associated with segregation: The most recent Quarterly report paints a rosy picture of the Department's response to this requirement. The Monitoring Team takes strong exception to this characterization. The ITP may be continued while in segregation but not consistently. Please see section XV(a)(iii), above, for a discussion of how ITPs are generally not continued in segregation. The Quarterly Report states "greater, or enhanced, care is being provided to mentally ill offenders in segregation than to those in general population." That may be the case but that is not what this requirement calls for. The requirement states "enhanced therapy as necessary to protect from decompensation that may be associated with segregation." The Monitoring Team did not observe this occurring while conducting 37 visits to 19 different facilities during the current reporting period.

Rounds: Rounds are well-established; during the monitoring team visits, all institutions have demonstrated that they have systems in place and designated staff to accomplish this. Nevertheless, interruptions to the system are not uncommon. In an analysis of six of the institutions visited,[34] 75% of segregation cases had rounds documented for the full length of the patient's placement. For most noncompliant records, there were gaps in the rounds' performance—either all patients missed for a week, or sporadic misses for individual patients. In 4% of cases, the records did not show any rounds contacts for those patients. Pontiac and Stateville-NRC had the strongest performance; each showed 100% compliance. The plaintiffs' counsel also raised the issue about whether BHTs are sufficiently qualified to conduct these rounds.

Pharmacological treatment: Pharmacological treatment does occur when an offender is placed in segregation. Of note, there was a psychiatric backlog of 668 visits on 5/24/19.

Supportive counseling by an MHP as indicated in the ITP: The Monitoring Team found that this episodically occurs. When it does occur, it is usually for only 15-30 minutes monthly.

Participation in multidisciplinary team meetings once teams have been established: This is really only occurring at Joliet and Logan. There may be some form of multidisciplinary involvement at other facilities, but not consistently throughout the Department.

MHP or mental health treatment team recommendation for post-segregation housing: This is occurring throughout the Department

[34] A total of 68 records across Graham, Illinois River, Pontiac, Stateville-NRC, Vienna, Western Illinois

Documentation of clinical contacts in the medical record: Clinical contacts were routinely documented in all records reviewed by the monitoring team.

Weekly unstructured out-of-cell time for mentally ill offenders who are in Administrative Detention or disciplinary segregation: This is generally occurring. There remains a serious problem with refusals, however.

XV(a)(vi):[35] Specific requirement: IDOC will ensure that, in addition to the care provided for in subsection (a)(v), *above*, mentally ill offenders who are in Administrative Detention or Disciplinary Segregation for periods longer than sixty (60) days will receive out-of-cell time in accordance with subsection (c) *below*.[36]

Findings: As of June 2018, it is required that mentally ill offenders housed in a control unit for longer than 60 days receive at least 8 hours of structured and 8 hours of unstructured activities per week. It is consistently the case that 12 or fewer institutions house patients in a control unit for this length of time and thus are subject to this requirement.

The monitoring team analyzed IDOC's systemwide tracking of out-of-cell time for this population.[37] According to these logs, early in the round, the patient population was being offered 15.3 hours per week ***on average***, and by late in the round, the ***average*** hours offered were exactly what they should be – 8 hours of structured and 8 hours of unstructured activities per week. Similarly, the April IDOC Quarterly Report provides a list showing the hours offered at each institution, with each meeting or exceeding the requirement, with one exception. That list was not consistent with logs maintained and provided by IDOC, for unknown reasons.[38]

Moreover, the averages do not reveal distinct differences in what the individuals are offered. Throughout the review, 31% to 32% of patients were ***not*** offered the required amount. This occurred consistently at Big Muddy River, Dixon, Menard, Shawnee, and Western Illinois. Menard has a large long-term segregation population and was particularly troubling; in the most recent month analyzed, nearly every patient in the sample had a multiple-week stretch where the only unstructured time offered was one or two showers per week, and sometimes not even that.

---

[35] This numbering from the Settlement Agreement is in error but this report will continue to use it to remain consistent with the numbering in the Settlement Agreement.

[36] Note: this refers to the second occurrence of a subsection (c), on page 20 of the Settlement Agreement

[37] The team reviewed a month early in the third year of monitoring and a month nearing the end of the monitoring period (June 2018 and February 2019). Where feasible, the review included all relevant cases for an institution. Where the relevant population is larger, the reviewer employed random selection method of every 4th, 6th, 10th, or 15th case, depending on the population size. In total, 154 cases were reviewed. The analysis controls for length of time each patient was in a control unit during the reviewed month, adjusting for releases to general population and time off unit for writs, crisis watch, etc.

[38] The monitoring team compared the Hours Offered data from individuals on the most recent log analyzed by the team (February) to the March data cited in the report, and the log matched or exceeded the report contents for only 2 institutions. The comparison was possible for 10 institutions; the others had no caseload patients in segregation longer than 60 days on the log, not surprisingly. The offerings could certainly vary from February to March, but the monitoring team has no information that would suggest a substantial change occurred in that time period.

IDOC also has a very high rate of refusals for all types of out-of-cell time. In total, only 9 patients in the sample, or 6%, actually received the required number of hours. And when the hours fell short, they did *not* just miss the mark; on average, patients received *half* of the requirements. The balance did shift over time, so that incremental improvement in structured therapeutic time was evident by February (on average, 4.3 hours per week),[39] a welcome advance.

IDOC indicates that MHPs meet with patients who refuse and document the reasons for the file. The monitoring team has noted refusal forms in the health care records but in all cases these contained only the patient's signature; the team encourages staff to expand into gathering reasons, as described, as this would be valuable information for treatment purposes. The April IDOC Quarterly Report also describes staff discussing during multidisciplinary meetings those patients who repeatedly refuse. Logs show substantial numbers of those patients at each institution with a relevant population; monitoring team members have attended a number of multidisciplinary meetings and have never observed this topic under discussion, though a good example was offered in IDOC's report. Bringing different disciplines' experience to identifying and addressing participation barriers would be quite effective.

No correctional system can guarantee full attendance in programming and patients will invariably refuse some programming. However, when 94% are either not being offered, or are refusing so often, that they commonly receive only half of the required hours, this is a systemic problem that IDOC is obligated to work to reduce.

XV(a)(vii): Specific requirement: If, at any time, it is determined by an MHP that a mentally ill offender in Administrative Detention or Disciplinary Segregation requires relocation to either a crisis cell or higher level of care, the MHP's recommendations shall be immediately transmitted to the CAO or, in his or her absence, a facility Assistant CAO, and the mentally ill offender shall be placed in an appropriate mental health setting (*i.e.*, Crisis Bed or elevated level of care) as recommended by the MHP[40] unless the CAO or Assistant CAO specifies in writing why security concerns are of sufficient magnitude to overrule the MHP's professional judgment. In such cases, the offender will remain in segregation status regardless of his or her physical location.

Findings: The Department is meeting this requirement.

XV(b) As to SMI offenders in Disciplinary Segregation:

XV(b)(i): Specific requirements: IDOC will organize Review Committees ('Committees') to review the segregation terms of all SMI offenders in segregation with at least 60 days of remaining segregation time as of the approval date of this Settlement Agreement. These Committees will be comprised of attorneys, security professionals, and MHPs.

---

[39] Unstructured time appeared to decline, although this may be a product of more accurate reporting of time associated with some activities. Taking structured and unstructured time together, however, the net was very similar: In June, the average hours received per person was 7.7, while that figure was 7.56 in February.

[40] IDOC's compliance with the portion of this provision regarding MHP recommendations for placement into crisis care is discussed elsewhere this report.

Findings: The Monitoring Team has previously found the Department to be in substantial compliance with this requirement. The most recent Quarterly report confirms that IDOC is continuing to meet the requirements of this subsection.

XV(b)(ii): Specific requirements: The Committees shall eliminate any and all 300 and 400 level tickets and the accompanying segregation time from each SMI offender's disciplinary record.

Findings: The Department is in substantial compliance with this requirement.

XV(b)(iii): Specific requirements: With regard to all remaining tickets, the Committees shall examine: (1) the seriousness of the offenses; (2) the safety and security of the facility or any person (including the offender at issue); (3) the offender's behavioral, medical, mental health and disciplinary history; (4) reports and recommendations concerning the offender; (5) the offender's current mental health; and (6) other legitimate penological interests.

Findings: The Department is in substantial compliance with this requirement.

XV(b)(iv): Specific requirements: The committees shall have the authority to recommend to the Chief Administrative Officer that an SMI offender's remaining segregation time be reduced or eliminated altogether based on the factors outlined in XV(b)(iii).

Findings: The Department is in substantial compliance with this requirement.

XV(b)(v): Specific requirements: The decision for reduction or elimination of an SMI offender's segregation term (excluding the elimination and reductions relative to 300 and 400 level tickets) ultimately rests with the CAO who, absent overriding concerns documented in writing, shall adopt the Committees' recommendations to reduce or eliminate an SMI offender's segregation term.

Findings: The Department is in substantial compliance with this requirement.

XV(b)(vi): Specific requirements: These reviews shall be completed within nine (9) months after approval of the Settlement Agreement.

Findings: The Department is in substantial compliance with this requirement.

XV(c) Mentally ill offenders in Investigative Status/Temporary Confinement:

XV(c)(i): Specific requirements: With regard to offenders in Investigatory Status/ Temporary Confinement, IDOC shall comply with the procedures outlined in 20 Ill. Admin. Code § 504 and Administrative Directive 05.12.103.

20 Illinois Administrative Code Section 504 Subpart D: Segregation, Investigative Confinement and Administrative Detention—Adult provides:

Applicability, definitions, and responsibilities for IDOC staff regarding placement of offenders in segregation status; segregation standards for offenders placed into segregation,

investigative confinement, administrative detention; and standards for recreation for offenders in segregation status.

AD 05.12.103 provides:

II (G): Requirements

The Chief Administrative Officer of each facility that houses SMI offenders shall:

1. Establish and maintain a list of offenders identified as SMI. This list shall be made available to the Adjustment Committee upon request.

2. Ensure all members of the Adjustment Committee receive training on administration of discipline and hearing procedures.

II (H): Disciplinary Process

1. When an offender, who has been identified as SMI, is issued an Offender Disciplinary Report, DOC 0317, for a major offense where the disciplinary action may include segregation time:

a. The shift commander shall, within 24 hours, notify the facility's Office of Mental Health Management.

b. The facility Mental Health Authority shall assign a reviewing MHP who shall review the offender's mental health record and DOC 0317 and, within 72 hours of the original notification, provide a completed Mental Health Disciplinary Review, DOC 0443 to the hearing investigator who shall consider the report during his or her investigation in accordance with Department Rule 504. The DOC 0443 shall, at a minimum, provide:

(1) The reviewing MHP's opinion if, and in what way, the offender's mental illness contributed to the underlying behavior of the offense for which the DOC 0317 was issued.

(2) The reviewing MHP's opinion of overall appropriateness of placement in segregation status based on the offender's mental health symptoms and needs; including, potential for deterioration if placed in a segregation setting or any reason why placement in segregation status would be inadvisable, such as the offender appearing acutely psychotic or actively suicidal, a recent serious suicide attempt or the offender's need for immediate placement in a Crisis Treatment Level of Care; and

(3) Based on clinical indications, recommendations, if any, for a specific term of segregation, including no segregation time, or specific treatment during the term of segregation.

2. In accordance with Department Rule 504: Subpart A, all disciplinary hearings shall be convened within 14 days of the commission of the offense; however, if the MHP provides the

offender is unable to participate due to mental health reasons, a stay of continuance shall be issued until such time the reviewing MHP determines the offender available to participate.

a. The Adjustment Committee shall take into consideration all opinions provided on the DOC 0443 and may request the reviewing MHP to appear before the committee to provide additional testimony, as needed.

b. If the MHP recommended, based on clinical indications, a specific segregation term, that no segregation time be served, or that a specific treatment during segregation is necessary, the committee shall adopt those recommendations.

c. If the Adjustment Committee disagrees with the recommendation of the reviewing MHP and recommends a more restrictive disciplinary action, the Adjustment Committee shall submit an appeal to the Chef Administrative Officer (CAO). The CAO shall:

(1) Review the recommendations of the reviewing MHP and the Adjustment Committee;

(2) Consult with the reviewing MHP regarding the appropriateness of the disciplinary action recommended by the Adjustment Committee; and

(3) Provide his or her final determination. Any deviation from MHP's recommendation shall be documented in writing on the Adjustment Committee Summary, DOC 0319, and shall be maintained as a permanent part of the offender's disciplinary file.

d. In accordance with Department Rule 504.80, a copy of the DOC 0317 and DOC 0319 shall be forwarded to the CAO for review and final determination. If the Adjustment Committee's final disposition recommends a term of segregation, the CAO shall compare the recommendation to that of the 0443.

e. All information, including the recommendation of the reviewing MHP and disciplinary action imposed, shall be documented in the Disciplinary Tracking System.

3. No later than the last day of the month following that being reported, the Adjustment Committee shall compile and submit to the respective Deputy Director a summary of the Adjustment Committee hearing of offenders identified as SMI, who were issued a DOC 0317 for a major offense for which the disciplinary action included segregation time.

a. The summary shall include the offense for which the DOC 0317 was issued, reviewing MHP's opinions and recommendations, and outcome and disciplinary action imposed by the Adjustment Committee.

b. Any recommendations by the Deputy director to change imposed disciplinary action shall be discussed with the Chief Administrative Officer, treating and reviewing MHP, and as necessary, the Adjustment Committee. Approved adjustments shall be made accordingly.

4. A copy of the DOC 0319 shall be provided to the offender.

Findings: Please see section XXV, page 91, Discipline of Seriously Mentally Ill Offenders, for a discussion of the disciplinary process.

II (I): Observation and Follow-up

1. Observation of offenders in segregation shall be conducted in accordance with existing policies and procedures.

2. Referrals for mental health services and response to offenders with serious or urgent mental health problems, as evidenced by a sudden or rapid change in an offender's behavior or behavior that may endanger themselves or others if not treated immediately, shall be handled in accordance with AD 04.04.100.

3. If, at any time, clinical indications suggest continued placement in segregation status poses an imminent risk of substantial deterioration to the an [sic] offender's mental health, the information shall be reviewed by the facility mental health authority.

4. Any recommendations by the mental health authority for reduction in segregation time or termination of segregation status shall be discussed with the CAO.

5. The CAO shall adjust the segregation term in accordance with the recommendations or, if the CAO does not agree with the recommendation of the mental health authority, he or she shall submit the issue to the respective Deputy Director for final determination.

Findings: Please see section XXV, page 98, for a discussion about "Observation and Follow-up."

XV(c)(ii): Specific Requirement: An MHP shall review any mentally ill offender being placed into Investigative Status/Temporary Confinement within forty-eight (48) hours of such placement. Such review shall be documented. This obligation will begin twelve (12) months after the budget contingent approval date.

Findings: Please see section XV(a)(iv), above, for a discussion on this requirement.

XV(c)(iii): Specific Requirement: IDOC will ensure that mentally ill offenders who are in Investigatory Status/Temporary Confinement for periods of sixteen (16) days or more receive care that includes, at a minimum:

1) Continuation of their ITP, with enhanced therapy as necessary to protect from decompensation that may be associated with segregation. Therapy shall be at least one (1) hour or more of treatment per week, as determined by the offender's individual level of care and ITP.
2) Rounds in every section of each segregated housing unit, at least once every seven (7) days, by an MHP, documented on IDOC Form 0380.
3) Pharmacological treatment (if applicable).
4) Supportive counseling by an MHP as indicated in the ITP.

5) Participation in multidisciplinary team meetings once teams have been established.
6) MHP or mental health treatment team recommendation for post-segregation housing.
7) Documentation of clinical contacts in the medical record.
8) Weekly unstructured out-of-cell time, which may include time for showers or yard time, of an amount equivalent to the out-of-cell time afforded to all segregation offenders at the relevant facility, unless more unstructured out-of-cell time is indicated by the offender's ITP. Instances where mentally ill offenders in segregation refuse out-of-cell unstructured time shall be appropriately documented and made available to the offender's mental health treatment team.

Findings: Please see section XV(a)(vi), above, for a discussion about this requirement.

XV(c)(iv): Specific Requirement: IDOC will ensure that, in addition to the care provided for in subsection (b)(iii), *above*, mentally ill offenders who are in Investigatory Status/Temporary Confinement for periods longer than sixty (60) days will receive out-of-cell time in accordance with subsection (c), *below*.[41]

Findings: Please see section XV(a)(vi), above, for a discussion about this requirement.

XV(c)(v): Specific Requirement: If, at any time, it is determined by an MHP that a mentally ill offender in Investigatory Status/Temporary Confinement requires relocation to either a crisis cell or higher level of care, the MHP's recommendation shall be immediately transmitted to the CAO or, in his or her absence, a facility Assistant CAO, and the SMI offender shall be placed in an appropriate mental health setting (*i.e.*, Crisis Bed or elevated level of care) as recommended by the MHP unless the CAO or Assistant CAO specifies in writing why security concerns are of sufficient magnitude to overrule the MHP's professional judgment. In such cases, the offender will remain in segregation status regardless of his or her physical location.

Findings: The Department is in substantial compliance with this requirement.

XV(c)[42]: Specific Requirement: Mentally ill offenders in a Control Unit setting for longer than sixty (60) days shall be afforded out-of-cell time (both structured and unstructured) in accordance with the following schedule:

i. For the first year of the Settlement Agreement, four (4) hours out-of-cell structured and four (4) hours out-of-cell unstructured time per week for a total of eight (8) hours out-of-cell time per week.

ii. For the second year of the Settlement Agreement, six (6) hours out-of-cell structured and six (6) hours out-of-cell unstructured time per week for a total of twelve (12) hours out-of-cell time per week.

iii. For the third year of the Settlement Agreement, eight (8) hours out-of-cell structured and eight (8) hours out-of-cell unstructured time per week for a total of sixteen (16) hours out-of-cell time per week.

[41] Note: this refers to the second occurrence of a subsection (c), on pages 19 and 20 of the Settlement.

[42] As above, this appears mislabeled in the Settlement but is carried forward here.

iv. For the fourth year of the Settlement Agreement, ten (10) hours out-of-cell structured and ten (10) hours out-of-cell unstructured time per week for a total of twenty (20) hours out-of-cell time per week.

Findings: Please see section XV(a)(vi), above, for a discussion of this requirement.

Structured out-of-cell time & unstructured out-of-cell time: Again, please see section XV(a)(vi), above, for a discussion of this requirement.

The 60-day requirement: The Department is not meeting the 60-day requirement for out-of-cell time for mentally ill offenders in segregation. Section XV(a)(vi) has an in-depth discussion about the current status of out-of-cell time within the Department.

Segregation-like settings: I continue to advocate for more out-of-cell time for mentally ill offenders housed in the R&Cs.

XV(d): Specific Requirement: The provisions of this Section shall be fully implemented no later than four (4) years after the approval of this Settlement Agreement.

Findings: The deadline for this finding has not been met.

XVI: SUICIDE PREVENTION

Summary: Crisis teams have been formed and trained and crisis intervention data is being tracked in the CQI system. Each facility has a designated crisis area and crisis beds have been removed from segregation settings. Each facility has an Institutional Directives regarding crisis care although some of these IRs lack the appropriate sections. There remains the question of custody staff acting as gatekeepers to the Crisis Intervention Teams.

Four completed suicides occurred during the reporting period. Administrative Reviews and Psychological Autopsies were completed on each of the suicide victims. There is a serious issue of IDOC not fully implementing the recommendations contained in these reviews. It is imperative that clinical leadership thoroughly review these four sets of reviews and put into effect the recommendations for reducing the risk of future suicides.

(XVI)(a): Specific requirements: IDOC shall comply with its policies and procedures for identifying and responding to suicidal offenders as set out in Administrative Directive 04.04.102 and the section titled "Identification, Treatment, and Supervision of Suicidal Offenders" in the IDOC Mental Health Protocol Manual (incorporated by reference into IDOC AD 04.04.101, section II (E)(2)). IDOC shall also ensure that Forms 0379 ("Evaluation of Suicide Potential"); 0377 ("Crisis Watch Record"); and 0378 ("Crisis Watch Observation Log") are used in conjunction with these policies and procedures.

The section titled "Identification, Treatment and Supervision of Suicidal Offenders" from

the IDOC Mental Health SOP Manual[43] provides general guidelines for the handling of suicidal offenders. AD 04.04.102, however, provides a number of specific requirements:

> II (F) Requirements**:** The Chief Administrative Officer of each facility shall:
> 1)Establish a Crisis Intervention Team.
> a. The Crisis Intervention Team shall consist of: (1) A Crisis Intervention Team Leader who shall be an MHP; (2) All facility MHPs and nursing staff; and (3) At least one member of the facility's security staff of the rank of Lieutenant or above. **NOTE:** Other Crisis Intervention Team members may be chosen from facility staff upon the recommendation of the Team Leader to ensure at least one member is on site at all times.
> b. Prior to serving, all members of the Crisis Intervention Team shall receive training in accordance with Paragraph II.g.1. Crisis Intervention Team Members on leave of absence shall be required to make up missed training upon return and prior to resuming service on the Crisis Intervention Team.
> c. All Crisis Intervention Team Members shall participate in quality assurance meetings no less than once per quarter.
> (1) Meetings shall be held to: (a) Review all events involving offender suicide during the previous quarter; (b) Review the Facility's Prevention and Intervention Plan in accordance with Paragraph II.G; and (c) Assess the adequacy of the facility's training program in relation to the facility's needs
> (2) Meetings shall be documented in writing and shall: (a) Include the date and minutes of the meeting, a list of all persons in attendance and any recommendations or issues noted; (b) Be submitted to the Chief Administrative Officer, the respective Regional Psychological Administrator and the Chief of Mental Health

Findings: The requirements of Administrative Directive 04.04.102, effective 11/1/17, are being met. That is, Crisis Teams have been formed and trained. Crisis Intervention data is tracked in the CQI system.

> 2) Designate a Crisis Care Area.
> a. Crisis care areas shall be used to house offenders determined by an MHP to require removal from his or her current housing assignment for the purpose of mental health treatment or observation.
> b. Excluding exigent circumstances as determined by the Director or a Deputy director, segregation units shall only be utilized for crisis care areas if no other crisis care areas are available, and only until alternative crisis care areas are available.
> c. Cells designated as crisis care areas shall: Allow for visual and auditory observation of the entire cell; Allow for prompt staff access; Control outside stimuli; Contain beds that are suicide resistant and constructed of a metal base, cinder block, concrete slab or herculite

[43] The Settlement references "Mental Health Protocol Manual." IDOC has changed the name of this manual to "Mental Health SOP Manual."

material; Contain a pass through or chuck holes that open out of the cell; Contain mesh coverings over all vents; Contain laminated glass over all windows or be safely and security glazed windows; and Be made appropriately suicide resistant and provide adequate lighting and temperature.

Findings: Each facility has a designated crisis area. The monitoring team has observed the crisis areas in the 19 separate facilities visited during the current reporting period and found them to have the required features. Crisis beds have finally been removed from segregation areas during the current reporting period.

II (G): Prevention and Intervention Plan

The Chief Administrative Officer, in consultation with the facility's mental health authority, shall establish a written procedure for responding to, and providing emergency mental health services, including prevention and intervention of emergency mental health situations. The procedure shall be reviewed annually and shall be approved by the Chief of Mental Health and shall include, at a minimum, provisions for the following: training, referrals for emergency mental health situations, crisis intervention team response, crisis watch, response to self-inflicted injuries and suicide, and quality improvement reviews.

Findings: IDOC has provided Institutional Directives for all institutions capturing the key provisions of the crisis intervention policy. The monitoring team has reviewed each Institutional Directive and found that they are consistent with the system's Administrative Directive. The great majority are comprehensive. There are five institutions whose directives are nearly complete but are missing a brief but significant section.

1) Training

The Chief of Mental Health, in consultation with the Office of Staff Development and Training shall establish standardized training programs that provide information on emergency mental health services. All training shall be provided by an MHP, or in the absence of the MHP, a current crisis team member and, where appropriate, shall include enhanced content specific to the facility.

a. Level I Training shall be required as part of annual cycle training for all staff that have regular interaction with offenders, and shall include a minimum of one hour of the following: (1) Elements of the facility's Prevention and Intervention Plan; (2) Demographic and cultural parameters of suicidal behavior in a correctional setting, including incidence and variations in precipitating factors; (3) Risk factors and behavioral indicators of suicidal behavior; (4) Understanding, identifying, managing and referring suicidal offenders, including the importance of communication between staff; (5) Procedural response and follow-up procedures including crisis treatment supervision levels and housing observation; and (6) Documentation requirements.

b. Level II Training shall be required as part of annual cycle training for all personnel identified in the facility's Prevention and Intervention Plan as having the authority to initiate a crisis watch. Level II training shall consist of a minimum of

four hours of in-depth didactic and experiential training in assessing suicide risk and procedures for initiating a crisis watch.

c. Level III Training shall be required for all Crisis Intervention Team members, excluding MHPs, and shall consist of 24 hours of advanced training in the philosophy of suicide prevention and continuous quality improvement of the facility's Prevention and Intervention Plan.

(1) Crisis Intervention Team members shall also be trained by an MHP, designated by the Chief of Mental Health, in consultation with the Office of Staff Development and Training. This training will give the Crisis Intervention Team member the ability to instruct on the standardized training curriculum that provides information on emergency mental health services during cycle training, in the absence of the MHP. (2) Training shall be completed prior to active service with the Crisis Intervention Team.

d. Clinical Continuing Education shall be required for all Crisis Intervention Team members and shall consist of a minimum of one hour per quarter of training to assist Crisis Intervention Team members in monitoring facility policy and procedure and in reviewing suicide attempts or completions. Clinical Continuing Education Training may be obtained through participation in the quarterly Crisis Intervention Team quality assurance meeting.

Findings: As previously reported, this training requirement has been met.

2) Referrals for Emergency Mental Health Situations: Staff shall immediately notify the Crisis Intervention Team, through his or her chain of command, of any situation whereby an offender exhibits behavior indicative of mental or emotional distress, imminent risk for harm to self or an attempted suicide.

Findings: Throughout the first three years of monitoring the Settlement Agreement, there have been concerns whether custody staff in all circumstances "immediately notify the Crisis Intervention Team, through his or her chain of command, of any situation whereby an offender exhibits behavior indicative of mental or emotional distress, imminent risk for harm to self or an attempted suicide." Please see section V(g) for details. This is a vexing problem that cannot be proven one way or the other. IDOC leadership is strongly encouraged to continually emphasize the importance of this issue with custody staff.

3) Crisis Intervention Team Response

a. At least one Crisis Team member shall be on site at all times. The designated Crisis Intervention Team Leader shall be available by phone when not on site.

b. The Chief of Mental Health and the respective Regional Psychological Administrator shall be notified within 24 hours of the suicide of an offender, and within 72 hours of any attempted suicide.

c. Upon notice of a potential crisis situation, a Crisis Intervention Team member shall: (1) Implement necessary means to prevent escalation and to stabilize the situation. (2) Ensure that the offender is properly monitored for safety. (3) Review

the situation with the Crisis Team Leader or and MHP to determine what services or referrals shall be provided. If the Crisis Intervention Team Leader is not on grounds and cannot be reached by telephone, and there are no MHPs on grounds, the Crisis Team member shall contact an alternative MHP and the review may be completed via telephone. (4) Initiate a crisis care treatment plan to monitor and facilitate the delivery of services, including referrals for mental or medical examination, and any additional recommendations of the MHP. The crisis care treatment plan shall be documented on the Crisis Watch Log, DOC 0377. Referrals for additional examination or services following the offender's release from a crisis care treatment level of care shall be documented on a DOC 0377. (5) If determined that the offender does not need to be placed in the crisis care area, notify the Shift Commander of any additional care requirements for security staff.

Findings: As previously reported, when called, the response of the Crisis Intervention Team is generally timely. Please see V(g) for a discussion of problems associated with the timely notification of the Crisis Intervention Team.

4) Crisis Watch
a. A crisis watch shall be initiated when: (1) An offender exhibits behavior that is likely to cause harm to him or herself. (2) Mental health issues render an offender unable to care for him or herself. (3) Gestures, threats or attempts of suicide are made. (4) The Evaluation for Suicide Potential, DOC 0379, if administered, indicates need. (5) Less restrictive measures have failed or are determined to be clinically ineffective.

Findings: This requirement has been met throughout the life of the Settlement Agreement. Based on numerous interviews with mentally ill offenders, a problem exists in that potentially suicidal offenders withhold their true degree of suicidality out of fear of being placed in a crisis bed with its very austere conditions and lack of meaningful psychiatric care.

b. Determination to initiate a crisis watch shall be made by an MHP. If an MHP is not available, the following individuals, in order of priority, may initiate a crisis watch: (1) Respective Regional Psychologist Administrator, (2) Any Regional Psychologist Administrator, (3) Chief of Psychiatry, (4) Chief of Mental Health Services, (5) Chief Administrative Officer in consultation with a Crisis Intervention Team Leader, (6) Back-up Duty Administrative Officer in consultation with a Crisis Intervention Team Member
c. Offenders in crisis watch shall not be transferred to another facility unless clinically indicated and approved by the Chief of Mental Health or in the absence of the Chief of Mental Health, the Chief of Psychiatry.
d. Upon initiation of a crisis watch, an MHP shall determine: (1) The appropriate level of supervision necessary in accordance with Paragraph II.E.; and (2) Allowable property, including the type and amount of clothing.
e. Unless medically contraindicated: (1) Water shall be available in the cell or offered at regular intervals. When water is not available in the cell, the offers shall

be documented on the DOC 0377. (2) Meals not requiring utensils shall be provided in the cell or crisis care area. If contraindicated, alternative nutrition sources shall be provided.
f. The offender's vital signs shall be taken by health care staff within 24 hours of placement on crisis watch, or sooner if the offender has been placed in restraints for mental health purposes.
g. Prior to placement in a designated crisis care area, the offender shall be strip-searched and the cell inspected for safety.
h. Offenders shall be monitored at appropriate intervals, dependent upon level of supervision. All observations shall be documented within the appropriate staggered intervals, on the Crisis Watch Observation Log, DOC 0378, and shall include staff's observation of the offender's behavior and speech, as appropriate.
i. The offender shall be evaluated by an MHP, or in his or her absence, a Crisis Intervention Team member, in consultation with the Crisis Team Leader, at least once every 24 hours. The evaluation shall assess the offender's current mental health status and response to treatment efforts. The evaluation shall be documented on the DOC 0377.
j. An offender's crisis watch shall only be terminated by an MHP following the completion of an evaluation assessing the offender's current mental health status and the offender's response to treatment efforts. The evaluation shall be documented in the offender's medical record and the termination of the crisis watch shall be documented on the DOC 0377.

Findings: IDOC is meeting the requirements of this subsection.

5) Response to Self-Inflicted Injury and Suicides
a. Responses to medical emergencies shall be in accordance with AD 04.03.108 and shall include immediate notification of an MHP.
b. In the event of attempted suicide, the preservation of the offender's life shall take precedence over preservation of the crime scene; however, any delay in response due to security factors shall be noted in the Incident Report, DOC 0434.

Findings: IDOC is meeting the requirements of this subsection

6) Quality Improvement Reviews
a. Mortality Review: In the event of an offender's suicide, the Chief of Mental Health shall designate an MHP to complete a psychological autopsy. The psychological autopsy shall be documented on the Psychological Autopsy, DOC 0375, and shall be submitted to the Chief of mental Health within seven working days of assignment.

b. Administrative Review

(1) In the event of an offender's suicide, the Chief Administrative Officer shall:

(a) Establish a clinical review team who shall systemically analyze the event. The Review Team shall consist of: i. Mental health and medical staff,

including an MHP, a psychiatrist and a registered or licensed practical nurse. Medical staff chosen for the clinical review team shall have no direct involvement in the treatment of the offender for a minimum of 12 months prior to the event. ii. A security staff supervisor. **NOTE:** Facility administrators or staff, whose performance or responsibilities maybe directly involved in the circumstances of the suicide, shall not be chosen for the review team.
(b) Designate a clinical review team Chairman who shall ensure all relevant documentation pertaining to the offender and his or her treatment including, but not limited to, the master file, medical record, Medical Director's death summary and the DOC 0375, if applicable, is available to the clinical review team.
(2) Within ten working days following the suicide, the clinical review team shall complete a review to:
(a) Ensure appropriate precautions were implemented and Department and local procedures were followed; and
(b) Determine if there were any personal, social or medical circumstances that may have contributed to the event, or if there were unrealized patterns of behavior or systems that may have indicated earlier risk.
(3) Upon completion of the review, the Chairperson shall submit a written report to the Chief Administrative Officer, the facility's Training Coordinator, the Chief of Mental Health and the respective Deputy Director summarizing the review team's findings and providing any recommended changes or improvements.

Findings: An Administrative Review and a Psychological Autopsy was conducted for the four suicides that occurred during the current reporting period. These reports are generally done well and contain a variety of recommendations regarding how to prevent future suicides. The most recent Quarterly Report lists the various ways that these recommendations are disseminated throughout the Department. As Monitor, I do not dispute that these recommendations are distributed to those in leadership who have the authority to enact the appropriate changes proposed in the Administrative Review and the Psychological Autopsy. The problem remains that these suggested changes are not routinely acted upon. The following are recommended changes to clinical practice made in Administrative Reviews and Psychological Autopsies that have not been acted upon in the current reporting period:

- "It is recommended that all psychiatric vacancies be filled."
- "It is recommended that all psychologist, QMHP, and Recreational Therapist positions be filled."
- "It is recommended that offenders who present with intellectual deficits receive psychological testing to aid in clarifying the appropriate diagnoses."
- "Insufficient out-of-cell programming hours were offered to offenders in the maximum-security (DPU) RTU setting."
- "It is encouraged that Correctional Counselors routinely attend the Multidisciplinary Treatment Team Meetings when possible."
- "The offender may have benefitted from further ADA assistance in regards to his hearing aid."

IDOC will continue to receive a rating of less than substantial compliance until it can demonstrate that it has enacted the changes to practice recommended in these post-suicide reviews.

(XVI)(b): Specific requirements: IDOC shall ensure that the policies, procedures, and record-keeping requirements identified in (a), *above*, are implemented and followed in each adult correctional facility no later than one (1) year after the approval of this Settlement Agreement.

Findings: The Department continues to fall short of its responsibilities for XVI(b).

XVII: PHYSICAL RESTRAINTS FOR MENTAL HEALTH PURPOSES

Summary: Restraints practices were consistent with those in previous reviews and largely consistent with policy. Face-to-face assessment before an order only took place in a minority of reviewed cases, however, even during clinical working hours. A few records did not reflect an attempt at less intrusive means, and should have, but overall practice has improved. Initial and extension orders were usually written within expected time limits, though there were exceptions.

Orders appropriately detailed the rationale and the criteria for release, and it was common to release patients earlier than the maximum ordered time. Timing records were incomplete, but it appears likely that at least 80% of restraints were removed by the 24-hour point and only three men were subject to very long times in restraints. Nothing came to the Monitor's attention that would suggest restraints being used as punishment.

(XVII)(a): Specific requirements: IDOC shall comply with its policies and procedures on the use of restraints, as documented in IDOC AD 04.04.103. These policies and procedures require documentation using IDOC Form 0376 ("Order for the Use of Restraints for Mental Health Purposes"). Records of restraint used on SMI offenders shall be maintained in log form at each facility and entries shall be made contemporaneously with the use of restraints.

IDOC AD 04.04.103 provides for:

II (G): Requirements

1. Restraints for mental health purposes shall be applied under medical supervision and shall only be used when other less restrictive measures have been found to be ineffective.

    a. Under no circumstances shall restraints be used as a disciplinary measure.

    b. Restraint implementation shall be applied by order of a psychiatrist, or if a psychiatrist is not available, a physician or a licensed clinical psychologist. (1) If a psychiatrist or a physician or a licensed clinical psychologist is not physically on site, a Registered Nurse (RN) may initiate implementation of restraints for mental health purposes. (2) The nurse shall then immediately make contact with the psychiatrist within one hour of the offender being placed

into restraints and obtain an order for the implementation. If the psychiatrist is not available, the nurse shall make contact with the physician or the licensed clinical psychologist.

2. Crisis treatment shall be initiated in accordance with AD 04.04.102.

   a. The initial order for the use of restraints shall not exceed four hours.

   b. Should subsequent orders become necessary, the time limit may be extended, but no subsequent order for restraint extension shall be valid for more than 16 hours beyond initial order. Documentation of the justification for extension of the restraint order shall be recorded in the offender's medical chart.

   c. If further restraint is required beyond the initial order and one extension, a new order must be issued pursuant to the requirements provide herein.

II (H): Orders for Restraints

1. Only a psychiatrist who has conducted a face to face assessment, or in the absence of a psychiatrist, a physician or licensed clinical psychologist, who has conducted a face to face assessment, may order the use of restraints for offenders in a crisis treatment supervision level of continuous watch or suicide watch when the current crisis level does not provide adequate safeguards.

2. If a psychiatrist, physician or licensed clinical psychologist is not physically on site, and the Crisis Team Member, after consultation with the on-call Crisis Team Leader or Mental Health Professional, in accordance with AD 04.04.102, has recommended the use of restraints, a RN may obtain an order from a psychiatrist or a physician or a licensed clinical psychologist via telephone.

3. The offender must be assessed, face to face by a psychiatrist, or in the absence of a psychiatrist, a physician or a licensed clinical psychologist within one hour of being placed in restraints. If a psychiatrist, or in the absence of a psychiatrist, a physician or a licensed clinical psychologist is not physically on site within the hour time limit, a RN shall conduct a face to face assessment, and present that assessment to the psychiatrist, the physician or the licensed clinical psychologist via a telephone consultation, and document accordingly in the medical chart. Verbal orders shall be confirmed, in writing, by the ordering individual within 72 hours.

4. Orders for restraints shall be documented on the Order for Use of Restraints for Mental Health Purposes, DOC 0376, and shall include: a. The events leading up to the need for restraints, including efforts or less intrusive intervention; b. The type of restraints to be utilized; c. The length of time the restraints shall be applied; d. The criteria required for the offender to be taken out of restraints (e.g. the offender is no longer agitated or combative for a minimum of one hour, etc.; and e. The offender's vital signs, checked by medical staff, at a minimum of every four hours. The frequency of vital signs checks for offenders with serious chronic health conditions may be required more frequently during the restraint period.

II (I) Implementation and Monitoring

1. Restraints shall be applied in a bed located in a crisis care area, or similar setting that is in view of staff. Immediately following the placement of an offender in restraints for mental health purposes, medical staff shall conduct an examination of the offender to ensure that: a. No injuries exist; b. Restraint equipment is not applied in a manner likely to result in injury; and c. There is no medical contraindication to maintain the offender in restraints.
2. Monitoring and documentation of visual and verbal checks of offenders in restraints for mental health purposes shall be performed as a continuous watch status or a suicide watch status in accordance with AD 04.04.102. All checks shall be documented on the Crisis Watch Observation Log, DOC 0378.
3. Two hours after application of restraints, and every two hours thereafter, an offender may be allowed to have movement of his or her limbs. Movement shall be accomplished by freeing one limb at a time from restraints and for a period of time of approximately two minutes. Movement shall only be allowed if the freeing of the limb will not pose a threat of harm to the offender being restrained, or others. Limb movement shall be documented in the offender's medical chart and by the watch officer on the DOC 0378. Denial of free movement and explanation for the denial shall be documented in the offender's medical chart by medical staff.
4. Release from restraints for short periods of time shall be permitted as soon as practical, as determined by a psychiatrist, or in the absence of a psychiatrist, a physician or clinical psychologist.
5. The amount of restraint used shall be reduced as soon as possible to the level of least restriction necessary to ensure the safety and security of the offender and staff.
6. Clothing shall be allowed to the extent that it does not interfere with the application and monitoring of restraints. The genital area of both male and females, and the breast area of females shall be covered to the extent possible while still allowing for visual observation of the restraints. Females shall not be restrained in a position where the legs are separated.
7. Restraints shall be removed upon the expiration of the order, or upon the order of a psychiatrist, or in the absence of a psychiatrist, a physician or licensed clinical psychologist, or in the absence of one of the approved aforementioned professionals being physically on site, an RN who, based upon observation of the offender's behavior and clinical condition, determines that there is no longer cause to utilize restraints. Observation of the offender's behavior and clinical condition shall be documented in the medical chart.
8. Offenders shall remain in, at minimum, close supervision status for a minimum of 24 hours after removal of restraints. Should any other crisis level or care status be utilized, justification of the care shall be documented in the offender's medical chart.
9. Documentation of the use of restraints for mental health purposes shall be submitted to the Agency Medical Director and shall include the DOC 0376 and subsequent nursing and mental health notes.
10. All events whereby the use of restraints has been issued shall be reviewed during quality improvement meetings in accordance with AD 04.03.125.

Findings: Restraints were used for mental health purposes 257 times, a monthly rate

similar to previous monitoring periods. Restraints were used in 14 IDOC institutions; unsurprisingly, this was predominantly at Dixon, Elgin, and Joliet. The use at Dixon showed a major increase, more than doubling from the numbers reported in the Monitor's Second Annual Report. Logan, Pontiac, and Stateville also showed significant use during this monitoring period.

The monitoring team previously determined that IDOC has appropriate policies governing the criteria for orders, who can issue them, and the maximum times to review them. The practices shown in restraints records reviewed during this monitoring period[44] were consistent those in previous reviews and largely consistent with policy. Face-to-face assessment was an exception. It is required unless there are no such professionals onsite; however, this only happened in a minority of reviewed cases. Professionals also are expected to attempt less intrusive means before ordering restraints; there were a few cases that did not seem to fulfill this requirement, but overall practice has improved since the last monitoring team analysis. Appropriately licensed staff wrote initial orders for four hours and always detailed the rationale. It was routine to write extension orders for no more than 16 hours. There were, however, rare exceptions to each of these timeline requirements.

There was indication of routine checks of the restraints and taking vital signs, but insufficient information in the material provided to make an assessment of this. Criteria for release were always specified and it was common, in the sampled records, to apply the criteria and release patients earlier than the maximum ordered time. During this monitoring period, times were logged less consistently, but it appears likely that at least 80% of restraints were removed by the 24-hour point, similar to the Second Annual Report finding. Only three men were subject to very long times in restraints. Two were restrained for five and six days, respectively, at Pontiac. Most disturbingly, one man was restrained for ***many months continuously*** at Stateville and now Joliet; he was discussed at length in the Second Annual Report.

Fourteen institutions were previously found in substantial compliance; no new information came to the attention of the monitoring team that would change that finding, so I consider them to remain in substantial compliance.

(XVII)(b): Specific requirement: IDOC will continue to comply with 20 Ill. Admin. Code §§ 501.30, 501.40 and 501.60, and Administrative Directive 05.01.126. The Administrative Code sections are titled Section 501.30: Resort to Force; Section 501.40: Justifiable Use of Force; and Section 501.60: General Use of Chemical Agents.

IDOC AD 05.01.126 provides for:

II (F): The Chief Administrative Officer shall ensure a written procedure for the use and control of security restraints is established. The written procedure shall provide for the following:

Use of Security Restraints

[44] The team reviewed records for 12 uses of restraints provided by IDOC from Graham, Illinois River, Lawrence, Logan, Menard, and Shawnee.

(1) Except as otherwise provided in AD 05.03.130 regarding pregnant offenders, security restraints shall be used: (a) To prevent an offender from escaping. (b) To retake an offender who has escaped. (c) To prevent or suppress violence by an offender against another person or property. (d) When transporting an offender outside the facility for the purposes of transfers, writs, etc., except when transporting offenders to assigned work details outside the facility, pregnant offenders for the purposes of delivery, or offenders assigned to the Moms and Babies Program on approved day release while transporting a minor child. (e) When transporting a transitional security offender for other than job related or programmatic activities directly related to successful completion of the transition center program.

(2) Except as otherwise provided in AD 05.03.130 regarding pregnant offenders, security restraints may be used: (a) When moving an offender who is in disciplinary segregation or who is in segregation pending investigation within the facility; or (b) Whenever the Chief Administrative Officer deems it is necessary in order to ensure security within the facility or within the community.

(3) Offenders on funeral or critical illness furlough shall be restrained in accordance with AD 05.03.127.

Inventory and Control

(a) A written master inventory of all security restraints, dated and signed by the Chief Administrative Officer, shall be maintained.

(b) All security restraints that have not been issued to staff shall be stored and maintained in a secure area or areas that are not accessible to offenders.

(c) A log documenting issuance and return of security restraints shall be maintained in a secure area or areas. The log shall include: (1) Date and time issued; (2) Receiving employees name; (3) Issuing employees name; (4) Date and time returned; and (5) Name of employee receiving the returned restraints.

(d) A written report shall be filed on lost, broken, or malfunctioning security restraints. The report shall be reviewed by the Chief of Security and maintained on file with the security restraints inventory records for no less than one year.

Findings: IDOC is fulfilling the requirements of this subsection.

(XVII)(c): Specific requirement: Physical restraints shall never be used to punish offenders on the mental health caseload.

Findings: Throughout its reviews, the monitoring team has not encountered any indications of restraints being used to punish patients. IDOC is in substantial compliance with this requirement.

(XVII)(d): Specific requirement: The provisions of this Section shall be fully implemented no later than one (1) year after the approval of this Settlement Agreement.

Findings: Compliance was not met as of the specified date

XVIII: MEDICAL RECORDS

Summary: IDOC is in substantial compliance with these provisions requiring the use of standardized forms and the transfer of records when a patient transfers. These provisions do not cover the quality of records.

(XVIII)(a): Specific requirement: In recognition of the importance of adequate records to treatment and continuity of care, no later than sixty (60) days after the approval of this Settlement Agreement, IDOC shall fully implement the use of the standardized forms it has developed to record offender mental health information and to constitute an offender's mental health file, including IDOC Forms 0372 (Mental Health Screening); 0374 (Mental Health Evaluation); 0284 (Mental Health Treatment Plan); 0282 (Mental Health Progress Note); 0387 (Mental Health Services Referral); 0380 (Mental Health Segregation Rounds); 0376 (Order for Use of Therapeutic Restraints for Mental Health Purposes); 0379 (Evaluation of Suicide Potential); 0378 (Crisis Watch Observation Log); 0377 (Crisis Watch Record); 0371 (Refusal of Mental Health Services); and 0375 (Psychological Autopsy).

Findings: IDOC has implemented the use of standardized forms throughout the life of the Settlement Agreement. Many of these forms have gone through modifications in an attempt to improve clinical care and decrease the paperwork burden of mental health staff. This requirement only speaks to the use of standardized forms and not the overall quality of the medical records. IDOC is in substantial compliance with this requirement.

(XVIII)(b): Specific requirement: No later than ninety (90) days after the approval of this Settlement Agreement, IDOC shall fully comply with Administrative Directive 04.03.100, § II(E)(7), which requires an offender's medical record, including any needed medication, to be transferred to any facility to which the offender is being transferred at the time of transfer.

AD 04.03.100, section II (E)(7): The medical record shall be transferred to the receiving facility at the time of offender movement.

(7)(a): In the event that an offender is transferred from the Illinois Department of Juvenile Justice to an IDOC facility, the entire original medical record shall be transferred with the offender. The transferring youth center may keep a copy of the medical record. Such movement shall be treated as a departmental transfer with regard to documentation.

(7)(b): The medical record and, if applicable, medication shall be sealed in a clear plastic envelope through which the offender's name and ID number can be easily identified.

(1) If the information on the DOC 0090 is not urgent in nature, the DOC 0090 shall be placed inside the front cover of the medical record.

(2) If the DOC 0090 contains urgently needed medical or medication disbursement information, the following steps shall be taken: (a) The DOC 0090 shall be folded in half to promote confidentiality and a notation of "URGENT MEDICAL INFORMATION" shall be made in bold print on the exposed (blank) side of the DOC 0090. (b) The folded DOC 0090 with the notation side up shall be enclosed on top of the medical record inside the clear plastic so that these individuals can be immediately identified and evaluated upon arrival at a new institution. (c) Prior to transferring an offender who has significant medical problems as determined by the transferring facility Medical Director, the transferring Health Care Unit Administrator or Director of Nursing shall telephone the receiving Health Care Unit Administrator or Director of Nursing to advise of the transfer.

(7)(c): A member of the receiving health care staff shall complete the Reception Screening section of the DOC 0090. The DOC 0090 shall be placed chronologically in the progress notes section of the medical record; no progress note shall be required.

Findings: IDOC is in substantial compliance with this requirement.

XIX: CONFIDENTIALITY

Summary: IDOC maintains the confidentiality of health care records.

Policies, procedures, and training are in place to support staff in keeping mental health contacts confidential as well; there have been substantial improvements over time and IDOC is largely successful in this, though there are a few troubling exceptions.

A form was implemented one year ago to improve informed consent. While useful, it is also inconsistently used in a way that can create confusion for treatment planning. The Monitor advises additional staff training to improve both informed consent and treatment planning practices.

XIX(a): Specific requirement: No later than six (6) months after the approval of this Settlement Agreement, the IDOC shall comply with the requirements of Administrative Directive 04.03.100, § II(E) (10) as to the confidentiality of mental health records.

AD 04.03.100, section II (E) (10) provides: Offender medical and mental health records are confidential. Access to medical and mental health records shall be limited to health care staff, other Department personnel and outside State and federal agencies on a need-to-know basis as determined appropriate by the Facility Privacy Officer or the Health Care Unit Administrator. All staff having access to medical records or medical information shall be required to sign a Medical Information Confidentiality Statement, DOC 0269, and a new DOC 0269 shall be signed during cycle training annually thereafter. The most recent DOC 0269 shall be retained in the staff member's training file.

Findings: IDOC is in substantial compliance with this requirement.

Specific requirement: Additionally, IDOC shall take the following steps to promote the confidential exchange of mental health information between offenders and persons providing mental health services:

XIX(b): Specific requirement: Within six (6) months after the approval of this Settlement Agreement, IDOC shall develop policies and procedures on confidentiality requiring mental health service providers, supervisory staff, and wardens to ensure that mental health consultations are conducted with sound confidentiality, including conversations between MHPs and offenders on the mental health caseload in Control Units. Training on these policies and procedures shall also be included in correctional staff training, so that all prison staff understand and respect the need for privacy in the mental health context.

Findings: IDOC modified AD 04.04.100, effective ate 6/1/17. As previously reported, this modification did not occur until over six months past the deadline. Notwithstanding this lateness, IDOC is in substantial compliance with this requirement.

(XIX)(c): Specific requirement: Confidentiality between mental health personnel and offenders receiving mental health services shall be managed and maintained as directed in the section titled "Medical/Legal Issues: 1. Confidentiality" in the IDOC Mental Health Protocol Manual (incorporated by reference into IDOC AD 04.04.101, section II (E)(2)).

This section Medical/Legal Issues: 1. Confidentiality in the IDOC Mental Health Protocol Manual provides:

> Confidentiality of the clinician-offender relationship is grounded in ethical and legal principles. It rests, in part, on the assumption that a patient will be deterred from seeking care and discussing the important matters relevant to therapy if there is not some guaranteed confidentiality in that relationship. Clinicians should clearly specify any limits of confidentiality of the offender-clinician relationship. This disclosure should occur at the onset of treatment, except in emergencies. Notwithstanding these necessary limits on confidentiality, relevant guidelines should be adhered to, to the greatest degree possible. 36
>
> Requests from outside organizations for Mental Health-related information about offenders shall be referred to the Treating Mental Health Professional. The release of any Confidential Mental Health Records must be accompanied by a consent form or release of confidential information form signed by the offender on an Authorization for Release of Offender Mental Health or Substance Abuse Treatment Information, (DOC 0240). In addition, the CAO shall be notified of this request.
>
> Offender disclosures made to a Mental Health Professional in the course of receiving Mental Health Services are considered to be confidential and privileged, with the following exceptions: Threats to physically harm self-and/or others; Threats to escape or otherwise disrupt or breach the security of the institution; Information about an identifiable minor

child or elderly/disabled person who has been the victim of physical or sexual abuse; All other information obtained by a Mental Health Professional retains its confidential status unless the offender specifically consents to its disclosure;

In addition, when confidential offender mental health information is required to be disclosed to other correctional personnel as indicated in that section, such information shall be used only in furtherance of the security of the institution, the treatment of the offender, or as otherwise required by law, and shall not otherwise be disclosed.

Findings: IDOC has demonstrated improvement in providing mental health services in a confidential setting over the course of the settlement agreement. As previously reported, all of the R&C facilities conduct their mental health screenings in a confidential manner. Additionally, a review of 14~~2~~ facilities[45] determined that the overwhelming majority of daily crisis contacts were conducted in confidential settings. Over the course of the reporting period the monitoring team noted fewer cell side contacts, which previously were an accepted method for delivering mental health services. Menard has installed glass doors/windows in the interview rooms which greatly facilitates confidentiality between the mentally ill offenders and the mental health staff.

Counsel for the plaintiffs, in an email to Chief Lindsay on April 19, 2019, reported:

"a significant problem with non-confidential treatment persists at Menard through the presence of correctional officers in the mental health treatment groups. In the North 2, even though class members are in restraints *and* inside cages that separate them from staff, officers remain in the room during mental health sessions. Groups for East and West Houses are run out of the dining hall. Correctional officers are in the room with the group, as well as in the tower. It is also common for other officers and prisoners to pass through the space during the session."

The monitoring team observed a similar issue with Pontiac crisis watch contacts occurring in cages in a hallway where officers and prisoners both pass through and stand in close proximity for extended periods. Given these serious violations of this subsection of the Settlement Agreement, IDOC will receive a rating of partial compliance. Hopefully, this situation will be immediately corrected.

(XIX)(d): Specific requirement: In addition to enforcing the consent requirements set forth in "Medical/Legal Issues: 2. Informed Consent" in the IDOC Mental Health Protocol Manual, incorporated by reference into the IDOC AD 04.04.101 section II (E)(2) within sixty (60) days after the approval of this Settlement Agreement, IDOC shall ensure that Mental Health Professionals who have a treatment/counseling relationship with the offender shall disclose the following to that offender before proceeding: the professional's position and agency; the purpose of the meeting or interaction; and the uses to which information must or may be put. The MHP shall indicate a willingness to explain the potential risks associated with the offender's disclosures.

Medical/Legal Issues: 2. Informed Consent in the IDOC Mental Health Protocol Manual provides:

[45] East Moline, Menard, Stateville-NRC, Dixon, Pontiac, Western, Vandalia, Robinson, Logan, Graham, Decatur, Vienna, Illinois River, and Danville.

> Before initiating psychotropic medication, the psychiatric provider must complete at least a brief history and Mental Status Examination to determine that the offender (a) has a basic understanding that he or she has a Mental Health Problem, (b) understands that medication is being offered to produce relief from that problem, and (c) is able to give consent to treatment. The clinician must also inform the offender about alternative treatments, the appropriate length of care, and the fact that he or she may withdraw consent at any time without compromising access to other Health Care. With the exception of Mental Health emergencies, informed consent must be obtained from the offender each time the Psychiatric Provider prescribes a new class of Psychotropic Medication.[46]

Findings: The Quarterly Report of April 23, 2019 states at the top of page 29 "The informed consent procedures (Subsection (d)) are addressed in Form 284, the mental health treatment planning form. A stand-alone confidentiality and consent form, DOC0537, was implemented in May 2018." Notwithstanding this statement, over the course of the reporting period, the monitoring team encountered numerous examples of both forms being used which contributed to two different treatment plans being created. I strongly recommend that more training be provided to all mental health staff regarding the proper use of these forms to help expedite the informed consent process. IDOC will receive a rating of partial compliance for this requirement.

XX: CHANGE OF SMI DESIGNATION

riteria of
seriou tal health
treatr al health
treatr

This metric has never been tracked by IDOC. Ongoing review of the overall number of SMI offenders coupled with the lack of complaints regarding the inappropriate removal of SMI designations suggests that no real difficulties exist concerning this requirement. As Monitor, I question if all of the mentally ill offenders who qualify for SMI designation actually receive this designation. I base this on clinical interviews of mentally ill offenders who clearly met criteria for SMI designation but did not receive this official designation.

ne above-
listed tally able
to rev eived any
complaints about offenders inappropriately losing their SMI status, IDOC will receive a rating of substantial compliance.

My opinion, however, is that not all eligible mentally ill offenders are designated as SMI. Over the reporting period the average percentage of mentally ill offenders in IDOC is approximately 42%. For male, mentally ill offenders the average is approximately 39% and for female mentally ill offenders the average is approximately 60%. Given my three years of experience monitoring the mentally ill population within IDOC, it is my opinion that the male average should be in the 50% range and the female average should be in the 65-70% range. I am well aware that this data is not pertinent to this requirement, but it is an issue that the Chief of Mental Health should seriously review.

---

[46] The Manual defines "Informed Consent": "Informed Consent is defined as consent voluntarily given by an offender, in writing, after he or she has been provided with a conscientious and sufficient explanation of the nature, consequences, risks, and alternatives of the proposed treatment." This section of the Manual also provides: "Offenders should be advised of the Limits of Confidentiality prior to their receiving any Mental Health Services." This requirement is nearly identical to the requirement discussed above regarding confidentiality, so the team does not address it again here under Informed Consent.

XXI: STAFF TRAINING

Summary: IDOC is fulfilling all of the requirements of this section of the Settlement Agreement. The Monitoring Team will not be reporting on this section moving forward unless directed by parties and/or the Court.

XXI(a): Specific requirement: Within one (1) year following the approval of the Settlement Agreement, Mental Health Administrative Staff referenced in Section XI(d) of this Settlement Agreement, IDOC shall develop a written plan and program for staff training as provided in subsection (b), *below*.

Findings: IDOC has met this requirement and will receive a rating of substantial compliance.

XXI(b): Specific requirement: Within two (2) years following the approval of this Settlement Agreement, all IDOC and vendor staff who interact with offenders shall receive training and continuing education regarding the recognition of mental and emotional disorders. As directed in the section titled "Training" in the IDOC Mental Health Protocol Manual (incorporated by reference into IDOC Administrative Directive 04.04.101, § II(E)(2)), this training shall include material designed to inform the participants about the frequency and seriousness of mental illness, and how to treat persons who have mental illness or persons manifesting symptoms of mental illness. In addition to training on confidentiality as provided in Section XXII (a), *above*, this training shall incorporate, but need not be limited to, the following areas: i) The recognition of signs and symptoms of mental and emotional disorders most frequently found in the offender population; ii) The recognition of signs of chemical dependency and the symptoms of narcotic and alcohol withdrawal; iii) The recognition of adverse reactions to psychotropic medication; iv) The recognition of signs of developmental disability, particularly intellectual disability; v) Types of potential mental health emergencies, and how to approach offenders to intervene in these crises; vi) Suicide prevention; vii) The obligation to refer offenders with mental health problems or needing mental health care; and viii) The appropriate channels for the immediate referral of an offender to mental health services for further evaluation, and the procedures governing such referrals.

Findings: IDOC was found to be in substantial compliance with this requirement on the midyear report of November 30, 2018. The Quarterly Report of April 23, 2019 provides further data supporting a continued rating of substantial compliance. This data from the Quarterly Report is consistent with the findings of the Monitoring Team over the course of the current reporting period. IDOC will continue to receive a rating of substantial compliance for this requirement.

XXI(c): Specific requirement: Within one (1) year following the approval of the Settlement Agreement, Mental Health Administrative Staff referenced in Section XI(d) of this Settlement Agreement, IDOC shall develop a written plan for the orientation, continuing education, and training of all mental health services staff.

Findings: As previously reported, IDOC has developed a written plan for the orientation, continuing education and training of all mental health services staff with the deadline of May 22, 2017.

XXII: PARTICIPATION IN PRISON PROGRAMS

Summary: IDOC is in substantial compliance with this requirement. Parties are encouraged to share with the monitoring team any additional data regarding the compliance status of this requirement.

(XXII)(a): Specific requirement: Unless contraindicated as determined by a licensed MHP, IDOC shall not bar offenders with mental illness from participation in prison programs because of their illness or because they are taking psychotropic medications. Prison programs to which mentally ill offenders may be given access and reasonable accommodations include, but are not limited to, educational programs, substance abuse programs, religious services, and work assignments. Offenders will still need to be qualified for the program, with or without reasonable accommodations consistent with the Americans with Disabilities Act and the Section 504 of the Rehabilitation Act, under the IDOC's current policies and procedures.

Findings: IDOC was found to be in substantial compliance with this requirement in the midyear report of November 30, 2018. The monitoring team did not encounter any problems with this requirement during the remainder of the current reporting period. Plaintiffs' counsel did receive one complaint from a mentally ill offender, however. This complaint involved a mentally ill offender who claimed to have been prevented from participating in a "life-skills reentry program" due to his being prescribed psychotropic medications. I am yet to receive any further documentation about the validity of this complaint. As such, IDOC will continue to be found in substantial compliance with this requirement.

XXIII: TRANSFER OF SERIOUSLY MENTALLY ILL OFFENDERS FROM FACILITY TO FACILITY

Summary: IDOC is in substantial compliance with this requirement.

XXIII(a): Specific requirement: To ensure continuity of treatment, unless a SMI offender is being transferred to another facility for clinical reasons, IDOC shall make best efforts to ensure that the offender's treating MHP is consulted prior to transfer. If such a consultation is not possible prior to transfer, the MHP shall be consulted no more than seventy-two (72) hours after effectuation of transfer. If a transfer is being made for security reasons only, the reasons for the transfer and the consultation with the offender's treating Mental Health Professional shall be documented and placed in the offender's mental health file.

Findings: IDOC is in substantial compliance with this requirement. I have personally observed mental health supervisors facilitating the transfer of mentally ill offenders and explaining at length to the treating MHP the reasons for transfer.

XXIII(b): Specific requirement: When a SMI offender is to be transferred from one prison to another, the sending institution, using the most expeditious means available, shall notify the receiving institution of such pending transfer, including any mental health treatment needs.

Findings: IDOC had received a rating of non-compliance for this requirement on the Second Annual Report. This was due to the fact that "numerous examples where the receiving facility had not been made aware of an offenders' particular mental health needs. This was also noted at Dixon in transfers between the STC and the segregation unit in the X-house. The Monitoring Team has not observed these same deficiencies during the second half of the current reporting period. IDOC will receive a rating of substantial compliance for this requirement.

XXIII(c): Specific requirement: The provisions of this section shall be fully implemented no later than one (1) year after the approval of this Settlement Agreement.

Findings: IDOC is in substantial compliance with this requirement.

XXIV: USE OF FORCE AND VERBAL ABUSE

Summary: Use of Force continues to be a contentious issue between the parties. The Monitoring Team conducted an analysis of a series of use of force incidents and found that in 9 of the 18 incidents reviewed, mental health was not called prior to OC being deployed and/or ERT performed a cell extraction. IDOC policies clearly state that "Force shall be employed only as a last resort or when other means are unavailable or inadequate…" This issue will be closely monitored during the next reporting period.

Specific requirements: IDOC agrees to abide by Administrative Directives 05.01.173 and 03.02.108(B)[47] and 20 Ill. Admin. Code § 501.30

Section 501.30 of the code, "Resort to Force," provides:

a) Force shall be employed only as a last resort or when other means are unavailable or inadequate, and only to the degree reasonably necessary to achieve a permitted purpose.
b) Use of force shall be terminated as soon as force is no longer necessary.
c) Medical screening and/or care shall be conducted following any use of force, which results in bodily injury.
d) Corporal punishment is prohibited.

AD 05.01.173, "Calculated Use of Force Cell Extractions" provides:

F. General Provisions

1. Use of force shall be terminated as soon as the need for force is no longer necessary.

[47] AD 03.02.108(B) does not appear to be the correct citation. The monitoring team believes the Settlement contemplated AD 03.02.108(I)(B).

2. Nothing in this directive shall preclude staff from immediately using force or applying restraints when an offender's behavior constitutes a threat to self, others, property, or the safety and security of the facility.

3. Restraints shall be applied in accordance with Administrative Directive 04.04.103 or 05.01.126 as appropriate.

4. Failure by the offender to comply with the orders to vacate is considered a threat to self, others, and the safety and security of the institution and may result in the use of chemical agents in accordance with Department Rule 501.70

5. Unless it is not practical or safe, cell extractions shall be video recorded from the time circumstances warrant a cell extraction until the offender is placed in the designated cell.

NOTE: Any interruption in recording, including but not limited to changing a video tape or battery shall orally be documented on the video tape.

6. Use of force cell extractions shall be performed by certified Tactical Team members as designated by the Tactical Team Commander. The Tactical Team Commander shall designate one or more members who may function as the Tactical Team Leader.

G. Equipment

1. The following equipment items shall be available to and used by Tactical Team members when conducting a calculated use of force cell extraction. a. Orange jump suits; b. Protective helmets and full-face shields; c. Knife resistant vests; d. Protective gloves; e. Restraints minimally including hand cuffs and leg irons; f. Protective convex shields; g. Batons (36-inch length by 1.5 inches in diameter of oak or hickory); h. Gas masks; i. Leather boots, purchased by the employee, a minimum of 8 inches high for ankle protection; and j. Video camera with a minimum of two batteries and a video tape.

2. Chemical agents shall be available and may be used in accordance [with] Department Rule 501.70.

501.70: Use of Chemical Agents in Cells (Consent Decree) provides:

> a) This Section applies only to the transfer of a committed person who has refused to leave his cell when so ordered. The transfer of a committed person shall be undertaken with a minimal amount of force. Only when the individual threatens bodily harm to himself, or other committed persons or correctional officers may tear gas or other chemical agents be employed to remove him.
>
> b) Prior to the use of tear gas or other chemical agents, the committed person shall be informed that such tear gas or other chemical agents will be used unless he complies with the transfer order.
>
> c) The use of tear gas or other chemical agents may be authorized only by an officer the rank of Captain or above. (For purposes of this rule, the shift supervisor or

higher authority in the Juvenile Division may authorize the use of tear gas or other chemical agents.)

d) Precautionary measures shall be taken to limit the noxious side effects of the chemical agents. In addition, the following procedures shall be followed whenever tear gas or other chemical agents are used to compel a committed person to leave his cell:

1) If circumstances allow, ventilation devices, such as windows and fans, shall be readied prior to the use of tear gas or other chemical agents. In any event, these devices shall be employed immediately after tear gas or other chemical agents are used. The purpose of this procedure is to minimize the effect of tear gas or other chemical agents upon other committed persons located in the cell house.

2) Gas masks shall be available for use by correctional officers at the time the tear gas or other chemical agent is used.

3) When a gas canister is placed inside a committed person's cell, the gas will quickly take effect and correctional officers shall enter the cell as soon as possible to remove the individual.

4) The committed person shall be instructed by the correctional officer to flush his eyes and skin exposed to the chemical agent with water. If the individual appears incapable of doing so, a member of the medical staff present shall perform this task. If no member of the medical staff is present, the correctional officer shall undertake this procedure.

e) An incident report shall be prepared immediately after the use of the chemical agent. This report shall be signed by each correctional officer involved in the transfer, who may indicate disagreement with any fact stated in the report.

f) The Chief Administrative Officer shall examine these incident reports to ensure that proper procedures were employed. Failure to follow proper procedures will result in disciplinary action.

g) Before Section 501.70 is modified, legal staff must be consulted. This Section was promulgated pursuant to Settlement litigation by order of the court. It may not be modified without approval of the court.

3. The following equipment items may be used by Tactical Team members when conducting a calculated use of force cell extraction. a. Throat protectors (cut resistant); and b. Elbow, groin, knee, and shin protectors

H. Tactical Team Structure for Calculated Use of Force Cell Extractions

The Tactical Team shall consist of six certified Tactical Team members for a single offender cell extraction and seven certified Tactical Team members for a multiple offender

cell extraction. One member of the team shall serve as the Tactical Team Leader; however, the team leader shall not be the person responsible for video recording the incident.

1. For a single offender cell extraction, the Tactical Team Commander shall designate members who shall be responsible for following functions. a. The shield person (also known as Number 1 person) shall use a shield and be the first member to enter the cell; secure the offender against the wall, bed, or floor; secure the offender's head and upper body; and orally communicate with the offender. b. Two members (also known as Number 2 and 3 persons) shall secure the offender's arms and hands and place restraints on the offender's wrists and ankles. c. A member (also known as Number 4 person) shall secure the doorway with a baton to prevent the offender from escaping, and if necessary, to assist in the application of restraints. d. A member (also known as Number 5 person) shall provide direct orders to the offender prior to the extraction; open the cell door to initiate the extraction; remain outside of the cell with a baton in the event the offender should attempt to escape from the cell; and deploy chemical agents if necessary. e. The video recording member (also known as Number 6 person) shall remain outside of the cell and video record the extraction including but not limited to: the warnings to the offender prior to the use of force; the issuance of three direct orders to vacate the cell; the notification that failure to comply constitutes a threat to self, others, and the safety and security of the institution; removal of the offender from the cell; escorting the offender for and treatment of medical care; and placement of the offender in a designated area.

2. For a multiple offender cell extraction, the Tactical Team Commander shall designate members who shall be responsible for following functions. a. The shield person (also known as Number 1 person) shall use a shield and be the first member to enter the cell; secure the first offender encountered against the wall, bed, or floor; secure the offender's head and upper body; and orally communicate with the offender. b. The assistant shield person (also known as Number 2 person) shall use a shield; secure the second offender encountered against the wall, bed, or floor; secure the offender's head and upper body; and orally communicate with the offender. c. A member (also known as Number 3 person) shall provide immediate back-up to the team member in most need of assistance by securing the offender's arms and hands and placing restraints on the offender's wrists and ankles. d. A member (also known as Number 4 person) shall provide immediate back-up to the team member with the other offender by securing the offender's arms and hands and placing restraints on the offender's wrists and ankles. e. A member (also known as Number 5 person) shall provide immediate back-up to the team members with the most combative offender by securing the offender's arms and hands for placement of restraints. f. A member (also known as Number 6 person) shall provide direct orders to the offender prior to the extraction; open the cell door to initiate the extraction; secure the doorway with a baton to prevent an offender from escaping, and if necessary, deploy chemical agents and assist in the application of restraints. g. The video recording member (also known as Number 7 person) shall remain outside of the cell and video record the extraction including but not limited to: the warnings to the offender prior to the use of force; the issuance of three direct

orders to vacate the cell; the notification that failure to comply constitutes a threat to self, others, and the safety and security of the institution; removal of the offender from the cell; escorting the offender for and treatment of medical care; and placement of the offender in a designated area.

I. Calculated Use of Force Cell Extraction Procedures

1. Once an officer has ordered an offender to move from the cell and the offender refuses, the officer shall report the refusal through the chain of command.

2. The Lieutenant or above shall again order the offender to vacate the cell. If the offender refuses, the Lieutenant or above shall report the refusal through the chain of command.

3. On site personnel shall begin video recording the offender's actions.

4. When time and circumstances permit, the Shift Commander shall obtain the approval of the Chief Administrative Officer for calculated use of force cell extractions. In all other situations, the Shift Commander or above shall approve the cell extraction.

5. If the decision is made to proceed with a cell extraction, the Shift Commander shall activate the Tactical Team.

6. The Zone Lieutenant or above shall: a. Secure the area by removing all non-involved staff and non-secured offenders; b. Ensure the video camera is present and recording the offender's actions; and c. Notify medical staff of the pending cell extraction.

7. Upon notification of a pending cell extraction, Health Care staff shall check the offender's medical file for pertinent medical information and be present in a secure area that is close to, but not in the immediate vicinity of the cell extraction.

8. Upon arrival of the Tactical Team, the Zone Lieutenant or above shall: a. Brief the Tactical Commander of pertinent information; b. Ensure the transfer of the video tape to a designated Tactical Team member to continue recording; c. Notify the Duty Administrative Officer of the incident, pending cell extraction, and other information as it becomes available; and d. Be available, if needed, but remain out of the immediate area of the cell extraction.

9. Prior to the use of force, the Tactical Team leader shall: a. Orally attempt to obtain the offender's voluntary compliance to vacate the cell or area prior to the use of force. In cells or areas with two or more offenders, each offender shall be given the opportunity to comply and be voluntarily removed. Whenever possible, offenders who comply shall be placed in restraints and removed prior to action being taken. b. Issue three direct orders for the offender to comply. c. Advise the offender that failure to comply with the orders to vacate may result in the use of chemical agents.

10. If the offender does not vacate the cell voluntarily, the Tactical Team shall remove the offender from the cell.

11. Following removal from the cell, the Tactical Team shall escort the offender to a designated area to be examined by Health Care staff.

12. Following the completion of the cell extraction including medical care, the Tactical Team member who video recorded the incident shall: a. Label the video tape with the date and location of the incident, offender name(s) and number(s), and the name of the employee who recorded the incident; b. If available, activate any security measures such as breaking the security tab on the VHS (Video Home System) video tape to prevent the video tape from being erased or recorded over; c. Tag the video tape as evidence and process it in accordance with Administrative Directive 01.12.112.

13. Unless otherwise directed to maintain longer, the video tape shall be retained in a secure area designated by the Chief Administrative Officer for three years following the date of the extraction.

14. Each employee who participated in the cell extraction or who was otherwise involved shall complete an Incident Report and other appropriate reports documenting the incident in its entirety. When necessary, the incident shall be reported in accordance with Administrative Directive 01.12.105. (AD 01.12.105 provides general instructions on the reporting of "unusual incidents.")

15. The Shift Commander shall ensure: a. A search of the involved area is completed after removal of the offender; b. The area is decontaminated if chemical agents were used; and c. Appropriate reports are completed and processed.

16. The Shift Commander or above shall debrief with the Tactical Team.

Findings: Use of force continues to be a serious issue with IDOC. As was correctly pointed out in the Quarterly report of April 23, 2019, in the midyear report of November 30, 2018, I made many serious allegations about the presence of an "informal" use of force system that exists in the Department, especially at Pontiac. The Quarterly Report then spends a great deal of energy criticizing the Monitor about the lack of evidence supporting these allegations and my lack of cooperation in following up on these allegations. In my opinion, these attacks on the monitoring process serve no helpful purpose in addressing the problems associated with the use of force within IDOC.

I met with the executive staff of IDOC on January 30, 2019 in part to clarify my position about what I saw as serious challenges regarding the use of force, especially at Pontiac. I attempted to make it clear that I wanted to point out the overall problems with use of force and was not looking for IDOC to necessarily follow up on all of my particular allegations of abuse. I left this January 30th meeting confident that IDOC and I agreed on how to proceed with this issue. So, it is disappointing that IDOC has returned to a more confrontational stance regarding this serious issue.

Plaintiffs' counsel sent a letter to the defendants' counsel on March 26, 2019 outlining some of their concerns about use of force. In particular, plaintiffs' counsel quoted several sections from 20 Ill. Admin. Code 501.30. This is one of the several controlling policies regarding the use of force in Section XXIV of the settlement agreement. In part, this policy states:

- Force shall be employed only as a last resort or when other means are unavailable or inadequate, and only to the degree reasonably necessary to achieve a permitted purpose.
- Use of Force shall be terminated as soon as force is no longer necessary.
- Medical screening and/or care shall be conducted following any use of force which results in bodily injury.
- Corporal punishment is prohibited.

Defendants' counsel responded to the plaintiffs' concerns in a four-page letter dated April 25, 2019. I will refer to this letter later in this section. To address the concerns of the plaintiffs' counsel and to evaluate IDOC's response to the requirements of this subsection, the monitoring team conducted a data-driven analysis of a sample of the use of force incidents during the reporting period. In particular, the incident reports from Pontiac, Logan, Menard and Pinckneyville for the months of January & February 2019 were reviewed. This reviewed determined that 18 use of force incidents occurred in these four facilities in January & February 2019. The results follow:

- In nine incidents, mental health staff were not called to intervene prior to OC being deployed and/or the ERT performing a forced cell extraction.
- In all the incidents use of force was terminated as soon as force was no longer necessary.
- In all cases where OC was deployed and/or the offender was injured, medical screening and/or care was conducted.
- No evidence of corporal punishment was found in these 18 incidents.

The overall assessment is that IDOC is not meeting the first requirement of "force shall be employed only as a last resort." The remainder of the requirements were met in this particular sample. This is consistent with the monitoring team's Year 2 analysis. In it, the team found tactical teams rigorously follow required procedures with 55% of reviewed activations resulting in no force. Takedowns kept the level of force to a minimum and were clearly well-handled in at least 75% of reviewed cases. The monitoring team did have some concerns about whether force was always being employed only as a last resort or when other means are unavailable or inadequate (the idea of necessary force), and only to the degree reasonably necessary (the idea of force not being excessive). About 30% of reviewed incidents demonstrated these types of problems or, more often, raised questions. Health care did follow every incident in the videos reviewed, and there was no evidence of corporal punishment in that data set either.

As noted above, defendants' counsel responded to plaintiffs' counsel's letter on April 25, 2019. This letter documented numerous efforts on the part of IDOC to address the challenges of use of force. Namely:

- Specific allegations of abuse have been forwarded to the appropriated investigative bodies
- All IDOC staff are trained in the appropriate use of force protocols. Correctional staff and mental health staff receive training specific to de-escalation.
- IDOC is in the process of implementing the use of De-escalation Response Teams (DRTs) comprised of specially trained staff who will attempt to de-escalate offenders and gain voluntary compliance.

- The Department is implementing a variety of additional changes relevant to excessive force claims such as body cameras and stationary surveillance cameras.
- At Pontiac in particular, a team consisting of internal affairs staff, medical staff, and a Shift Supervisor conduct daily wellness checks every shift to check on the wellness and physical appearance of offenders designated as SMI who have continually reported allegations of excessive force or abuse.
- When excessive force complaints are received, each complaint is investigated by IDOC staff.
- Staff are also provided training and programs for their own mental health and wellness.
- This letter ends with the statement "The Department takes any and all allegations of excessive force or staff abuse seriously and is committed to fully investigating all allegations.

Additionally, IDOC is working to prevent unnecessary force by preparing officers to deescalate situations. IDOC reports it has integrated a de-escalation course titled Verbal Judo into its pre-service security training for all incoming officers, and that all members of Crisis Intervention Teams, Hostage Negotiation Teams, and Tactical Teams have been trained, reportedly a total of more than 2,000 staff. This is part of a package of training being offered at Western, Hill, and Pontiac as well. The package also includes topics that increase understanding, such as Mental Health in Corrections and Implicit Bias, which could support decisions not to immediately use force.[48] In previous reports, I have noted the possibility that the highly stressful conditions at Pontiac may be contributing to inappropriate uses of force and I called for attention to the needs of staff. IDOC reports that it began in February offering trainings in Trauma-Informed Correctional Care and Staff Wellness, with a plan for all Pontiac staff receive these.

Finally, in previous analyses, the monitoring team found 11 institutions to be in substantial compliance on Use of Force. No contrary information has come to the monitoring team's attention, so I consider those institutions to continue to be in substantial compliance.

I wholeheartedly applaud the efforts of IDOC to address the challenges associated with use of force, especially at Pontiac, when dealing with seriously mentally ill offenders. IDOC will receive a rating of partial compliance for this subsection.

Professional Conduct

AD 03.02.108(I)(B), "Standards of Conduct" provides: The Department shall require employees to conduct themselves in a professional manner and, whether on duty or off duty, not engage in conduct that is unbecoming of a State employee or that may reflect unfavorably on or impair operations of the Department.

[48] Some courses reportedly were provided to all staff, while others were required for security and clinical staff. The monitoring team has received documents substantiating this for 68% to 100% of the reported total staff, depending on location and course.

Findings: Since the midyear report, the monitoring team has not received any reports of unprofessional conduct. However, since the reporting period covers May 23, 2018-May 22, 2019, IDOC will receive a rating of partial compliance due to the serious problems noted in the midyear report.

XXV: DISCIPLINE OF SERIOUSLY MENTALLY ILL OFFENDERS

Summary: A data-driven analysis of the disciplinary system was conducted by Dr. Kapoor. She noted continued improvement since the midyear report of November 30, 2018. Areas for improvement included improving the quality of reporting on DOC 0443, MHPs are still not conducting face-to-face assessments of SMI offenders, different standards are being applied for similar offenses at various facilities and a large number of tickets were written for medication hoarding. This last issue calls into questions the effectiveness of the medication distribution system within IDOC. Although this issue has significantly decreased, mentally ill offenders are still being written up for self-injurious behaviors.

XXV(a): Specific requirement: IDOC has implemented system-wide policies and procedures governing the disposition of disciplinary proceedings in which SMI offenders face potential segregation terms as a result of a disciplinary hearing for a major offense as defined in 20 Ill. Admin. Code section 504.50(d)(3). Those policies and procedures are contained in AD 05.12.103.

AD 05.12.103 provides:

G. Requirements

The Chief Administrative Officer of each facility that houses SMI offenders shall:

1. Establish and maintain a list of offenders identified as SMI. This list shall be made available to the Adjustment Committee upon request.

2. Ensure all members of the Adjustment Committee receive training on administration of discipline and hearing procedures.

H. Disciplinary Process

1. When an offender, who has been identified as SMI, is issued an Offender Disciplinary Report, DOC 0317, for a major offense where the disciplinary action may include segregation time:

a. The shift commander shall, within 24 hours, notify the facility's Office of Mental Health Management.

b. The facility Mental Health Authority shall assign a reviewing MHP who shall review the offender's mental health record and DOC 0317 and, within 72 hours of the original notification, provide a completed Mental Health Disciplinary Review, DOC 0443 to the hearing investigator who shall consider the report during his or her investigation in accordance with Department Rule 504. The DOC 0443 shall, at a minimum, provide:

(1) The reviewing MHP's opinion if, and in what way, the offender's mental illness contributed to the underlying behavior of the offense for which the DOC 0317 was issued.

(2) The reviewing MHP's opinion of overall appropriateness of placement in segregation status based on the offender's mental health symptoms and needs; including, potential for deterioration if placed in a segregation setting or any reason why placement in segregation status would be inadvisable, such as the offender appearing acutely psychotic or actively suicidal, a recent serious suicide attempt or the offender's need for immediate placement in a Crisis Treatment Level of Care; and

(3) Based on clinical indications, recommendations, if any, for a specific term of segregation, including no segregation time, or specific treatment during the term of segregation.

2. In accordance with Department Rule 504: Subpart A, all disciplinary hearings shall be convened within 14 days of the commission of the offense; however, if the MHP provides the offender is unable to participate due to mental health reasons, a stay of continuance shall be issued until such time the reviewing MHP determines the offender available to participate.

a. The Adjustment Committee shall take into consideration all opinions provided on the DOC 0443 and may request the reviewing MHP to appear before the committee to provide additional testimony, as needed.

b. If the MHP recommended, based on clinical indications, a specific segregation term, that no segregation time be served, or that a specific treatment during segregation is necessary, the committee shall adopt those recommendations.

c. If the Adjustment Committee disagrees with the recommendation of the reviewing MHP and recommends a more restrictive disciplinary action, the Adjustment Committee shall submit an appeal to the Chef Administrative Officer (CAO). The CAO shall:

(1) Review the recommendations of the reviewing MHP and the Adjustment Committee;

(2) Consult with the reviewing MHP regarding the appropriateness of the disciplinary action recommended by the Adjustment Committee; and

(3) Provide his or her final determination. Any deviation from MHP's recommendation shall be documented in writing on the Adjustment Committee

Summary, DOC 0319, and shall be maintained as a permanent part of the offender's disciplinary file.

d. In accordance with Department Rule 504.80, a copy of the DOC 0317 and DOC 0319 shall be forwarded to the CAO for review and final determination. If the Adjustment Committee's final disposition recommends a term of segregation, the CAO shall compare the recommendation to that of the 0443.

e. All information, including the recommendation of the reviewing MHP and disciplinary action imposed, shall be documented in the Disciplinary Tracking System.

3. No later than the last day of the month following that being reported, the Adjustment Committee shall compile and submit to the respective Deputy Director a summary of the Adjustment Committee hearing of offenders identified as SMI, who were issued a DOC 0317 for a major offense for which the disciplinary action included segregation time.

a. The summary shall include the offense for which the DOC 0317 was issued, reviewing MHP's opinions and recommendations, and outcome and disciplinary action imposed by the Adjustment Committee.

b. Any recommendations by the Deputy director to change imposed disciplinary action shall be discussed with the Chief Administrative Officer, treating and reviewing MHP, and as necessary, the Adjustment Committee. Approved adjustments shall be made accordingly.

4. A copy of the DOC 0319 shall be provided to the offender.

Findings: The Department continues to state that "This provision does not impose any obligations on IDOC."[49] As Monitor, I strongly disagree with their position. IDOC "has implemented system-wide policies and procedures governing the disposition of disciplinary proceeds in which SMI offenders face potential segregation terms as a result of a disciplinary hearing for a major offense…"[50] IDOC, however, does have the obligation to appropriately implement the disciplinary policies and procedures.

To properly monitor IDOC's obligations under XXV(a), I assigned Dr. Kapoor to conduct a review of the disciplinary process for SMI offenders, as she has throughout the life of the Settlement Agreement. Her findings are as follows:

I performed an updated review of the disciplinary process for seriously mentally ill (SMI) offenders in the Illinois Department of Corrections (IDOC). In January and February of 2019, IDOC conducted its own audit of compliance with the SMI discipline and RHU provisions of the *Rasho* Settlement Agreement. This audit found between 0% compliance (Shawnee) and 98.2% (Joliet Treatment Center) compliance with the settlement agreement, with most facilities between

[49] Quarterly Report of April 23, 2019, page 33.
[50] Ibid

70% and 95% compliant. Overall, IDOC rated its own compliance with the "Discipline/RHU" section of the settlement agreement as 70% in Jan/Feb of 2019. A wide variety of reasons for noncompliance were found, including:

- Shift commander not notifying MHP of RHU placement
- MHP not completing 0443 forms completely
- MHP not submitting the forms to the hearing officer in a timely manner
- MHP not evaluating the patient's chart and treatment plan
- MHP not completing a progress note (0282) at the time of review

Corrective action plans were developed at some IDOC facilities in order to address these deficiencies. Because I am unable to assess whether these problems have been remedied (e.g., I do not have access to the medical charts to check whether a progress note was completed, nor do I know the timeliness of submission of DOC 0443 forms), I base my conclusions in this report only on a review of the following documents:

1. IDOC Administrative Directive 05.12.103, "Administration of Discipline for Offenders Identified as Seriously Mentally Ill."

2. IDOC April 2019 Quarterly Reports re: original *Rasho* settlement agreement and court order from December 20, 2018

3. Adjustment Committee reports, Mental Health Disciplinary Review (DOC 0443), and Offender Disciplinary reports (DOC 0317) for a total of 142 disciplinary infractions adjudicated during April 2019, representing approximately 20% of incidents involving SMI offenders at the following facilities:

    1. Centralia – two incidents
    2. Danville – one incident
    3. Decatur – eight incidents
    4. Dixon – 14 incidents
    5. East Moline – two incidents
    6. Elgin – one incident
    7. Graham – one incident
    8. Hill – two incidents
    9. Illinois River – 11 incidents
    10. Jacksonville – four incidents
    11. Joliet Treatment Center – 10 incidents
    12. Lawrence – 17 incidents
    13. Logan – 13 incidents
    14. Menard – eight incidents
    15. Pinckneyville – eight incidents
    16. Pontiac – 30 incidents
    17. Shawnee – two incidents
    18. Sheridan – three incidents
    19. Stateville NRC – 12 incidents

20. Vandalia – one incident
21. Vienna – three incidents
22. Western Illinois – two incidents

Overall Findings

Overall, I see continued improvement since my last report in November 2018, particularly with regard to the individualized assessment of whether mental illness contributed to an inmate's problematic behavior. In November 2018, MHPs found that mental illness was a significant factor in just 1 out of 125 disciplinary infractions (0.8%). In April of 2019, that number rose substantially, to 18 out of 142 infractions (12.7%).

In addition to this progress, IDOC has maintained its compliance in several other areas of the Settlement Agreement:

1. Segregation is not being used as a punishment (for SMI offenders) for 300- and 400-level infractions at any IDOC facility.

2. The Adjustment Committee consistently receives input from Mental Health regarding SMI inmates. In reviewing 142 infractions, I found just one instance at Pontiac in which it was not clear that the Adjustment Committee had considered mental health's recommendations in reaching its conclusions. IDOC's internal audit revealed similar results, with just two instances in which mental health input was not sent to the hearing officer in a timely manner.

3. As was the case in my November 2018 report, I did not see any cases in which inmates received disciplinary infractions for suicide attempts, self-injury, or suicide attempts.

4. Evaluations of offenders by MHPs (as documented in the DOC 0443 forms) appeared more individualized overall and contained less "boiler plate" language and pejorative descriptions of inmates. When problematic behavior was described by MHPs, appropriately clinical and non-judgmental language was used.

5. In the vast majority of cases, the Adjustment Committee is following IDOC's policy 05.12.133, Section H.2, which states, in relevant part:

> *If the MHP recommended, based on clinical indications, a specific segregation term, that no segregation time be served, or that a specific treatment during segregation is necessary, the committee* ***shall*** *adopt those recommendations (emphasis added).*
>
> *If the Adjustment Committee disagrees with the recommendation of the reviewing MHP and recommends a more restrictive disciplinary action, the Adjustment Committee shall submit an appeal to the Chief Administrative Officer (CAO).*

In the 142 records I reviewed, the Adjustment Committee issued a sanction that was equal to or less than the Mental Health recommendation in all but four cases. All four of these cases involved staff assaults at Pontiac CC and are described in more detail below. At all other facilities, mental health's recommendations were followed consistently by the Adjustment Committee.

Areas for improvement include:

1. The quality of mental health (MH) evaluations documented on the DOC 0443 form remains variable. In many cases, the reviewing MHP did not clearly state a rationale for his/her conclusions. In other cases, the documentation is incomplete or does not support the MHP's recommendation. For example, one DOC 0443 form from Hill Correctional Center simply states:

   > *This offender has an SMI designation. He works with his therapist and psychiatrist to monitor mental health symptoms but has displayed severe affective instability.*

   The MHP then recommends 0-6 months of segregation time for an assault on an officer, even though the accompanying incident report clearly shows that the inmate exhibited affective instability at the time of the offense.

   In another example at Menard, two inmates were charged with the same offense after officers found five cans of chewing tobacco in their possession. For one inmate, the MHP recommended 0-9 months of segregation time, and a different MHP recommended 4 months of segregation time for the other inmate. No explanation for the varied recommendations was given. Additional incidents also occurred at Menard in which MHPs noted that an inmate was off his medications or on crisis watch when a ticket was issued, but they nonetheless found that the inmate "could be held accountable for his actions" without much of an explanation.

2. MHPs are still not performing face-to-face assessments of SMI offenders after they are charged with disciplinary infractions in most cases; the 0443 forms are completed based on a chart review and/or discussion amongst the mental health staff. As far as I can tell from the documentation, MHPs only at Pinckneyville (sometimes, not consistently), Shawnee, and Vienna appear to be interviewing the inmates about the circumstances of disciplinary infractions.

3. When making specific recommendations regarding segregation time, MHPs at different facilities appear to be using different standards/guidelines, if they are using any at all. For example, at some facilities the MHP's segregation recommendation was uniformly one half of the typical sanction for the offense, while at other facilities the recommendation was seemingly chosen at random. For example, in one case at Dixon, an MHP recommended segregation time of "0 to 190 days" for the offense of having contraband pills in the cell, which struck me as both random and oddly specific (why a maximum of 190 days and not 180 or 200?). In another case at Dixon, two inmates

received tickets for fighting with each other. For one inmate, the MHP recommended 0-45 days segregation, and for the other inmate, a different MHP recommended 0-3 months segregation. Nothing in the documentation explained the reason for the different recommendations (e.g., was one inmate the aggressor, did one display more symptoms, was one easily victimized?). At Joliet Treatment Center, an assault on an officer led mental health to recommend "one year and 10 days of transformation time," which is another oddly specific recommendation that was made without explanation.

As noted in my previous reports, additional training for the mental health staff across IDOC regarding how/why to recommend particular disciplinary sanctions to the Adjustment Committee may be helpful. Currently, the range of recommended sanctions is very wide, and many of the recommendations seem arbitrary.

4. There seem to be more tickets written for contraband in cells during this review period, especially for psychiatric medications or unidentified crushed pills at Dixon, Lawrence, and Illinois River. This raises some concerns about the thoroughness of nursing checks during direct-observation medication administration. During my January 2019 visit to Dixon, we discussed this concern, as a recent completed suicide had indirectly involved contraband medication, and the facility acknowledged that nursing shortages and high turnover did sometimes lead to less than thorough mouth checks.

5. MHPs at Lawrence CC seem to recommend particularly wide ranges and harsh sanctions for offenses. For example, an MHP recommended 6 months of segregation for trying to trade one pill (Effexor 75 mg), 3 months for a transgender inmate refusing housing, and "full 6 months" for having an erect penis in hand while talking to an officer. These harsh recommendations were often not followed by the Adjustment Committee, which generally reduced the sanctions into a more normal range. In addition, I noted that one inmate at Lawrence received 16 disciplinary infractions in one month, and no mention was made in the documentation of considering him for a higher level of care; he was simply given longer time in segregation. Perhaps this documentation exists elsewhere, and the inmate has been referred to JTC or another appropriate treatment facility, but I did not review it.

6. Pontiac is in a category by itself, with a much higher total number of disciplinary infractions and a disproportionately high number of them issued for public masturbation. I have never visited Pontiac, but the pattern of disciplinary infractions seems to indicate a patient population that his highly regressed, as well as an institutional culture in which mental health's input is not valued.

   For example, in 4 out of the 30 disciplinary infractions I reviewed at Pontiac, MHPs concluded that an inmate's problematic behavior was caused by a clinical decompensation and recommended no segregation time. In all four cases, the Adjustment Committee gave the inmate segregation time anyway:

   1. MH recommends no seg time → inmate given 6 months
   2. MH recommends no seg time → inmate given 1 month

3. MH recommends no seg time (inmate was on crisis watch) → given 1 month
4. MH recommends no seg time → inmate given 1 month

Notably, all four cases involved assaults on corrections officers. The Adjustment Committee did follow IDOC policy regarding appeal to the Chief Administrative Officer, and the rationale for their decision was documented in three of the four cases. Therefore, I do not think that IDOC is out of compliance with its policies or the Settlement Agreement; I flag the issue mainly as a marker of institutional culture in which mental health recommendations are being consistently overruled in cases where custody officers are injured by inmates.

Additional Requirements:

I. Observation and Follow-up

1. Observation of offenders in segregation shall be conducted in accordance with existing policies and procedures.

Findings: Weekly cell front rounds are generally being performed in segregation by BHTs.

In a letter to Chief Lindsay dated April 19, 2019, plaintiffs' counsel made a comment about the quality of the segregation rounds being conducted at Menard. They stated "BHTs are making weekly rounds in the segregation units by walking through the galleries and pausing only briefly at cell-front to ask Class Members how they are doing. When Class Members ask for help or state a need to see mental health, the BHTs simply tell them to put in a request slip and walk on. The BHTs do not engage in any real conversation, nor do they regularly take the time to look into their cells to assess their living conditions (which can be a sign of deterioration." As Monitor, I have not received any follow up from either party regarding this issue. I request that parties provide me with any additional information that would help to determine if the BHTs are truly qualified to perform this essential duty.

2. Referrals for mental health services and response to offenders with serious or urgent mental health problems, as evidenced by a sudden or rapid change in an offender's behavior or behavior that may endanger themselves or others if not treated immediately, shall be handled in accordance with AD 04.04.100.

Findings: The Department continues to struggle to meet this requirement as reflected in the number of backlogged mental health referrals. As of 5/24/19, there were 297 mental health evaluations, 185 (62%) of which were greater than 14 days late.

3. If, at any time, clinical indications suggest continued placement in segregation status poses an imminent risk of substantial deterioration to the an [sic] offender's mental health, the information shall be reviewed by the facility mental health authority.

Findings: This is not occurring. IDOC continues to tolerate the presence of severely

mentally ill offenders in its segregation units.

4. Any recommendations by the mental health authority for reduction in segregation time or termination of segregation status shall be discussed with the CAO.

Findings: The Department is meeting this requirement.

5. The CAO shall adjust the segregation term in accordance with the recommendations or, if the CAO does not agree with the recommendation of the mental health authority, he or she shall submit the issue to the respective Deputy Director for final determination.

Findings: The Department is meeting this requirement.

(XXV)(b): Specific requirement: No later than one (1) year after approval of this Settlement Agreement, IDOC, in consultation with the Monitor, shall develop and implement policies and procedures to provide that, for mentally ill offenders, (i) punishment for self-injurious behavior (*e.g.,* suicide attempts or self-mutilation) is prohibited; (ii) punishment for reporting to IDOC staff or vendor staff feelings or intentions of self-injury or suicide is prohibited; and (iii) punishment for behavior directly related to self-injurious behavior, such as destruction of state property, is prohibited unless it results in the creation of a weapon or possession of contraband.

Findings: In her report, Dr. Kapoor noted "As was the case in my November 2018 report, I did not see any cases in which inmates received disciplinary infractions for suicide attempts or self-injury. As Monitor, however, I have received reports from plaintiffs' counsel regarding discipline of class members who participate in self-injurious behaviors. One case in particular is of a mentally ill offender who received 45 days of segregation, 3 months of C grade and 6 months restriction on contact visits. Evidently, he was in a crisis cell and overdosed on medications. I request follow up from parties regarding this alleged incident.

(XXV)(c): Specific requirement: For any offender who is in RTU or inpatient treatment for serious mental illness, the disciplinary process will be carried out within a mental health treatment context and in accordance with this Section. Discipline may include loss of privileges or confinement to cell on the treatment unit for a specified period but may not entail ejecting an offender from the treatment program.

Findings: IDOC is meeting this requirement.

(XXV)(d): Specific requirement: No later than six (6) months after the approval of this Settlement Agreement, IDOC, in consultation with the Monitor and the IDOC's designated expert, shall develop and implement a pilot Behavior Treatment Program ("BTP") at Pontiac CC for SMI offenders currently subject to sanction for a serious disciplinary infraction. IDOC will review this pilot and consider implementation at other facilities.

Findings: Pontiac staff and IDOC administration report they have held weekly planning meetings for such a unit since early December 2018. In the meantime, a small Behavior Treatment Program began at Joliet in November 2018 and is treating 28 patients as of this writing.

Appropriate patients display behavioral issues and poor affect regulation; patients have transferred from Pontiac and Dixon and reportedly there is a transfer plan in place for other potential residents who have been identified.

Treatment reportedly is based on Dialectical Behavior Therapy and focuses on teaching skills and giving opportunities to practice these skills to improve behaviors and to engage in more socially appropriate behaviors. The program is set up to encourage residents to make appropriate decisions and be responsible for their choices. The four main skills of focus are mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance. There reportedly are reentry services and release planning for patients who will discharge or be paroled from this unit.

The monitoring team is told that the unit operates with the following staffing, all of which is filled except for one MHP out on family leave: 1 Educator, 2 Unit Directors, 3 MHPs, 4 BHTs, 1 Recreation Therapist, 1 RN, 8 Correctional Treatment Officers and 1 supervisor, and 1 Clinical Counselor.

This BTP is designed ultimately to serve 98 patients in two dorms. As mentioned, 28 beds are currently filled in one dorm. IDOC intends to open a second dorm in August 2019.

These steps are far short of treating the number of people needing behavior management treatment, and were taken significantly later than the Settlement Agreement deadline. However, this a critical treatment resource for IDOC, and all steps represent improvement. The Monitor urges IDOC to prioritize the scaling up of this initial effort. This would both meet essential treatment needs and help ameliorate staffing issues, as highly disproportionate staff time is spent on these patients in outpatient settings not equipped for them; properly placing these patients in a BTP would preserve precious staff time for other treatment and compliance responsibilities and could improve staff retention.

XXVI: CONTINUOUS QUALITY IMPROVEMENT PROGRAM (CQI)

Summary: IDOC is found in substantial compliance with both provisions of this section.

(XXVI)(a): Specific requirement: IDOC shall fully implement the requirements of IDOC Administrative Directive 04.03.125 (Quality Improvement Program), together with the program described in the section entitled "Mental Health Quality Assurance/Continuous Quality Improvement Program" in the IDOC Mental Health Protocol Manual (incorporated by reference into IDOC AD 04.04.101 (Eff. 8/1/2014), section II (E)(2)) and the process described in the section entitled "Peer Review Process" in the IDOC Mental Health Protocol Manual. As part of this implementation, there will be particular focus on ensuring that any deficiencies identified by the required information-gathering and committee review become the basis of further actions to improve the quality of mental health services at each facility throughout IDOC.

Findings: IDOC is in substantial compliance with the requirements of this section.

XXVI(b): Specific requirement: The statewide CQI Manager (Section XI(b), *above*) shall have the responsibility of ensuring that the steps identified in subsection (a), *above,* are taken.

Findings: IDOC is in substantial compliance with the requirements of this section.

XXVII: MONITORING

Only three specific requirements of this section will be discussed in detail.

XXVII(d): Specific requirement: Should IDOC, during the life of this Settlement Agreement, deny any request of the Monitor relating either to the budget or staff he believes are required for the monitoring, IDOC shall notify the Monitor and Plaintiffs' counsel of the denial.

Findings: I remain on the record requesting an increase in the hourly rate allocated to members of the monitoring team. I request, at a minimum, a letter from IDOC leadership explaining why the monitoring team's hourly rate has not been increased in three years.

XXVII(f)(iv): Specific requirement: The Monitor may make recommendations for modifications or improvements to IDOC operations, policies and procedures related to the provision of adequate mental health care to class members. Such recommendations should be justified with supporting data. IDOC shall accept such recommendations, propose an alternative, or reject the recommendation.

Findings: This has been occurring throughout the life of the Settlement Agreement.

XXVII(f)(v): Specific requirement: The Monitor shall strive to minimize interference with the mission of IDOC, or any other state agency involved, while at the same time having timely and complete access to all relevant files, reports, memoranda, or other documents within the control of IDOC or subject to access by IDOC; having unobstructed access during announced on-site tours and inspections to the institutions encompassed by this Settlement Agreement; having direct access to staff and to offenders; and having the authority to request private conversations with any party hereto and their counsel.

Findings: IDOC is in substantial compliance with this requirement.

XXVIII: REPORTING AND RECORDKEEPING

Summary: IDOC has consistently met this requirement.

Specific requirement: Beginning with the first full calendar quarter after the approval of the Settlement Agreement, IDOC shall submit to Plaintiffs' counsel and the Monitor, within thirty (30) days after the end of each calendar quarter during the life of this Settlement Agreement, a quarterly progress report ("quarterly report") covering each subject of the Settlement Agreement. This quarterly report shall contain the following: a progress report on the implementation of the requirements of the Settlement Agreement, including hiring progress as indicated in Section IX (d), *supra*; a description of any problems anticipated with respect to meeting the requirements of the Settlement Agreement; and any additional matters IDOC believes should be brought to the attention of the Monitor.

Findings: The Department is meeting this requirement.

CONCLUSION

Staffing remains a major impediment for the Department to achieve full compliance with the terms of the Settlement Agreement. Additionally, the Department has continued challenges in meeting the requirements involving Mental Health Evaluations and Referrals, Treatment Planning, Medication, Segregation, Confidentiality, Use of Force and Discipline. I look forward to continued cooperation from both parties as we move into year four.

Respectfully submitted,

/s/ Pablo Stewart, M.D. Dated: 5/24/19

Pablo Stewart, MD