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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	)	

SECOND ANNUAL REPORT OF MONITOR PABLO STEWART, MD

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BACKGROUND

IDOC: IDOC consists of 28 adult correctional facilities. Among these are four maximum security facilities (including a facility for women), and two women's facilities. Four of the facilities have Reception and Classification units where inmates are received into IDOC. Two of the facilities, Logan and Dixon, have Residential Treatment Units. The Joliet Treatment Center began receiving offenders on October 4, 2017 and as of May 1, 2018 has a census of 41. The RTU at Pontiac is not operating as of the submission of this report. The Amended Settlement Agreement states that the RTU at Pontiac is to open no later than July 6, 2018. 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 issues 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
- 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 36 items with deadlines on or before May 22, 2018, 15 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 Executive Summary.

Amended Settlement Agreement provision	**Timeline**	**Substantial Compliance?**
Crisis Beds are to be outside Control Units (except Pontiac)	May 2016	No
Regional Director hires	June 2016	Yes
State employee at each facility to supervise State clinical staff, monitor and approve vendor staff	June 2016	No
Architectural plans to Monitor	July 2016	Yes
12 Mental Health Forms in use	July 2016	Yes
Treating mental health professionals[1] disclose information to patient	July 2016	No
Medical Records and medication transferred with patient	August 2016	No
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	No
Propose any amendment to Staffing Plan	August 2016	No finding
Any objections to proposed amended Staffing Plan	October 2016	No finding

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

All policies/procedures/ADs specified in Settlement Agreement – drafts to Plaintiffs and Monitor	November 2016 (unless otherwise specified)	No
Confidentiality: records, mental health information, policies and training	November 2016	No
Behavior Treatment Program pilot	November 2016	No
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	No
Inmate Orientation policy and procedure	May 2017	Yes
Crisis beds at Pontiac moved to protective custody	May 2017	No
Suicide Prevention measures	May 2017	No
Physical Restraints measures	May 2017	Some institutions
Staff Training plan and program developed	May 2017	Yes
Discipline: policies related to self-injury	May 2017	No
Mental health staff Training plan and program developed	May 2017	Yes
Transfers: consults and notification	May 2017	No
Mentally ill Control Unit residents >60 days receive 12 hours out of cell time weekly	June 2017-May 2018	Some institutions
Staffing: quarterly hiring reports, meeting targets	Quarterly from October 2017 on	No
Mental health referrals and evaluations	November 2017	No
Staffing to run RTU at Joliet	November 2017	No
Central office staff hires for policies and recordkeeping	November 2017	No
RTU Programming and Office Space	January 2018	
Staffing hires – Dixon, Pontiac, Logan	January-July 2018	No
RTU Bed Space	January-October 2018	No
Inpatient Bed Space construction	January-November 2018	No
Screening conducted with sound privacy	May 2018	Yes
Training for all State and vendor staff with inmate contact	May 2018	
Mentally ill Control Unit residents >60 days receive 16 hours out of cell time weekly	June 2018-May 2019	Target date has not arrived
MHP review within 48 hours after Investigative Status/Temporary Confinement placement	July 2018	No

Inpatient Facility – transfer ownership and expand, policies	November 2018	Target date has not arrived
Mentally ill Control Unit residents >60 days receive 20 hours out of cell time weekly	June 2019-May 2020	Target date has not arrived
Segregation and Temporary Confinement for mentally ill: housing decisions, MHP review, treatment and out-of-cell requirements	May 2020	No
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	No
Inmate Orientation	Reasonable time	Yes
Treatment Plans	Reasonable time	No
Psychiatry Review frequency	Reasonable time	No
Follow-up after Specialized Treatment Settings	Reasonable time	No
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	No finding
Mental illness does not prevent access to prison programs	Reasonable time	No finding
Use of Force and Verbal Abuse	Reasonable time	Some institutions
Discipline system conforms to AD 05.12.103	Reasonable time	No
Discipline in RTU or inpatient is carried out in a mental health treatment context	Reasonable time	Yes
Quality Improvement Program implemented	Reasonable time	No

METHODOLOGY / MONITORING ACTIVITIES

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

To accomplish the monitoring obligations, the monitoring team sought information in a variety of ways. The monitoring team conducted 31 site visits to a wide range of 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 Dixon, Logan and Joliet. The Monitor personally inspected the Mental Health Unit at Pontiac on four separate occasions.

During the monitoring period, the Monitor was called as a witness by counsel for the plaintiffs during an Evidentiary Hearing before Judge Mihm and testified on December 18 and 19, 2017. He was called back to complete his testimony on February 27 and 28, 2018. During the course of the Evidentiary Hearing, the Monitor became aware that the Department and Wexford have been collecting tremendous amounts of data on a variety of subjects related to the Settlement Agreement. These sets of data include but are not limited to out-of-cell time, psychiatric and MHP backlog information and staffing levels. Of note, the monitoring team has considered data in our previous two reports to the Court. For this second annual report, however, the monitoring team has utilized this information to conduct additional data driven analyses of numerous requirements of the Settlement Agreement such as staffing, out-of-cell time and delays in assessments, treatment planning and psychiatric care.

The monitor also met with the Director and Assistant Director, as well as the Chiefs of operations, mental health, quality assurance and legal. The Monitor also met with counsel for the plaintiffs on several occasions. The Monitor received and considered reports prepared by counsel for the plaintiffs regarding IDOC's response to the Settlement Agreement, as well as receiving and considering reports prepared by counsel for the defendants. The Monitor personally reviewed numerous court filings by various class members as well as attempting to interview these individuals. Of note, over the course of the monitoring period, the various members of the monitoring team interviewed and reviewed the medical records of several hundred offenders. This number of offenders evaluated represents a sufficiently robust sample of the mental health population of the IDOC. Therefore, the opinions presented in this monitoring report are based on a substantial-sized clinical sample of offenders.

In advance of the site visits, a variety of materials were requested. These materials included policies, procedures, training materials, a variety of clinical data, internal audits and reports, inmate grievances, incident reports, various logs, and other materials. The responsiveness to the monitoring team's request for some of the data sets began to slow down during the course of this monitoring period. That is, some data was not received in a timely manner. In addition, the data when received was sometimes disorganized and difficult to interpret. It is unclear why this occurred. Other data sets improved in consistency, timeliness and quality. The monitoring team has made every effort to include the most up to date data in this report.

Monitoring began immediately following the submission of the First Annual Report on May 22, 2017. The monitoring team, once again, was purposefully kept small in consideration of the budgetary issues facing Illinois in general and IDOC in particular. The rates of compensation were also purposely kept in the low range.

The monitoring team made the following site visits during the current monitoring period:

Big Muddy River	**Danville**	**Dixon**
8/24-8/25/17 Ms. Morrison	12/14-12/15/17 Ms. Morrison	8/31-9/1/17 Dr. Kapoor 1/11-1/12/18 Dr. Kapoor

East Moline 1/23-1/24/18 Ms. Morrison	**Elgin** 4/24/18 Dr. Stewart	**Graham** 2/2/18 Dr. Stewart
Hill 9/7-9/8/17 Ms. Morrison	**Illinois River** 2/14-2/16/18 Ms. Morrison 3/6/18 Dr. Stewart	**Joliet** 6/20/17 Dr. Stewart 2/6/18 Dr. Stewart
Lawrence 10/18-10/20/17 Ms. Morrison	**Logan** 1/9-1/10/18 Dr. Kapoor 2/1/18 Dr. Stewart 3/13/18 Dr. Stewart	**Menard** 11/8-11/9/17 Dr. Kapoor
Pinckneyville 8/21-8/24/17 Ms. Morrison 10/16/17 Dr. Stewart 4/9/18 Dr. Stewart	**Pontiac** 6/19/17 Dr. Stewart, Ms. Morrison 9/11/17 Ms. Morrison 9/19/17 Dr. Stewart 12/13/17 Ms. Morrison 12/16-12/17/17 Dr. Stewart 3/20/18 Dr. Stewart 4/26-4/27/18 Ms. Morrison	**Robinson** 10/23-10/24/17 Ms. Morrison
Sheridan 9/8/17 Dr. Stewart	**Stateville and Northern Reception Center** 6/20/17 Dr. Stewart, Ms. Morrison 11/7/17 Dr. Stewart	

EXECUTIVE SUMMARY

During this current monitoring period, May 23, 2017-May 22, 2018, IDOC leadership has been generally cooperative and helpful with the work of the monitoring team. The Director and Assistant Director, as well as the Chiefs of Operations, Legal, Mental Health and Psychiatry have made themselves available to the Monitor regarding the implementation of the various requirements of the Settlement. In addition to this cooperation and availability, numerous IDOC staff members encountered during the various site visits have demonstrated a willingness for implementing the requirements of the Settlement. This was especially true of the staff at Pinckneyville, Sheridan, Illinois River, Joliet Treatment Center and Elgin.

As Monitor, I wish to make this summary brief so the reader may focus on the body of the report. On the 2nd anniversary of monitoring the Settlement Agreement, the Department is noncompliant with 18 of 25 sections and substantially compliant in only 3 sections (orientation, housing assignments and training.)[2] As is explained more fully in the body of the report, these noncompliance ratings are primarily due to inadequate staffing. This understaffing takes two forms. One is found in facilities that are understaffed based on the staffing levels of the Approved

[2] Four sections were given a rating of "no finding" due to a lack of sufficient data to arrive at a finding of substantial compliance or noncompliance.

Remedial Plan. The 2nd form of understaffing is found in those facilities that were in fact fully staffed based on the staffing levels of the Approved Remedial Plan. This second category of understaffing is based on the fact that psychiatric and mental health staff are unable to fully complete significant aspects of the Settlement Agreement. It has become painfully clear to the monitoring team over the first two years of the Settlement Agreement that the staffing levels of the Approved Remedial Plan are totally inadequate to meet the mental health and psychiatric needs of the mentally ill offender population of the Department. The only chance the Department has of ever meeting the requirements of the Settlement Agreement is to significantly augment the staffing levels called for in the Approved Remedial Plan and then fully staff all facilities.

The following areas, which will be reported in great detail in the body of the report, require immediate attention: mental health and psychiatric evaluations, treatment planning, medications and their proper distribution, transition of offenders from crisis care and segregation, moving crisis beds out of control units, enforced medications, removing mentally ill offenders from segregated housing, stopping custody staff from acting as gatekeepers to the Crisis Intervention Team, the overuse of physical restraints, medical records, the lack of confidentiality, discipline of mentally ill offenders and use of force and verbal abuse. I refer the reader to the summaries associated with each section of the Settlement Agreement for greater details of each of these areas of noncompliance.

The final area I wish to point out in this summary is the persistent evidence of physical abuse perpetrated by the custody staff at Pontiac on the mentally ill offenders housed in the mental health unit as well as other segregated housing units at Pontiac. I have personally visited Pontiac seven times over the past two years. I have never directly observed this abuse as the custody staff are too savvy to assault the mentally ill offenders in my presence. I have interviewed numerous mentally ill offenders, however, who have provided extremely credible reports of physical abuse and verbal abuse. At least one of these assaults is documented in the offender's medical record and was corroborated by mental health staff. I have recently received more first-hand information about the culture of abuse that exists at Pontiac. I am requesting that the Department conduct a full scale investigation of this abuse and report the results to the monitoring team as this is clearly a component of the Settlement Agreement. I have also received information regarding alleged incidents of custody staff intimidating mental health staff at Logan and Pontiac. I am also requesting that the results of the investigation into these incidents be provided to the monitoring team.

The monitoring team has met 100's of dedicated mental health staff, custody staff and administrators during the first two years of the Settlement Agreement. It is a shame that the Department allows the hard work and dedication of these staff to be sullied by a minority of individuals who have no business working in corrections.

A summary of compliance findings is as follows:

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

Requirement	Compliance Status
IX: ADDITIONAL MENTAL HEALTH STAFF	Overall: Noncompliance Subfindings supporting overall finding:
(IX)(a), (b)	Noncompliance
(IX)(c)	No finding
(IX)(d), (e)	Substantial compliance
(IX)(f)	Noncompliance
X: BED/TREATMENT SPACE	Overall: Noncompliance Subfindings supporting overall finding:
(X)(a),(b)(i)	Substantial compliance
(X)(b)(ii)	Target date has not arrived
(X)(c)(i)	Substantial compliance
(X)(c)(ii)	Target date has not arrived
(X)(d),(e)	Noncompliance
(X)(f)	22 institutions: Substantial Compliance; 4 Noncompliance
(X)(g)	Target date has not arrived
(X)(h)	Target date has not arrived
(X)(i)	Substantial compliance
XI: ADMINISTRATIVE STAFFING	Overall: Noncompliance Subfindings supporting overall finding:
(XI)(a)	Substantial compliance
(XI)(b),(c), (d)	Noncompliance
XII: MEDICATION	Overall: Noncompliance Subfindings supporting overall finding:
(XII)(a)	Substantial Compliance
(XII)(b)	Noncompliance
(XII)(c)(i), (ii), (iii), (iv), (v), (vi)	Noncompliance
XIII: OFFENDER ENFORCED MEDICATION	Finding: Substantial Compliance for 15 institutions Noncompliance for the remaining institutions

Requirement	Compliance Status
XIV: HOUSING ASSIGNMENTS (XIV)(a) (XIV)(b) (XIV)(c)	Overall: Substantial compliance Subfindings supporting overall finding: Substantial compliance Substantial compliance Substantial compliance
XV: SEGREGATION (XV)(a)(i) (XV)(a)(ii),(iii),(iv),(v),(vi), (vi)(sic) (XV)(a)(vii) (XV)(b)(i),(ii), (iii), (iv) (v), (vi) (XV)(c)(i) (XV)(c)(ii) (XV)(c)(iii), (iv), (XV)(c)(sic) (XV)(d)	Overall: Noncompliance Subfindings supporting overall finding: Substantial compliance Noncompliance Substantial compliance No finding Noncompliance Target date has not arrived Noncompliance Noncompliance Target date has not arrived
XVI: SUICIDE PREVENTION (XVI)(a), (b)	Overall: Noncompliance Subfindings supporting overall finding: Noncompliance
XVII: PHYSICAL RESTRAINTS FOR MENTAL HEALTH PURPOSES (XVII)(a) (XVII)(b),(c) (XVII)(d)	Overall: Noncompliance Subfindings supporting overall finding: Substantial compliance as to 14 institutions; Noncompliance as to the rest of the institutions Substantial compliance Noncompliance
XVIII: MEDICAL RECORDS (XVIII)(a)	Overall: Noncompliance Subfindings supporting overall finding: Substantial compliance

Requirement	Compliance Status
(XVIII)(b)	Noncompliance
XIX: CONFIDENTIALITY (XIX)(a) (XIX)(b) (XIX)(c),(d)	Overall: Noncompliance Subfindings supporting overall finding: No finding Noncompliance Noncompliance
XX: CHANGE OF SMI DESIGNATION	Finding: No finding
XXI: STAFF TRAINING (XXI)(a) (XXI)(b) (XXI)(c)	Overall: Substantial compliance Subfindings supporting overall finding: Substantial compliance Substantial compliance Substantial compliance
XXII: PARTICIPATION IN PRISON PROGRAMS	Finding: No finding
XXIII: TRANSFER OF SERIOUSLY MENTALLY ILL OFFENDERS FROM FACILITY TO FACILITY (XXIII)(a) (XXIII)(b),(c)	Overall: Noncompliance Subfindings supporting overall finding: Substantial compliance Noncompliance
XXIV: USE OF FORCE AND VERBAL ABUSE	Finding: Substantial compliance for 11 facilities Noncompliance for the remaining facilities
XXV: DISCIPLINE OF SERIOUSLY MENTALLY ILL OFFENDERS (XXV)(a),(b)(c)(d)	Overall: Noncompliance Subfindings supporting overall finding: Noncompliance
XXVI: CONTINUOUS QUALITY	Overall: Noncompliance

Requirement	Compliance Status
IMPROVEMENT PROGRAM (XXVI)(a), (b)	Subfindings supporting overall finding: Noncompliance
XXVII: MONITORING	Finding: no finding
XXVIII: REPORTING AND RECORDKEEPING	Finding: no finding

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/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: As discussed above, the team institutes the "Substantial Compliance" and "Non-compliance" ratings for each provision, as specified in the Settlement. In actual fact, these may mask true performance. In practice, IDOC has made limited progress on a number of requirements. These possibly could be more accurately described as "partially compliant," but by the terms of the Settlement, those provisions must be found in Non-compliance.

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, to date, I felt it more appropriate to consider system-wide compliance prior to evaluating the compliance of specific facilities. Two years of reviews have yielded enough data to assess certain practices, and specific facilities have begun to reach substantial compliance for some requirements. Most Settlement Agreement provisions are complex with many factors to fulfill, so the substantial compliance findings are few, but this is an important step forward.

IV: INITIAL (INTAKE) MENTAL HEALTH SERVICES: SCREENING

Summary: The monitoring team visited all four R&C facilities. The findings were that all R&C units were conducting screenings in a timely manner by appropriate staff in confidential settings utilizing the proper form. When records were available, they were reviewed by the screening MHPs. Problems with obtaining essential mental health records from the referring jails were present at all four R&C facilities. After two years of dealing with this problem, the Department still hasn't come up with a plan to address it. MHPs at the R&C facilities also do not have timely access to essential mental health records of those offenders who have previously been incarcerated in IDOC. Again, the Department has not come up with a solution to this issue in the first two years of the Settlement Agreement.

"Evaluations of Suicide Potential" were being properly administered to offenders transferred from an R&C facilities, including offenders transferred back to NRC on writs.

Policies and Procedures have been developed to ensure that an offender who has a current prescription for psychotropic medication is able to continue the medication without interruption. This was generally being accomplished but problems were noted in the timely continuation of medications. Problems also existed, however, in the timely follow up by psychiatric providers as well as the changing of offenders' medications without sufficient explanation.

(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: The monitoring team visited all four of IDOC's reception centers during this reporting period. This requirement was being met at all four of IDOC's reception centers (Northern Reception Center [NRC], Logan, Menard and Graham.) For example, incoming offenders were screened upon arrival at Graham. 16 of 17 offenders reviewed had their screening accomplished within the 24-48 hours requirement at the NRC.

(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: All of the reception centers were fulfilling this requirement. At the NRC, for example, 17 of 17 screenings reviewed confirmed that IDOC Form 0372 was being used and that the screenings were conducted by MHPs or unlicensed staff that were being supervised by licensed MHPs.

(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 reviewed this requirement at the facilities inspected during this reporting period. This requirement was being met at all of the inspected facilities. Staff consistently spoke of this practice being routine. In the monitoring team's chart reviews, the Evaluation of Suicide Potential was completed within one day for at least 64 new arrivals and only one appeared to have been missed.[4] There were a few notable exceptions at Pontiac, but overall, this requirement is being met.

(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: All of the reception centers were conducting mental health screenings in spaces that ensured sound confidentiality.

(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

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

[4] The team recorded new arrival information as it was discovered among random chart samples in different levels of care. The team did not cross-reference lists of arrivals to verify that these evaluations were present in every case.

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. AD 04.04.101, effective date 5/1/2016 (Mental Health Non-Emergency Services), states in section II(F)(1)(a) "The Chief of Mental Health Shall: Develop and Maintain a Mental Health Standard Operating Procedural (SOP) Manual." Page 78 of the SOP Manual under the section, Psychotropic Medication, states "for those offenders who arrive at an IDOC facility on a verifiable, prescribed psychotropic medication, the psychotropic medication shall be continued (bridged) for up to 30 days or until such time as a psychiatric provider can evaluate the inmate for ongoing psychotropic medication. This evaluation may be no more than 30 days from arrival into an IDOC facility."

Throughout the monitoring period, however, the reception centers have not been able to consistently meet the requirements of this subsection. That is, bridge orders are inconsistently written for those offenders who arrive with a verifiable prescription. At NRC, delays of three weeks and a delay of two months were noted in initiating the bridge orders. Similar delays in initiating bridge orders were noted at Graham. Dr. Kapoor noted that at Menard psychotropic medications orders were consistently ordered for offenders who entered the facility with a verifiable prescription for psychotropic medications.

An especially difficult problem was noted at the Logan R&C. R&C staff reports that offenders frequently arrive from county jails without adequate medical records. This includes absence of essential information such as current medications. When this occurs, staff is responsible for calling the jail and requesting information, which sometimes can take several days to arrive. The warden and the psych administrator were alerted to this problem and stated that they will follow up with the county jails to ensure continuity of care.

Another significant problem is that these offenders whose medications are bridged at reception centers do not routinely see a psychiatric provider within the 30-day window called for in this subsection. These delays are noted to be several weeks to several months.

Once offenders transfer *within* IDOC, however, medication continuity was excellent. In a monitoring team study of patients under psychiatric care at eight institutions,[5] 66 patients arrived at a monitored institution during 2017 or 2018, and 95% of them received their psychotropic medication within one day. Psychiatrists or other physicians did write 30-day bridge orders and a majority of new arrivals were seen within that time. Indeed, 36% were seen sooner, a better practice for patients who are unknown to the staff. With 23% of new arrivals, however, it took longer to meet with psychiatry, up to five months. Problematic examples occurred at most institutions monitored and were most often seen at Danville. Big Muddy River had good practice with no delayed cases noted.

As the continuation of medications is such an important issue, the Department will continue to receive a noncompliance rating until the above-mentioned problems are addressed.

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[5] Big Muddy River, Danville, East Moline, Hill, Illinois River, Lawrence, Pinckneyville, Robinson. Whenever a study is described in this report as occurring at eight institutions, it refers to this group of facilities.

(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: Overall, this requirement is generally being met throughout the Department. The monitoring team, however, encountered several significant problems with this requirement during the reporting period. At NRC, there were numerous examples where the offenders' medications had been changed by the prescribers. In none of these cases were the reason(s) for the changes documented in the medical record. There was also no documentation that the prescribers discussed with the offenders the reason for these changes, what the new medication was expected to do, what alternative treatments were available and what, in general, are the side effects of the new medication. At Menard, the documentation of the psychiatric contacts was noted to be especially poor, with no clinical rationale for the psychiatrist's treatment decisions documented.

(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).

Findings: As previously reported, the reviewed screenings generally address the topic areas outlined in this section, however, the mental status examinations documented on IDOC Form 0372 continue to be inadequately completed. That is, descriptions of the offenders' mental status are often very terse with phrases such as "okay" or "I'm fine." It is critically important to adequately document an offenders' mental status as it is the basis of diagnostic and treatment decisions. Also, of note, is the overall poor quality of the medical records at NRC, Menard and Graham, making it difficult to follow the clinical course of an offender.

Specific requirement: The screening process shall also include review of the records, which accompany the offender.

Findings: There remains significant problems with offenders' records:

- Not all offenders coming from county jails are accompanied by their medical/mental health records. For those offenders who are accompanied by medical/mental health records, staff routinely reviews them. There are, however, a significant number of offenders who arrive at the reception centers from county jails without records. The staff is at a tremendous disadvantage in the absence of these records. They must rely on self-reporting which routinely results in delays in continuing previously prescribed medication, both psychiatric and non-psychiatric. These delays can be clinically dangerous to the offenders.
- Another serious problem concerns offenders who have previously received psychiatric care

within IDOC. There is currently no mechanism for reception center staff to retrieve these records in a timely manner. Again, this puts reception center staff at a disadvantage and the offenders at risk of harm.

- Of note, both of these problems have been reported to IDOC for at least a year. The monitoring team is not aware of any progress being made to address these significant problems. The Quarterly Report of April 25, 2018 states on page 3 “However, if records do not accompany offenders, the Department does not have the authority to mandate that jails provide mental health records and the Agreement does not require it.” The Monitor is well aware that the Department cannot “mandate” jails to provide this records. The Department could easily coordinate with county jails to have mental health records accompany the offender to the R&C center, which would greatly reduce their risk of harm.
- It is notable that this quarterly report is silent on obtaining the records of offenders who have previously spent time in IDOC. The Department absolutely has control of these records.

This subsection of the Settlement Agreement will be found to be in noncompliance until such time as the Department develops a system where previous treatment records of offenders arriving at an R&C center are available at the time of mental health screening.

V: MENTAL HEALTH EVALUATION AND REFERRALS

Summary: Mental health evaluations are not being conducted in a timely manner in IDOC as reflected by the backlog of 495 mental health evaluations as of May 18, 2018. Of note, Western’s backlog is 174 and Graham, an R&C facility, has a backlog of 109. This is obviously a significant problem that the Department has not been able to remedy during the first two years of the Settlement Agreement.

The Department does have the required policies and procedures detailing the manner in which referrals and evaluations are to be conducted. As noted above, the Department is not able to meet the requirement of completing a mental health evaluation within 14-days of referral.

As reported extensively in the first two monitoring reports, there remains credible evidence to show that custody staff continue to act as “gate keepers” to the Crisis Intervention Teams. This is a very serious problem that demands immediate attention from IDOC leadership.

(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’s Quarterly report of April 25, 2018 states “All items in subsection (a) through (j) are in place and are currently being implemented.” Regarding subsection (a), nothing could be further from the truth. The Wexford-produced backlog data, reporting on the week of

May 18, 2018, documents that there is a total of 495 Mental Health Evaluations that are anywhere from 1 to 60 days backlogged. Please note, a backlog of one day reflects that the wait time for a mental health evaluation has already been 15 days. The facilities where the backlogs are occurring: Western (174), Graham (109), Lawrence (53), Pinckneyville (23), Menard (30), Hill (26), Pontiac (27), Dixon (2), Illinois River (35), Centralia (8), Logan (4), Danville (2), Big Muddy (1) and Vienna (1). The Department has not made any progress in reducing this backlog over the reporting period as the backlog has actually increased. The reported backlog for mental health evaluations for the week ending May 26, 2017 was 404.

Similarly, in an analysis of 76 relevant patients' health care records,[6] the monitoring team found 70% had timely evaluations. While the late evaluations were generally completed one to two weeks later, a few took two to four months to complete or appear to have been missed altogether. East Moline had an impressive 100% compliance on this requirement in this sample. Hill and Lawrence had the furthest to go; Lawrence's systems were more-timely in providing evaluations to men who transferred straight to Segregation than to those transferring into general population.

(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 found that referrals are being made by staff utilizing the proper forms as well as by self-referral by the offender. As one indication, when reviewing the health care records of 176 patients, the monitoring team noted more than 225 referrals. These were made among mental health staff; after Segregation rounds; by custody, medical, and other staff; by families and cellmates; and by self-referral. MHPs at many institutions noted that receiving staff referrals, including from custody staff, has become commonplace, and that some custody staff alert them to unusual behavior or other signs of mental health decline, not solely suicidality. While not all custody staff have adopted these practices, these are important steps forward.

(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

[6] In a sample of 176 records drawn from eight institutions, 76 patients had arrived at the reviewed institutions in 2017 or 2018 and had not recently been evaluated at a reception center.

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:
(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, the Department has an Administrative Directive (04.04.100), effective date of 6/1/2017, which has been approved by the Monitor and addresses the requirements of this subsection of the Settlement. The Administrative Directive received wide distribution within the Department with a memo that reinforced the requirements contained therein and instructed all wardens to have the requirements read at roll call repeatedly. As each institution is responsible for establishing these procedures, the monitoring team has reviewed relevant Institutional Directives. Performance looks strong, with more than half of the institutions to date having demonstrated they have Institutional Directives carrying forward all of these provisions; the team will continue its review in the upcoming monitoring period.

As noted in other sections of this report, staff and self-referral procedures are clearly in use in all institutions where the monitoring team has inquired. There were a few examples in health care records or logs of referrals demonstrating that staff also accept and respond to referrals from offenders' families, others outside the prisons, or offenders on behalf of each other. In monitoring team interviews of mailroom and Visiting staff, some spoke knowledgeably and gave examples of referrals they had made, while others seemed unaware of the procedures or their role. The monitoring team has verified that information for outside sources to make referrals is on the IDOC website.

(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: As reported in the midyear report, this requirement is not being met throughout the Department. For example, due to the large volume of mentally ill offenders processed by NRC,

only those offenders who have previously been designated SMI receive a mental health referral and evaluation.

(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 stated in V(c) above, the Monitor approved Administrative Directive 04.04.100, effective date of 6/1/2017, outlines how other offenders and/or family members may refer an offender for a mental health evaluation and this is carried forward in nearly all of the Institutional Directives reviewed to date. The policy is reflected in offender handbooks and the IDOC website. While examples of such referrals were few, the team did encounter such referrals on facility logs and in health care records, and staff described a few examples during interviews. The monitoring team did not review record keeping mechanisms during this monitoring period.

(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 stated in V(a) and V(d) above, this requirement is not being met for initial evaluations. Of note, the average weekly backlog for mental health evaluations between 3/16-5/4/18 has been 421. This means that over this seven-week period, an average of 421 offenders per week who have been referred for a mental health evaluation have had to wait longer than the 14-day requirement.

MHP response to referrals for routine mental health services in mainline institutions appeared much better than the evaluation timelines. The monitoring team analyzed referrals present in the health care records of 176 patients across eight institutions.[7] MHP notes in those records reflected responses to referrals from other mental health staff, Segregation rounds, custody staff, medical, other staff, families, other offenders, and by self-referral. Of the 144 referrals answered by MHPs, 94% were timely.[8] A handful of exceptions took three to six weeks for response, or seem to have been missed, but these were rare. This 94% rate of timely mental health evaluations is curious given that the backlog numbers for the institutions in question were 140 for the week of May 18, 2018. This finding calls into question the accuracy of the data reported by Wexford.

(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 04.04.100 has been updated, with the approval of the Monitor since the original Settlement Agreement was filed with the Court on January 21, 2016. The pertinent section of AD 04.04.100 which applies to this requirement is II (G)(4)(b)(3). It states “The facility Crisis

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[7] This sample was drawn from records at Big Muddy River, Danville, East Moline, Hill, Illinois River, Lawrence, Pinckneyville, and Robinson.

[8] These included first responses to noncompliance referrals, as provided in policy. The analysis did NOT include calls expressly labeled as seeking a Crisis Intervention member; those are analyzed separately.

Intervention Team **shall** (emphasis added) be contacted immediately for offenders with serious or urgent mental health problems, as evidenced by a sudden or rapid change in an offender's behavior that may endanger themselves, if not treated immediately."

The monitoring team has received complaints from plaintiffs' counsel and from numerous offenders at a variety of facilities that custody staff act as gatekeepers for the Crisis Intervention Team. These complaints have been present throughout the duration of the Settlement Agreement. The Monitor met with the Director on November 10, 2016 to discuss this issue. The Director assured the Monitor at that time that he considered this to be a very serious issue and that he would speak to his wardens. The situation improved immediately. Since that intervention by the Director, however, these complaints of gate keeping have steadily increased. The Crisis Intervention Team plays an exceedingly important role in the mental health care delivery system. Due to a combination of staffing shortages and the tremendous workload shouldered by the MHPs, the Crisis Intervention Team often is the only way for mentally ill offenders to speak with a clinician. Numerous mentally ill offenders have informed the monitoring team that they have to threaten to harm themselves in order to be seen by the Crisis Intervention Team. This situation requires immediate attention by IDOC leadership staff.

(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).

Findings: IDOC Form 0374 is routinely used by mental health staff to record the results of a mental health evaluation at all of the facilities monitored.

(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: This requirement is being met at all of the facilities monitored.

(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: The deadline for fully implementing the requirements of this section of the Settlement Agreement was November 22, 2017. As noted above, IDOC has not been able to fulfill the requirements of this section as reflected by the tremendous number of backlogged mental health evaluations (assuming the data is accurate.)

VI: MENTAL HEALTH SERVICES ORIENTATION

Summary: As previously reported, IDOC continues to fulfill the requirements of this section of the Settlement. The required policy has been in place since at least 2013. Each facility has produced its own orientation manual which satisfy this requirement. A comprehensive orientation program was present at each facility monitored.

(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 does not utilize a department-wide orientation manual. Each facility has produced its own orientation manual. The Monitor has previously reviewed the orientation manual from each facility and found them to fulfill the requirements of this section.

(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: AD 04.01.105, Facility Orientation, effective 7/1/13, governs facility orientation. This AD states "The Department shall establish a comprehensive orientation program for incoming offenders at all correctional facilities that shall include the distribution of an orientation manual prepared in a format consistent throughout the Department." A comprehensive orientation was present at each facility monitored.

VII: TREATMENT PLAN AND CONTINUING REVIEW

Summary: Treatment plans are generally not being prepared collectively in the Department. The only facility that has accomplished this throughout the reporting period is the STC at Dixon. Joliet, Logan and Illinois River began this in February 2018; Elgin, the inpatient facility has done this since its opening in April 2018.

As of May 18, 2018, there was a backlog of 484 treatment plans in the Department.

The Monitor has encouraged the Department to rethink its approach to treatment planning throughout the first 18 months of the Settlement Agreement due to the overall poor quality of the treatment planning process. The Department's response was to modify the treatment planning document, 0284, which the Monitor approved for use starting February 1, 2018. It is too early to determine if this new form will help the Department satisfy the treatment planning requirements of the Settlement Agreement.

In a review of mentally ill offenders at the outpatient level of care, the monitoring team found that 92% had a treatment plan within the year preceding the review. This compares with only 15-30% of mentally ill offenders assigned to segregation having their treatment plans reviewed and updated per the requirements of the Settlement Agreement.

Prior to February 1, 2018, 100% of the mentally ill offenders assigned to crisis care did not have their treatment plans reviewed and updated upon entrance and weekly thereafter. In response to this glaring deficiency, the Department developed a treatment planning document for use during an offender's stay on crisis care. This form was approved by the Monitor and implemented February 1, 2018. Again, it is too early to determine if this new form will meet the requirements of the Settlement Agreement. Problems were noted, however, in incorporating this crisis care plan into the offender's overall treatment plan when discharged from crisis care.

Finally, the Department is not meeting its requirements regarding the frequency of psychiatric follow ups. This is reflected in the psychiatric backlog data. As of May 18, 2018, there was a backlog of 1209 psychiatric evaluations and follow ups throughout the Department.

(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: This subsection of the Settlement Agreement continues to be problematic for IDOC. It remains the interpretation of the monitoring team that "such plans will be prepared collectively by the offender's treating mental health team" means that all mental health staff involved in an offender's care will meet together at the same time to discuss the offender's case and collaboratively prepare the treatment plan. This is not occurring in almost any facility in the Department.

One of the reasons that IDOC has been unable to meet this requirement is lack of a sufficient number of qualified mental health staff. As will be discussed in greater detail in Section IX, the first two years of the Settlement Agreement have demonstrated that the staffing levels of the Approved Remedial Plan are inadequate to address the needs of the mentally ill population of IDOC. It is my firm opinion that the requirements of the Settlement Agreement, including the issue of Treatment Planning, cannot be met with the staffing levels set by the Approved Remedial Plan.

The facilities where treatment planning is accomplished collectively include Logan[9], Joliet and Illinois River. They only began doing this, however, in February 2018. The inpatient facility at Elgin, which opened on April 2, 2018, prepares treatment plans collectively by the offender's treating mental health team. Finally, the STC RTU unit at Dixon has been collectively preparing treatment plans since January 2017. At Lawrence and Illinois River, all disciplines confer in a

[9] Logan has been conducting multi-disciplinary treatment plan meetings with offenders in RTU and inpatient level of care, but not for those offenders in outpatient since December 2016.

daily meeting about crisis watch and other key cases. Here and in other institutions, there are occasional chart notes indicating that an MHP and a psychiatrist have conferred about the patient's treatment needs. At Lawrence, staff have instituted a 30 minute per line case consultation time for psychiatrists and MHPs, and the psychiatric physician's assistant and psychiatrist confer weekly. These measures are useful toward coordinating care, though they are not a substitute for full treatment planning on the whole caseload.

The remainder of the facilities prepare their treatment plans in much more haphazard fashions. One example is that the MHP will prepare a treatment plan independently and then the other members of the treatment team will sign the plan at a later date. Another method observed is that a given mentally ill offender will have two treatment plans in his record. One plan has been prepared by the MHP and another plan prepared by the psychiatric provider. The monitoring team has observed that these plans often have inconsistent diagnoses and differing approaches to patient care.

In a review of 135 general population health care records, 92% had treatment plans within the year preceding the review. The few that seemed to be missing any treatment plans were at Big Muddy River, Hill, and Illinois River. However, this review was concentrated at eight institutions; equally important is the fact that as of the week of May 18, 2018, there were a total of 484 treatment plans that were backlogged across the Department. Regardless of how one interprets the term "collectively", this backlog of 484 treatment plans results in a non-compliance finding for this subsection of the Settlement Agreement.

(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: The Monitor has been encouraging IDOC to modify Form 0284 throughout the duration of the monitoring process. This was due in part to the fact that Form 0284 in its original structure was very long, cumbersome and did not facilitate the provision of mental health care to the mentally ill offender population. The Monitor approved a modification to Form 0284 effective February 1, 2018. It was the Monitor's hope that this modified treatment planning document would better facilitate the delivery of mental health services. Of note, the Monitor made it very clear that this modified treatment planning form did not absolve the Department of its responsibility to prepare the treatment planning form "collectively by the offender's treating mental health team." The monitoring team has reviewed numerous files in which the new form was being utilized. The new form is a slight improvement over the previous one. It is too early to arrive at any more definitive opinions on the utility of this new form and whether it results in improved mental health services for the mentally ill offender population of IDOC.

It is also too early to determine if this new form will satisfy the requirements of this subsection of the Settlement Agreement. That is, does it include treatment goals, frequency and duration of intervention/treatment activities, and staff responsible for treatment activities. The monitoring team will continue to review offender records in order to better evaluate this new form's effectiveness in addressing these treatment planning requirements.

The majority of the team's monitoring preceded the implementation of the new form. The original IDOC Form 0284 has been in use throughout most of the monitoring period. The vast majority of these treatment plans were boilerplate in nature with little reference to the patient's particular issues or interventions tailored to addressing them. For example, in an analysis of 135 general population health care records, across eight institutions, only 12% of the treatment plans were tailored to the patient. The same issue was present in Segregation settings and in the other facilities that the team monitored.

(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: Previous reviews of this issue by the monitoring team has determined that the overwhelming majority of outpatients have a treatment plan. The poor quality of these plans is addressed in other sections. In a review of 135 general population health care records, there were few who had reached the point where an annual update would be due; those 13 patients all had updated treatment plans, and 10 of them were timely. However, more than 30% of the patients had updated plans in the interim, suggesting that staff thought it was clinically indicated.

Prior to February 1, 2018, treatment plans were not reviewed and updated when an offender had a level of care change, including going in and out of crisis care, as discussed in the next section. As discussed below, treatment plans were updated on Segregation placement in only 30% of the placements reviewed.

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: Prior to February 1, 2018, treatment plans were not reviewed and updated upon entrance to crisis care and thereafter once weekly, or more frequently if clinically indicated, and upon discharge. In fact, there was a complete absence of treatment planning for mentally ill offenders going into crisis care. Lawrence was an exception; in 88% of the 40 crisis watch admissions the monitoring team reviewed, a treatment plan form was completed, but the content was generic enough that it did not constitute a change in plan. In a review of 86 crisis watch records across seven other institutions, there were treatment plans in only five of these placements. Treatment plan updates after discharge were similarly rare, even after lengthy or repeated crisis watches in which one would want to address the drivers. None of these eight institutions updated the treatment plans weekly or upon discharge.

In response to the Monitor's concerns about this lack of treatment planning, the Department developed a treatment planning form for use while an offender was in crisis care. This form was approved by the Monitor and implemented on February 1, 2018. It is too early to arrive at any definitive opinions about the use of this new treatment planning form. Its use has improved the treatment of mentally ill offenders on crisis in those cases reviewed by the monitoring team. The overall utility of this form is yet to be determined. That is, when the offender is discharged from crisis care it is not clear how this new treatment plan will be incorporate into the offender's overall

care. More clinical experience with this new crisis treatment planning form is needed before a final opinion can be reached regarding its usefulness.

The inpatient psychiatric unit at Elgin opened on April 2, 2018 with five patients. A review of these five patients on April 24, 2018 revealed that the treatment planning requirement on admission is being met. The majority of mentally ill offenders who carry the "inpatient" level of care designation is not housed at Elgin. This cohort was not monitored for their frequency of treatment planning for this report.

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: The newly opened RTU at the Joliet Treatment Center is meeting this requirement. Dr. Kapoor noted that the RTU at Logan and the STC RTU at Dixon are meeting this requirement, but in the X-House at Dixon, treatment plans are completed sporadically and without input of a multidisciplinary team.

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: In the monitoring team's analysis of 123 placements, 15% showed a treatment plan update within one week. IDOC indicated that its internal audit found a much higher compliance rate.[10] Another 15% did update the treatment plan, but it was untimely.

Among the subset clearly in Segregation long enough to require monthly updates,[11] staff did update these plans each month in 73% of the placements, and another handful had updated plans in some months but not others.

This requirement is not consistently being met anywhere in IDOC. The lack of an adequate number of mental health staff is the reason that this requirement is not being met. The monitoring team has conducted 31 facility visits during this reporting period. At each of these facilities the staff reported that if they performed the requirements of this subsection of the Settlement Agreement then they would have to omit performing another requirement. As will be explained in Section IX, the Authorized Remedial Plan does not allow for enough staff to meet the requirements of the Settlement Agreement.

(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:

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[10] In IDOC's April 2018 quarterly report, it cited a *February* 2018 audit; it appears this may be different from the March 2018 audit cited elsewhere. It is unclear how many Segregation charts were included in the February 2018 audit. The audit found only one case to be noncompliant in updating the treatment plan within one week. No findings were reported as to monthly treatment plan updates.

[11] This totaled 30 placements in the monitoring team's sample.

(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.

Findings: This requirement is not consistently being met in the majority of IDOC facilities. This is due in large part to the chronic understaffing of psychiatric providers as demonstrated by the following backlog data:

- As of the week of 5/18/18, there was a total backlog of 1209 psychiatric visits
  - 16 face-face evaluations
  - 505 face-face follow ups
  - 11 telepsych evaluations
  - 677 telepsych follow ups
- At the time of the midyear report, November 3, 2017, there were a total backlog of 2106 psychiatric visits
  - 100 face-face evaluations
  - 928 face-face follow ups
  - 153 telepsych evaluations
  - 925 telepsych follow ups
- At the beginning of the reporting period, May 26, 2017 there were a total backlog of 3397
  - 195 face-face evaluations
  - 1117 face-face follow ups
  - 228 telepsych evaluations
  - 1857 telepsych follow ups

Regarding the subsections (i)-(iii):

(i): For mentally ill offenders at the outpatient level of care, psychiatric visits routinely exceeded this 30-day threshold. This occurred in the absence of any documentation of stability. For more on this issue, please see XII(b), below.

(ii): This requirement was being met for offenders at the RTU level of care at the STC at Dixon and the Joliet Treatment Center but not at the RTU at Logan. The problems encountered at Logan were due in large part to an inadequate number of psychiatric providers.

(iii): The mentally ill offenders designated as "inpatient" level of care were generally evaluated by psychiatric providers at least every 30 days. The actual inpatients at Elgin hadn't

been there for 30 days at the time of the monitoring visit. A discussion with the attending psychiatrist, Dr. Zarif, confirmed that all of the inpatients will be evaluated much more frequently than every 30 days.

In a review of 176 mentally ill offenders across eight institutions only 47% of responses by psychiatric providers were timely and the late responses were generally much later. While the majority of late responses took three weeks to two months, it was not uncommon for them to take longer or for the referral to receive no response at all.[12] This was particularly troubling in the significant minority where the patient had discontinued medication but was asking to resume it. All reviewed institutions had examples of good practice; the patterns of problematic practice were found more often at Pinckneyville, Danville, Hill, and Big Muddy River.

A review of the psychiatric backlog data for the reporting period demonstrates that the psychiatric backlog has been partially reduced by the use of telepsychiatry. In my letter to Dr. Hinton of October 1, 2017, I described how the Department was in an emergency due to its lack of psychiatric services for the mentally ill offender population. I went on to state that "telepsychiatry can play a role in addressing this emergency." I also listed eight concerns that I had about the use of telepsychiatry. To date, Dr. Hinton has not acknowledged receipt of this letter. This lack of acknowledgement is especially troubling in that on October 2, 2017 Dr. Hinton rolled out a plan to reduce the huge psychiatric backlog. His plan included an increased use of telepsychiatry. During the recent evidentiary hearing, Dr. Hinton reaffirmed the increased use of telepsychiatry within the Department. During this same hearing I stressed the need for the Department to develop an evidence-based protocol for the use of telepsychiatry. Finally, in a letter to Dr. Hinton on March 3, 2018, I posed the following questions:

- "Please send me the current protocols, with references, that staff follows when providing psychiatric care vis telepsychiatry;
- Please send me the actual percentage of time that IDOC utilizes telepsychiatry versus face-face care;
- In addition to this data, please send me a breakdown, by facility, of FTE's of onsite psychiatric providers versus tele-psychiatric providers."

Although Dr. Hinton acknowledged receipt of this letter, he is yet to respond to my questions. Based on this lack of an approved evidence-based protocol, I call into serious question the use of telepsychiatry within the Department. IDOC will receive a rating of noncompliance in all requirements involving the use of telepsychiatry until such time that an evidence-based protocol for the use of telepsychiatry is submitted to the Monitor for approval.

(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.

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[12] Specifically, in this sample, there were 99 staff or self-referrals to psychiatrists. Where multiple referrals were made before a response, this was counted only as 1 referral from the first date. Noncompliance referrals are excluded as they were analyzed separately. In this sample, 47 were seen (or scheduled, if the patient was a no-show) within 14 days. Another 14 were seen in 3-4 weeks, 18 were seen in 6-8 weeks, 11 were seen in 10-14 weeks, 1 was next seen after 6.5 months, and 9 appeared to receive no response.

Findings: As previously reported, during the current reporting period, the monitoring team reviewed several hundred medical records of SMI offenders. Multiple progress notes were present in all of the medical records reviewed. It is impossible to determine if these progress notes reflect "each clinical contact with an SMI offender." There was a range of quality observed in these reviewed notes. Some were very poor and did little to elucidate "future steps to be taken as to that offender based on the MHP's observations and clinical judgment."

VIII: TRANSITION OF OFFENDERS FROM SPECIALIZED TREATMENT SETTINGS

Summary: MHPs approve the return of SMI Offenders to general population from a specialized treatment setting; the STC at Dixon is the only facility that utilizes a multidisciplinary team to fulfill this function.

Menard and Stateville proper were the only facilities who were conducting the five-day follow up requirement for offenders coming off crisis care during the entire reporting period. The monitoring team observed four other facilities that began meeting this requirement as of December 2017.

The Evaluation of Suicide Potential was mostly conducted (81%) within the first week of an offender's discharge from crisis care. Only 56% were seen monthly thereafter.

Finally, the requirement for a 30-day follow up of mentally ill offenders discharged from crisis care to general population or an outpatient level of care was only verified in five facilities.

(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: The monitoring team confirmed that the treating MHPs approve the return of SMI offenders to general population from a specialized treatment setting. At the time of this report, the only treatment team performing this duty is at the STC at Dixon. Treatment teams have been formed at several facilities, such as Logan and the Joliet Treatment Center. The monitoring team was unable to evaluate if these newly formed teams were performing this function.

(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: IDOC did create such a form and systems are in place to remind clinicians of

these contacts. IDOC set the expectations for this follow-up effective in December 2017. The monitoring team has only verified that certain facilities are performing this five working day follow-up of offenders transitioning from Crisis placement. These include Logan, East Moline, Pinckneyville and Illinois River, which began these follow up visits in December 2017. Also, as previously reported, Stateville proper and Menard were conducting these follow up visits at the time of the midyear report.

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 monitoring team analyzed 53 crisis watches for which this follow-up would be expected.[13] Among those records, 81% were seen within seven (7) calendar days with an administration of the Evaluation of Suicide Potential (IDOC Form 0379) and another small handful were seen slightly late. The monitoring team observed other facilities who were in compliance with these standards as well. IDOC reports that a March 2018 internal audit found strong results on this practice.[14]

Only a few facilities conduct the six months of follow up. Of 45 relevant crisis watches analyzed,[15] only 56% of the patients had been seen monthly; another 11% had been seen during some months but were missed in others. Institutions conducting this follow-up well include: Menard, Stateville proper, Lawrence, Robinson, and Pinckneyville.

(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: This is not generally occurring throughout IDOC. The major reason for this not occurring is lack of a sufficient number of staff, even in those facilities which are "fully staffed" per the requirements of the Approved Remedial Plan. The monitoring team did observe this happening in a few facilities during the reporting period. These include Menard, Pontiac, Pinckneyville, Logan and Illinois River.

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[13] Records in this sample were reviewed at Big Muddy River, Danville, East Moline, Hill, Illinois River, and Robinson. This sample excludes those who had not reached the seven-day point as of the review, or who had been readmitted to crisis watch before that date.

[14] IDOC's April 2018 quarterly report notes that only 5 charts were found to be out of compliance with this requirement. The entire audit reviewed 375 charts; it is unclear how many of those included crisis watches.

[15] Records in this sample were reviewed at Big Muddy River, Danville, East Moline, Lawrence, Pinckneyville, and Robinson. Monitors counted a record as in compliance if it had a contact in each of the months since crisis watch discharge, regardless of how many months had elapsed (up to six). The sample omitted any patients who had been out of crisis watch less than 30 days.

IX: ADDITIONAL MENTAL HEALTH STAFF

Summary: The Department has not met its staffing requirements for the RTU at Dixon and Logan. The target date for meeting staffing requirements for the RTU at Pontiac is July 6, 2018. Given the significant staffing shortages at Pontiac at the time of this report, it is highly unlikely that they will meet this requirement.

The RTU at Joliet has also not met its staffing requirements.

Throughout the life of the Settlement Agreement, the defendants have not proposed amendments to the Approved Remedial Plan of May 2016.

The Monitor conducted an analysis comparing psychiatric and mental health backlog data with the Department's current staffing situation. Due to a variety of reasons, the Approved Remedial Plan of May 2016 is not sufficient to meet the requirements of the Settlement Agreement. This staffing plan needs to be completely rethought.

The Department is including hiring progress reports in its Quarterly Reports.

Finally, this report serves as official notification that the Department has never met its staffing goals throughout the life of the 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 4/20/18:

- Dixon:
  - Mental Health Unit Directors- 3.00 FTEs vacant
  - Pre-Doc-intern psychologists- 2.00 FTEs vacant
  - Staff psychologists- 2.97 FTEs vacant
  - QMHPs- 4.00 FTEs vacant
  - BHTs- 1.00 FTEs vacant
  - Psychiatrists- 5.20 FTEs vacant
- Logan:
  - Mental Health Unit Directors- 3.00 FTEs vacant
  - Post-Doc psychologists- 2.00 FTEs vacant
  - Staff psychologist- 1.00 FTEs vacant
  - QMHPs- 2.00 FTEs vacant

  - Psychiatrists- 4.41 FTEs vacant
  - Rec therapist- 1.00 FTEs vacant
  - Staff assistant- 1.00 FTEs vacant
  - BHTs- 2.00 FTEs vacant
  - RN-mental health- 1.00 FTEs vacant
- Pontiac:
  - Mental Health Unit Directors- 2.00 FTEs vacant
  - Post-Doc psychologists- 2.00 FTEs vacant
  - QMHPs- 2.00 FTEs vacant
  - Psychiatrists- 4.15 FTEs vacant

The deadline for Dixon and Logan to have the required number of staff was February 6, 2018. The deadline for Pontiac is July 6, 2018. Dixon and Logan are clearly not in compliance with Logan's staffing deteriorating during the reporting period. Although the deadline for Pontiac has not arrived, it is very unlikely they will be in compliance by July 6, 2018.

(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: As of 4/20/18, the following vacancies were reported for Joliet:

- Post-Doc psychologist- 1.00 FTEs vacant
- Pre-Doc psychologists- 2.00 FTEs vacant
- Staff psychologist- 1.00 FTEs vacant
- QMHPs- 1.00 FTEs vacant
- BHTs- 1.00 FTEs vacant
- RN-MH- 11.00 FTEs vacant
- Psychiatrists- 4.50 FTEs vacant

Joliet is currently noncompliant with this subsection of the Settlement Agreement.

(IX)(c): Specific requirement: 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: The defendants did not propose an amendment to the staffing plan within three months from the approval of the Settlement Agreement. Given the persistent staffing problems coupled with the tremendous backlogs of psychiatric and MHP services, the Monitor undertook a staffing analysis which compared psychiatric and mental health backlog data to IDOC's current staffing situation. The actual study is attached to this report as appendix 1. A brief summary follows:

- The Illinois Department of Corrections' (IDOC) total offender population has decreased from 48,653 in 2014 to 41,011 in 2018. However, its mental health caseload has risen from 10,910 in 2014 to 12,140 in 2018. Further, IDOC's SMI population has risen from 4,662 in 2014 to 5,035 in 2018.

- IDOC's original staffing plan, the Approved Remedial Plan of May 2016, was based on a smaller mentally ill and SMI population than IDOC currently maintains.

- Based on the data provided by IDOC and Wexford, it is evident there is a substantial backlog of cases for both facilities that are not "fully" staffed, and for those that are "fully" staffed. Of note, IDOC provided this data to the monitoring team, which had nothing to do with its collection.

- The data provided by IDOC and Wexford, however, does not capture all of the areas where backlogs may exist. This data only includes psychiatric and mental health evaluations, follow up visits and treatment planning. Other significant areas of treatment deficiencies include but are not limited to individual and group psychotherapy, care for those offenders assigned to crisis watches and segregation status, proper implementation of disciplinary and restraint procedures, use of force issues, multidisciplinary treatment planning and monitoring medication compliance.

- The original staffing plan is no longer appropriate to adequately meet the needs of IDOC's mentally ill and SMI offender population. This staffing plan needs to be totally rethought if IDOC hopes to fulfill the requirements of the Settlement Agreement.

(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: Based on 31 facility visits, it is readily apparent that the Mental Health Professionals holding positions listed on Exhibits A and B of the Approved Remedial Plan have these positions allocated solely to the provision of mental health services mandated by the Settlement Agreement.

(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: The Quarterly Reports prepared by IDOC contain hiring progress reports.

(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 reported in IX(a), above, Dixon and Logan have not met their staffing target requirements for both psychiatrists and MHPs. As reported in IX(b), above, Joliet has not met it staffing target requirements. The following facilities have also not met their staffing target requirements:

- Psychiatric vacancies: Graham, Lawrence, Menard, Pinckneyville, Pontiac, Shawnee, Stateville R&C, Stateville proper, Western and Danville (12 of 28 facilities)
- MHP vacancies: Big Muddy, Danville, Graham, Hill, Illinois River, Lawrence, Lincoln, Menard, Pinckneyville, Pontiac, Robinson, Shawnee, Stateville proper, Western, Southwestern Illinois, Stateville NRC and Vienna (19 of 28 facilities)
- This section of the report will serve as official notification to parties that the above-listed facilities have not met their target staffing requirements.

X: BED/TREATMENT SPACE

Summary: The four required RTU facilities have been identified. The RTUs at Dixon and Logan have met their target dates for beds. The target dates for additional construction at Dixon and for the RTU beds at Pontiac and Joliet, as well as additional beds for Logan, have not arrived. The need for higher levels of care is starkly illustrated by the numbers of crisis care stays over 10 days, multiple crisis care placements—as many as 25 per patient in less than a year, restraints use, referrals to RTU, and length of wait for those beds.

The Department is currently not reporting the number of hours that offenders assigned to an RTU are actually receiving. This number is reported as "offered."

The Department has made good progress in the creation of an inpatient facility. At the time of this report, however, it had not made 22 beds available to females. The target date for this requirement was April 6, 2018. As of April 24, 2018, the census was five.

Crisis beds continue to be located in control units in a few institutions. Most facilities use control unit beds rarely, if at all, but the higher usage rates at a few facilities call into question whether theirs can be considered overflow usage. In crisis care, there continues to be a lack of "aggressive mental health intervention."

Adequate RTU treatment space is present at the Logan and Joliet. There should be adequate treatment space at Dixon and Pontiac upon completion of their current construction projects.

(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 meeting this requirement. Renovations, upgrades and retrofits to create bed/treatment space for SMI offenders requiring residential care have occurred at all four facilities (Dixon, Logan, Joliet and Pontiac).

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

(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: Dr. Hinton provided the Monitor with the following numbers on May 2, 2018:

- Dixon-RTU bed count of 676. The deadline for additional construction to increase treatment and administrative office space is July 6, 2018.
- Pontiac-No number was provided for RTU beds at Pontiac. The deadline for this requirement is July 6, 2018. Based on the monitoring team's visits to Pontiac, it doesn't appear that this deadline will be met.
- IYC-Joliet-The deadline for the 360 RTU beds and programing space is October 6, 2018. Dr. Hinton reported the RTU bed count to be 422. During my tour of Joliet on February 5, 2018, the Warden informed me that 422 RTU beds would eventually be available. She did not provide me with a time line for these beds to come on line. This 422 number does not represent the actual number of offenders receiving RTU level of care. The census on April 12, 2018 was 37 and on May 1, 2018 was 41.
- This subsection of the Settlement will be reported as "Target date has not arrived."

(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: Dr. Hinton informed the Monitor on May 2, 2018 that the RTU bed count at Logan was 122. Warden Austin informed the Monitor on March 13, 2018 that the RTU bed count was 80 and that it had been at that number since November 2016. The Warden also spoke about the opening of Building 41 that has 22 beds for offenders designated at the inpatient level of care.

(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. The requirement has been met.
(B) The deadline for creating RTU beds and programming space for an additional 28 female offenders is July 6, 2018. This will be reported as "target date has not arrived."

(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: There has been an urgent need for beds at higher levels of care, including RTU beds, throughout the first two years of the Settlement Agreement. Objective evidence of this need includes:

- Institutions without an RTU have initiated 61 referrals in recent months.[16]
- Logan has been filling 10 beds per month internally; Dixon did not report to the monitoring team its internal referrals.
- With the system's highest levels of four-point restraints use, second highest number of enforced medication decisions, an average of 80 crisis watches per month, and very high rates of incident reports, there is undoubtedly an urgent need at Pontiac. This facility has made *two* referrals to a higher level of care in recent months, so the need is as yet

[16] This total draws on logs from all institutions except Logan and Dixon. The logs principally reflect referrals in February and March 2018, but some capture some 2017 referrals as well.

unquantified. This lack of referrals to higher levels of care is extremely bothersome given that Pontiac houses a large number of the most severely impaired, mentally ill offenders in the Department.

- Crisis watch beds are used for very lengthy periods. At least 63 people lived on crisis watch for twice as long as the intended use, or more, and were *not* referred to higher levels of care (that is, in addition to the 61 noted above).[17] Some of these patients were on watch for months, including two patients who have lived there for *10 months*, one of them in restraints for most of that time.
- Over a recent nine-month period, at least 428 men and women have had from 3 to *25* crisis watches each, a potential sign of instability.
- Once referred, there can be significant waits for the existing higher level of care beds. While some transfer in a short time, waits of one month to more than six months are more the norm.[18]

Dixon RTU: At the time of the midyear report, mentally ill offenders were being offered approximately 6 hours per week of structured time and 12 hours per week of unstructured time. IDOC began reporting structured and unstructured out-of-cell time for mentally ill offenders in segregation in January 2018. They are not currently reporting these hours for mentally ill offenders assigned to an RTU. The Quarterly Report of April 25, 2018 is silent regarding the number of out-of-cell hours offered and/or completed for mentally ill offenders assigned to an RTU. Similar to the reporting requirements for mentally ill offenders assigned to segregation, the Monitor will request that IDOC maintain this data for mentally ill offenders assigned to an RTU.

Pontiac Mental Health Unit: The Monitor has had numerous discussions with the Chief of Mental Health regarding the status of the RTU at Pontiac. The current understanding is that the RTU won't officially open until sometime after the completion of the construction projects. There are many mentally ill offenders currently housed on the Mental Health Unit that are assigned an RTU level of care designation. These offenders are among the most impaired of the entire IDOC system. Multiple reviews of these particular offenders reveal that during the reporting period, they received significantly less out-of-cell time than is required by this subsection of the Settlement Agreement. This lack of required out-of-cell time has resulted in an over usage of crisis watches, restraints and use of force incidents. The Monitor is hopeful that the new facility will allow for these extremely mentally ill individuals to finally receive the care they so desperately need.

Logan RTU: Documenting the out-of-cell time for the mentally ill offenders assigned to RTU level of care is similar to Dixon. That is, the out-of-cell time is reported as "offered" and not the actual number of hours of participation. The number of hours offered, however, does exceed the requirements of this subsection of the Settlement Agreement.

Joliet RTU: Similar to Dixon and Logan, Joliet does not report actual participation in out-of-cell activities. At the time of the Monitor's February 6, 2018 visit, mentally ill offenders are being offered 15 hours of structured and unstructured hours of out-of-cell activities per week.

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[17] This number is at minimum and cannot be completely discerned, as some institutions do not record discharge dates when an admission spans two months.

[18] At least one-third of referrals waited for these periods. An equal number of log entries are missing information needed to calculate these lengths of time.

(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: IDOC has made reasonable progress in fulfilling the requirements of this subsection of the Settlement Agreement. It had an IGA in place by September 7, 2016 with 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. A facility for female offenders was opened April 2, 2018, six days before the deadline. Of note, only five female offenders have been admitted into the facility as of April 24, 2018. The Chief of Mental Health informed the Monitor during his April 24, 2018 visit to the facility that he would provide a detailed plan about how the patient population would be increased to the 22-bed minimum. This detailed plan was not received by the submission of this report.

(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 is yet to fulfill the requirements of this subsection of the Settlement Agreement. Pontiac has maintained crisis beds in Control Units for the entire duration of the Settlement Agreement. As noted above, the specific requirement 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 the approval of the

Settlement Agreement." Pontiac still maintains crisis cells in North House. IDOC has attempted to characterize these crisis cells in North House as "overflow" cells. The Monitor has personally inspected Pontiac on four occasions during the reporting period. On each of these visits there have been multiple mentally ill offenders housed in the crisis cells on North House. Custody staff confirm that the crisis cells in North House "always" house mentally ill offenders. Logs indicate 19% of Pontiac's crisis watches occurred in North House in 2017 and early 2018.[19] The staff at Pontiac also utilize cells in the Mental Health Unit and the Infirmary for purposes of housing mentally ill offenders on crisis watches.

Due to construction projects occurring in the protective custody unit during this reporting period, crisis clients could not be housed on this unit. This meant that the crisis cells in North House were even more significantly utilized – more than half of the crisis watches in the months for which the Monitor has data.[20]

During the monitoring period, Lawrence routinely housed its crisis watches in a control unit building. The administration identified and rehabilitated alternative space and remedied this problem as of the first quarter of 2018. A number of institutions report using Segregation on an overflow basis but a few, in addition to Pontiac, raise concerns. Logs show that Stateville proper has used "overflow" on an increasing basis throughout 2018. Lincoln has few crisis watches, but it was a concern that 25% were in segregation on overflow. With both Stateville and Lincoln, around half of the overflow placements exceeded the 72 hours allowed. Dixon is among those reporting it also uses segregation on an overflow basis, though it appears this is rare; there were no such cases appearing on logs from June 2017 through February 2018.

After comparing the locations of Segregation, crisis watch overflow, and crisis watch cells at each institution with their crisis watch logs, it does appear that control units are not being used, or are used very rarely for overflow, in the rest of IDOC's institutions.[21] Monitors' observations and staff interviews were consistent with the logs in at least seven sites. Thus, the following institutions are in substantial compliance with this provision: Big Muddy River, Centralia, Danville, Decatur, East Moline, Graham, Hill, Illinois River, Jacksonville, Kewanee, Lawrence, Logan, Menard, Pinckneyville, Robinson, Shawnee, Sheridan, Southwestern Illinois, Taylorville, Vandalia, Vienna, and Western Illinois.

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.

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[19] According to Crisis Watch logs provided by IDOC monthly from October 2017 through January 2018. IDOC indicated there was lack of clarity when recording housing location on logs provided prior to that time.

[20] Per Crisis Watch logs provided by IDOC in February and March 2018.

[21] This was verified for 16 institutions in logs or monitors' onsite visits. An additional 6 institutions do not include cell locations on their logs, but their crisis watch censuses are not high, there is no indication of improper practice, and the consistency across institutions over time suggests that the risk of violation is low and any violation there would likely be "minor or occasional."

Findings: IDOC has never fulfilled the requirements of this subsection of the Settlement Agreement. In the previous two reports to the court, the monitoring team has emphasized the important role that crisis beds play within a well-functioning mental health system. Currently in IDOC, the crisis beds do not serve as a "short-term, 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." This deficiency is due to multiple reasons that include but are not limited to:

- Inadequate mental health and psychiatric evaluations
- Consistently poor treatment planning
- Insufficient individual and group psychotherapy
- Substandard psychiatric care
- Absence of a reliable medication distribution system
- Custody staff acting as "gate keepers" for the Crisis Intervention Teams
- Overreliance on segregation to house mentally ill offenders
- Extremely inadequate support for mentally ill housed in segregation
- Custody staff that participate in physical and emotional abuse of mentally ill offenders and administrators that turn a blind eye to such abuses
- Insufficient availability of more intensive levels of psychiatric care.

All of this contributes to the fact that crisis beds are extremely oversubscribed. This oversubscription of crisis beds results in stays that often exceed 10 days. A review of crisis-watch logs for a majority of the monitoring period revealed that at least 392 crisis watches exceeded the expected 10 days.[22] Among those, 61 people lived in crisis watch from *one to ten months*.

Little to no "aggressive mental health interventions designed to reduce the acute, presenting symptoms and stabilize the offender" occurs with the mentally ill placed on crisis watch. These offenders receive a suicide risk assessment upon entry and daily contacts with an MHP. These contacts do not always occur in a confidential setting which functionally negates their benefits. Psychiatrists rarely see patients at this level of care. Starting in February 2018, a monitor-approved "Crisis Care Plan" began to be used department wide[23]. This Crisis Care Plan has begun to address the treatment planning requirements stated in the Settlement Agreement. Although called for in the Settlement Agreement, psychiatric providers do not consistently evaluate mentally ill offenders placed on crisis. IDOC still has a long way to go to meet the requirements of this subsection 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,

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[22] The team reviewed crisis watch logs from all institutions from June 2017 through February 2018, except the materials spanned July 2017 through February 2018 for Pontiac and Stateville. This number is at minimum and cannot be completely discerned as some institutions do not log the discharge date when an admission spans two months.

[23] This Crisis Care Plan was approved to address the complete lack of treatment planning that had previously been occurring with offenders placed on crisis.

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: IDOC is currently meeting this requirement at Logan and Joliet. Dixon and Pontiac should satisfy this requirement upon completion of their construction projects.

(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 target dates for this requirement have not arrived.

(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: As previously reported, the Monitor received the required floor plans within the time frame specified in the Settlement. These floor plans are consistent with the requirements of the Remedial Plan.

XI: ADMINISTRATIVE STAFFING

Summary: Regional Directors have been hired and working full time throughout the reporting period.

A Statewide Quality Improvement Manager has been hired but has only been working full time in this position since January 16, 2018.

Seven clinical supervisor positions were vacant at the time of this report.

Four of ten required central office staff positions are vacant at the time of this report.

(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: As reported previously, IDOC hired three regional directors who are all licensed psychologists prior to the filing of the Settlement Agreement. They are:

- Dr. Horn, northern regional director, hired March 2014
- Dr. Sim, central regional director, hired January 2015. He was working full time in this capacity until he was appointed to be the Statewide Quality Improvement Manager on February 16, 2017. He was working in this dual capacity, devoting 75% of his time to his central regional director duties until January 16, 2018. On this date, Dr. Luke Fairless, a licensed psychologist, became the full-time central regional director.
- Dr. Reister, southern regional director, hired December 2014.

(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: This position was filled on 2/16/17, eight days before the deadline, by Dr. Sim. For the first 11 months he held this position, Dr. Sim was only devoting 0.25 FTE to the duties of Statewide Quality Improvement Manager. He only began working full-time in this position on 1/16/18. Dr. Sim's part-time role in this position is emblematic of the fact that IDOC is yet to operate a statewide continuous quality improvement program.

(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: IDOC is yet to satisfy the requirements of this subsection of the Settlement Agreement. As of the time of submission of this report, the following facilities do not have a clinical supervisor in place:

- Danville (backlog of 2 mental health evaluations, 1 mental health treatment plan and 110 mental health follow ups)
- Elgin

- Graham (backlog of 109 mental health evaluations, 124 mental health treatment plans and 257 mental health follow ups)
- Jacksonville
- Lawrence (backlog of 53 mental health evaluations, 16 mental health treatment plans and 152 mental health follow ups)
- Robinson (backlog of 1 mental health treatment plan and 28 mental health follow ups)
- Vandalia (backlog of 14 mental health treatment plans and 18 mental health follow ups)
- Western's clinical supervisor began May 14, 2018. (backlog of 174 mental health evaluations, 113 mental health treatment plans and 136 mental health follow ups)

Persistent vacancies exist almost two years after the deadline. It is obvious that these vacancies are contributing to the problems that IDOC is having in fulfilling the requirements of the Settlement Agreement. These vacancies are also causing unnecessary suffering for the mentally ill offender population. This is especially evident at Graham, which serves as one of the Department's R&C centers. All backlog data is current as of May 18, 2018.

(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: The deadline for fulfilling the requirements of this subsection of the Settlement Agreement was November 22, 2017. To date, IDOC has filled the position of Training Director, Statewide Quality Improvement Manager, Chief of Psychiatry, and the three Regional Directors. Four (4) central office staff positions remain vacant. Of note, the only positions that were filled at the time of the November 22, 2017 deadline were the Regional Directors, the Training Director and 0.25 FTE of the Statewide Quality Improvement Manager. This is yet another example where IDOC is not able to meet the requirements of the Settlement Agreement and the mentally ill offender population is unnecessarily suffering.

XII: MEDICATION

Summary: Medication administration is documented contemporaneously in a given offender's medical record. The Department has not been able to ensure that SMI offenders with a new prescription are seen at least twice within the first 60 days of starting a medication. Mentally ill offenders are also not seen at least every 30 days or every 60 to 90 days once stability has been documented. At the time of this report, there was a backlog of at least 1182 psychiatric follow up visits.

There continue to be serious problems with medication distribution, documentation of medication efficacy and side effects, and following protocols for blood work and medical/neurological evaluations and informed consent.

There continues to be a serious problem with medication noncompliance. Staff do not routinely follow protocols for proper intervention with offenders who are displaying poor medication 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: There are many problems associated with the proper prescribing, distribution and monitoring of medications within IDOC. The one issue that is consistently being met, however, is the contemporaneous recording on the offender's medical records of all medications administered and contacts with medical staff as to medications. IDOC is in compliance with the requirements of this subsection of the Settlement Agreement.

(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: Throughout the Settlement Agreement's implementation, IDOC has not been able to meet the requirements of this subsection. There may be isolated locations where these requirements are being met, such as the STC RTU unit at Dixon and the Joliet Treatment Center. Overall, however, they are not being met as reflected in the number of follow-up visits that are not being completed on time. As of May 18, 2018, there are 1182 psychiatric follow-up appointments backlogged throughout the Department. This backlog includes 188 mentally ill offenders assigned to the RTU level of care.

In fact, Dixon experienced a falling off of services during the monitoring period. Dr. Kapoor noted in August 2017 that this facility was meeting the requirements of this subsection of the Settlement Agreement. That is, psychiatrists were seeing offenders every 30 days in confidential settings. On a follow-up visit in January 2018, she reported that this situation had deteriorated in that visits were routinely occurring every 2-3 months. Of note, these visits were occurring cell side or at tables in the dayroom that didn't allow for confidentiality.

The monitoring team analyzed the frequency and type of psychiatric appointments in the health care records of 164 patients under psychiatrists'[24] care across an additional eight institutions in 2017-2018. Psychiatric staff offered the best care at Lawrence and Illinois River, where there were a number of examples of seeing patients monthly as a routine and then increasing the interval to no more than 90 days once the patients appeared stable. This was not universally true, but it occurred far more than in the other sites.

In most of these sites, there were examples of closer follow up in situations that called for it: patients new to the caseload or a particular medication, patients experiencing side effects, after crisis watch placements, or after medication was discontinued at the patient's request. At least 76 instances of this closer follow-up were evident. Occasionally psychiatrists saw patients twice in 60 days after a new medication, as required, but it was rare. There were, however, examples where psychiatrists did *not* follow up with patients in these vulnerable situations, seeing them only after 90 days without there being the requisite stability. Offenders at Logan, for example, reported that, due to being unable to speak directly with a psychiatrist about problems with their medications or discuss alternatives, they often stopped taking their medications.

Apart from the practice at Lawrence and Illinois River described above, the frequency of appointments did not seem to follow a pattern. Some appointments occurred at 90 days, sometimes serially, but they were punctuated by at least 27 instances of patients not being seen for 4, 5, 6, 7 or even 8 months. As noted in prior Monitor's reports, some psychiatrists renewed, changed, or

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[24] The team will use "psychiatrist" and "psychiatric" to refer to psychiatrists, psychiatric nurse practitioners, and psychiatric physician's assistants.

discontinued medication without seeing the patient at the time or soon thereafter. This was observed to some extent at nearly all of the institutions monitored and was most prevalent at Pinckneyville. Pinckneyville designed and has been implementing a corrective action plan on point. IDOC has made efforts to reduce this practice and fewer instances were observed in 2018.

It is common for IDOC psychiatrists to write medication orders for four to six months. This occurred for at least 32% of the patients reviewed. While not a specific feature of the Settlement Agreement, it is inappropriate psychiatric practice. The monitoring team also has concerns about psychiatric response to referrals from screening, related to side effects, patient requests to resume medication, and follow-up on patient noncompliance with medication. These are discussed in sections (V)(b) and (XII)(c)(vi), respectively.

(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: IDOC continues not to meet this requirement. In terms of writing and filling medication orders, continuity was good from month to month and with new orders, though gaps—usually one or a few days, but occasionally for four to ten weeks—were evident with 30 medication orders in charts reviewed. However, ensuring proper delivery of the prescribed medications was problematic, especially in segregated housing units. Medications are administered at the cell front through the food slot. This allows for "cheeking" of the medication. That is, offenders appear to have taken their medications but actually are able to hoard the pills and capsules. This hoarded medication then is traded for commissary items, for other medications or for use in suicide attempts. The monitoring team is not aware of any efforts made by IDOC to address this issue.

(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: This continues to be a problem. As stated in the midyear report, "in the overwhelming majority of the medical records reviewed during the reporting period, little to no attention was paid to either the efficacy or the side effects of the prescribed medications." Since the midyear report, no real improvement in this regard has been noted by the monitoring team. Again, the most likely explanation for these note deficiencies is the lack of a sufficient number of staff, who then have less time for thorough practice and documentation, as well as completing fewer appointments. As reported above, as of May 18, 2018, there was a total backlog of 1182 psychiatric follow up appointments throughout IDOC. The highest rates were at Menard (289), Shawnee (167), Pontiac (144) and Stateville (116).

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

Findings: This is occurring haphazardly within the Department. That is, in the majority of the medical records reviewed, there was some evidence of lab work being obtained, blood pressure monitoring and neurological evaluation. Unfortunately, these efforts were random in nature and didn't appear to follow any standard protocol.

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

Findings: As reported above, there were some lab work being performed to address side effects but not based on any accepted protocol. Also, it didn't appear that the results of this lab work were taken into consideration in the administration of psychotropic medications.

(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: First of all, over 1,000 mentally ill offenders did not even have the opportunity to receive this explanation or ask questions because their appointments hadn't occurred. During the reporting period, a significant number of psychiatric visits did not occur in confidential settings. This lack of confidentiality dissuades the offender from speaking openly and honestly about their treatment. The only facilities where this requirement was being met were the STC at Dixon, Joliet and Elgin.

(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: IDOC's compliance is very poor on this requirement. In reviewing the health care records of 164 patients, the monitoring team encountered at least 50 occasions in which the patients did not take their medication for extended periods. Only three clearly were referred at the three-day point; the timing of some referrals is unclear, while 12 were referred after one to three weeks of nonadherence. It appears half were not referred at all. Once referred, many were seen in a reasonable time, but 20% were delayed from two and one-half weeks to two months. Illinois River is among those institutions with this difficulty, but since the monitoring team's site visits, staff report proactive steps they have taken across multiple departments to improve this issue.

When questioned why this requirement was not being accomplished, staff at a variety of facilities reported that they just didn't have the time to do this. This lack of time has recently become exacerbated by the Department's appropriate emphasis on the following requirements of the Settlement Agreement: (the following is a partial listing)

- five-day follow ups of offenders recently discharged from crisis care
- treatment planning requirements for those offenders in crisis care and segregation
- the direct participation of MHPs in the disciplinary process

- attempts at multidisciplinary treatment planning
- providing adequate number of structured out-of-cell activities for mentally ill offenders assigned to segregation

XIII: OFFENDER ENFORCED MEDICATION

Summary: Offenders are subject to enforced medication in half of IDOC's facilities, with the great majority concentrated in just 3 institutions. When considering an enforced medication order, IDOC convenes Treatment Review Committees composed of the required professionals who have been trained for the purpose. Offenders generally receive notice, though proof of compliance could be stronger.

Offenders usually attend the hearings; there is no indication of difficulty exercising this right. Requests for witnesses appear rare; in the one reviewed instance, witness testimony was denied on a questionable basis.

While notices and hearing packets cite the required rationale, the clinical evidence was not strong in 15% of reviewed cases. Appropriate hearing decisions are issued. It is noteworthy that, for a sizeable number of offenders, decisions have remained in effect for 10 to 27 years.

Reviewed videos depicted humane and effective practice when administering enforced medication.

The monitoring team finds 15 institutions in Substantial Compliance with subsection XIII.

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: The monitoring team reviewed institutional logs and a 18% sample of the cases therein.[25] Over the period of review, the monitoring team learned of 195 people subject to enforced medication. They were highly concentrated at Dixon (109), Pontiac (30), and Logan (14). Another 11 institutions had numbers in the single digits and another 13 did not use enforced medication at all. The use of this intervention has increased since 2017.

For all non-emergency cases reviewed, facilities fulfilled their obligation to convene a Treatment Review Committee composed of the required professionals or a reasonable substitution, such as a Medical Director where a psychiatrist is not generally onsite. Each facility reviewed has provided a list of staff who have been trained and serve as Treatment Review Committee members.

Records verified that a Staff Assistant is always appointed for the patient. It appears that providing written notice, with all the required elements, to the patient is routine; this was clearly documented in 77% of cases and there was some indication that the compliance percentage is higher. Patients regularly attend the hearings. With the two refusals in this sample, the hearing record described the committee's attempts to engage the patient. In one case, the patient was excluded because he had been assaultive toward staff the night before as well as the same day. While another handful of documents omitted mention of the patient's attendance, there was no indication that patients are not being provided that right.

The basis for enforced medication decisions must be 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. While hearing packets cite this rationale, the clinical evidence was not strong in 15% of reviewed cases to warrant this intrusive measure. There were examples of this concern across most institutions reviewed. Among the emergency medication documents, one stood out as offering no rationale at all.

Reviews yielded only one patient who asked for witnesses. They were denied; one was understandably considered irrelevant but denying the other on the basis of being an inmate seemed contrary to the patient's rights. Each record did contain a written summary of the hearing and the committee's reasons for its decision. These were generally detailed and well-reasoned; two declined to approve the enforced medications for well-supported reasons and one of those offered an alternative plan. The monitoring team also reviewed a handful of videos of enforced medication being administered at Pontiac and Illinois River and these were handled well by custody and nursing staff.

It remains noteworthy that, once in place, these decisions can remain in effect for very lengthy periods. The monitoring team has encountered at least 19 people subjected to enforced medication for *10 to 27 years.* While the Code does not set time limits, these lengths of time are antithetical to a mechanism meant for acute situations. IDOC leaves it to the patients to raise the right of appeal available to them every six months. The Monitor would prefer to see IDOC adopt a practice of annual reviews, which is more in keeping with the nature of these decisions.

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[25] IDOC provided logs for all institutions for June 2017 through February 2018. The team reviewed 30 records of enforced medication hearings, and documentation of 6 emergency uses. These were drawn from 12 of the 14 institutions at which these practices occurred.

All of Hill's and Sheridan's cases were in compliance. The following institutions are in substantial compliance with XIII: Centralia, Danville, Decatur, East Moline, Graham, Hill, Jacksonville, Kewanee, Lincoln, Robinson, Sheridan, Southwestern Illinois, Taylorville, Vandalia, and Vienna.

XIV: HOUSING ASSIGNMENTS

Summary: MHPs are informed of housing changes by security staff. MHPs are also consulted about post-segregation housing recommendations. MHPs do not report that their housing recommendations are overridden by security staff.

(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 has created a form that is well-designed to guide practice on all three provisions of XIV, and IDOC reports that it is widely in use. During the monitoring period, IDOC administration distributed a memo to all facilities reinforcing this requirement and those that follow in (b) an (c). The monitoring team has confirmed that at least 65% of institutions have carried forward the Settlement Agreement language in Institutional Directives, and facilities such as Pontiac, Graham, and Illinois River have enhanced it with procedures that will better facilitate the policies being carried out. While local policies are not required by the Settlement Agreement, they are a good mechanism to support implementation of this section's provisions.

During site visits, staff often spoke of good collaboration on housing decisions. For example, at Logan staff reported that security officers consult with mental health staff regarding housing decisions, as did staff at Danville, East Moline, Hill and Lawrence. At Dixon and Big Muddy River, on the other hand, the placement office was not always proactively informing mental health staff about housing moves. It is noteworthy that, in facilities where mental health appointments all take place in the mental health offices, general population cell moves would not affect scheduling or access. MHPs and administrative staff responsible for scheduling do report monitoring the Offender 360 database regularly, as required under this provision.

(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: This is generally occurring in the institutions monitored with the exception of Dixon and Robinson, which committed to changing practice to conform to this requirement. As

previously reported, several facilities send a daily email about cell moves of mentally ill offenders, especially those assigned to segregation.

(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: This requirement is being met. Interviews with mental health administrators and staff revealed that security officers did not override their recommendations for housing placement for mentally ill offenders.

XV: SEGREGATION

Summary: Double-cell reviews are in place, and all facilities are in the process of implementing this requirement.

The segregation units are countertherapeutic for the mentally ill offenders housed there. These units tend to be filthy, loud, chaotic and worsen the psychiatric and medical conditions of those offenders who are housed there. The mentally ill offenders should be removed from segregated housing.

The monitoring team found varying degrees of compliance with the requirement of continuing, at a minimum, the treatment specified in the ITP when a mentally ill offender is placed in Segregation.

The Department is not meeting the requirement that an MHP shall review any mentally ill offender no later than forty-eight (48) hours after initial placement in Administrative Detention or Disciplinary Segregation.

MHPs were not routinely reviewing and updating treatment plans of offenders within one week of placement in segregation. A separate sample of 30 charts demonstrated a higher rate of monthly reviews, however.

The Department began collecting data on structured and unstructured out-of-cell activities in January 2018. Chief Funk should be complemented on her efforts to get this program off the ground. Of note, refusals are still being counted toward the total number of out-of-cell hours which is contrary to the requirements of the Settlement Agreement.

The requirements regarding the reduction of segregation time were not monitored during the current reporting period.

As to all of the above requirements, the analysis applies equally to offenders in the Administrative Detention/Disciplinary Segregation/Investigatory Status/ Temporary Confinement.

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: The following was noted in the midyear report: "The Quarterly Report of 10/23/17 states "Double-cell reviews are in place, and all facilities are in the process of implementing the requirements of this Section. On June 23rd, a memo was sent to all wardens reminding them of the requirements outlined in this section. Additionally, wardens were instructed to draft institutional directives reiterating the requirements in this section. The Monitor had requested a list of facilities that have complied with this requirement. On November 20, 2017, the Monitor received confirmation from Chief Funk "that all facilities have an institutional directive relative to the double celling of special populations." Additionally, Psych Administrators at several institutions, including Logan, Lawrence, and Illinois River, convincingly described to the monitoring team the particulars of this process and its routine nature. The monitoring team confirms that this requirement continued to be met during the second half of the reporting period. The Department is meeting the requirements of this subsection of the Settlement Agreement.

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: Not much has significantly changed in regard to this requirement during the reporting period. The segregation units are countertherapeutic for the mentally ill offenders housed there. These units tend to be filthy, loud and chaotic with the exception of the RTU at Logan. They do not contribute to the provision of mental health treatment. In other correctional systems with a large population of mentally ill offenders in segregated housing, the mentally ill offenders are separated from non-mentally ill offenders. That is, there are segregated housing units just for the mentally ill. IDOC should seriously consider this as an option if it is not willing to remove all mentally ill offenders from segregated housing. The current situation results in the deterioration of the mentally ill offenders assigned to 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: It is important to note that the overall quality of treatment planning in IDOC is poor. A modified treatment planning document was approved for use by the Monitor on February 1, 2018. It is too early to state what effects this new form has had on the overall quality of treatment planning. Given these facts, the monitoring team found varying degrees of compliance with this requirement during the reporting period. Assistant Monitor Ginny Morrison reviewed the records of at least 123 Segregation placements in 2017-2018. This review involved the following facilities: Big Muddy River, Danville, East Moline, Hill, Illinois River, Lawrence, Pinckneyville and Robinson. She found that the treatment plans in place in general population appeared to be followed after the offenders' segregation placement. Also, Menard was found to be providing weekly or semi-weekly counseling visit to the mentally ill offenders in segregation.

These findings contrast with those at Pontiac where the ITP is rarely implemented when a mentally ill offender is placed in segregation. This fact may also reflect the very poor quality of treatment planning that is generally encountered at Pontiac.

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 monitoring team analyzed health care records related to 123 Segregation placements,[26] across eight institutions, during the monitoring period. These are the same institutions noted in XV(a)(iii), above. Those records showed contact by an MHP or BHT within

[26] The number of patients differs because some had multiple Segregation placements in 2017-2018; each placement was analyzed. All men reviewed were on the mental health caseload.

the first two days in only 31% of the placements. A previous analysis of 76 segregation placements in 2017 found a compliance rate of only 36%. Since the team's site visits, Danville described proactive steps it has taken to improve on this requirement.

Similar findings were encountered at other monitored facilities. Logan only began meeting this requirement in February 2018. This was also true for Illinois River. The staff at Pinckneyville reported to the Monitor that their efforts at meeting this particular requirement come at the expense of meeting other requirements of the Settlement Agreement such as following up incidents of medication noncompliance. Finally, Dr. Kapoor reported that Dixon is not meeting this requirement.

The findings of the monitoring team are in stark contrast to those reported by IDOC in its Quarterly Report of April 25, 2018. It states "Following internal auditing in March 2018, the Department found only four (4) instances of a mentally ill offender not being seen by an MHP within 48 hours of placement in segregation out over 375 chart reviews across 19 facilities." The Monitor has not reviewed this "internal auditing" but assumes that it is the monthly CQI report. As is reported in section XXVI, below, the CQI auditing instrument has not yet been verified as an accurate measure of the clinical activities of IDOC. Also, this audit of 375 charts was not particularly directed at offenders who had recently been placed in segregated housing. In order for this number of four (4) to be meaningful, the number of reviewed charts of mentally ill offenders who have been recently placed in segregated housing should also be reported.

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: In the monitoring team's same analysis of 123 placements, 15% showed a treatment plan update within one week. IDOC indicated that its internal audit found a much higher compliance rate.[27] Another 15% also updated the treatment plan, but it was untimely. A previous analysis reported on the midyear report showed a 22% compliance rate with this requirement.

Among the subset clearly in Segregation long enough to require monthly updates,[28] staff did update these plans each month in 73% of the placements, and another handful had updated plans in some months but not others.

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.

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[27] In IDOC's April 2018 quarterly report, it cited a *February* 2018 audit; it appears this may be different from the March 2018 audit cited elsewhere. It is unclear how many Segregation charts were included in the February 2018 audit. The audit found only one case to be noncompliant in updating the treatment plan within one week. No findings were reported as to monthly treatment plan updates.

[28] This totaled 30 placements in the monitoring team's sample.

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.
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: This was not occurring during the reporting period. Of note, the monitoring team found no evidence of "enhanced therapy" being provided to the mentally ill offenders in segregation.

Rounds: There is excellent practice on this requirement. Of 145 Segregation placements reviewed by the monitoring team, 92% consistently met this standard. In the remaining placements, rounds documentation was present but appeared to reflect missed contacts. Big Muddy River, Danville, and East Moline each had 100% performance on this responsibility. Hill, Illinois River, and Pinckneyville had the farthest to go; Pinckneyville has designed and is implementing a corrective action plan on this point. IDOC reports that Pontiac conducts weekly rounds in two of it Segregation buildings, and biweekly rounds in the other building.

Pharmacological treatment: Although many mentally ill offenders are prescribed medications, significant problems exist with ensuring proper medication compliance. This includes problems ensuring that offenders actually take their medication. Also, offenders are not evaluated and followed up per the requirements the settlement agreement.

Supportive counseling by an MHP as indicated in the ITP: There were MHP contacts in 46% of the 123 relevant Segregation placements in the monitoring team's review. The team did not compare the frequency of contact to the treatment plans.

Participation in multidisciplinary team meetings once teams have been established: Multidisciplinary teams had not been established at the institutions the monitoring team reviewed as of the time of those visits.

MHP or mental health treatment team recommendation for post-segregation housing: Clinicians at Danville, East Moline, Hill, Illinois River, and Lawrence all described good systems for giving input into post-segregation housing and good receptivity to it. Big Muddy River had not begun this practice as of summer 2017 but committed to doing so.

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 requirement is not regularly met in the Department. The monitoring team did not find any examples of increased unstructured out-of-cell time being indicated by the offender's ITP. The monitoring team also did not find any instances where mentally ill offenders in segregation, who refuse out-of-cell unstructured time, had these refusals appropriately documented and made available to the offender's mental health treatment team.

XV(a)(vi):[29] 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.*[30]

Findings: For the second year of the Settlement Agreement, the requirement is to provide mentally ill offenders a minimum of 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. As noted in the wording of this requirement, the actual language is "will receive." Accordingly, the statement of "offer the amount of out of cell time" as noted on page 16 of the Quarterly Report of April 25, 2018 is not applicable to the terms of the Settlement Agreement.

As reported previously, The Department has not had a system to accurately track the requirements of this subsection. The Monitor met with the Department's leadership team, including the Director, on February 6, 2018 while on a tour of the Joliet Treatment Center. The Department agreed to begin tracking both structured and unstructured out-of-cell time utilizing a form that had been developed by the staff at Pinckneyville. This new tracking scheme would provide a weekly accounting of unstructured and structured out-of-cell time per individual mentally ill offender. The department further agreed to collect this data from all facilities beginning in January 2018 and forward the data for the months of January, February and March 2018 to the Monitor by April 15, 2018. Chief Funk is the staff responsible for implementing this program of data collection.

This program of data collection got off to a slow start. That is, for the month of January, only 21 of 28 facilities reported their structured out-of-cell data and none reported their unstructured out-of-cell data. These figures did not significantly improve for February with 21 of 28 facilities reporting structured out-of-cell data and 2 of 28 facilities reported their unstructured out-of-cell data. The facility response rate did improve for March with 23 of 28 reporting structured out-of-cell data and 23 of 28 reporting unstructured out-of-cell data. The Monitor is aware that some of the non-reporting facilities may not have had mentally ill offenders that required this type of out-of-cell activities. These facilities should have submitted reports to that effect rather than not submitting a report at all.

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[29] 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.

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

The reporting of the data is also problematic. Refusals to participate in structured and unstructured activities are counted towards the total. The Department is not consistently meeting the 12-hour requirement. For example, looking at the week of 3/18/18 at Pontiac, only 4 of 48 mentally ill offenders received at least 6-hours of structured out-of-cell activities. A notation of "limited staff" was made in an attempt to explain why the remaining 44 mentally ill offenders did not receive the required out-of-cell time. Also, at Pontiac for the week of 3/26/18, only 7 of 48 mentally ill offenders actually received the required 6 hours of unstructured out-of-cell time although 34 of 48 were reported to have met this threshold. In the case of the 34, refusals were counted toward the total.

The Monitor notes that this data collection represents a major shift in the way that the Department has been tracking this information. These initial efforts are acknowledged as a significant improvement but a lot of work remains to be done. At this point in the Settlement, it is the opinion of the Monitor that the Department still is not consistently providing the required out-of-cell time to those mentally ill offenders who have been in segregated housing for more than 60 days. This opinion is based on chart reviews conducted in numerous facilities as well as a review of the data collected for January, February and March 2018.

Chief Funk should be applauded for her efforts at attempting to implement this seismic shift in the way the Department conducts its business. The Monitor will be working directly with her to build on these initial accomplishments.

Anecdotally, health care records reflect significant time in mental health-run groups at Pinckneyville and Lawrence, and in some instances at Illinois River and Danville. Danville counseling leadership described an excellent system to provide tailored programming in the rare event that men are in Segregation beyond 60 days; reportedly, this typically occurs 1:1, as it is even more rare for multiple men to have terms that long at the same time. The administrations at Big Muddy River, East Moline, and Robinson indicated that Segregation terms are almost always 30 days or less, and logs and other information supported that. Nevertheless, East Moline and Lawrence provided groups to their patients well before the 60-day point.

Pontiac has been creative and ambitious in creating new space for programming. In early 2018, it opened new rooms, converted dead space, and had further retrofits under way. As of April 2018, the administration reported it can run three groups concurrently because of these expansions.

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[31] 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.

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

Findings: The Department is meeting the requirements of this subsection of the Settlement Agreement.

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.

Findings: This requirement was not monitored during the current reporting period.

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: This requirement was not monitored during the current reporting period.

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: This requirement was not monitored during the current reporting period.

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: This requirement was not monitored during the current reporting period.

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: This requirement was not monitored during the current reporting period.

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

Findings: This requirement was not monitored during the current reporting period.

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, Discipline of Seriously Mentally Ill Offenders, for a discussion about 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: The Department does not have a functioning system to meet the requirements of this subsection of the Settlement Agreement. Weekly rounds, conducted by BHTs, do take place in segregation. These rounds are conducted at cell side and do not function as mental health assessments. As reported above, custody staff continue to act as gatekeepers to the Crisis Intervention Teams. Problems also exist in the proper continuation of the offenders' ITP while they are in segregation.

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: The target date has not arrived for 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 (a)(vi), page 61, 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.*[32]

Findings: Please see section (a)(vi), page 63, 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 meeting the requirements of this subsection of the Settlement Agreement.

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

XV(c)[33]: 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.

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 (a)(vi), pages 62- 63, above, for a discussion of this requirement.

Structured out-of-cell time & unstructured out-of-cell time: Again, please see (a)(vi), pages 62-63, above, for a discussion regarding this requirement. Of note, it is the hope of the Monitor that the Department will fine tune its collection of out-of-cell data. This would allow for a definitive assessment of this very important issue.

The 60-day requirement: As was reported in the first annual report, it remains a serious concern that this particular requirement of the Settlement only calls for increased out-of-cell time for offenders in segregation for more than 60 days. Any amount of segregation causes its own unique set of mental health issues. It can exacerbate preexisting mental health issues as well as causing new mental illness to occur.

During the current reporting period, the monitoring team noted that Stateville Proper is offering all mentally ill offenders in segregation structured out-of-cell time. Pinckneyville is offering structured out-of-cell time to mentally ill offenders in segregation after 55 days. The staff told me that they will attempt to offer structured out-of-cell time after 45 days in the future. Chart reviews confirmed that East Moline and Lawrence provided groups to their patients very soon after placement, well ahead of the 60-day point.

Segregation-like settings: The Monitor has a similar concern regarding out-of-cell time for those inmates who, while not in formal segregation, are in segregation-like confinement for a prolonged period of time. Mentally ill offenders often stay in R&C units for longer than 60 days. This is a particular problem at the Stateville and Menard R&Cs. Efforts should be made to provide mentally ill offenders in R&C units the same amount of structured and unstructured out-of-cell time that is provided to offenders housed in control units.

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

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 Department is struggling to meet the overall requirements of this section of the Settlement. The deadline for most of these provisions is 2.5 years in the future. The monitoring team will continue to closely review these issues moving forward.

XVI: SUICIDE PREVENTION

Summary: Crisis Intervention Teams had been established and trained at all facilities. The monitoring team does not have information if crisis intervention team members participate in quarterly quality assurance meetings.

The expected policies have been demonstrated in 22 facilities. The training requirements associated with this section of the Settlement Agreement have been met.

Crisis Intervention Teams are present in all monitored facilities. Crisis watch is overutilized due to an overall lack of adequate mental health and psychiatric services. Gatekeeping by custody staff remains a concern. Aggressive mental health and psychiatric treatment does not occur on crisis watch. Some crisis cells are still located in segregated housing units.

There were five completed suicides during the monitoring period. Post-suicide reports are completed in a timely manner. These reports do not contain a robust corrective action component. As such, the potential lessons learned from these tragedies is not being adequately utilized by the Department to improve its overall quality of mental health and psychiatric services.

(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[34] provides general guidelines for the handling of suicidal offenders. AD 04.04.102, however, provides a number of specific requirements:

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

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: Every IDOC institution operating as of July 2017 has provided a list of staff designated to the Crisis Intervention Team and has represented that each listed person has participated in the required training. Not all lists reflect staff's positions, but many indicate that MHPs, nurses, and lieutenants are included. This has also been confirmed during onsite interviews and the monitoring team has observed crisis intervention paperwork signed by nurses, MHPs, and other disciplines. The monitoring team does not have information about whether Crisis Intervention Team Members participate in quality assurance meetings.

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 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 institution has provided the locations of their designated crisis care areas. The monitoring team has viewed the crisis care areas in each facility toured and has found them to have the required features. For the most part, crisis care is not in segregation, but there are notable exceptions. For a full discussion, please see X(f), above.

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: To date, 22 institutions have provided this written procedure with the required components. The monitoring team will verify the status of procedures in the remaining facilities in upcoming monitoring periods.

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: 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: There are extensive references to staff notifying the Crisis Intervention Team found in incident logs, incident reports, health care records, referral documents, four-point restraints documentation, and use of force videos. For example, in reviewing a sample incident logs, all but two facilities recorded Crisis Intervention Team referrals and these totaled 627 in just a few months. IDOC has supplied the monitoring team with memos to wardens reinforcing this requirement as a very important obligation and encouraging investigation of all accusations of failure to notify the Crisis Intervention Team. At the same time, it has been very troubling that the Monitor has received sustained complaints at some institutions from offenders asserting that their requests for crisis intervention did not receive a response.

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: Please refer to section V(g), above.

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: Each institution provides a log of crisis watch placements to the monitoring team monthly. In any given month, one or two low custody-level institutions may have no placements, but all other facilities use crisis watch regularly. From June 2017 through February 2018, 4,480 crisis watches were captured on logs. Examples of placement for each of the specified reasons have been evident in health care records, crisis watch logs, and incident logs, and MHPs confirm in interviews that there regularly are placements for these reasons.

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: Health care records reflected that MHPs, Crisis Intervention Team members, or regional administrators make the decision to initiate crisis watch, including specifying the level of supervision. The monitoring team has observed orders concerning allowable property, and has observed patients consuming meals without utensils, but has not systematically reviewed whether these are ordered. In all videos viewed by the monitoring team in which a patient was brought to crisis watch by a tactical team, the videos confirmed that a strip search takes place; the video and reports are silent as to whether the cells are inspected for safety. There are a troubling number of incidents in which patients have materials in crisis watch with which they self-injure.

It is common for the monitoring team to observe officers conducting continuous or periodic watches and recording them on the Crisis Watch Observation Log. The team has also noted these logs stored in health care records but has not undertaken a review of them.

It is the practice in IDOC for MHPs to meet with crisis watch patients daily. The monitoring team analyzed 126 crisis watch placements drawn from eight institutions. MHPs at Big Muddy River, Lawrence and Pinckneyville met these patients daily with only a very rare missed day. Hill, East Moline and Illinois River generally upheld the standard, but there were some cases with significant gaps. Danville and Robinson appeared to struggle with this requirement, with substantial gaps, or sometimes no documentation at all, in a majority of the placements reviewed. Progress notes reflected meaningful therapeutic contacts and, where the monitoring team was able to observe these contacts, they were tailored, goal-directed, genuine treatment. As discussed in subsection XIX, these contacts could be hampered in facilities that conducted them cell side—which the team observed among these institutions as well as other facilities outside this group--but were

run effectively in private rooms at other institutions. MHPs did evaluate and document the patients' readiness for discharge consistently in this sample reviewed.

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: The Department is meeting this requirement.

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: Five mentally ill offenders committed suicide during the monitoring period. The Administrative Reviews and Psychological Autopsies were completed on four of the five suicides at the time of this report.

As reported in the first annual and midyear reports, the Administrative Reviews in these cases make recommendations, but they contain no clear corrective action plan that delineates who is responsible for following up on each recommendation, the time frame in which changes should be made, or the plan to reassess problem areas. IDOC Administrative Directive 04.04.102 (Suicide Prevention and Intervention and Emergency Services) is also vague in this area, specifying no action beyond simply reporting the Administrative Review team's findings to the Chief Administrative Officer, Training Coordinator, and Chief of Mental Health. This is a critical flaw in IDOC's suicide prevention strategy, rendering the mortality reviews essentially meaningless for affecting systemic change. Also, the psychological autopsy refers to the corrective actions in the administrative review. The net result is the lack of a systematic, departmental corrective action plan. This means that the lessons learned from these suicides, at best, remain at the particular institution where the suicide occurred.

These post-suicide reports are an essential tool that the Department could better use to improvement the treatment of all mentally ill offenders. These reports, including corrective action plans, require wide dissemination throughout the Department. It has been the Monitor's observation that these post-suicide reports are not being utilized in this manner.

(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: Not much has significantly changed regarding these requirements during the reporting period. As was previously reported, IDOC has shown some improvement in its ability to meet the requirements of this section of the Settlement during the monitoring period. Overall, however, IDOC falls short of being in substantial compliance. All the items in this section are of critical importance. Ongoing concerns about the responsiveness of the Crisis Intervention Teams requires constant supervision and training of all staff involved. The poor quality of psychiatric and mental health services leaves mentally ill offenders at increased risk for suicide and contributes to their spending excessive periods of time in crisis and restraints. The administrative review process of offender suicides needs to be rethought. The current process does not allow for corrective action to be implemented throughout IDOC to prevent future suicides.

XVII: PHYSICAL RESTRAINTS FOR MENTAL HEALTH PURPOSES

Summary: Restraints are used in just over half of IDOC facilities but are concentrated in just three. Orders are issued only by the correctly licensed staff who observe the time limits but may not always conduct face-to-face assessment even though they are onsite.

It appears that some facilities could attempt less intrusive means more often, though very recent improvements are promising. Criteria for release are always indicated.

A significant minority of restraints uses—about 20%--extended from one to four days. Documents suggested there could be very long intervals between efforts to monitor and mitigate the health effects. However, previous practice in restraining offenders over their heads has been corrected, and there was no indication of restraints being used as a disciplinary measure.

The monitoring team is finding 14 institutions in Substantial Compliance with subsection XVII(a), the use of restraints for mental health purposes.

(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:

The Department modified its policy concerning restraints, Administrative Directive 04.04.103, in November 2017. The monitoring team reviewed institutional logs and a 23% sample

of the restraints uses therein.[35] Over the period of review, there were 196 uses of restraints for mental health purposes. They were highly concentrated at Pontiac (90), Logan (46), and Dixon (36). Both Dixon and Pontiac saw substantial *reductions* in their use of this method in recent months. Another 12 institutions used restraints minimally—four or fewer times in the period reviewed—and another 12 did not use them at all.

Reviewing for adherence to IDOC policy, the team found that initial orders are always written for four hours or less. They are generally written by psychologists and occasionally by psychiatrists or other physicians, all of whom meet requirements. A face-to-face assessment is required unless there are no such professionals onsite; this was only clearly met in 62% of reviewed cases.[36]

Making efforts at less intrusive intervention was also a weakness. Orders are written on DOC 0376, which calls for this information, but no reviewed cases had such an entry. In some cases, increasing the level of supervision, or consultation with a psychiatrist, were evident, but these were a minority. Since March, Pontiac staff, supported by regional and headquarters staff, have concentrated on routinely employing less intrusive means, and this has significantly reduced the number of restraints uses in a very short time. While all institutions recorded the rationale for the orders, as required, about 25% of them suggested that less intrusive methods would ordinarily have been called for. There was no indication of restraints being used as a disciplinary measure.

Orders were consistently reviewed timely and 40% of restraints were removed by the end of four hours. Where extension orders were written, they were written for no more than 16 hours, with extremely rare exceptions. For the most part, initial and extension orders did specify criteria for release and it was assessed both at the orders' expiration and, in about 25% of cases, well before then. A troubling countertrend at Pontiac, however, was the 10% where staff notes suggested the criteria had been met, but restraints were not removed for several more hours.

Policy requires staff to release a restrained person's limbs every two hours and to monitor vital signs every four hours. The records from most institutions either showed problems in this regard or were not provided. Illinois River, Joliet, Pinckneyville, and Western Illinois documented good practice with limb releases. Pontiac's practice was highly variable; a majority were compliant or nearly so, but noncompliant records showed disturbingly long gaps. The monitoring team also reviewed videos of 12 limb releases at Pontiac. All were handled respectfully with a reasonable amount of time unrestrained; access to food, water, and toileting; and nursing checks of restraint tightness and radial and pedal pulses.

A significant minority of restraints uses—about 20%--employed multiple extension orders extending up to four days. These occurred almost exclusively at Pontiac. In one complex and disturbing case, a patient at Stateville has been restrained continuously for at least nine *months*.

A few institutions bear highlighting in this discussion. Pontiac has had significant issues in

[35] IDOC provided logs for all institutions for July 2017 through February 2018, as well as March and April logs for Pontiac, the institution with the highest amount of usage. The team reviewed 45 records drawn from 12 of the 15 institutions at which restraints were used, and the sample was more heavily weighted to Pontiac.

[36] A case was determined to be compliant if each order—initial and extension—involved a face-to-face assessment OR a telephone order where the need for an order arose outside of business hours.

restraints use during the year but has also made meaningful progress in addressing them. It has by far the highest use, twice as many as the next institution. It also is responsible for nearly all restraints lasting longer than 20 hours;[37] there are only two other instances systemwide. Staff is 100% compliant in ensuring that orders are written and renewed within the required lengths of time and with criteria for release included, but there are indicia that less restrictive means have not been attempted as much as advisable, telephone orders sometimes substitute for face-to-face assessments during working hours, and there can be long gaps in the documentation of limb releases and vital sign monitoring. Through 2017, at least some patients were restrained with their hands above their heads. However, each of these factors shows significant improvement in April. Pontiac bought new restraints beds in early 2018 and all subsequent videos viewed by the monitoring team demonstrate that patients' arms are now consistently restrained by their sides. Staff has concentrated on attempting less intrusive methods and the number of cases dropped dramatically in April. Several aspects of documentation also improved that month. These are promising signs.

While Stateville only has one restraints case, it is an extraordinary and troubling one in which the man has been *continuously* restrained since May 2017, reportedly both for mental health and medical reasons. While it is clear a higher level of care is indicated, the patient has been treated at Dixon and staff report they have made referrals to the Illinois Department of Mental Health, a private psychiatric hospital, and the Federal Bureau of Prisons, each of which denied a transfer. An Interstate Compact exchange was reportedly considered but rejected as inappropriate.

Orders for this man are renewed at the required intervals each day. The monitoring team has reviewed over 300 pages of these orders; they appear to show extremely infrequent face-to-face contacts and capture much less detail than is present in some shorter-term cases about releases for walks, showers, or attempts to manage the patient without restraints. However, staff provided a summary of efforts in recent months, including planned, specific incentives and a weekly clinical and custody administration case conference, and there are reportedly dozens of health care record volumes with additional, related information. The Monitor will review this case in more depth and work with IDOC to determine the placement and treatment options that have a greater chance of reducing this highly undesirable situation.

In general, the restraints cases reviewed by the monitoring team at Logan and Dixon were handled well. With much of the restraints use concentrated at these institutions, continued monitoring is warranted in the upcoming year.

Hill and Western Illinois infrequently used restraints, restricted the use to short periods, and consistently fulfilled requirements in all the domains discussed above. The following institutions are in substantial compliance with XVII(a)'s provisions concerning Use of Restraints for Mental Health Purposes: Big Muddy River, Centralia, Decatur, East Moline, Hill, Jacksonville, Kewanee, Lincoln, Robinson, Southwestern Illinois, Taylorville, Vandalia, Vienna, and Western Illinois.

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[37] That is, going beyond an initial order and one extension order.

(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

(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: The Department is meeting these requirements at the majority of its facilities. The Monitor has previously reviewed the Institutional Directives called for in this subsection of the Settlement Agreement for 21 facilities. This was reported in the midyear report.

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

Findings: In the monitoring team's reviews, there was no indication that restraints were used for punishment.

(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: Due to the problems noted in subsection (a), above, the provisions of this subsection have not been fully implemented at this time.

Psychiatrists in other correctional as well as community settings routinely evaluate patients that require restraints for the need of emergency psychotropic medication. It is unclear to the Monitor why IDOC doesn't adhere to this minimal standard of care. The Department should review this practice and strongly consider the appropriate administration of emergency psychotropic medications for those mentally ill offenders that require placement in restraints. The use of medications would likely reduce the length of time that a mentally ill offender has to remain in restraints.

XVIII: MEDICAL RECORDS

Summary: The required forms are in wide use in IDOC. A modified 0284 (treatment planning form) was approved by the Monitor as was a new "Crisis Care" form. These forms were put into use on February 1, 2018.

The disorganized and incomplete condition of the medical records is often an impediment to treatment and continuity of care.

(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: Throughout 2017-2018, the monitoring team has observed the first 10 forms consistently in use in health care records throughout the state. Reviewers have occasionally encountered form 0371 documenting refusals. In the suicides that have come to the Monitor's attention, a 0375 Psychological Autopsy was completed. IDOC is in substantial compliance with this provision.

(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: The monitoring team did not evaluate this requirement during the current monitoring period.

XIX: CONFIDENTIALITY

Summary: The monitoring team did not review the DOC 0269 forms during the reporting period. AD 04.04.100 was updated during the reporting period to reflect that all mental health and psychiatric interactions with offenders "shall" be conducted in a confidential manner. This has not been happening consistently during the reporting period. The best example of confidential interactions between staff and offenders occurs during the intake screening process. Please note that the incidence of confidential interactions has improved over the duration of the Settlement Agreement. Unfortunately, there still remains numerous examples of critical staff-offender interactions occurring in nonconfidential settings. These include but are not limited to daily crisis watch contacts, routine MHP contacts and psychiatric evaluations.

The Monitor approved an omnibus informed consent document on November 7, 2017. This was done to address the deficient state of informed consent practices within the Department. More experience with this new form is required to properly assess its efficacy.

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: The subsection of the Settlement Agreement was not monitored during this reporting period.

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 date 6/1/2017, to address the policy and procedure requirement of this subsection of the Settlement Agreement. Training on these policies and procedures is included in correctional staff training. IDOC will receive a rating of noncompliance for this subsection due to the fact that they were over six months tardy in responding to 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
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> 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.
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> 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: Subsection II(F)(2)(b) of AD 04.04.100, effective date 6/1/2017, establishes the requirement for confidentiality within IDOC. It states "All mental health services **shall**, (emphasis added), be conducted in a manner which ensures confidentiality and sensitivity to the offender

regardless of status or housing assignment. As reported in the midyear update "Throughout the course of this reporting period, the monitoring team found persistent examples of this requirement not being met. These include but are not limited to daily crisis evaluations being conducted cell side, custody staff standing within hearing distance of clinical encounters, and groups being held in open areas where custody routinely pass through."[38]

The best examples of IDOC fulfilling their confidentiality requirements can be found in the R&C units. As reported in section IV above, the monitoring team observed that all mental health screening took place in settings that allowed for confidentiality. This fact is evidence that IDOC is capable of meeting the requirements of this section of the Settlement Agreement.

IDOC continues to struggle with meeting the requirements of this subsection of the Settlement Agreement. Daily crisis evaluations are being conducted cell side at Pontiac North House. This problem at Pontiac was exacerbated during the reporting period as construction occurred on the protective custody gallery. This meant that during the period of construction, mentally ill offenders were not able to be housed on this gallery where they at least had the option of being seen in a confidential setting.

Confidentiality practices are varied with crisis watch patients in the minimum- and medium custody institutions monitored. Hill and Illinois River have good practice, using private offices for crisis watch contacts. Big Muddy River, Danville and East Moline were seeing patients cell side but have since made important improvements allowing these contacts to be private; East Moline took the added step of retrofitting a space to make this possible.

Dr. Kapoor reports that although confidentiality of mental health assessments in the X-House at Dixon has improved, crisis assessments are still done at cell side in complete view of officers and within earshot of other inmates. In addition, it appears that psychiatric evaluations are again being conducted cell side, even though the facility built confidential evaluation rooms in the X-House for this purpose.

Confidentiality practices are strong for general population and Segregation contacts at the minimum- and medium custody facilities the monitoring team visited. The team observed all of these spaces and tested out their sound level, and their sound and visual privacy, and clinicians reported that they feel confidentiality is protected and they have good cooperation with custody staff in this regard. Big Muddy River, Danville, East Moline, Hill, Illinois River, Lawrence, Pinckneyville, Robinson, and Stateville all permit 1:1 contacts with no officer in the room nor posted close enough to hear. These occur in offices in the mental health unit, in the infirmary, on the living units, and in hallway offices. Only one institution routinely posts an officer in the room for telepsych appointments, and the monitoring team encouraged a change in this practice.

At these institutions, general population groups are generally offered in education building classrooms. Converted rooms on or near the housing units provide group space in Segregation and, in a few instances, for general population. Some are completely away from traffic. Others are adjacent to other activity, but prisoners do not queue there and groups do not seem unduly exposed to officers. Officers are not in the rooms; in some cases, they are posted outside, but the monitoring

[38] Monitor's Midyear report of November 22, 2017, pages 89-90.

team observed them to be at a reasonable distance. Two institutions do not meet these standards in their Segregation structured activity space; the monitoring team discussed alternatives with their administrations.

Some progress is being made in other institutions in that more staff offices and interviewing rooms are being constructed where staff are able to see their patients in a confidential setting. IDOC reports that different institutions—including Stateville NRC, Pontiac, and Menard--have carried out construction to create confidential clinical space or improve existing space for this purpose. The monitoring team has observed a substantial increase in treatment space at Pontiac in 2018, including creative use of space for groups in West House and a very private space nearing completion for MHP individual contacts, and telepsych, in that same building. Additionally, IDOC reports that some institutions have adjusted offender movement patterns in service of supporting confidentiality in mental health appointments.

(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:

> 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.[39]

Findings: For the first 18 months of the Settlement Agreement, there was little indication that IDOC paid attention to this important requirement. This lack of attention was due in large part to the tremendous shortages of both MHPs and psychiatric providers. On 11/7/17 the Monitor approved the use of a new omnibus consent form in hope that this new form would help address these deficiencies. At the time of this report, it is too early to fully assess the impact of this new

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[39] 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.

form. The monitoring team will continue to monitor this important issue moving forward.

XX: CHANGE OF SMI DESIGNATION

Summary: Changes of SMI designation is currently not being surveyed by the Department. Overall population data reveals that the absolute number of SMIs in the Department has increased during the reporting period. This absolute increase, however, does not address this requirement. The Monitor will request that IDOC collect data on this topic during the 3rd year of the Settlement Agreement. Reports continue to reach the Monitor regarding mental health staff being pressured to remove on offender's SMI designation prior to disciplinary proceedings. The Monitor will personally investigate these alleged incidents during the next reporting period.

Specific requirement: The determination that an offender, who once met the criteria of seriously mentally ill, no longer meets such criteria must be made by the offender's mental health treatment team and documented in the offender's mental health records. Until mental health treatment teams are established, this function shall be performed by a treating MHP.

Findings: As was previously reported: **"**The monitoring team found good practice on this requirement at Dixon; team members also spoke with the Psych Administrators at three institutions to learn their local practices. At Stateville, change in diagnosis or SMI status are both data points that are logged after every psychiatry appointment; in such cases, the full mental health team reportedly would meet to discuss whether they concur. Hill staff report they would consult the IDOC and Wexford regional administrators and would follow the patients for three to six months after any such change in designation, particularly if the inmate was being considered for removal from the caseload.

The Pinckneyville Psych Administrator anticipates such changes would be rare, since they have not occurred during her tenure and she finds little disagreement among the department's disciplines. She asserts that, should such a case occur, she would convene a case conference and would only approve the change if the entire treatment team agreed. When offenders request to be seen only as needed or to come off the caseload, there are forms for department or Wexford approval and, like Hill, the staff would maintain the SMI designation while monitoring the inmate for a number of months.

This information serves as part of the picture concerning changes in SMI designation; the monitoring team has not undertaken a systematic investigation of this issue. The monitoring team continues to receive reports that mentally ill offenders are losing their SMI status prior to disciplinary proceedings. These reports are unsubstantiated at this time. The monitoring team will attempt to conduct a systematic review on this issue for the 2nd annual report."[40]

The Monitor attempted to conduct a systematic review of this issue for the 2nd annual report. This review was presented with challenges as change of SMI designation is not a statistic

[40] Midyear report of Monitor Pablo Stewart, M.D., page 92

that is surveyed by IDOC. An overall review of the number of SMI offenders within IDOC demonstrates that this number continues to rise. For example, the number of SMI offenders was 5027 on December 22, 2017. This number rose to 5111 on April 12, 2018. This statistic, however, only establishes that the overall number of SMIs is increasing. It does not say anything about individual SMI offenders who may be losing their status inappropriately. The Monitor has continued to receive reports of mental health staff being pressured by facility leadership to remove the SMI designation of a mentally ill offender prior to disciplinary proceedings. Th Monitor will personally investigate these incidents moving forward.

Beginning in year three of the Settlement Agreement implementation, I will request that IDOC track the number of mentally ill offenders who have a change of their SMI designation including the reason why the change was made.

XXI: STAFF TRAINING

Summary: IDOC timely submitted a staff training plan. The implementation of that plan was also accomplished in a timely manner.

The Department should modify its training protocol to include a peer-mentor component.

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: As previously reported, IDOC has met this requirement by submission of this plan and program for staff training to the Monitor within one (1) year following the approval of the Settlement Agreement.

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: Chief Lindsay confirmed that this training requirement was completed within the requisite timeframe. The monitoring team will work with IDOC to review verification of this training as well. As I testified during the evidentiary hearing, this training should include a peer-mentor component. That is, after the classroom training is completed, staff should be paired with experienced peer-mentors to more closely observe how the theoretical information about dealing with mentally ill offenders is applied in real world situations.

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 within the deadline of May 22, 2017.

XXII: PARTICIPATION IN PRISON PROGRAMS

Summary: This requirement was not reviewed during the current reporting period.

(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: This requirement was not reviewed by the monitoring team for the 2nd annual report.

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

Summary: The Department still has problems ensuring the continuity of care when mentally ill offenders are transferred within and between facilities.

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 meeting the requirements of this subsection of the Settlement Agreement.

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: This requirement has not been consistently met during the reporting period. The monitoring team came upon numerous examples where the receiving facility had not been made aware of an offender's particular mental health needs. This problem also is occurring in transfers within a given facility. Problems were noted at Dixon in transfers between the STC and the segregation unit in the X-house.

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: As the above-described problems occurred during the 2nd year of the Settlement Agreement, IDOC is currently not meeting this requirement

XXIV: USE OF FORCE AND VERBAL ABUSE

Summary: Incident logs suggest that use of force is concentrated at three institutions, took place rarely at another 17 facilities, and did not occur during the monitoring period at six institutions. The monitoring team finds 11 institutions in Substantial Compliance.

A large majority of the reviewed incidents were handled professionally and according to procedure. Tactical teams rigorously follow required procedures with 55% of reviewed activations resulted in no force. Takedowns kept the level of force to a minimum and were clearly well-handled in at least 75% of reviewed cases. With a mentally ill population, it is always a question whether force is used when the patient's mental state prevents him from understanding and complying and other means are necessary to gain control; in the incidents reviewed, however, IDOC managed this situation well. A large number of staff are newly receiving de-escalation training and it will be institutionalized in new officer training and in De-escalation Response Teams.

On the other hand, the monitoring team does have some concerns about whether force is 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 and bear continued monitoring by facility leadership and the monitoring team.

Corporal punishment is an open question with persistent complaints at Pontiac that the Monitor finds credible and which have not, in his view, been adequately addressed in almost 24 months of raising it. Multiple examples of alleged custody staff abuse as well as several alleged incidents of unprofessional conduct at Logan are very troubling.

Specific requirements: IDOC agrees to abide by Administrative Directives 05.01.173 and 03.02.108(B)[41] 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

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[41] 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).

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

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: For purposes of this assessment, the monitoring team considers "use of force" to encompass takedowns or other physical means to bring an offender under control, beyond ordinary restraints; use of OC; and activations of tactical teams, whether they ultimately engage in force or not. In the monitoring team's understanding, uses of force are not tracked separately, but are included in facility incident logs. In doing so, facilities sometimes use different recording methods and language. For these reasons and because it is difficult to prove a negative, it is not possible to establish with certainty the exact number of uses of force or whether all are captured in the system. While one can neither confirm nor rule out the claims of undocumented uses of force, the substantial number that are documented indicates a functional system in place. Incident logs indicate that there are six IDOC institutions that did not use these types of force in the period reviewed, 17 facilities where it is rare, and three facilities where it is concentrated—Dixon, Logan, and Pontiac. Of note, the most seriously mentally ill offenders are housed at these three facilities.

To assess compliance with use of force requirements, the monitoring team reviewed documentation of 192 incidents involving mental health patients, drawn from 18 facilities.[42] Documentation sources varied. All were identified by log entries, many of which gave a detailed description. Some were supplemented by emailed or incident report summaries, while apparently full incident reports supported 82 of the reviews. Additionally, the team reviewed 29 videos of calculated use of force.[43]

As noted above, the following are the keys to appropriate use of force under the Code: (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, (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, and (d) corporal punishment is prohibited.

While much is being handled well, the monitoring team does have some concerns about whether force is 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).

First, the positive. A large majority of the incidents appeared to have been handled professionally and according to procedure. Tactical teams rigorously follow the Administrative Directive steps[44] and, when a team was activated, 55% of reviewed incidents concluded without force being used. OC was often used to break up offender fights to prevent further injury. Takedowns kept the level of force to a minimum and were clearly well-handled in at least 75% of reviewed cases. With a mentally ill population, it is always a question whether force is used when the patient's mental state prevents him from understanding and complying and other means are necessary to gain control; in the incidents reviewed, however, IDOC managed this situation well and, with very few exceptions, the force was necessary given the patient's behavior in his decompensated state.

There were, however, exceptions where it appeared other means were available and could have been adequate. There were incidents where a general population offender was running away from an officer, or turning away from the wall and arguing during handcuffing, and the officer's response was to use OC. Despite the general pattern of responding as needed with decompensated patients, there were a few videotaped cases where there was no apparent danger or urgency to a crisis watch or segregation extraction; delaying the extraction and attempting other means of influence would have been an adequate next step that might have rendered force unnecessary.

Some other cell extractions used OC but the tactical team almost immediately entered the cell and very rough takedowns were necessary because of the offender's violent resistance. Giving the OC time to take effect would have been an adequate next step that, while there are no

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[42] These were identified in institutional incident logs spanning June 2017 through March 2018. Some incidents were reviewed from each of 18 institutions; since the highest number of incidents is evident at Pontiac, that institution provided the largest number of incidents in this review as well.

[43] The team also reviewed videos of enforced medication administration and use of four-point restraints, but those are not included in this analysis. They are discussed in sections XIII and XVII, respectively.

[44] Based on those steps visible in the videos viewed.

guarantees, might have rendered additional force unnecessary. About 24% of the OC use was to stop an offender in the act of self-harm either in crisis watch or in housing. Reports depicted a few of these cases as very urgent, but most did not have that appearance. IDOC policy calls for this intervention, but in the Monitor's experience, such usage should be extremely rare and the Monitor objects to this type of use as a general policy.

Some other incidents suggested that force may have exceeded the degree reasonably necessary. There were incidents where the custody staff, including supervisors, wrote that they punched the offender. There were incidents where only one of the statements mentioned an offender's injury, or its occurrence was unexplained or other key facts were missing, or those descriptions were highly unusual; these reports raise questions. There are also suggestions of unnecessary suffering where decontamination appeared delayed or may or may not have been refused; it was also common in videos for offenders to be kept on their knees for 10- to 20-minute stretches after they were restrained and were awaiting steps in the process.

All told, about 30% of reviewed incidents demonstrated these types of problems or, more often, raised questions. Among these identified issues, the most frequently occurring were reports with missing or unusual descriptions of key information, and OC use to stop self-injury. For all other issues, each had a small number of examples, so they may or may not rise to a pattern, but they bear monitoring both by the institutional leadership and the monitoring team.

As to the other core features of the Code, use of force did appear to be terminated as soon as force was no longer necessary although, as mentioned, while the need to continue control of certain offenders remained, there may be equally effective, and less harsh, methods to do so without maintaining them on their knees for lengthy periods. Officers routinely offered medical screening and care on the videos, and the screening was sometimes recorded, and officers noted its occurrence in reports. It does appear this takes place, although fairly often there was no incident report statement from nursing staff or note evident in the health care record so it was not possible to definitively verify this.

Corporal punishment did not come to the monitoring team's attention in these reviews,[45] which suggests the prohibition is being honored. At the same time, the Monitor must take into account the equally serious, ongoing reports of physical abuse carried out by the custody staff on mentally ill offenders at Pontiac. The Monitor has personally interviewed numerous mentally ill offenders at Pontiac who give very credible reports of abuse being carried out by the custody staff especially on the mental health unit and on the North House. The Monitor also has received copies of at least 25 court filings that outline similar incidents of physical abuse as well as multiple reports from plaintiffs' counsel about these type of incidents. The Monitor has reported these incidents to IDOC leadership for at least the past 18 months to no avail. The Monitor takes this issue extremely seriously and looks forward to immediately working with IDOC to resolve this issue.

In terms of the specific Administrative Directive requirements governing tactical teams, OC use, and cell extractions, these appear well-executed. The tactical teams are constituted as required, and members are assigned to and perform the specified roles. A review of videos

[45] There could be an argument that the extended kneeling is corporal punishment, but there is no indication of intent in those actions.

indicates the specified equipment is available and in use. The monitoring team did not examine the chain of command authorizations, notifications, and preparations preceding and after the incidents, but the fact that other aspects of the reports and filmed procedures hue closely to the requirements suggests that these are also being conducted.

Videos were available for all but one of the monitoring team's requests and were labeled consistent with the provisions of 501.70, suggesting this is common practice. In a small number of cases (14%), the lighting, or where the camera was placed, did not allow the viewer to see the activity for some portions of the incident. The offender was always given direct orders and told what to expect if he did not follow them. Many of the incidents were undertaken with a minimal amount of force; the exceptions are described above. The monitoring team did not examine cell decontamination practices, but it appeared routine to offer and provide eye wash to flush offenders' eyes, again with the few exceptions noted above. Incident reports are routinely prepared. The monitoring team did not examine the administration's system for review of incident reports, though review signatures were noted.

Finally, IDOC reports that it has undertaken a very useful initiative training staff in de-escalation techniques that have the potential to generate voluntary offender compliance and prevent the need for use of force. The monitoring team is informed that more than 1,500 staff have completed the training and that it has been integrated into training for all incoming Correctional Officer Trainees and Correctional Treatment Officer Trainees. The Department is in the process of creating and training De-escalation Response Teams. This is a most welcome development.

Overall, 12 institutions have a substantial track record of not conducting force or conducting only force that is necessary and not excessive, and they appear to be in compliance with the other Code and Administrative Directive provisions. The monitoring team finds the following institutions in substantial compliance as to Use of Force: Decatur, East Moline, Graham, Jacksonville, Kewanee, Robinson, Shawnee, Sheridan, Southwestern Illinois, Taylorville, and Vienna.

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.

Findings: There have been several critical issues in regards to "Professional Conduct" during the reporting period. The first is a series of vandalisms that occurred to the cars of mental health staff while they were parked in the staff parking lot at Logan. Several cars were "keyed" between December 2016 and October 2017. A new Chief Administrative Officer, Warden Austin, came to the facility in August 2017. An investigation began during the summer of 2017. The Monitor has not been informed of the results of this investigation. The working hypothesis has been that the perpetrators of this vandalism are custody staff upset about the ever increasing mental health focus of the facility. I must emphasize that this is just a hypothesis at this time and has not

been proven. Regardless, this is a very significant incident which Warden Austin is taking very seriously. I look forward to being informed of the results of the investigation into these incidents.

The Monitor has recently been informed of an alleged incident of a mental health staff being overtly intimidated by custody staff at Pontiac. I must emphasize that this is an alleged incident at this point. The Monitor will personally investigate this allegation during the next reporting period.

The psychiatric literature regarding stress reactions among law enforcement officers clearly demonstrates that rates of excessive force increase when an officer suffers from increased levels of stress. After observing the mentally ill offenders and the custody staff at Pontiac for the past two years, it is abundantly evident that the staff is suffering from a chronic stress reaction from working with this challenging population of mentally ill offenders. The staff are in great need of therapy and support. The degree of stress that plague the staff is no excuse for physical abuse, however. A much greater degree of psychiatric services for the mentally ill offenders combined with psychological support for the custody staff would go a long way at reducing the incidents of staff abuse.

XXV: DISCIPLINE OF SERIOUSLY MENTALLY ILL OFFENDERS

Summary: Very little has changed in this area since the November 2017 data-driven analysis of 10 facilities for the months of June and July 2017; the same problems that were highlighted then continue in March 2018. These problems include: the quality of mental health (MH) evaluations documented on the DOC 0443 form is generally poor, MHPs are not performing face-to-face assessments of SMI offenders after they are charged with disciplinary infractions, the specific recommendations made by MHPs regarding the length of an offender's confinement in segregation appear to be chosen at random, ranging from 0 days to 6 months, with no clear rationale, at several facilities, every single Mental Health Review (0443) form contained identical language, and every single one determined that the inmate's mental illness did not contribute to the offense behavior and some facilities are not following IDOC policies regarding discipline.

The review did find some positive aspects, including: segregation is not being used as a punishment (for SMI offenders) for 300- and 400-level infractions at any IDOC facility, the Adjustment Committee consistently receives and reviews input from Mental Health regarding SMI inmates and unlike the report from November 2017, mentally ill offenders are not being written up for refusing medications, hording pills or self-injurious behavior.

There has been improvement but much more is needed before a substantial compliance rating can be assigned to this section of the Settlement Agreement.

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: For the purposes of this report, Assistant Monitor, Reena Kapoor, M.D., conducted the following data-driven analysis: Dr. Kapoor reviewed the Adjustment Committee reports, Mental Health Disciplinary Review (DOC 0443), and Offender Disciplinary reports (DOC 0317), for approximately 20% of disciplinary incidents involving SMI offenders that were adjudicated during March 2018 at the following facilities:

1. Big Muddy River – two incidents involving two offenders
2. Centralia – four incidents involving four offenders
3. Danville – one incident
4. Graham—four incidents involving three offenders
5. East Moline – two incidents involving two offenders
6. Hill – two incidents involving two offenders
7. Illinois River – eight incidents involving six offenders
8. Lawrence – six incidents involving six offenders
9. Lincoln – one incident
10. Logan – eight incidents involving eight offenders
11. Menard – seven incidents involving seven offenders
12. Pinckneyville – six incidents involving five offenders
13. Pontiac – 27 incidents involving 27 offenders
14. Robinson – two incidents involving two offenders
15. Shawnee – four incidents involving four offenders
16. Sheridan – four incidents involving four offenders
17. Southwestern – two incidents involving two offenders
18. Stateville – five incidents involving five offenders
19. Vandalia – one incident
20. Vienna – four incidents involving four offenders
21. Western – two incidents involving two offenders

Her results follow:

Overall Findings

Very little has changed in this area since my November 2017 data-driven analysis of 10 facilities for the months of June and July 2017; the same problems that I highlighted then continue in March 2018. First, I will mention the good things:

1. Segregation is not being used as a punishment (for SMI offenders) for 300- and 400-level infractions at any IDOC facility. This is consistent with IDOC's revised policies and the Settlement Agreement.

2. The Adjustment Committee consistently receives and reviews input from Mental Health regarding SMI inmates. This is also consistent with IDOC policy.

3. In contrast to my November 2017 findings, I did not see any cases in which inmates received Disciplinary Infractions for behaviors that would be better handled through clinical intervention, such as refusing medication, hiding pills, or self-harm.

Several problems remain:

1. As I noted before, the quality of mental health (MH) evaluations documented on the DOC 0443 form is generally poor. In the vast majority of evaluations that I reviewed, the MHP did not clearly state a rationale for his/her conclusions or recommendations. This is particularly problematic in cases where the MHP has drawn sweeping conclusions that are unfavorable to the offender, such as that the offender "is manipulating the system to get what he wants" or "has a manipulative communication style" (see below for details).

2. MHPs are not performing face-to-face assessments of SMI offenders after they are charged with disciplinary infractions. The 0443 form is completed based on a chart review and/or discussion amongst the mental health staff, with no mention of ever asking the inmate about his/her version of events. This lack of face-to-face assessments is most likely due to understaffing and/or the tremendous work load for which MHPs are responsible.

3. The specific recommendations made by MHPs regarding the length of an offender's confinement in segregation appear to be chosen at random, ranging from 0 days to 6 months, with no clear rationale. As noted in my November 2017 report, additional training for the mental health staff across IDOC regarding how/why to recommend particular disciplinary sanctions to the Adjustment Committee may be helpful, as it appears that recommendations vary widely between facilities and individuals, with no clinical rationale for the differences.

4. At several facilities, every single Mental Health Review (0443) form contained identical language, and every single one determined that the inmate's mental illness did not contribute to the offense behavior. This raises concerns about the adequacy and individualized nature of the MHPs' 0443 assessments. In fact, in my review of 102 total disciplinary infractions for this report, only in one case did an MHP find that mental illness contributed to the offense.

5. Some facilities (Centralia, Danville, Sheridan) appear not to be following IDOC's policy that requires the Adjustment Committee either to adopt the Mental Health recommendations regarding sanctions for a SMI offender or to document clearly why this recommendation was not followed.

<u>Individual Facility Findings</u>

1. *Big Muddy River*

Two incidents were reviewed. One involved consensual kissing with another offender, and the other involved an offender who threw a cup of water at a wall. Both cases were reviewed by an MHP, and the Adjustment Committee then followed the MHP's recommendations. It was not clear whether the MHP actually assessed the offender after the disciplinary infraction; both 0443 reviews appear to have been completed based on chart review alone. In the latter case, I had some concern about the certainty with which the MHP reached a conclusion that the offender had a "manipulative communication style," especially since this finding was seemingly unrelated to the offense conduct in question. While I appreciate the MHP's effort to make an individualized assessment of the inmate, I would expect a thorough 0443 form to make a link between this description of the offender and the behavior resulting in the disciplinary infraction, or else to exclude such a pejorative description.

2. *Centralia*

Four incidents were reviewed. In all cases, an MHP reviewed the case and completed an 0443 form. In all cases, no rationale for the MHP's conclusion was provided; the form simply stated the MHP's conclusion that mental illness did not contribute to the offense behavior. It also did not appear that the MHP actually evaluated the inmate in reaching these conclusions.

In one of the four cases (inmate AB), the Adjustment Committee's final sanction was much greater than that recommended by Mental Health (45 days vs. 15 days in segregation). No rationale was given for the discrepancy, which violates IDOC's policy (05.12.133, Section H.2) for resolving differences between Mental Health and the Adjustment Committee. The policy 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 AB's case, The Adjustment Committee report contains the CAO's signature and notes that Mental Health recommended 15 days segregation, but it does not have any explanation for why the CAO thought it was appropriate to disregard this recommendation. A similar problem was noted in my November 2017 report about the disciplinary process at Centralia; it does not appear to have been corrected.

3. *Danville*

In the one incident provided for review, mental health gave a completely generic assessment of the offender, with no correlation between the clinical status and the

recommended sanction of 0-1 mo segregation and 0-2 month loss of privileges. In addition, the Adjustment Committee ultimately issued a higher sanction than mental health recommended (1 mo segregation, 2 mo C-grade, disciplinary transfer, and 1 mo loss of commissary) without providing any explanation for the discrepancy.

4. *East Moline*

Two incidents were reviewed. In both cases, the MHP opined that mental illness contributed to the offense and recommended a reduced sanction (verbal reprimand in one case, 5 days segregation and housing change in the other). The Adjustment Committee followed these recommendations in both cases.

5. *Graham*

Two of the four MH reviews are done in a detailed and individualized manner, including an interview of the offender after the alleged offense. The other two MH reviews contained boiler-plate language, and it did not appear than an interview was conducted. No documentation of the Adjustment Committee's final decisions was provided, so I could not assess whether Graham was following IDOC's policy to follow the MH recommendation unless a specific reason is documented as to why that was not done.

6. *Hill*

Two incidents were reviewed. I have some concern about the somewhat hostile and unsympathetic tone used by the Psych Administrator in her assessments. For example, one incident documents a history of irritability and poor frustration tolerance, but then concludes, "There does not appear to be any mitigating factors that contributed to the [offense] with the exception of his problems. If found guilty, segregation would be appropriate." In the other incident, she wrote, "He is manipulating the system to get what he wants," and recommended 45 days segregation for the offense of "stroking his penis while looking at MHP." In both cases, the Adjustment Committee followed the MH recommendations and clearly documented how they arrived at their conclusions.

7. *Illinois River*

Eight incidents were reviewed. It appeared that the Adjustment Committee reviewed Mental Health's recommendations in each case and followed these recommendations. The documentation from MHPs was poor; no rationale for the opinions was given on any of the 0443 forms.

8. *Lawrence*

Six incidents were reviewed. In all cases, the Adjustment Committee followed Mental Health's recommendations. However, the mental health evaluations appear to have been done poorly. They were based solely on chart review, and every single 0443 form

contained the exact same language, raising significant questions about whether MHPs are performing individualized assessments.

9. Lincoln

One incident was reviewed; an SMI inmate got into a fight with a peer over a card game. The MHP recommended "no more than 3 months segregation," and the Adjustment Committee decided upon 15 days. Again, it did not appear that the MHP interviewed the inmate or looked into the circumstances of the infraction before opining on the 0443 form.

10. Logan

Eight incidents were reviewed. All of the 0443 forms contained identical language about the MHP's opinion; no individualized rationale for the opinion was documented. Also, the opinion was based entirely on chart review and consultation with the treating MHP, and it did not include an interview of the offender regarding the circumstances surrounding the disciplinary infraction. The Adjustment Committee followed the MHP's recommendations in all eight cases.

11. Menard

Seven incidents were reviewed. In all cases, the MHP concluded that the offender's mental illness was unrelated to the offense conduct, and all of the documentation on the 0443 forms was identical. It was clearly a form note with the names changed for each case. No interview of the offender was conducted by the MHP, and the opinion about the offender's culpability was based on the last documented mental status in the progress notes. Given how poor the psychiatric care at Menard continues to be, this system for conducting MH/discipline assessments is inadequate. In all cases, the Adjustment Committee either followed the Mental Health recommendations or chose a lesser sanction.

12. Pinckneyville

Documentation related to 6 incidents was reviewed. In each case, the Adjustment Committee followed the MHP's recommendation regarding segregation placement. As in other facilities, the MHP's documentation of the rationale for his/her opinions is poor. The opinion was simply stated, without any justification or supporting facts, in all but one of the six cases.

13. Pontiac

27 incidents were reviewed. In all cases, the sanction imposed by the Adjustment Committee fell within the range recommended by Mental Health (e.g. 0-30 days). In all cases, the MHP opined that the offender's mental illness did not contribute to the offense conduct. Only one of the 0443 forms documented a clear reason for this opinion; all of

the others contained the same formulaic language. It was not clear to me that the MHP had performed a meaningful review of each individual case and offender.

14. Robinson

Two incidents were reviewed. In both cases, the Adjustment Committee followed Mental Health's recommendations. The MHPs completing the 0443 forms provided no rationale for their opinions regarding the appropriateness of segregation placement or its recommended duration.

15. Shawnee

Four incidents were reviewed. In all cases, the Adjustment Committee followed the recommendations from Mental Health regarding segregation placement. In contrast to my findings in November 2017, the MHP evaluations during this review were formulaic and did not appear to include an interview of the offender. All four 0443 forms contained identical language regarding the offender's mental state and the appropriateness of segregation, raising significant questions about whether an individualized assessment was completed.

16. Sheridan

Four incidents were reviewed. In three of the four cases, the Adjustment Committee imposed significantly harsher sanctions than those recommended by Mental Health, and the documentation includes no rationale for this discrepancy. The Adjustment Committee paperwork is signed by the Chief Administrative Officer, but he/she did not give a reason why the Mental Health recommendations were disregarded. This appears to violate IDOC's policy 05.12.133. In addition, the Mental Health evaluations at Sheridan were poor; they included no justification or supporting facts for the MHP's conclusions.

17. Southwestern

Two incidents were reviewed. In one case, the MHP's recommendation for no segregation time was followed by the Adjustment Committee. In the other case, the charge was thrown out (unrelated to the MHP's evaluation). Again, it did not appear that the MHP had evaluated the inmate after the disciplinary infraction; the conclusions were based on chart review alone.

18. Stateveille

Five incidents were reviewed. In all cases, the Adjustment Committee issued a sanction that was equal to or less than the recommendation of Mental Health. Again, the Mental Health documentation was poor, with no explanation of the MHP's conclusions or individualized assessment of the offender. In one case, the MHP seemed to recommend a

harsh sanction for no clear reason, stating that "0-6 months" of segregation was appropriate for a SMI offender who was caught with a tattoo needle.

19. Vandalia

One incident involving an offender who made threats toward a CO was reviewed. The MHP provided input that the mental illness did not contribute to the offense conduct. No justification for this conclusion was given. The Adjustment Committee issued a sanction that was less harsh than the recommendation from Mental Health (14 days vs. 30-45 days of segregation).

20. Vienna

Four incidents were reviewed. In all cases, the inmate's illness was determined not to have contributed to the offense conduct. These conclusions were reached based on chart review and consultation with the treating MHP, with no face-to-face evaluation of the offender. In all cases, the Adjustment Committee followed Mental Health's recommendations.

21. Western

Two incidents were reviewed. (The facility provided incident reports and emails related to several other incidents, but no corresponding Adjustment Committee reports or 0443 forms, so I could not draw any conclusions about these). In both cases, the MHP recommended that mental illness was "not a factor" in the offenses. The Adjustment Committee accepted this recommendation and issued a sanction that was within the range recommended by Mental Health.

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: The requirements of this subsection were not being met during the reporting period.

(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: As previously reported, the Monitor has not been approached by IDOC to consult on this specific requirement. However, Dr. Kapoor reported above "In contrast to my November 2017 findings, I did not see any cases in which inmates received Disciplinary Infractions for behaviors that would be better handled through clinical intervention, such as refusing medication, hiding pills, or self-harm."

(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 currently meeting these requirements. During the reporting period, however, plaintiffs' counsel raised concerns that this requirement wasn't being accomplished at Pontiac. In the Quarterly Report of April 25, 2018, IDOC reported "In response to concerns raised by the plaintiffs' at Pontiac, the Department has confirmed it is complying with this portion of the Agreement."

(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: Over the duration of the Settlement Agreement, the Monitor has been presented with several plans regarding this Behavioral Treatment Program. To date, this program has not been implemented in any IDOC facility.

XXVI: CONTINUOUS QUALITY IMPROVEMENT PROGRAM (CQI)

Summary: The Statewide CQI Manager, Dr. Sim, only began working fulltime in this position on January 16, 2018. He was able to develop and implement a monitoring instrument in September 2017. This instrument was found to not having a robust corrective action element. The instrument was modified and implemented January 2018. A tremendous amount of data has been collected. It is too early to determine if this new instrument will result in an improvement in the care of mentally ill offenders. Two significant problems persist, however. AD 04.04.104 remains in draft form with no implementation date set. Also, not all of the facilities have a designated mental health authority which is preventing IDOC from truly having a department-wide CQI program.

(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: Overall, this requirement is not being met by the Department. Both the statewide CQI Manager and the regional administrators audit facilities; each regional administrator is expected to review 450 health care records per quarter. However, as to self-audits, IDOC's Quarterly Report of April 25th states "Since September 2017 a standardized audit tool has been implemented at every facility **where a mental health authority is employed**," but at the time of the Monitor's midyear report, at least six facilities were without a mental health authority. At the submission of this report, at least seven facilities were without a mental health authority. This fact alone ensures that IDOC will receive a rating of noncompliance for this requirement.

This persistent staffing deficiency should not completely negate the progress that Dr. Sim has made regarding CQI. He did develop a monitoring instrument that was put into partial use starting September 2017. Due in part to the lack of a robust corrective action component to the September 2017 monitoring instrument, Dr. Sim introduced a modified instrument in January 2018. With this instrument, corrective action plans were generated based on the monthly audit data. Of note, these corrective action plans must be approved by the regional directors and the responsibility of implementing this plan falls on the mental health authorities.

Due to the implementation of this new instrument only occurring in January 2018, it is too early to adequately assess its effectiveness. Moving forward, the monitoring team will be evaluating both the effectiveness of the corrective action plans as well as the efficacy of the monitoring instrument itself. It is important to note, however, that the findings of the Statewide Mental Health Authority Audits for February 2018 are generally consistent with those of the monitoring team. That is, these February Audits found significant deficiencies in the areas of use

of the suicide potential form, mental health evaluations, treatment planning, mental health follow up, crisis contact and intervention, psychiatric services, restraints and discipline.

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: The Monitor has several concerns about this particular requirement. As reported in XI(b) above, the current CQI manager has only been working fulltime in this position since January 16, 2018. Prior to that date, his position was 75% central regional director and 25% statewide CQI manager. Also, this requirement states "statewide CQI manager **shall** (emphasis added) have the responsibility of ensuring that the steps identified in subsection (a), *above,* are taken." Dr. Sim may have the responsibility as outlined in this subsection, but he doesn't have the authority to implement those actions needed to fulfill his duties at statewide CQI manager. For example, the administrative directive 04.04.104, which outlines the CQI program, has remained in draft form throughout the duration of the Settlement Agreement. Dr. Sim does not have the authority to implement this AD. Also, the stated reason for not implementing this draft AD is that not all facilities have a designated mental health authority. Dr. Sim does not have the authority to fill these vacant positions. Until such time that these two very critical components of the statewide CQI program are met, the Department will continue to receive a rating of noncompliance for this subsection of the Settlement Agreement.

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: The Monitor submitted a request for an increase in the hourly compensation for the members of the monitoring team in June 2017. No formal response has been received by the time of submission of the 2nd annual report.

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: As of the submission of this report, IDOC is providing tele-psychiatric services in the absence of an approved protocol. The Monitor made a request to Dr. Hinton for this protocol on March, 2018. No response has been received to date. I request that the Department provide the Monitor with an evidence-based protocol detailing how tele-psychiatric services are being provided by June 15, 2018.

Administrative Directive 04.04.100, effective 6/1/17, 1(B), Policy Statement, states "The Department shall ensure offenders have access to **adequate** (emphasis added) mental health

services." The psychiatric field has progressed to the point where the provision of mental health and psychiatric services for female patients must be accomplished in a "gender responsive and trauma-informed" manner. The Department has made some efforts in this regard but falls short of the current standard of practice. Attached as appendix 2 is a review of the current literature regarding gender specific and trauma-informed care to incarcerated women. The Monitor looks forward to working with the Department to ensure that female offenders receive "adequate mental health services."

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 has generally been meeting this requirement.

XXVIII: REPORTING AND RECORDKEEPING

Summary: The Department has been submitting quarterly reports for the duration of the Settlement Agreement. These reports contain the information required but are not always objective in their findings.

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: IDOC has been submitting quarterly reports to Plaintiffs' counsel and the Monitor for the duration of the Settlement Agreement. These reports generally contain the information required by this subsection of the Settlement Agreement. These reports are not necessarily objective in their descriptions of the progress that IDOC is allegedly making towards implementing the requirements of the Settlement Agreement. They are clearly written from the defendants' perspective and don't always comport with the facts. With those caveats, IDOC is in substantial compliance with this requirement.

CONCLUSION

The Department continues to struggle to meet the requirements of the Settlement Agreement. The data from the previous two years of monitoring substantiates that the staffing levels of the Approved Remedial Plan are grossly inadequate to meet the requirements of the Settlement Agreement. Until the staffing issue is adequately addressed, the Department will continue to flounder in its efforts to meet the requirements of the Settlement Agreement.

Respectfully submitted,

Pablo Stewart, M.D.[46] Dated: May 27, 2018

Pablo Stewart, MD

[46] Indicates electronic signature

APPENDIX 1

Illinois Department of Corrections Psychiatry and MHP Backlog: Staffing Considerations

I. EXECUTIVE SUMMARY:

- The Illinois Department of Corrections' (IDOC) total population has decreased from 48,653 in 2014 to 41,011 in 2018. However, its mental health caseload has risen from 10,910 in 2014 to 12, 140 in 2018. Further IDOC's SMI population has risen from 4,662 in 2014 to 5,035 in 2018.
- IDOC's original staffing plan was based on a lower mentally ill and SMI population than IDOC currently maintains.
- Based on the data provided by IDOC and Wexford, not collected by the Monitoring team, it is evident there is a substantial backlog of cases for both facilities that are not "fully" staffed, and for those that are "fully" staffed.
- The data provided by IDOC and Wexford does not capture all of the areas where a backlog may exist.
- The original staffing plan is no longer appropriate to adequately meet the needs of IDOC's mentally ill and SMI offender population.

The overarching goal of the following analyses is to identify backlog psychiatric and mental health professional (MHP) trends in the context of the Illinois Department of Correction (IDOC)'s current staffing situation. Specifically, the aim of these analyses is to: 1) Identify facilities with staffing vacancies that have a backlog of cases; and, 2) identify facilities that are fully staffed but still have a backlog of cases. Identifying and working to clear backlog cases is essential for maintaining proper correctional mental health care. Further, doing so in a timely manner is key for the effective evaluation, treatment, and follow up care of offenders with mental illness (Ford, Trestman, Wiesbrock, & Zhang, 2009; Forrester, MacLennan, Slade, Brown, Exworthy, 2014). Addressing backlog cases as soon as possible should be a top priority for a correctional institution, particularly those with a growing population of offenders with mental illness. For example, while IDOC's total population has been decreasing from 2014 (n = 48,653) to 2018 (n = 41,011), its mental health caseload has risen from 10,910 in 2014 to 12, 140 in 2018. Further IDOC's SMI population has risen from 4,662 in 2014 to 5,035 in 2018 (see Figure 1 in Appendix A).

For the purposes of the current analyses, a "backlog" case is a case that exceeds the recommended time for action as described by IDOC and the Settlement Agreement. All analyses are derived from the most up-to-date facility data and staffing information as of April 20,2018. Decatur, East Moline, Jacksonville, Joliet Treatment Center, Kewanee, and Taylorville are not included in the following analyses as these facilities do not have a Psychiatric or MHP backlog as of April 20, 2018.

II. SECTION 1 – PSYCHIATRIC OVERVIEW

Table 1 shows the Psychiatric Backlog data for facilities as of April 20, 2018. As described above, Decatur, East Moline, Jacksonville, Joliet Treatment Center, Kewanee, and Taylorville are not included as these facilities do not have a Psychiatric backlog. Table 2 shows similar data, but with Face to Face/New and Telepsych/New collapsed into one 'New' column, and Face to Face/Follow Up and Telepsych/Follow Up collapsed into one 'Follow Up' column. Psychiatry has fairly few New backlogged cases from seven

facilities (n = 35), but with many Follow Up backlogged cases from 18 facilities (n = 1037).

Table 1. Overview of Weekly Psychiatry Backlog Data.

	Face - Face		TelePsych		Total
	New	Follow Up	New	Follow Up	
Dixon	1	78	0	40	**119**
Graham	0	31	0	0	**31**
IL River	0	13	0	0	**13**
Lawrence	0	1	0	5	**6**
Lincoln	0	15	0	0	**15**
Logan	0	0	0	12	**12**
Menard	4	165	0	158	**327**
Pinckneyville	0	4	0	0	**4**
Pontiac	5	11	0	0	**16**
Robinson	0	0	0	31	**31**
Shawnee	0	0	0	135	**135**
Sheridan	0	0	0	78	**78**
Southwestern	0	0	0	8	**8**
Stateville	0	113	0	0	**113**
Stateville RNC	1	22		0	**23**
Vandalia	0	0	8	21	**29**
Vienna	0	0	15	72	**87**
Western	0	0	1	24	**25**
Total	11	453	24	584	1072

Table 2. Condensed Overview of Weekly Psychiatry Backlog Data.

	New	Follow Up	Total
Dixon	1	118	**119**
Graham	0	31	**31**
IL River	0	13	**13**
Lawrence	0	6	**6**
Lincoln	0	15	**15**
Logan	0	12	**12**
Menard	4	323	**327**
Pinckneyville	0	4	**4**
Pontiac	5	11	**16**
Robinson	0	31	**31**

Shawnee	0	135	**135**
Sheridan	0	78	**78**
Southwestern	0	8	**8**
Stateville	0	113	**113**
Stateville RNC	1	22	**23**
Vandalia	8	21	**29**
Vienna	15	72	**87**
Western	1	24	**25**
Total	**35**	**1037**	**1072**

Table 3 provides a breakdown of the backlogged cases by number of days backlogged as of April 20, 2018. This table is also condensed into only one New column and only one Follow Up column.

Table 3. Psychiatry Breakdown – Number of Days Backlogged.

	New						**Follow Up**						
	Total	**1-14 Days**	**15-30 Days**	**31-45 Days**	**46-60 Days**	**>60 Days**	**Total**	**1-14 Days**	**15-30 Days**	**31-45 Days**	**46-60 Days**	**>60 Days**	**Facility Total**
Dixon	**1**	1	0	0	0	0	**118**	69	41	7	0	0	**119**
Graham	**0**	0	0	0	0	0	**31**	31	0	0	0	0	**31**
IL River	**0**	0	0	0	0	0	**13**	13	0	0	0	0	**13**
Lawrence	**0**	0	0	0	0	0	**6**	4	0	1	0	1	**6**
Lincoln	**0**	0	0	0	0	0	**15**	15	0	0	0	0	**15**
Logan	**0**	0	0	0	0	0	**12**	8	4	0	0	0	**12**
Menard	**4**	3	0	1	0	0	**323**	103	108	66	27	19	**327**
Pinckneyville	**0**	0	0	0	0	0	**4**	3	1	0	0	0	**4**
Pontiac	**5**	3	2	0	0	0	**11**	10	0	0	0	1	**16**
Robinson	**0**	0	0	0	0	0	**31**	22	9	0	0	0	**31**
Shawnee	**0**	0	0	0	0	0	**135**	110	24	1	0	0	**135**
Sheridan	**0**	0	0	0	0	0	**78**	77	0	0	1	0	**78**
Southwestern	**0**	0	0	0	0	0	**8**	8	0	0	0	0	**8**
Stateville	**0**	0	0	0	0	0	**113**	76	37	0	0	0	**113**
Stateville RNC	**1**	1	0	0	0	0	**22**	22	0	0	0	0	**23**
Vandalia	**8**	8	0	0	0	0	**21**	21	0	0	0	0	**29**

Vienna	**15**	6	6	0	1	2	**72**	40	31	0	0	1	**87**
Western	**1**	1	0	0	0	0	**24**	18	4	2	0	0	**25**
Total	**35**	**23**	**8**	**1**	**1**	**2**	**1037**	**650**	**259**	77	**28**	**22**	**1072**

Figure 2 shows the progression of total backlog cases (New and Follow Up) over time, beginning on September 22, 2017, and ending on April 20, 2018. A large spike in total backlogged cases occurred between December 15, 2017, and January 12, 2018, but quickly fell. Other than this spike, the total number of backlogged cases has been decreasing over the last seven months.

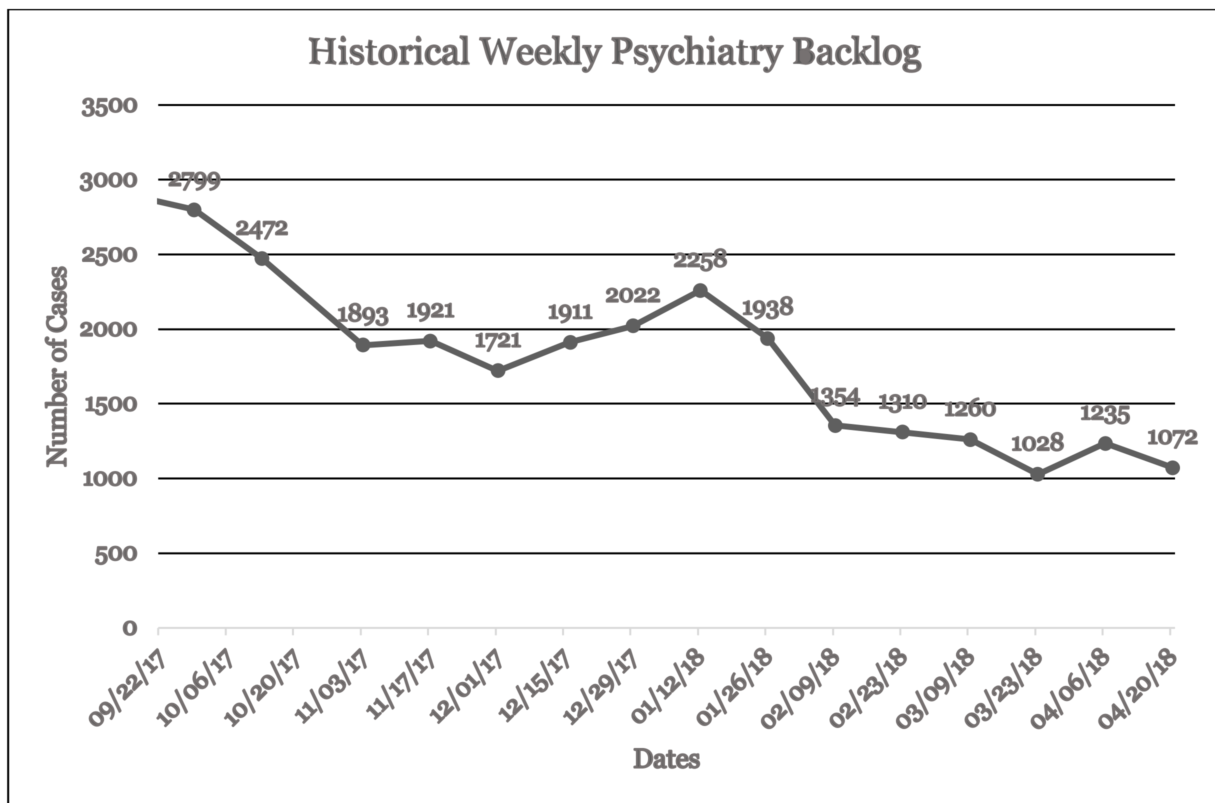

Figure 2. Historical Weekly Psychiatry Backlog.

III. SECTION 2 – MHP OVERVIEW

Table 4 shows the MHP Backlog data for facilities as of April 20, 2018. As described above, Decatur, East Moline, Jacksonville, Joliet Treatment Center, Kewanee, and Taylorville are not included as these facilities do not have an MHP backlog. Twelve facilities have a backlog of MH Evaluations (*n* = 406), thirteen facilities have a backlog of MH Treatment Plans (*n* = 508), and nineteen facilities have a MH Follow Up backlog (*n* = 1,573)

Table 4. Overview of MHP Weekly Backlog Data.

	MH Evaluation	MH Treatment Plan	MH Follow Up	Total
Big Muddy	0	0	12	**12**
Centralia	15	25	104	**144**
Danville	0	0	3	**3**
Dixon	14	115	65	**194**
Graham	113	125	291	**529**
Hill	12	16	79	**107**
IL River	13	17	161	**191**
Lawrence	45	10	159	**214**
Lincoln	2	0	6	**8**
Logan	11	26	43	**80**
Menard	18	6	160	**184**
Pinckneyville	14	20	31	**65**
Pontiac	18	17	88	**123**
Robinson	0	0	18	**18**
Shawnee	0	0	165	**165**
Sheridan	0	17	16	**33**
Stateville	0	0	32	**32**
Vandalia	0	23	41	**64**
Western	131	91	99	**321**
Total	**406**	**508**	**1573**	**2487**

Tables 5, 6, and 7 provide a breakdown of the backlogged cases by type and by number of days backlogged as of April 20, 2018.

Table 5. MHP – MH Evaluations - Number of Days Backlogged.

	1-14 Days	15-30 Days	31-45 Days	46-60 Days	> 60 Days	Total	Facility Total
Big Muddy	0	0	0	0	0	**0**	**12**
Centralia	2	9	4	0	0	**15**	**144**
Danville	0	0	0	0	0	**0**	**3**
Dixon	11	3	0	0	0	**14**	**194**
Graham	25	21	3	5	59	**113**	**529**
Hill	7	0	3	5	5	**12**	**107**
IL River	9	3	1	0	0	**13**	**191**
Lawrence	8	32	5	0	0	**45**	**214**
Lincoln	1	1	0	0	2	**2**	**8**
Logan	10	1	0	0	0	**11**	**80**
Menard	8	4	3	0	3	**18**	**184**
Pinckneyville	7	1	0	1	5	**14**	**65**
Pontiac	16	2	0	0	0	**18**	**123**
Robinson	0	0	0	0	0	**0**	**18**
Shawnee	0	0	0	0	0	**0**	**165**
Sheridan	0	0	0	0	0	**0**	**33**
Stateville	0	0	0	0	0	**0**	**32**
Vandalia	0	0	0	0	0	**0**	**64**
Western	4	11	7	11	98	**131**	**321**
Total	**108**	**88**	**26**	**22**	**172**	**406**	**2487**

Table 6. MHP – MH Treatment Plans - Number of Days Backlogged.

	1-14 Days	15-30 Days	31-45 Days	46-60 Days	> 60 Days	Total	Facility Total
Big Muddy	0	0	0	0	0	**0**	**12**
Centralia	4	0	2	2	17	**25**	**144**
Danville	0	0	0	0	0	**0**	**3**
Dixon	17	24	12	15	47	**115**	**194**
Graham	12	23	11	11	68	**125**	**529**
Hill	4	4	0	8	0	**16**	**107**
IL River	7	7	1	2	0	**17**	**191**
Lawrence	1	0	1	1	7	**10**	**214**
Lincoln	0	0	0	0	0	**0**	**8**
Logan	7	6	5	2	6	**26**	**80**
Menard	1	1	1	0	3	**6**	**184**
Pinckneyville	1	0	0	1	18	**20**	**65**
Pontiac	7	0	0	0	10	**17**	**123**
Robinson	0	0	0	0	0	**0**	**18**
Shawnee	0	0	0	0	0	**0**	**165**
Sheridan	6	4	0	0	7	**17**	**33**
Stateville	0	0	0	0	0	**0**	**32**
Vandalia	2	7	2	4	8	**23**	**64**
Western	10	0	2	0	79	**91**	**321**
Total	**79**	**76**	**37**	**46**	**270**	**508**	**2487**

Table 7. MHP – MH Follow Up - Number of Days Backlogged.

	1-14 Days	15-30 Days	31-45 Days	46-60 Days	> 60 Days	Total	Facility Total
Big Muddy	12	0	0	0	0	**12**	**12**
Centralia	46	38	12	8	0	**104**	**144**
Danville	3	0	0	0	0	**3**	**3**
Dixon	32	6	3	1	23	**65**	**194**
Graham	60	67	41	22	101	**291**	**529**
Hill	31	30	18	0	0	**79**	**107**
IL River	52	54	51	3	1	**161**	**191**
Lawrence	76	55	8	7	13	**159**	**214**
Lincoln	5	0	1	0	0	**6**	**8**
Logan	38	4	0	1	0	**43**	**80**
Menard	140	19	0	1	0	**160**	**184**
Pinckneyville	28	3	0	0	0	**31**	**65**
Pontiac	68	16	4	0	0	**88**	**123**
Robinson	17	1	0	0	0	**18**	**18**
Shawnee	90	60	15	0	0	**165**	**165**
Sheridan	9	3	3	0	0	**16**	**33**
Stateville	31	1	0	0	0	**32**	**32**
Vandalia	11	8	6	4	12	**41**	**64**
Western	21	26	16	18	18	**99**	**321**
Totals	**770**	**391**	**178**	**65**	**168**	**1573**	**2487**

Figure 3 shows the progression of total backlog cases (MH Evaluations, MH Treatment Plans, and MH Follow Ups) over time, beginning on October 6, 2017, and ending on April 20, 2018. Overall, the total number of backlogged cases has been decreasing over the last seven months.

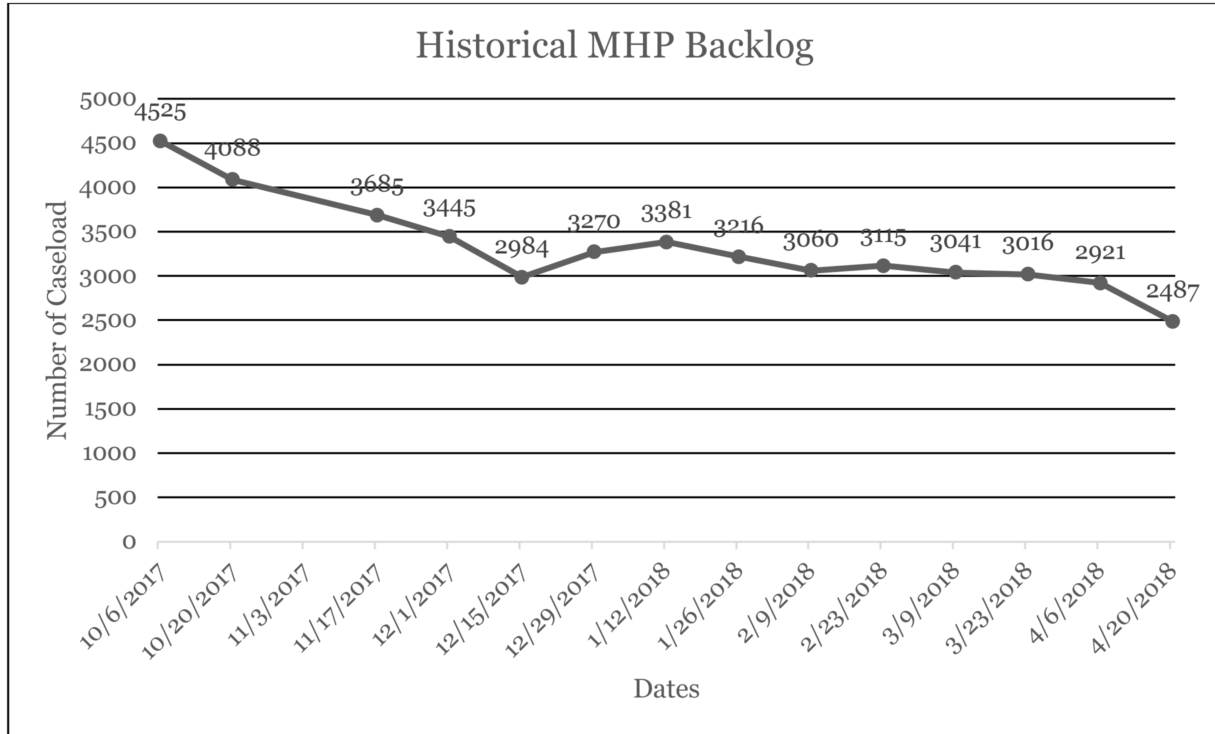

Figure 3. Historical MHP Backlog.

IV.

V. SECTION 3. PSYCHIATRY STAFFING

Table 9 details the Budgeted FTE staffing, Filled FTE staffing, number of individuals making up the Filled FTE, and Budgeted Vacant FTE staffing. Facilities highlighted in green indicate that they are fully staffed or has less than or equal to 0.10 Total Budgeted Vacant FTEs. Facilities highlighted in yellow indicate that they have a Budgeted Vacant FTE between 0.11 and 4.99. Facilities highlighted in red indicate that they have a Budgeted Vacant FTE greater than or equal to 5.00.

Table 9. Overview of Psychiatry Staffing.

	Psychiatry				RN - Psychiatric				Total Facility Vacancies
	Budgeted FTE	Filled FTE	No. on Staff	Budgeted Vacant FTE	Budgeted FTE	Filled FTE	No. on Staff	Budgeted Vacant FTE	
Big Muddy	1.50	1.40	2	0.10	0.00	0.00	0	0.00	**0.10**
Centralia	1.00	1.00	2	0.00	0.00	0.00	0	0.00	**0.00**
Danville	1.50	1.25	2	0.25	0.00	0.00	0	0.00	**0.25**
Dixon	10.00	4.80	6	5.20	0.00	0.00	0	0.00	**5.20**
Graham	2.00	1.27	4	0.73	0.00	0.00	0	0.00	**0.25**
Hill	2.00	2.00	4	0.00	0.00	0.00	0	0.00	**0.00**
IL River	1.00	1.00	1	0.00	0.00	0.00	0	0.00	**0.00**
Lawrence	3.00	2.50	3	0.50	0.00	0.00	0	0.00	**0.50**
Lincoln	0.50	0.43	1	0.07	0.00	0.00	0	0.00	**0.07**
Logan	10.00	5.59	9	4.41	1.00	1.00	1	0.00	**4.41**
Menard	6.00	1.83	4	4.17	0.00	0.00	0	0.00	**4.17**
Pinckneyville	3.50	2.78	4	0.73	0.00	0.00	0	0.00	**0.73**
Pontiac	6.00	1.85	3	4.15	0.00	0.00	0	0.00	**4.15**
Robinson	0.50	0.45	1	0.05	0.00	0.00	0	0.00	**0.05**
Shawnee	1.25	1.00	1	0.25	0.00	0.00	0	0.00	**0.25**
Sheridan	1.00	1.00	1	0.00	0.00	0.00	0	0.00	**0.00**
Southwestern	0.25	0.20	1	0.05	0.00	0.00	0	0.00	**0.05**
Stateville RNC	5.00	3.5	6	1.50	0.00	0.00	0	0.00	**1.50**
Stateville	4.00	1.10	3	2.90	0.00	0.00	0	0.00	**2.90**
Vandalia	0.50	0.48	2	0.02	0.00	0.00	0	0.00	**0.02**
Vienna	0.50	0.40	1	0.10	0.00	0.00	0	0.00	**0.10**
Western	1.50	0.75	1	0.75	0.00	0.00	0	0.00	**0.75**

Figures 4 to 14 in Appendix B demonstrate the total number of backlogged cases in the context of staffing for facilities that are not meeting their full complement of Psychiatry staff (e.g., indicated by yellow or red highlighting in Table 9). Danville is not listed in these figures as it does not currently have any backlogged psychiatry cases.

Figures 15 to 21 in Appendix C demonstrate the total number of backlogged cases in the context of staffing for facilities that are meeting their full complement of Psychiatry staff, or are within 0.10 Budgeted Vacant FTE (e.g., indicated by green highlighting in Table 9). Big Muddy, Centralia, and Hill are not included in these figures as they do not currently have any backlogged psychiatry cases.

VI. SECTION 4. MHP STAFFING

Table 10 details the Budgeted FTE staffing, Filled FTE staffing, number of individuals making up the Filled FTE, and Budgeted Vacant FTE staffing. Facilities highlighted in green indicate that they are fully staffed. Facilities highlighted in yellow indicate that they have a Budgeted Vacant FTE between 0.11 and 4.99. Facilities highlighted in red indicate that they have a Budgeted Vacant FTE greater than 5.00.

Table 10. Overview of MHP Staffing.

	Psychologist			QMHP			BHT			Staff Assistant			Recreational Therapist			RN-Mental Health			Total Facility Vacant FTE
	Budgeted FTE	Filled FTE	Budgeted Vacant FTE	Budgeted FTE	Filled FTE	Budgeted Vacant FTE	Budgeted FTE	Filled FTE	Budgeted Vacant FTE	Budgeted FTE	Filled FTE	Budgeted Vacant FTE	Budgeted FTE	Filled FTE	Budgeted Vacant FTE	Budgeted FTE	Filled FTE	Budgeted Vacant FTE	
Big Muddy	0.00	0.00	0.00	3.00	3.00	0.00	1.00	1.00	0.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	**1.00**
Centralia	0.00	0.00	0.00	1.00	1.00	0.00	0.00	0.00	0.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**0.00**
Danville	0.00	0.00	0.00	3.00	2.00	1.00	0.00	0.00	0.00	2.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	**2.00**

Dixon[a,b]	8.65	3.68	4.97	18.0	14.0	4.00	18.0	17.0	1.00	8.00	8.00	0.00	2.00	2.00	0.00	0.00	0.00	0.00	**9.97**
Graham	0.00	0.00	0.00	3.00	3.00	0.00	1.00	0.00	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**1.00**
Hill	0.00	0.00	0.00	4.00	3.00	1.00	0.00	0.00	0.00	2.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	**2.00**
IL River	0.00	0.00	0.00	5.00	4.00	1.00	4.00	4.00	0.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**1.00**
Lawrence	0.00	0.00	0.00	8.00	7.00	1.00	0.00	0.00	0.00	2.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	**2.00**
Lincoln	0.00	0.00	0.00	2.00	2.00	0.00	0.00	0.00	0.00	1.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	**1.00**
Logan[a]	6.00	4.00	2.00	21.0	19.0	2.00	14.0	12.0	2.00	5.00	4.00	1.00	2.00	1.00	1.00	5.00	4.00	1.00	**9.00**
Menard	2.00	0.00	2.00	9.00	6.00	3.00	9.00	8.00	1.00	4.00	4.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**5.00**
Pinckneyville	1.00	0.00	1.00	7.00	6.00	1.00	2.00	2.00	0.00	3.00	2.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	**3.00**
Pontiac[a]	5.00	3.00	2.00	13.00	11.00	2.00	5.00	5.00	0.00	3.00	3.00	0.00	1.00	1.00	0.00	0.00	0.00	0.00	**4.00**
Robinson	0.00	0.00	0.00	2.00	2.00	0.00	0.00	0.00	0.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	**1.00**
Shawnee	0.00	0.00	0.00	3.00	1.00	2.00	1.00	1.00	0.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**2.00**
Sheridan	0.00	0.00	0.00	3.00	3.00	0.00	0.00	0.00	0.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**0.00**
Southwestern	0.00	0.00	0.00	1.00	1.00	0.00	0.00	0.00	0.00	1.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	**1.00**
Stateville RNC	0.00	0.00	0.00	5.00	4.00	1.00	0.00	0.00	0.00	3.00	2.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	**2.00**
Stateville	2.00	2.00	0.00	7.00	7.00	0.00	4.00	4.00	0.00	1.00	1.00	0.00	0.00	0.00	0.00	2.00	0.00	2.00	**2.00**
Vandalia	0.00	0.00	0.00	2.00	2.00	0.00	0.00	0.00	0.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**0.00**
Vienna	0.00	0.00	0.00	2.00	1.00	1.00	0.00	0.00	0.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**1.00**
Western	0.00	0.00	0.00	3.00	3.00	0.00	0.00	0.00	0.00	2.00	2.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**0.00**

[a]Psychologist includes Post-Doc Psychologists, Pre-Doc Intern Psychologists, Staff Psychologists, and Additional Clinical Psychologist Coverage

[b]Staff Assistant includes Staff Assistant and Assistant Site Manager-Mental Health

Figures 22 to 37 in Appendix D demonstrate the total number of backlogged cases in the context of staffing for facilities that are not meeting their full complement of MHP staff (e.g., indicated by yellow or red highlighting in Table 10). Southwestern, Stateville RNC, and Vienna are not listed in these figures as they do not currently have any backlogged cases.

Figures 38 to 40 in Appendix E demonstrate the total number of backlogged cases in the context of staffing for facilities that are meeting their full complement of MHP staff (e.g., indicated by green highlighting in Table 10)

VII. SECTION 5. LEVEL OF CONCERN

Table 11 represents the dispersion of all backlogged facilities into four groups (Appropriately Staffed – Backlog Present, Not Appropriately Staffed – Backlog Present, Not Appropriately Staffed – No Backlog Present, and Appropriately Staffed – No Backlog Present) and subsequently into four urgency categories (Level 4, Level 3, Level 2, and Level 1, respectively).

Facilities in Level 1 have their full complement of staff and do not presently have any cases backlogged. No further action is needed for these facilities.

Facilities in Level 2 do not have their full complement of staff, but do not have any cases backlogged. While this is not an immediate concern, facilities in this category should make efforts to fulfill their Budgeted FTE requirements in order to prevent backlog in the future.

Facilities in Level 3 do not have their full complement of staff, and they have backlogged cases. Increasing the staffing at these facilities to fulfill their Budgeted FTE requirements should help to ease some of the backlog. However, understaffing (in the context of the Budgeted FTE) may not be the only issue to address. For example, Graham has a large total backlog of MHP cases (n = 529), yet they are only vacant 1.00 BHT position. It is likely that more staff than was originally budgeted will be required to address this backlogged caseload.

Facilities in Level 4 have their full complement of staff, yet they still have backlogged cases. Despite their fulfillment of their Budgeted FTE staffing, the excess of backlogged Psychiatry and MHP cases at these facilities indicates that the originally budgeted amount may be inappropriate. For example, Centralia has zero Budgeted FTE vacancies, yet has over 100 total backlogged MHP cases. These facilities should consider an increase in staffing or a restructuring of responsibilities for the current staff.

Table 11. Level of Concern.

Level 4 Appropriately Staffed[c] – Backlog Present	
Psychiatry	MHP
Illinois River	Centralia[f]
Lincoln	Sheridan
Robinson	Vandalia
Sheridan	
Southwestern	
Vandalia	
Vienna	
Level 3 Not Appropriately Staffed – Backlog Present	
Psychiatry	MHP
Dixon[d,f]	Big Muddy
Graham	Danville
Lawrence	Dixon[e,f]
Logan	Graham[h]
Menard[g]	Hill[f]
Pinckneyville	Illinois River[f]
Pontiac	Lawrence[f]
Shawnee[f]	Lincoln
Stateville RNC	Logan[e]
Stateville[f]	Menard[f]
Western	Pinckneyville
	Pontiac[f]
	Robinson
	Shawnee[f]
	Stateville
	Western[g]
Level 2 Not Appropriately Staffed – No Backlog Present	
Psychiatry	MHP
Danville	Southwestern
	Stateville NRC
	Vienna
Level 1 Appropriately Staffed – No Backlog Present	
Psychiatry	MHP
Big Muddy	
Centralia	
Hill	

[c]Fully staffed with ≤ .10 Budgeted Vacant FTE
[d]Total facility budgeted vacant FTE ≥ 5.00
[e]Total facility budgeted vacant FTE ≥ 9.00
[f]Total facility number of backlogged cases ≥ 100
[g]Total facility number of backlogged cases ≥ 300
[h]Total facility number of backlogged cases ≥ 500

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Forrester, A., MacLennan, F., Slade, K., Brown, P., Exworthy, T. (2014). Improving access to psychological therapies in prison. *Criminal Behavior and Mental Health, 24*(3), 163-168.

APPENDICES

Appendix A

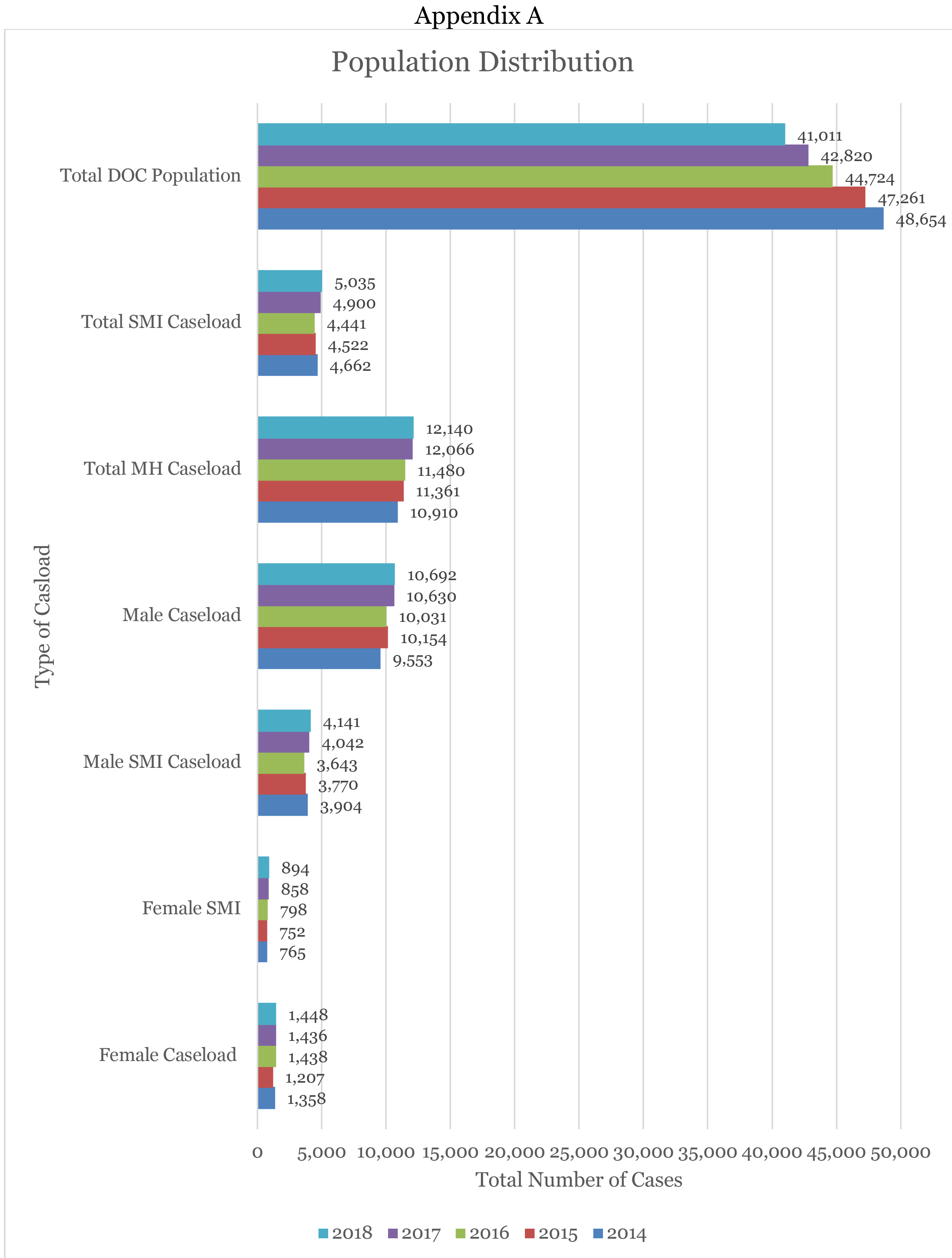

Figure 1. Population Distribution of Caseloads by Year.

Appendix B

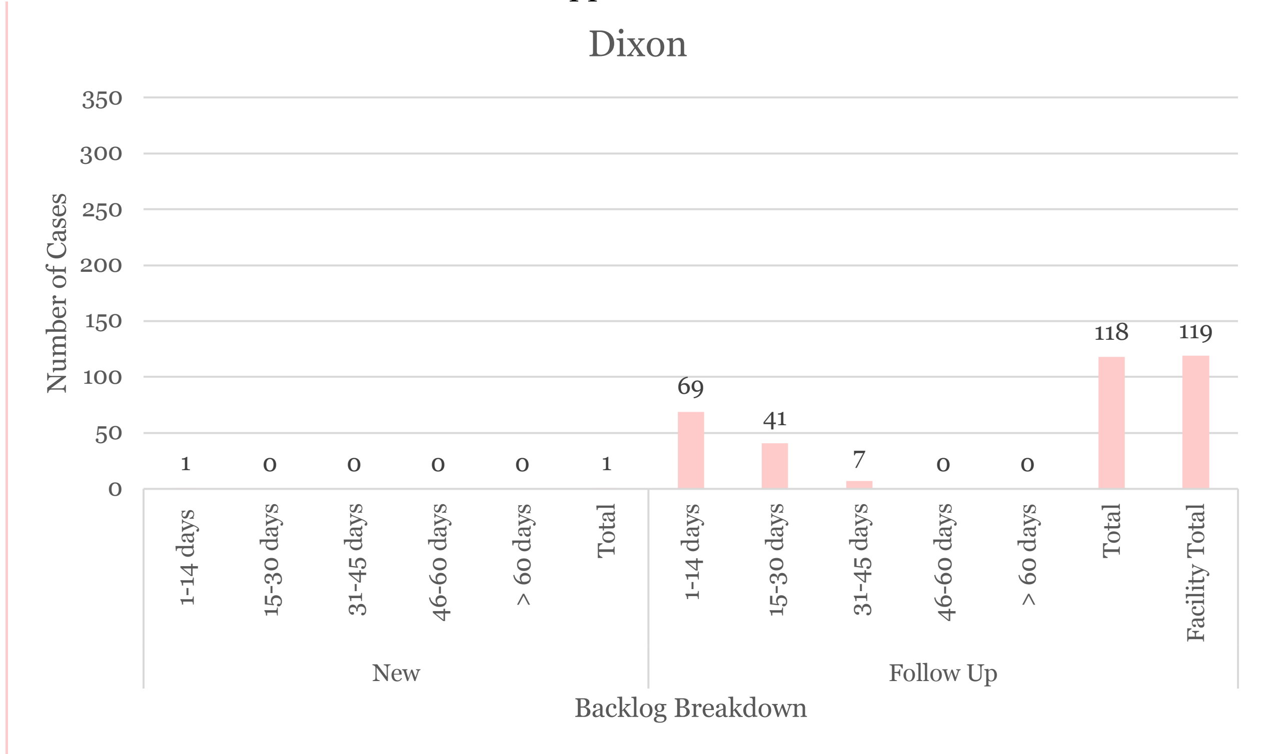

Figure 4. Dixon Total Psychiatry Backlog – High Level of FTE Vacancies.

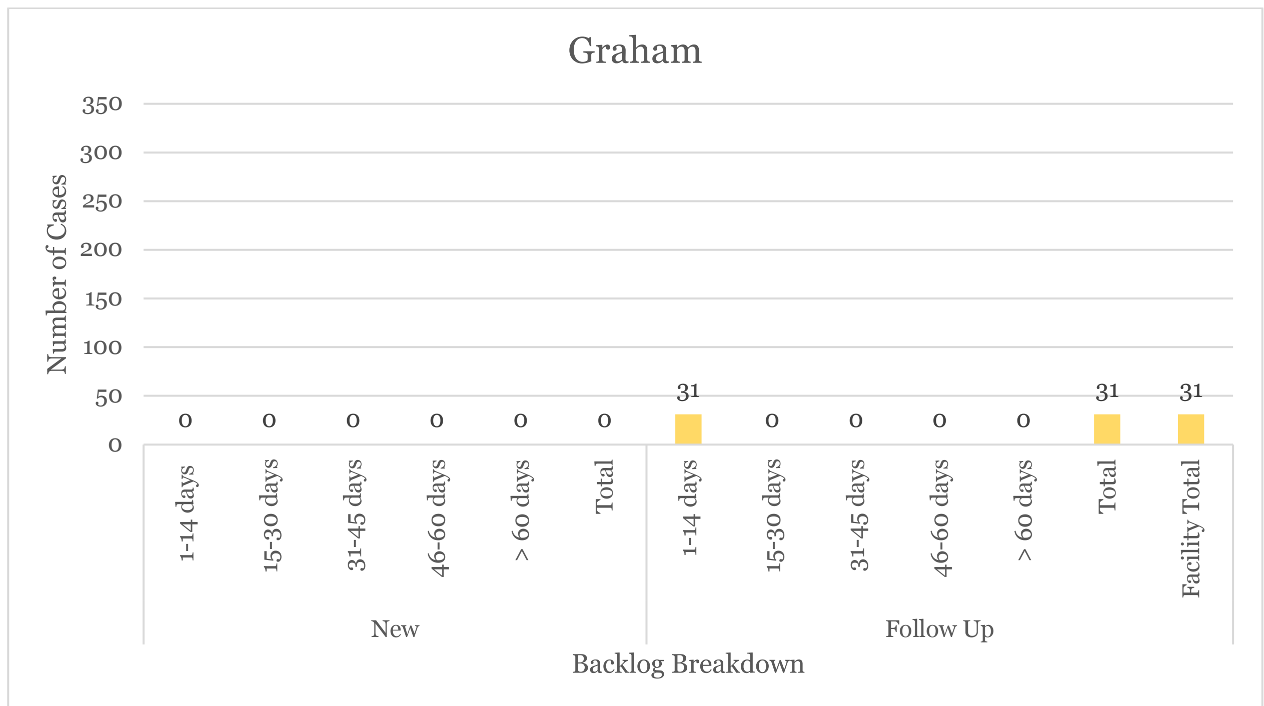

Figure 5. Graham Total Psychiatry Backlog – Moderate Level of FTE Vacancies.

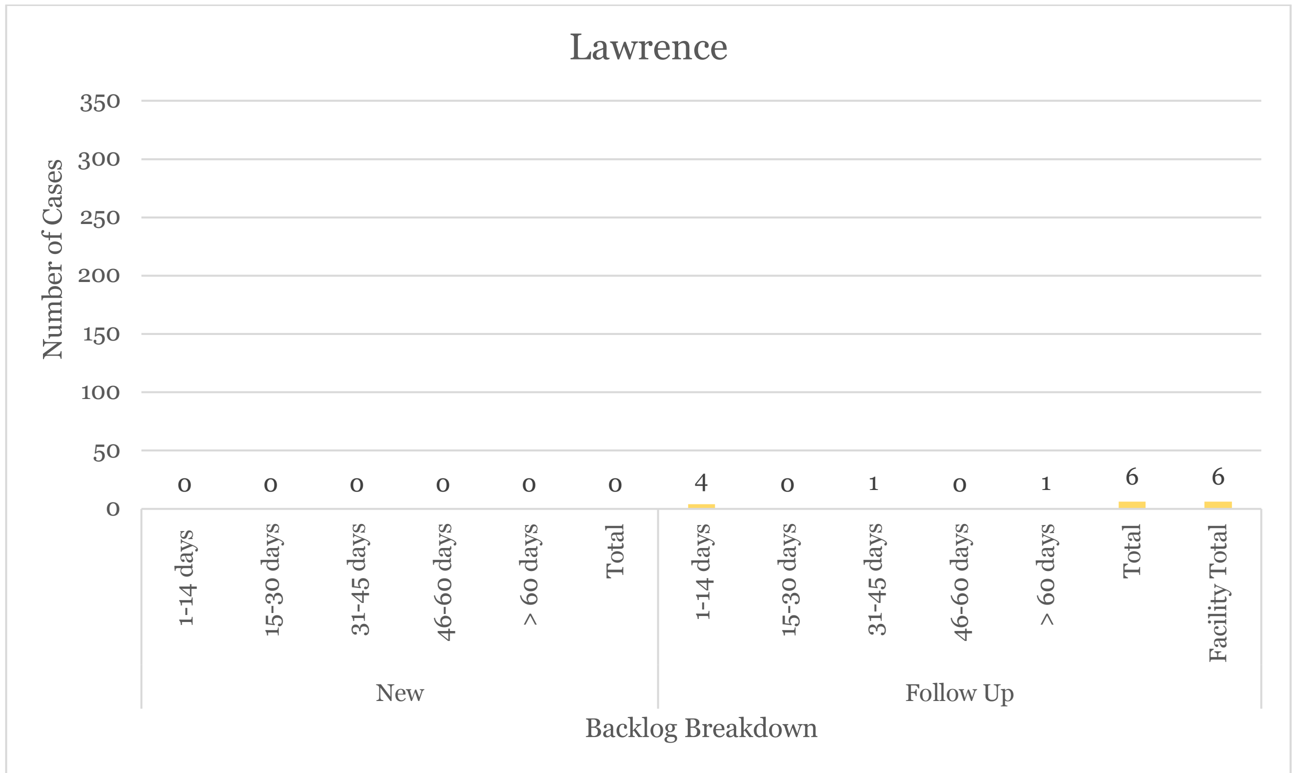

Figure 6. Lawrence Total Psychiatry Backlog – Moderate Level of FTE Vacancies.

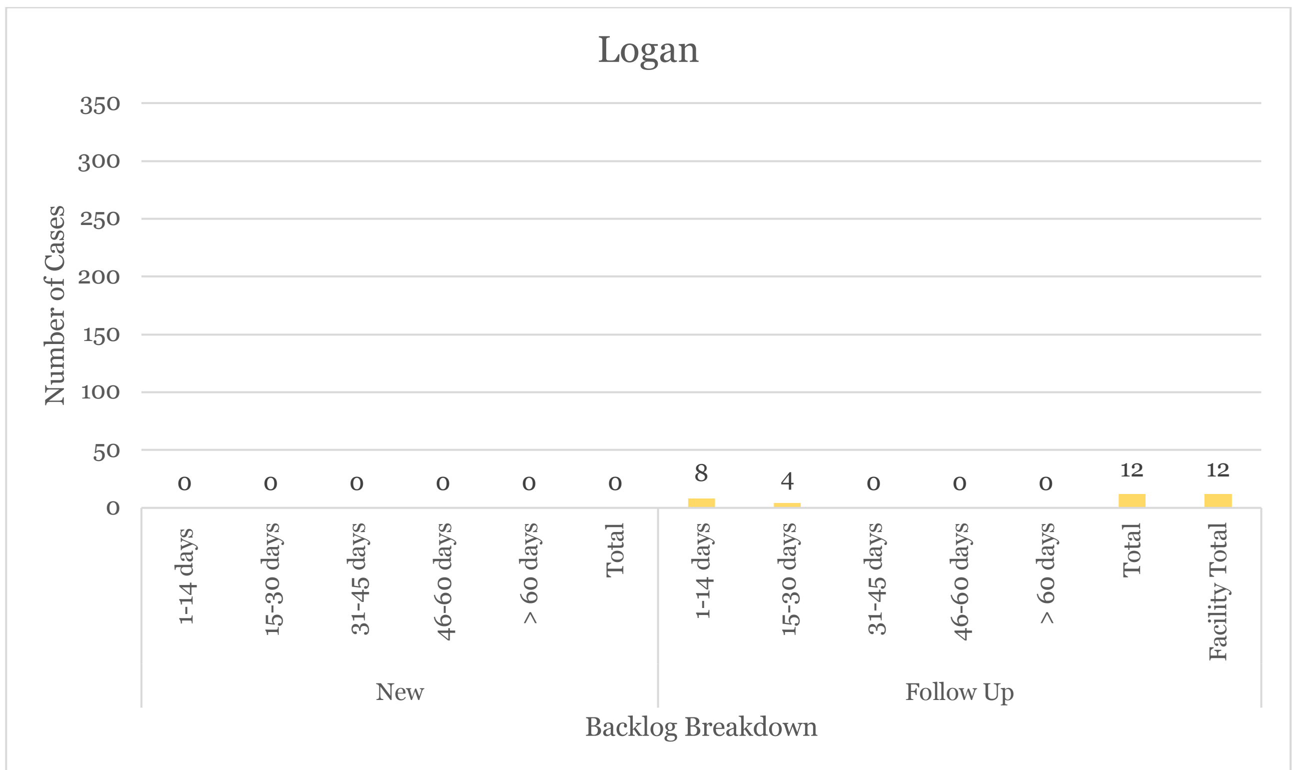

Figure 7. Logan Total Psychiatry Backlog – Moderate Level of FTE Vacancies.

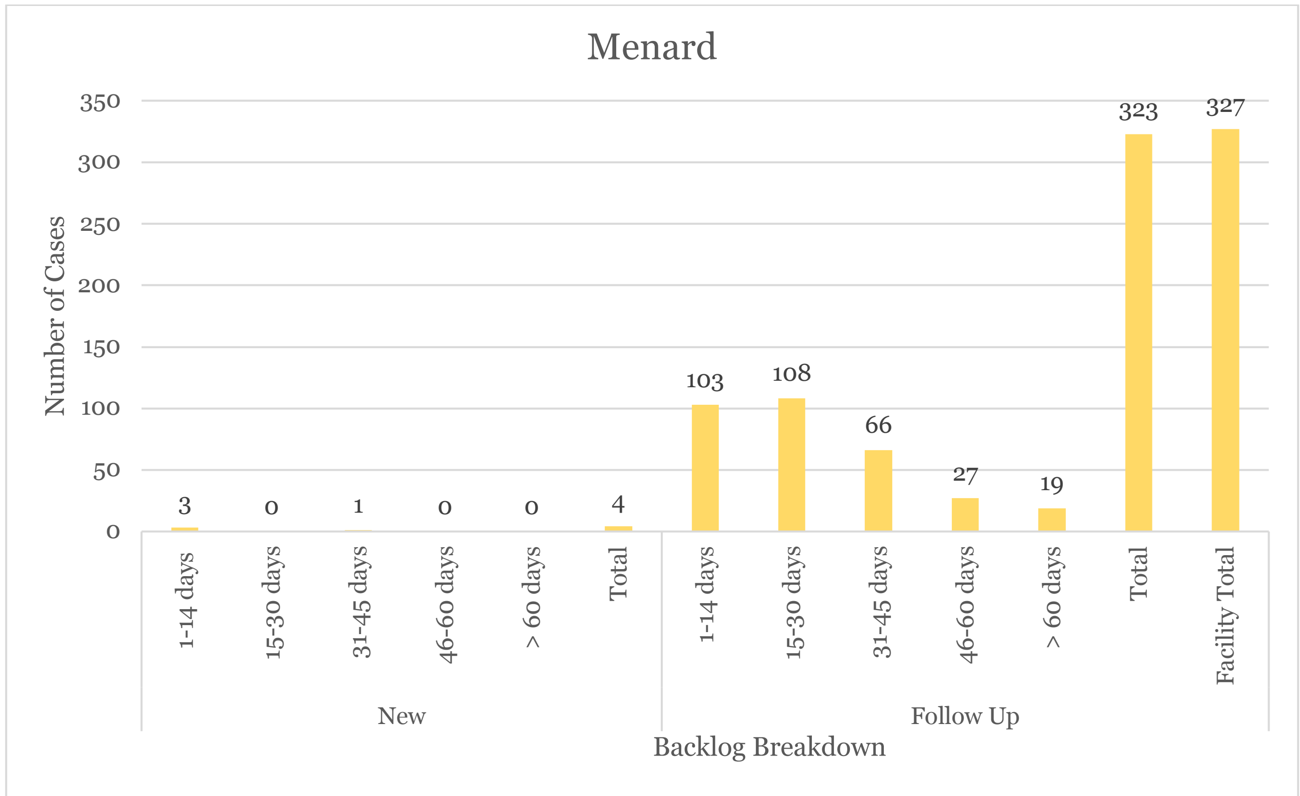

Figure 8. Menard Total Psychiatry Backlog – Moderate Level of FTE Vacancies.

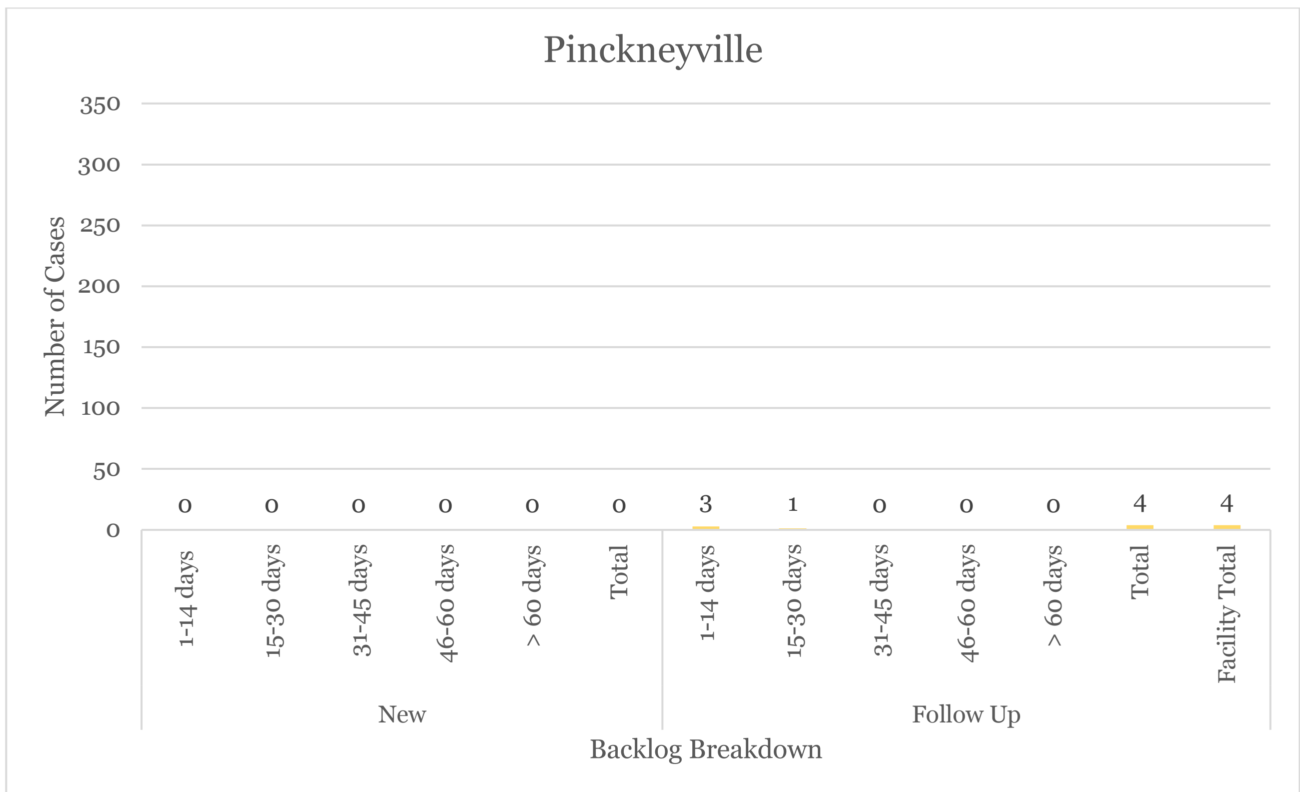

Figure 9. Pinckneyville Total Psychiatry Backlog – Moderate Level of FTE Vacancies.

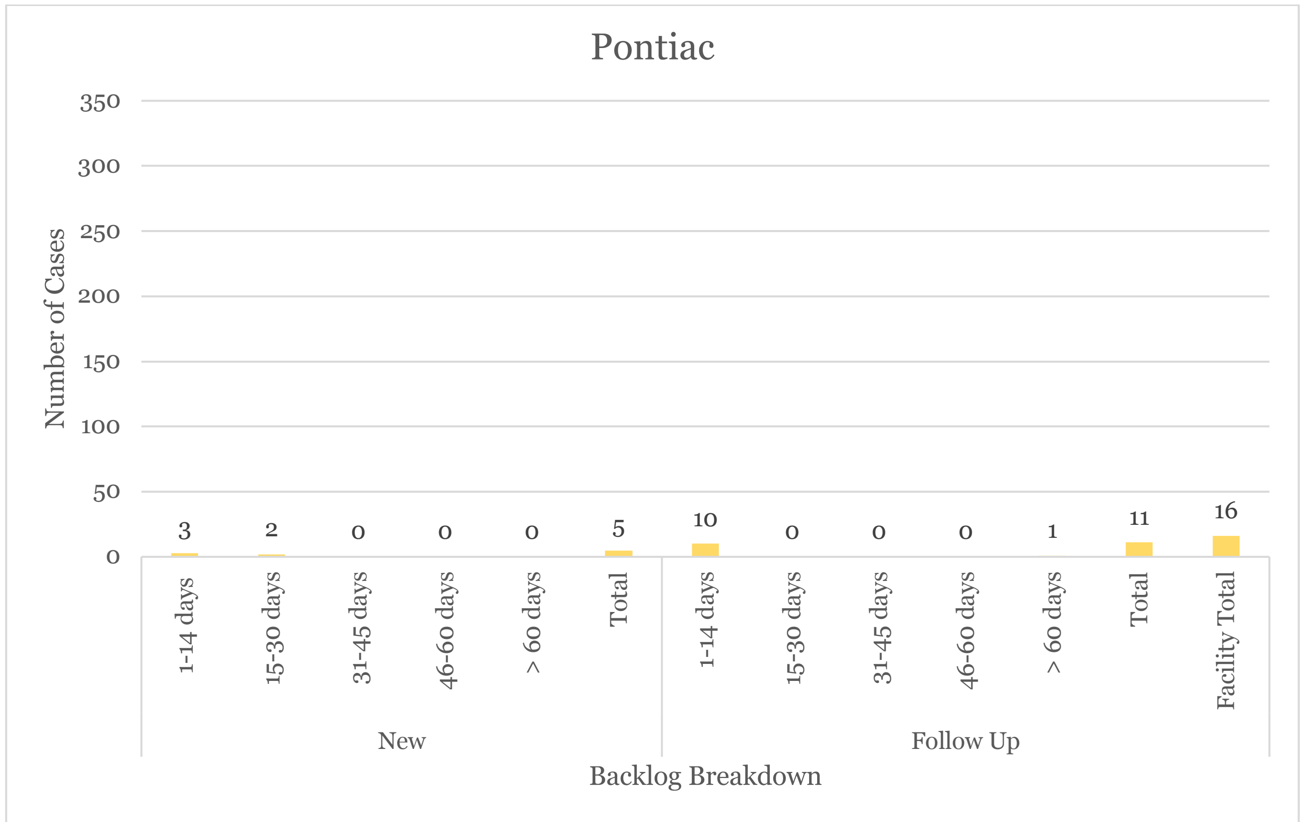

Figure 10. Pontiac Total Psychiatry Backlog – Moderate Level of FTE Vacancies.

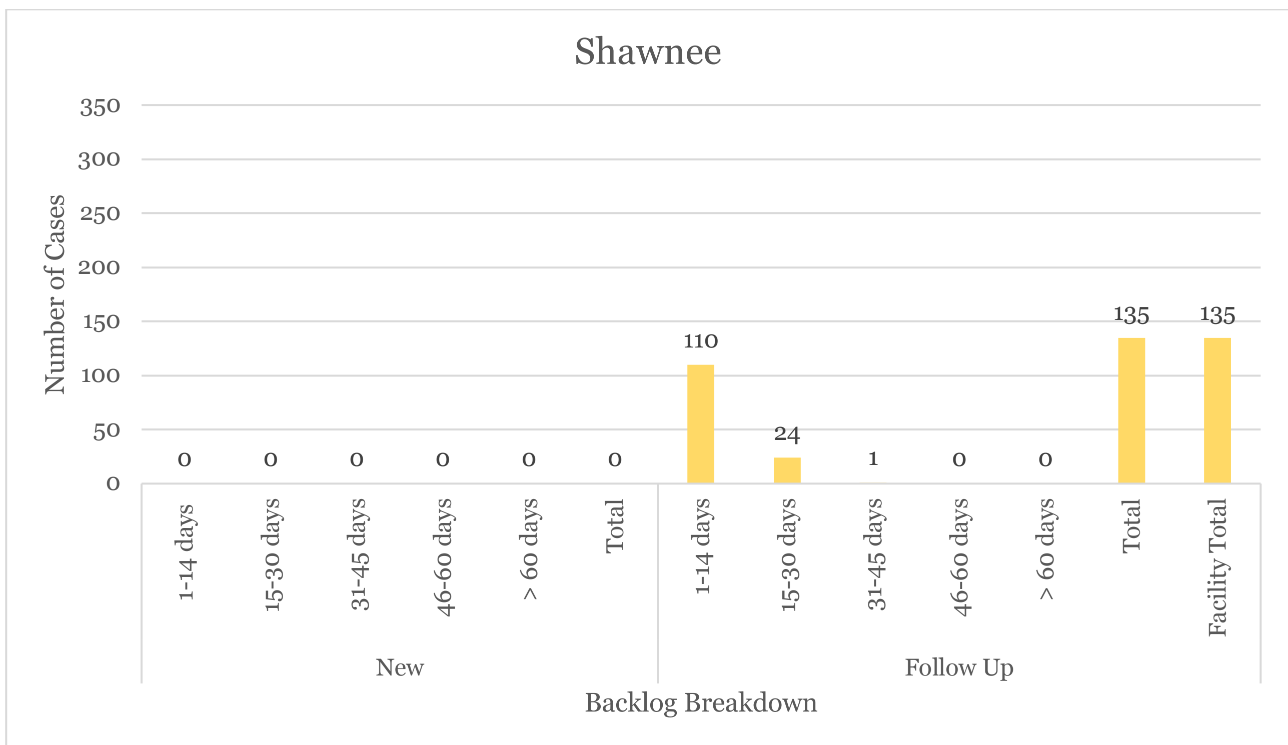

Figure 11. Shawnee Total Psychiatry Backlog – Moderate Level of FTE Vacancies.

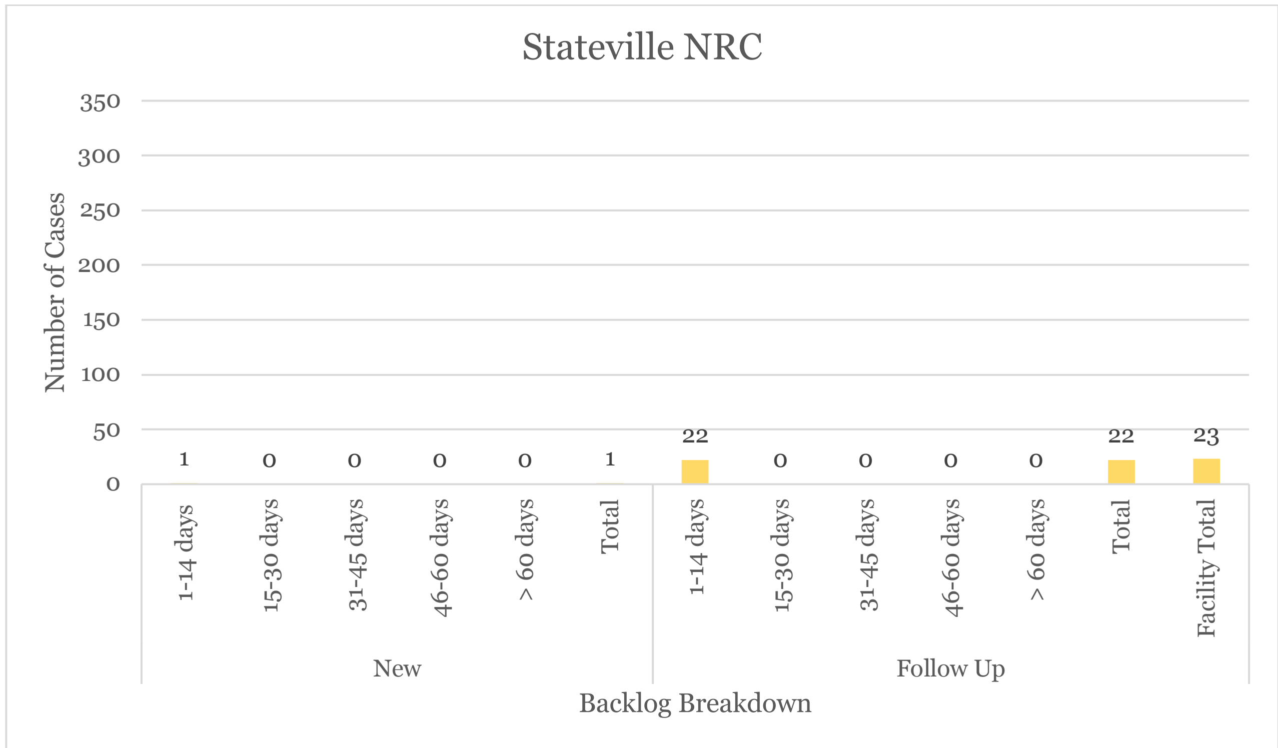

Figure 12. Stateville RNC Total Psychiatry Backlog – Moderate Level of FTE Vacancies.

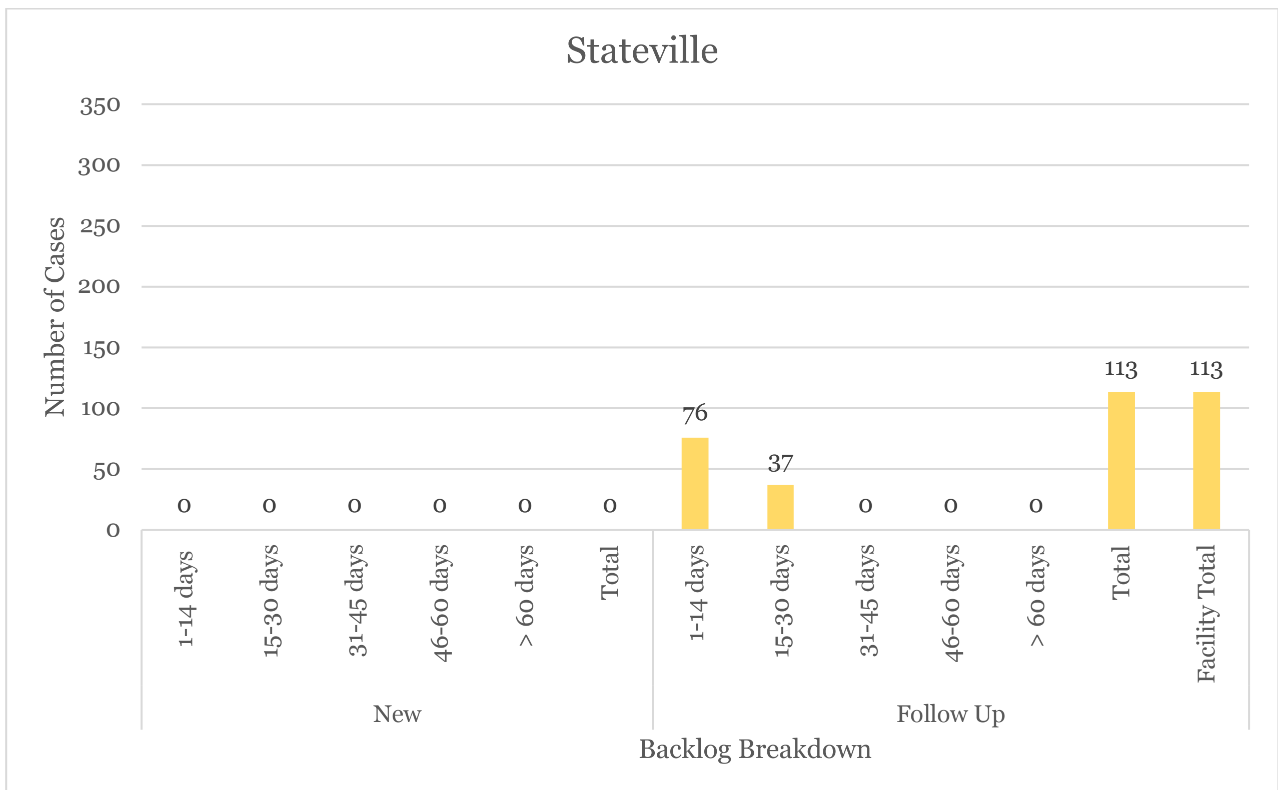

Figure 13. Stateville Total Psychiatry Backlog – Moderate Level of FTE Vacancies.

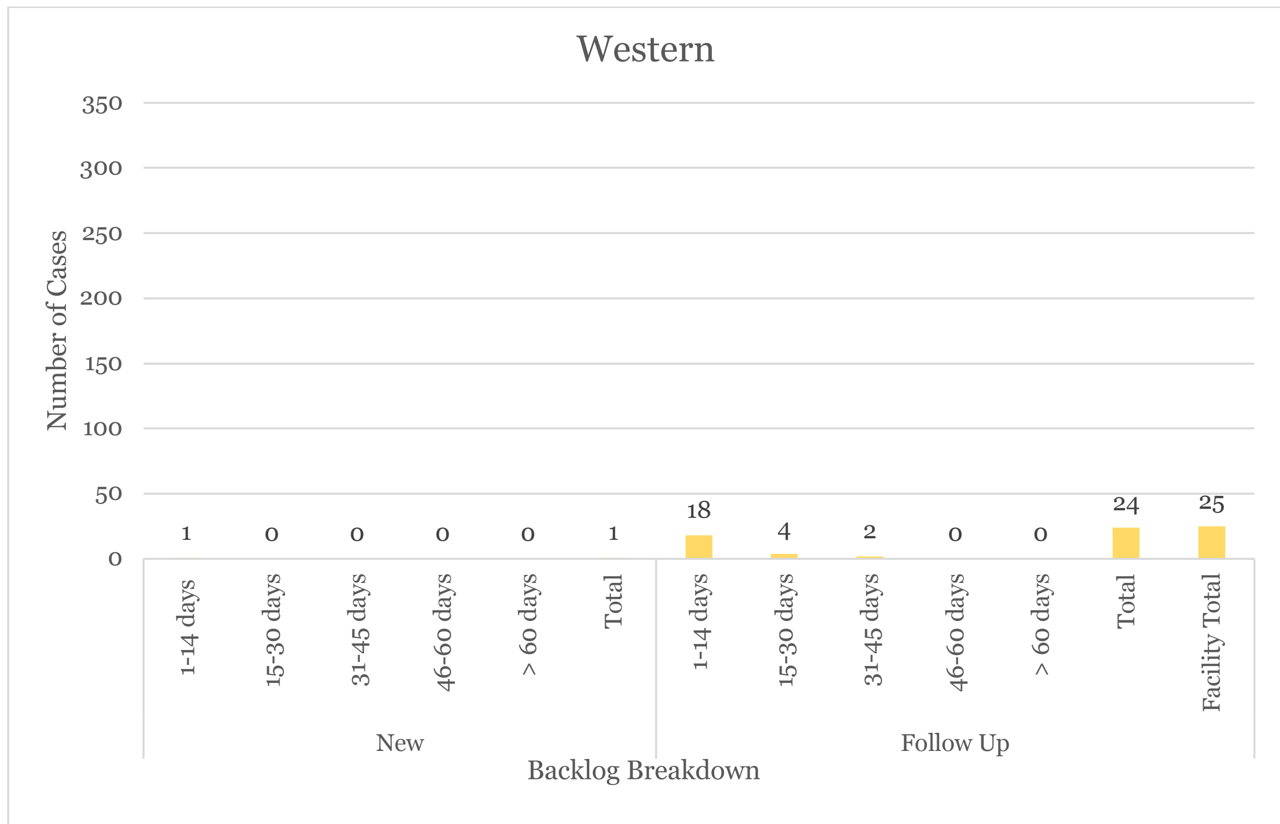

Figure 14. Western Total Psychiatry Backlog – Moderate Level of FTE Vacancies.

Appendix C

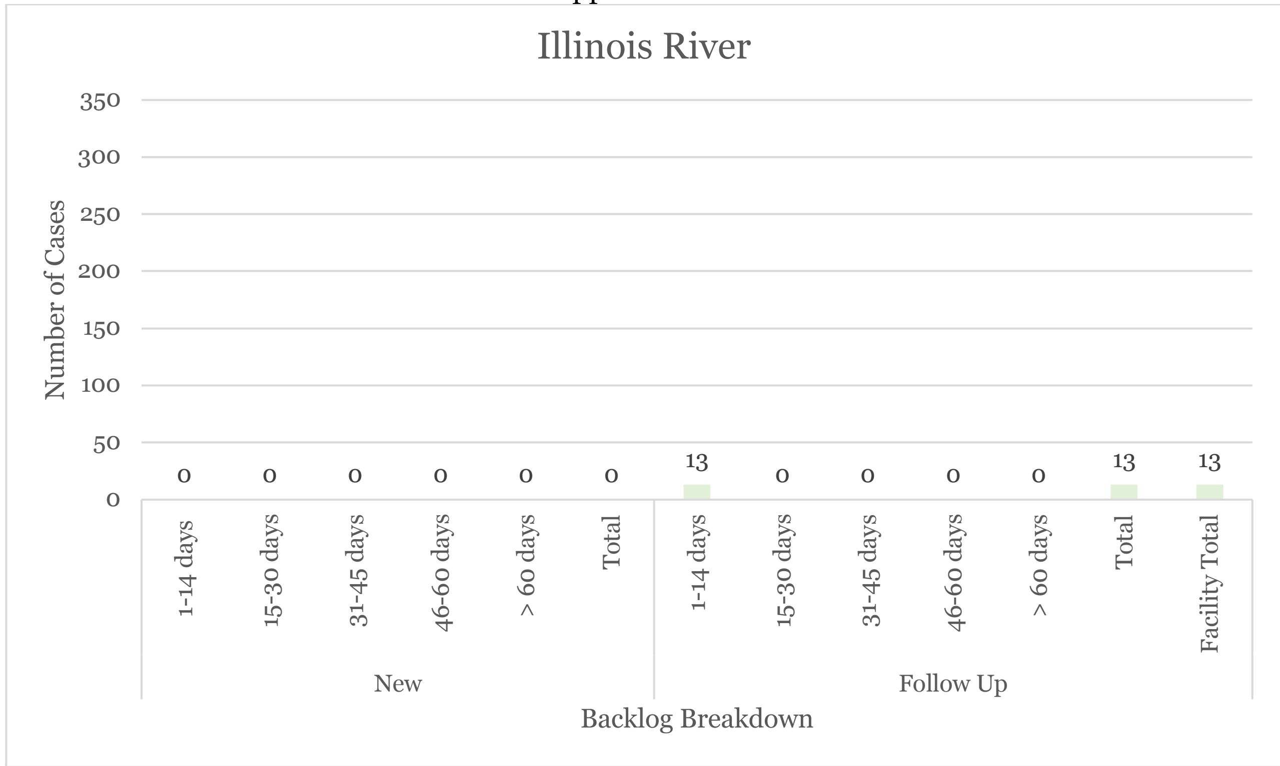

Figure 15. Illinois River Total Psychiatry Backlog – Low/No Level of FTE Vacancies.

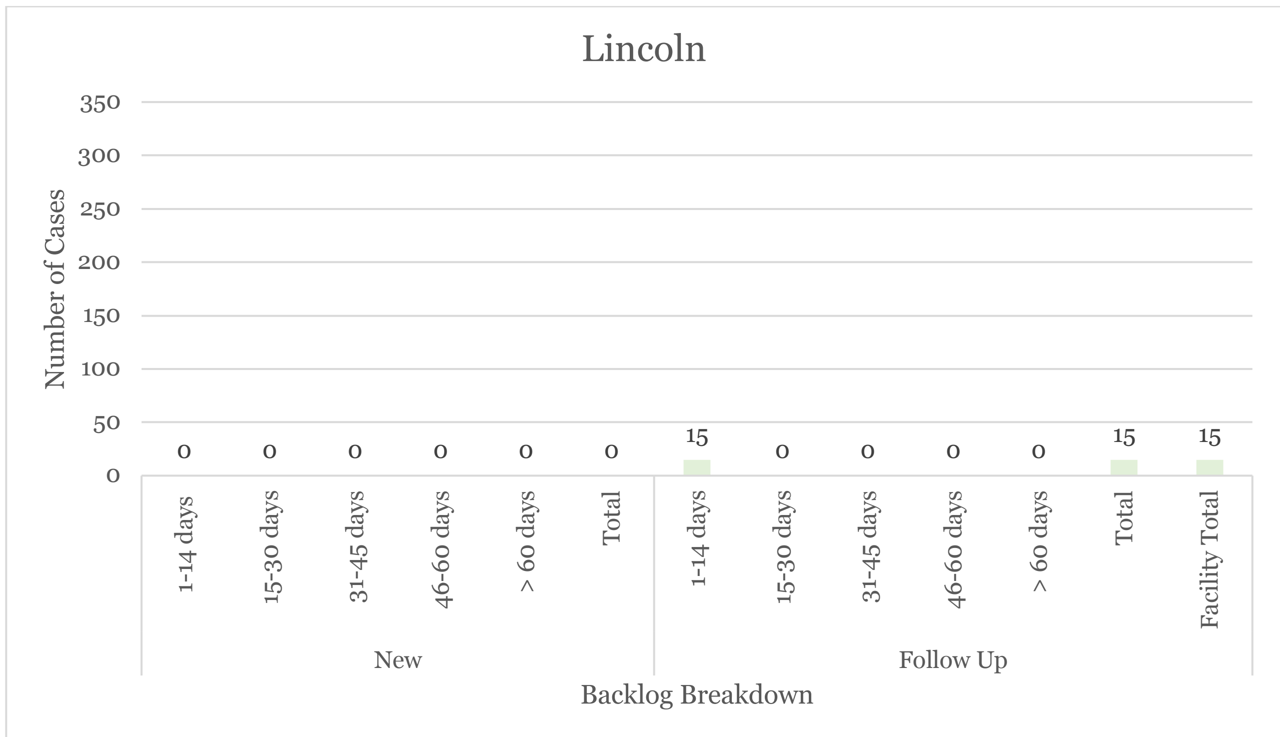

Figure 16. Lincoln Total Psychiatry Backlog – Low/No Level of FTE Vacancies.

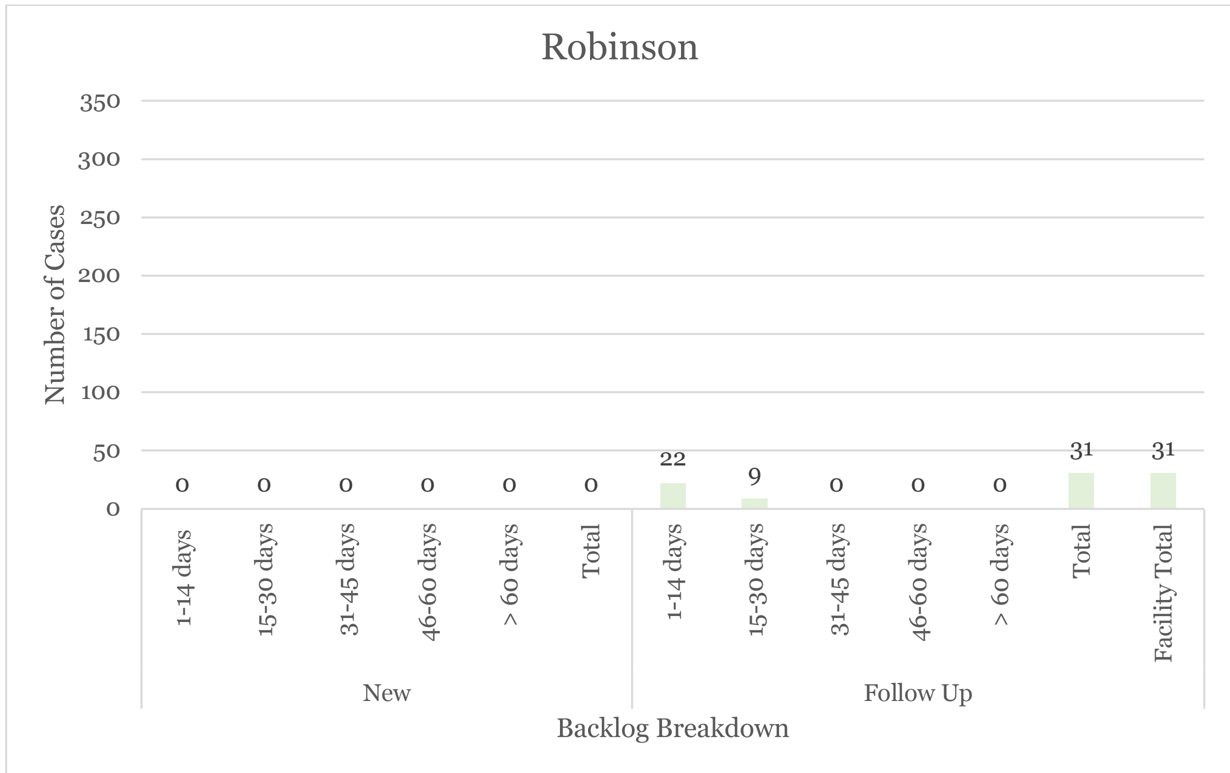

Figure 17. Robinson Total Psychiatry Backlog – Low/No Level of FTE Vacancies.

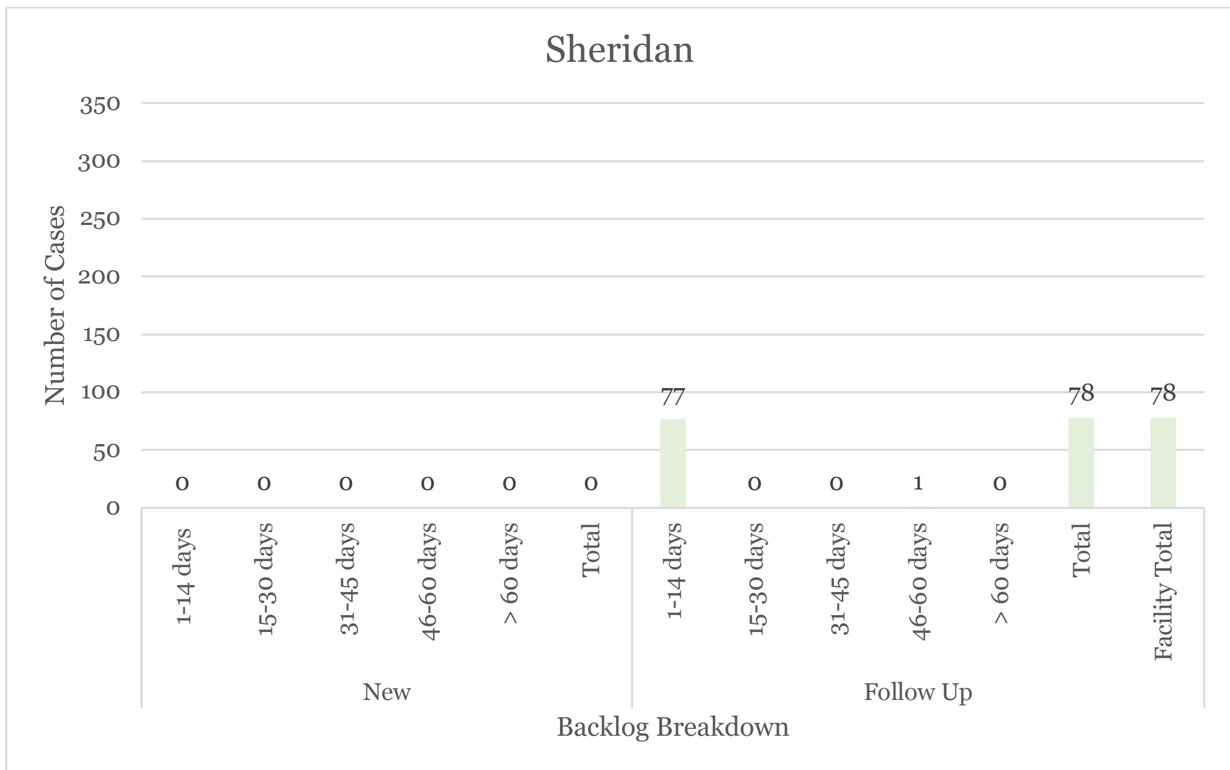

Figure 18. Sheridan Total Psychiatry Backlog – Low/No Level of FTE Vacancies.

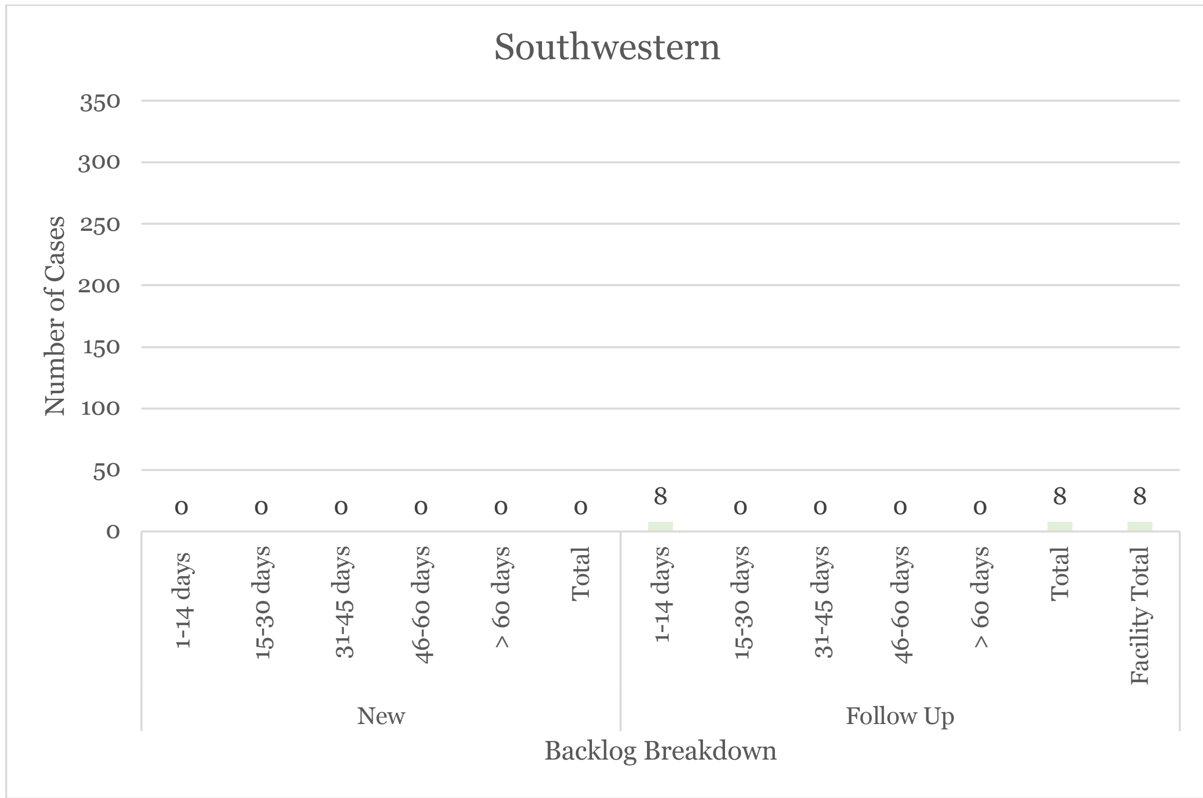

Figure 19. Southwestern Total Psychiatry Backlog – Low/No Level of FTE Vacancies.

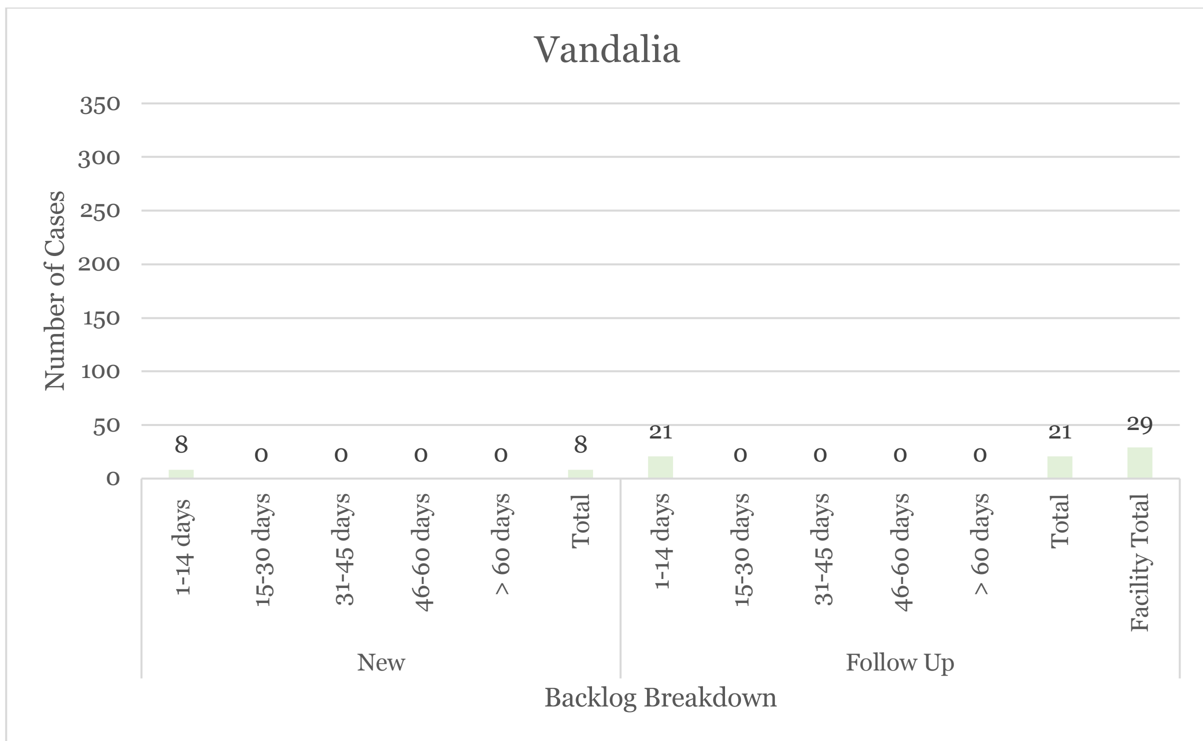

Figure 20. Vandalia Total Psychiatry Backlog – Low/No Level of FTE Vacancies.

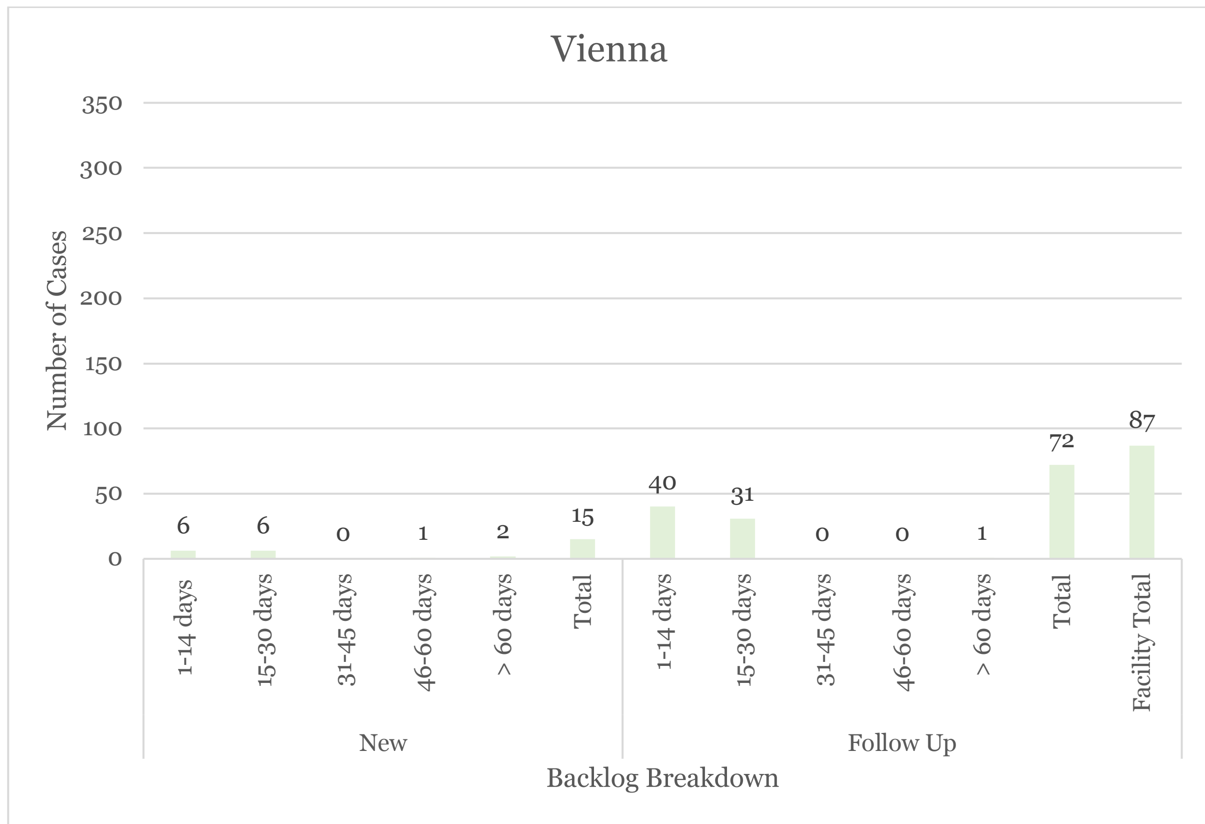

Figure 21. Vienna Total Psychiatry Backlog – Low/No Level of FTE Vacancies.

Appendix D

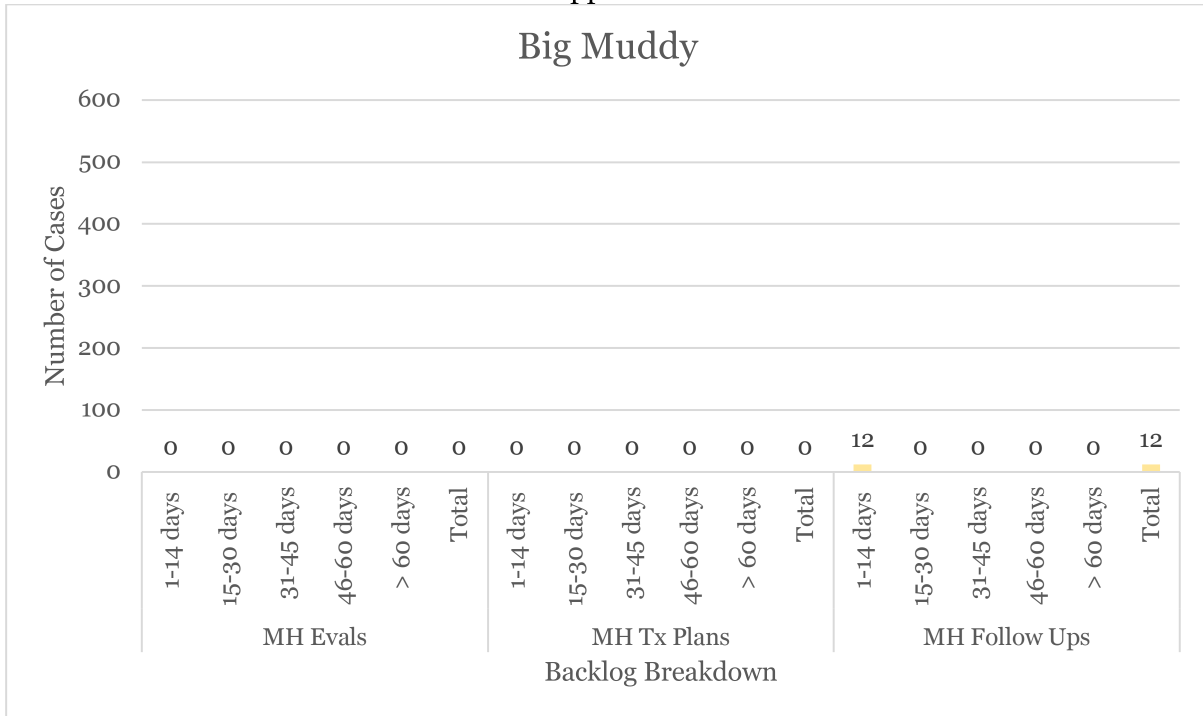

Figure 22. Big Muddy Total MHP Backlog – Moderate Level of FTE Vacancies.

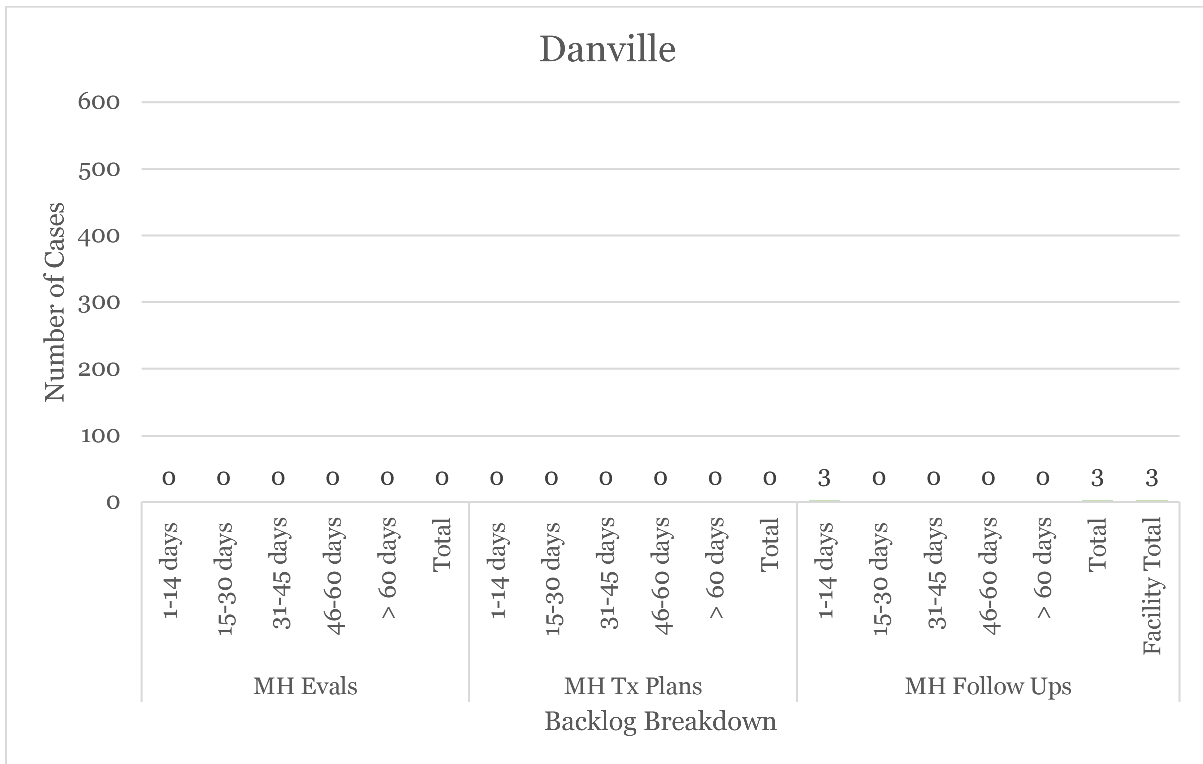

Figure 23. Danville Total MHP Backlog – Moderate Level of FTE Vacancies.

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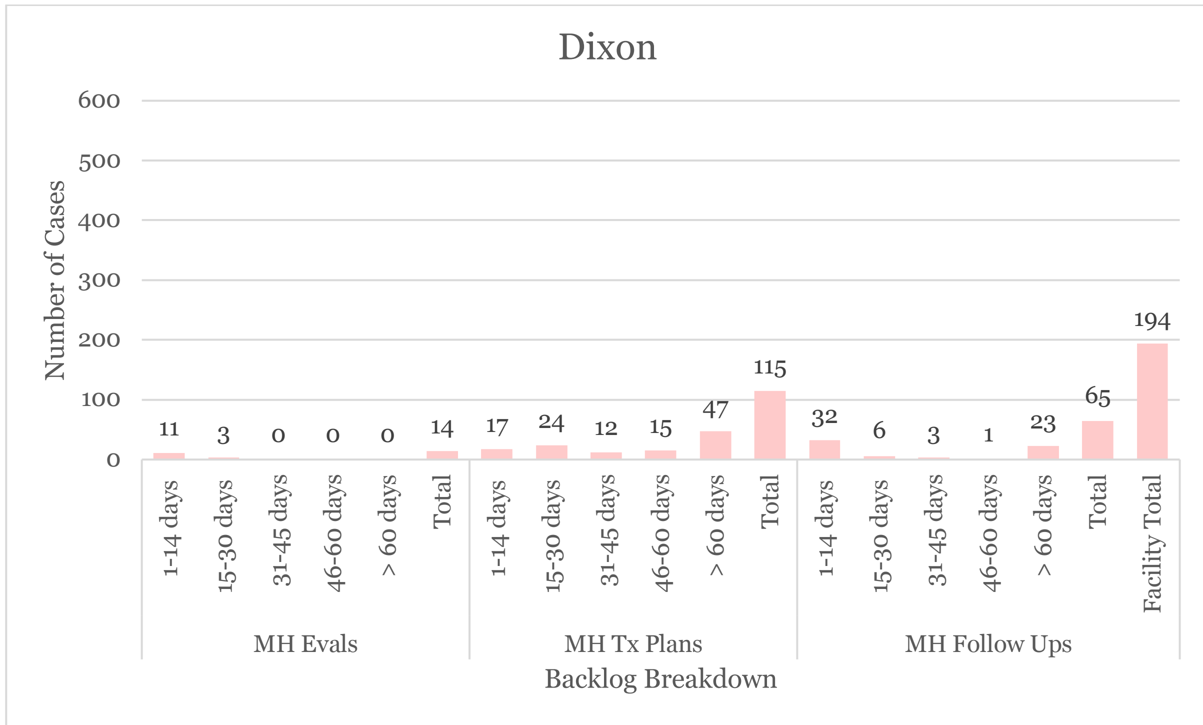

Figure 24. Dixon Total MHP Backlog – High Level of FTE Vacancies.

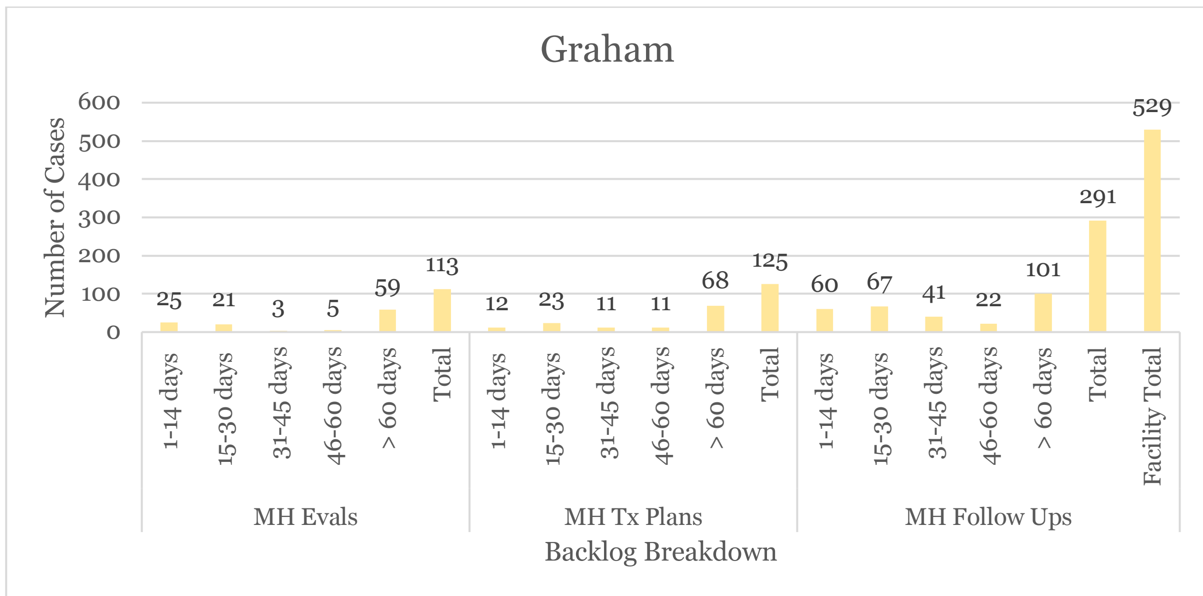

Figure 25. Graham Total MHP Backlog – Moderate Level of FTE Vacancies.

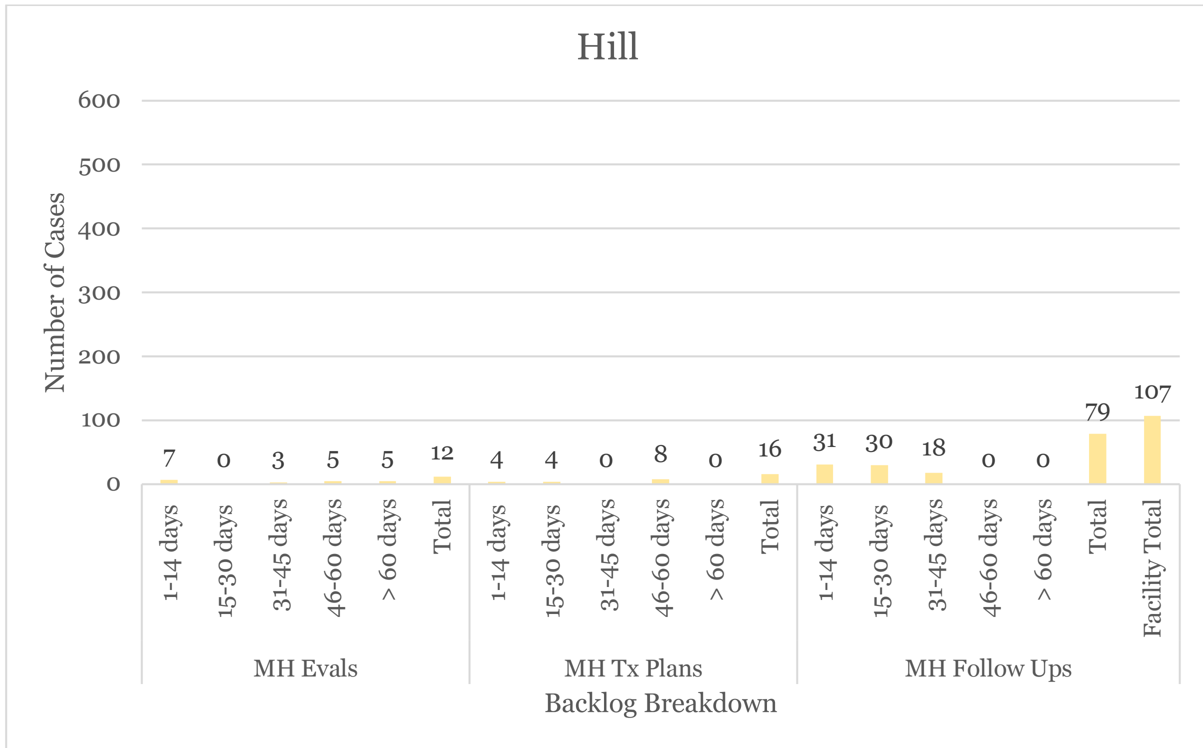

Figure 26. Hill Total MHP Backlog – Moderate Level of FTE Vacancies.

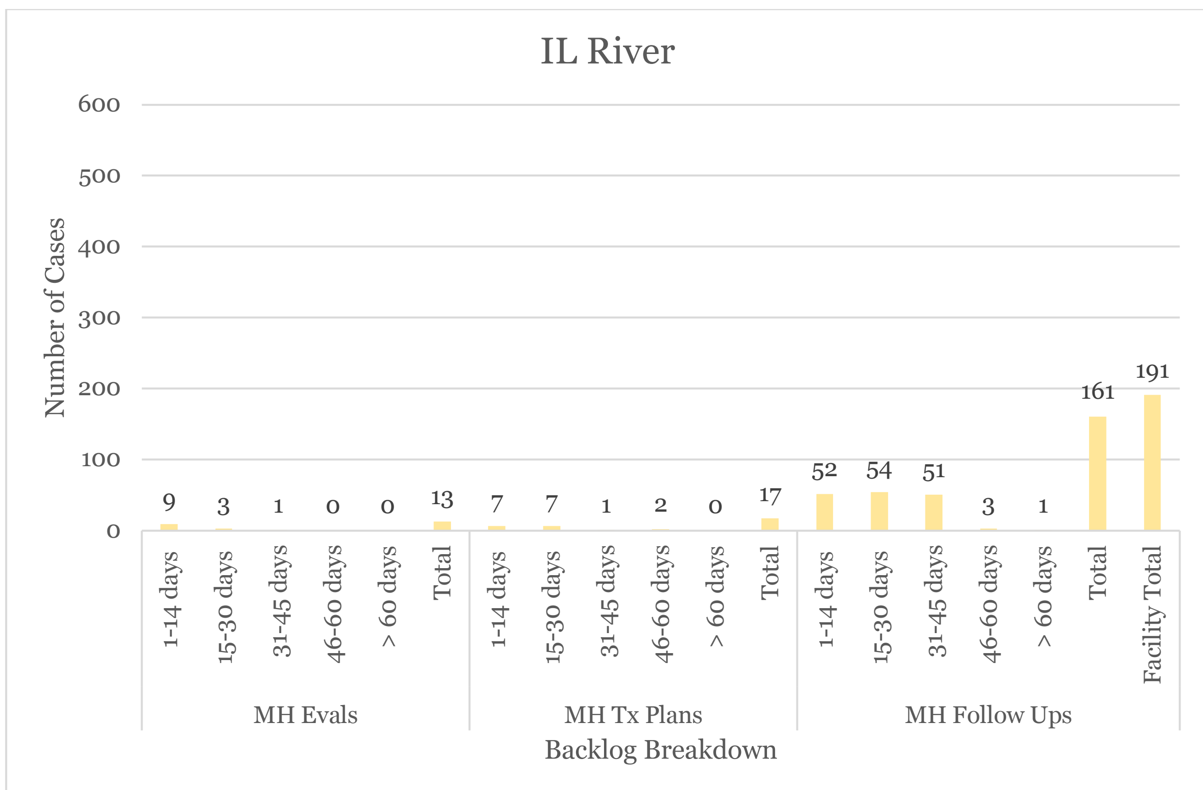

Figure 27. IL River Total MHP Backlog – Moderate Level of FTE Vacancies.

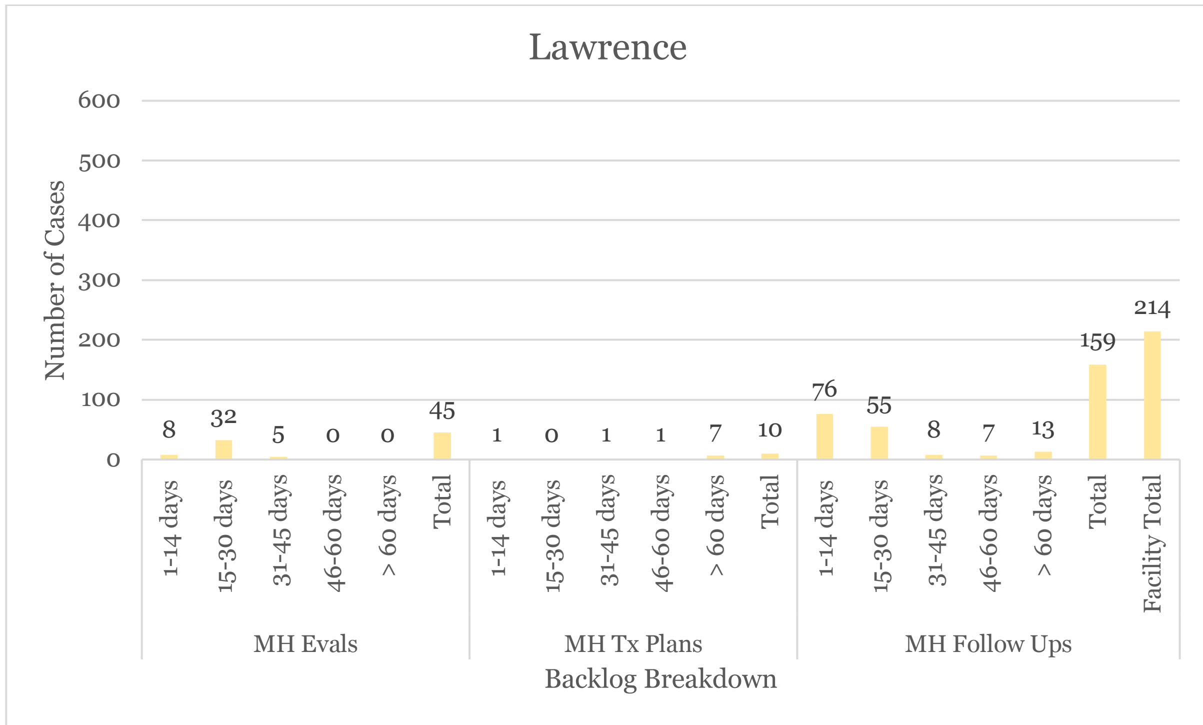

Figure 28. Lawrence Total MHP Backlog – Moderate Level of FTE Vacancies.

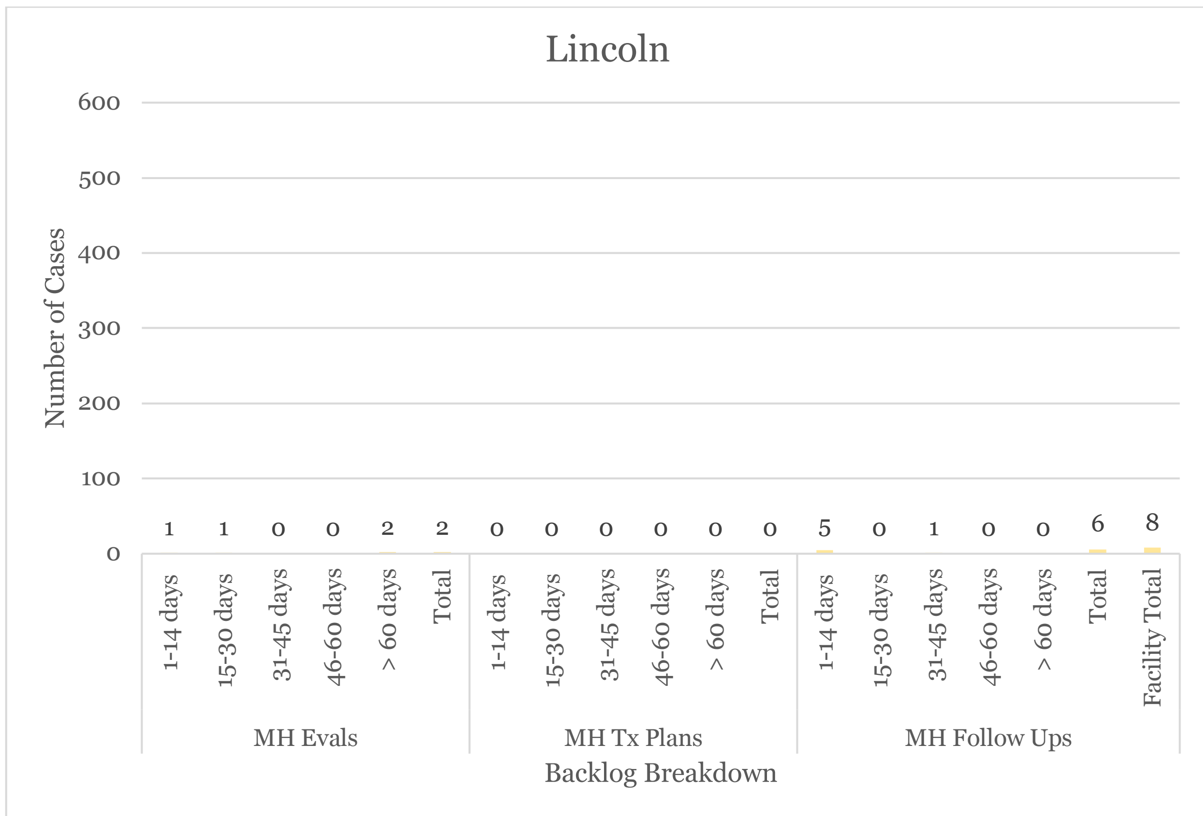

Figure 29. Lincoln Total MHP Backlog – Moderate Level of FTE Vacancies.

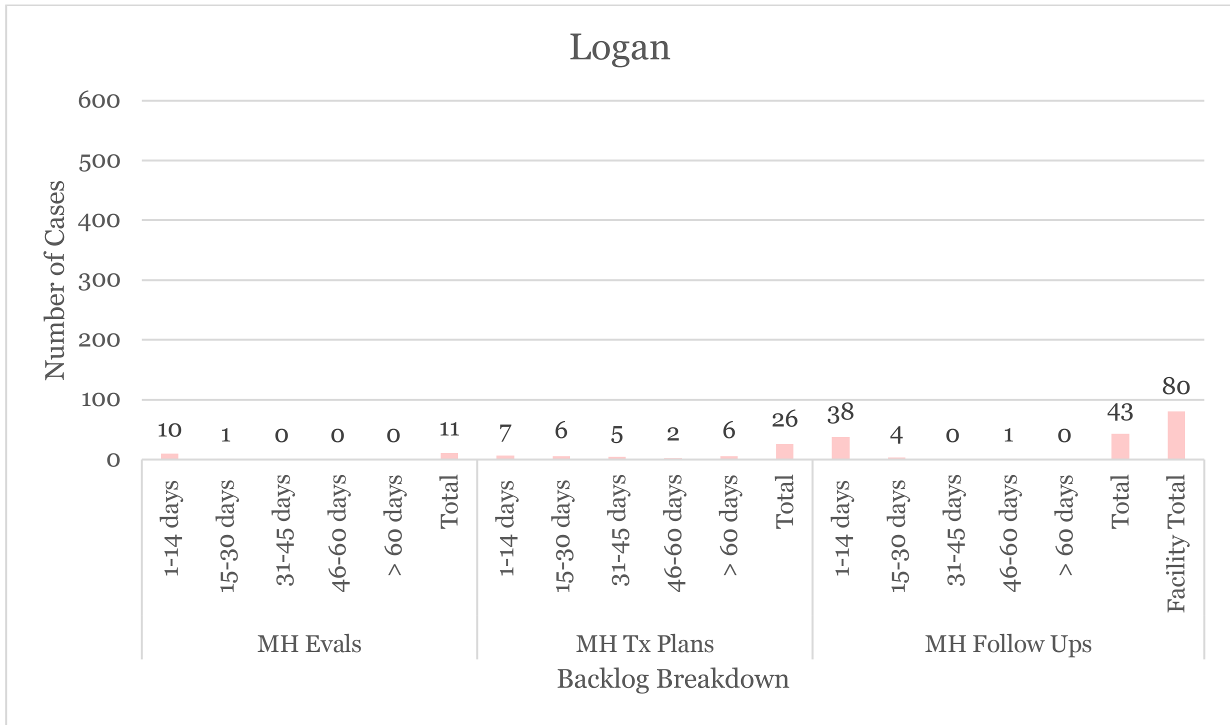

Figure 30. Logan Total MHP Backlog – High Level of FTE Vacancies.

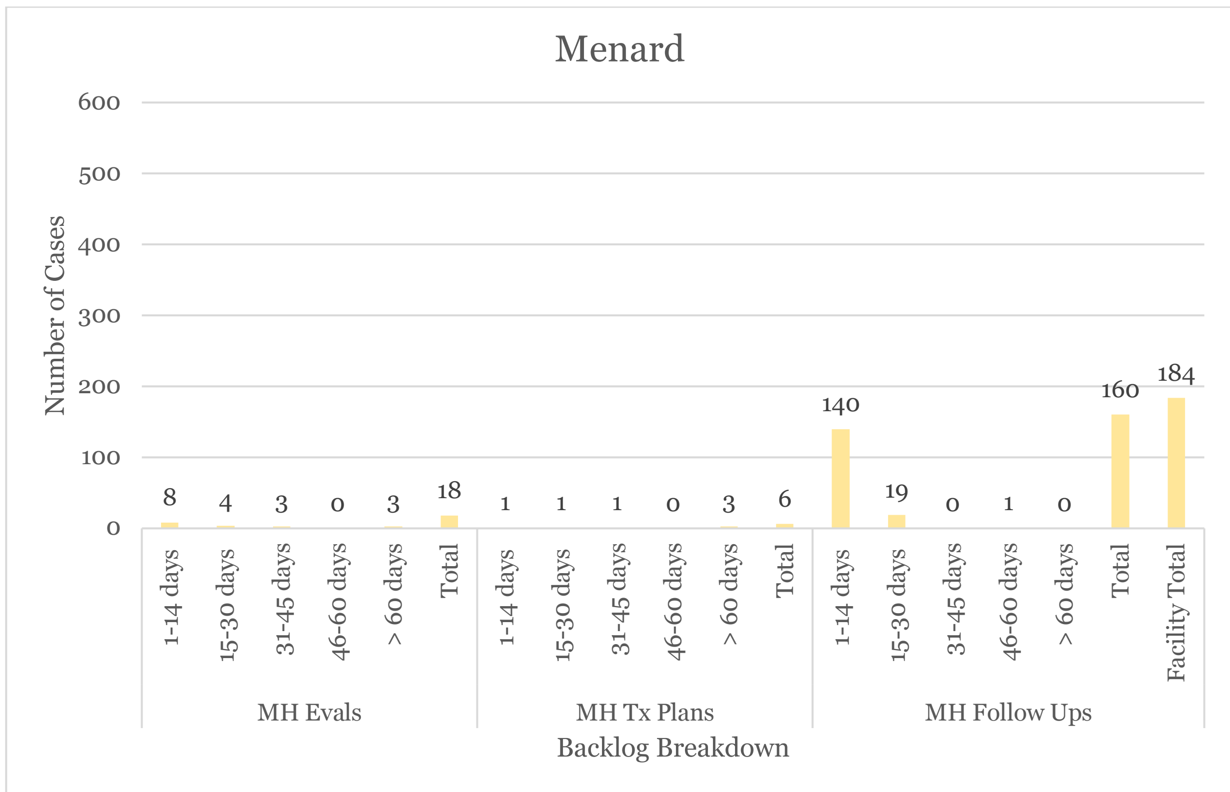

Figure 31. Menard Total MHP Backlog – Moderate Level of FTE Vacancies.

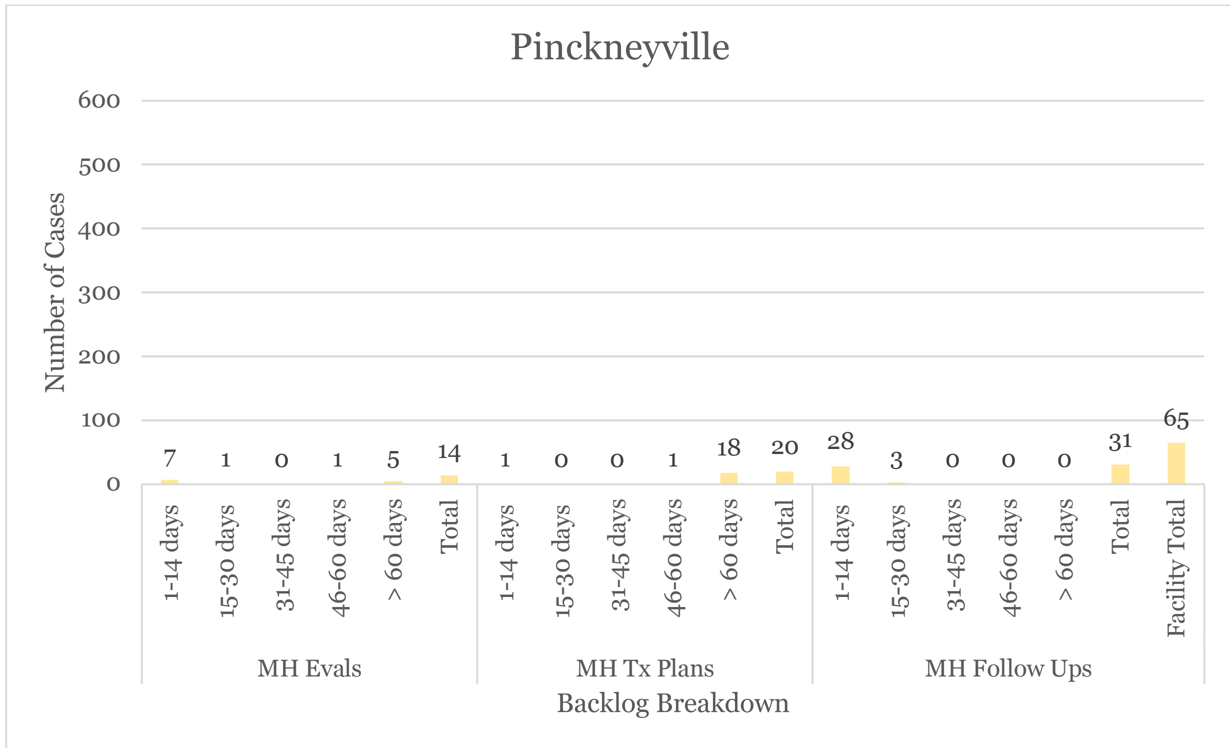

Figure 32. Pinckneyville Total MHP Backlog – Moderate Level of FTE Vacancies.

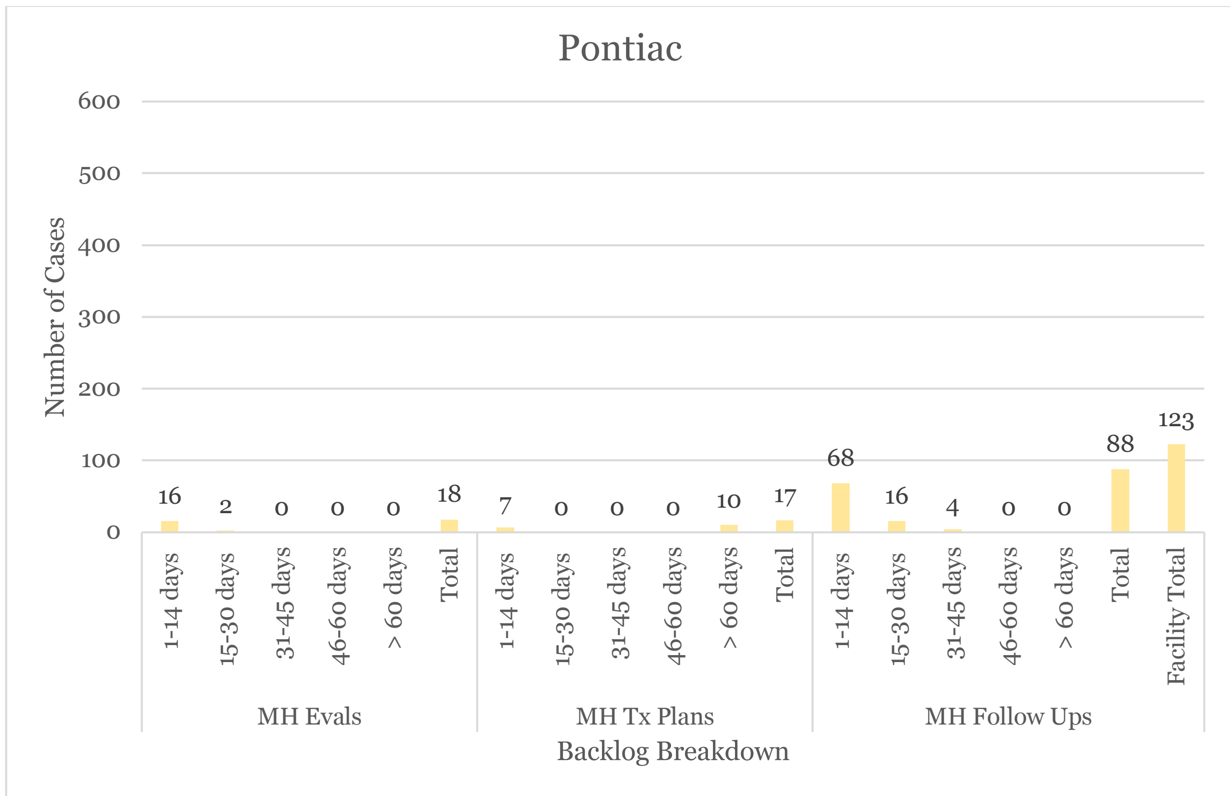

Figure 33. Pontiac Total MHP Backlog – Moderate Level of FTE Vacancies.

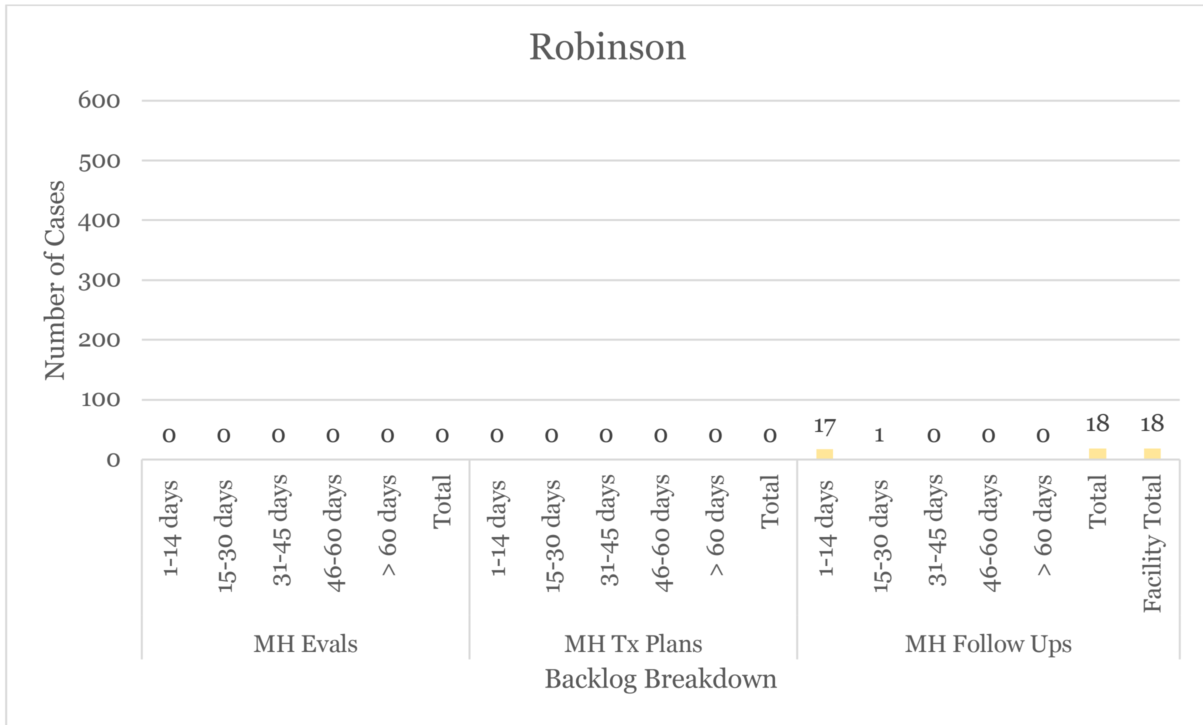

Figure 34. Robinson Total MHP Backlog – Moderate Level of FTE Vacancies.

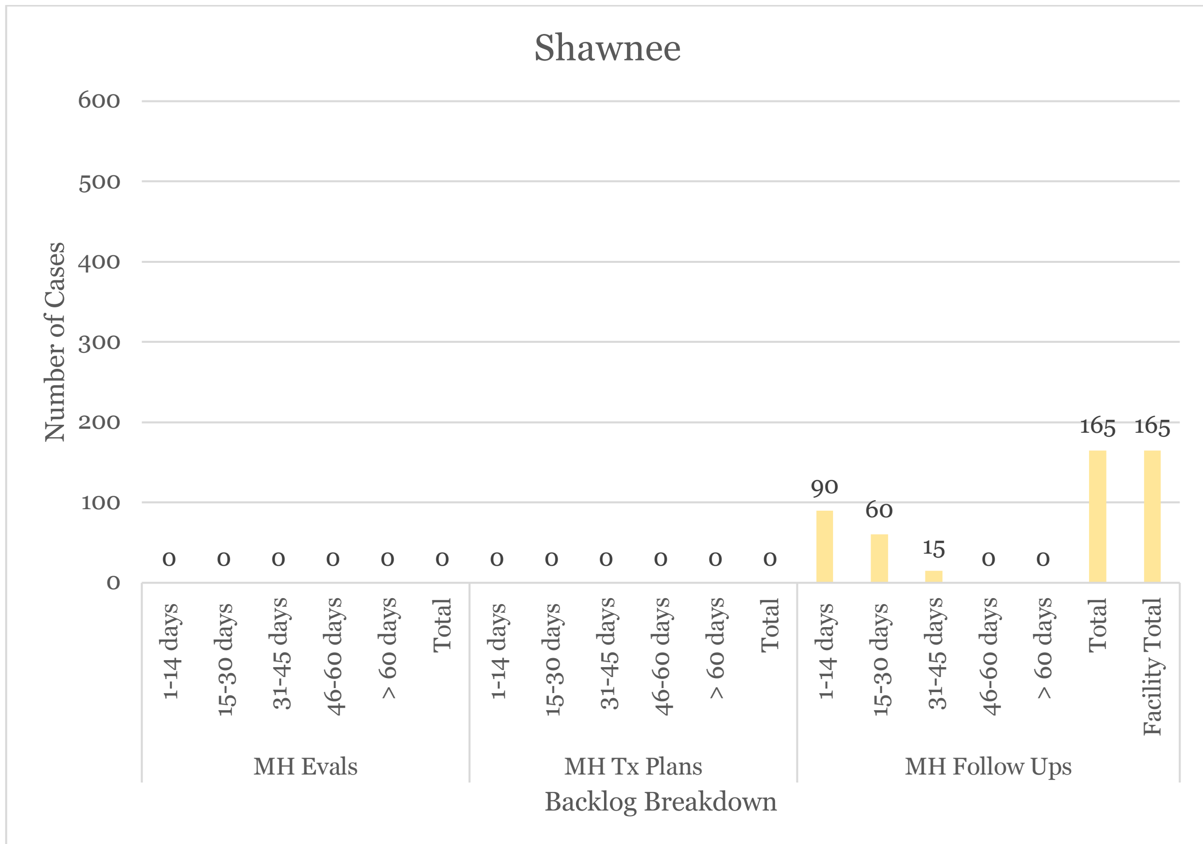

Figure 35. Shawnee Total MHP Backlog – Moderate Level of FTE Vacancies.

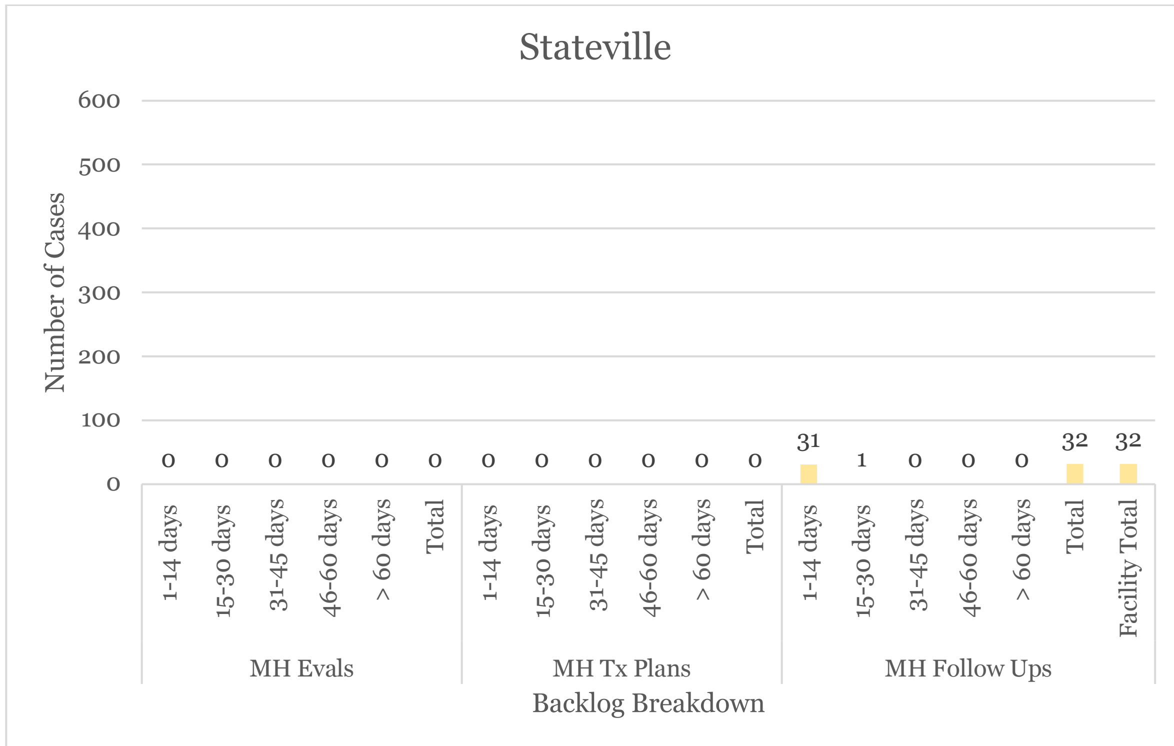

Figure 36. Stateville Total MHP Backlog – Moderate Level of FTE Vacancies.

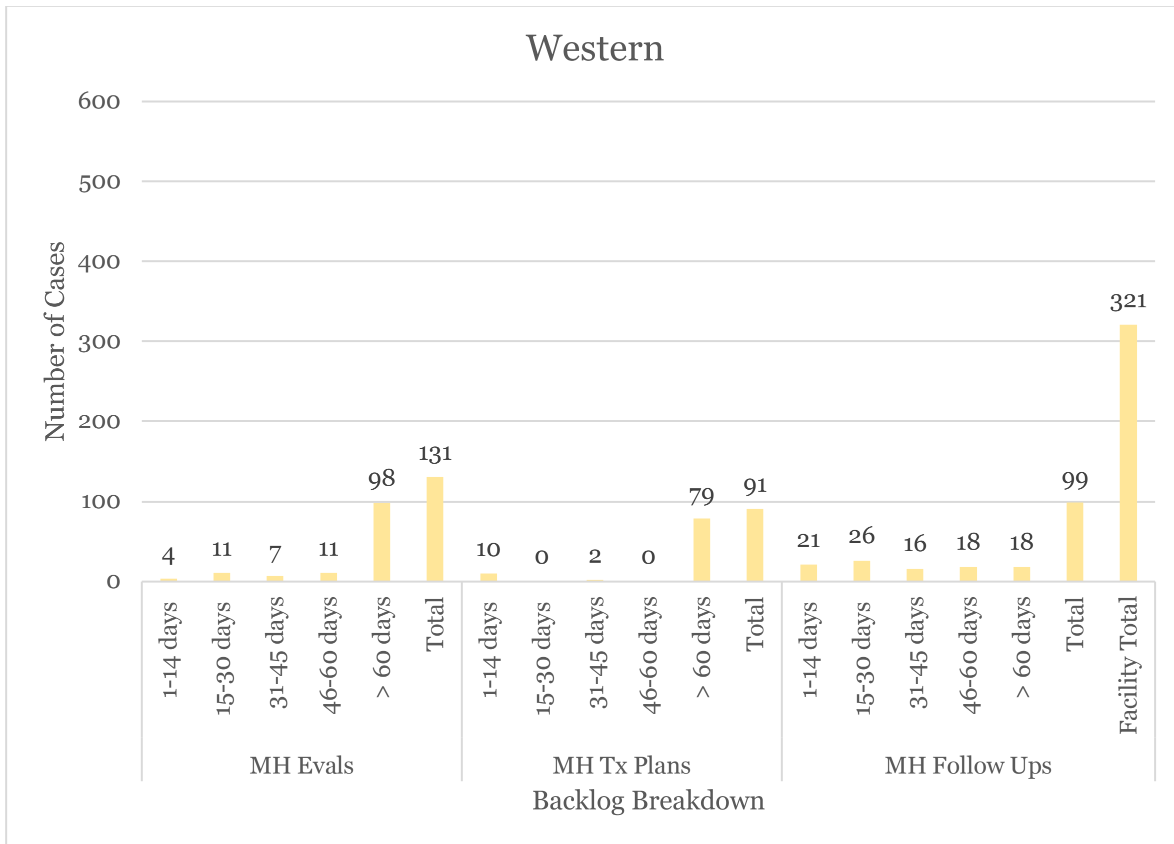

Figure 37. Western Total MHP Backlog – Moderate Level of FTE Vacancies.

Appendix E

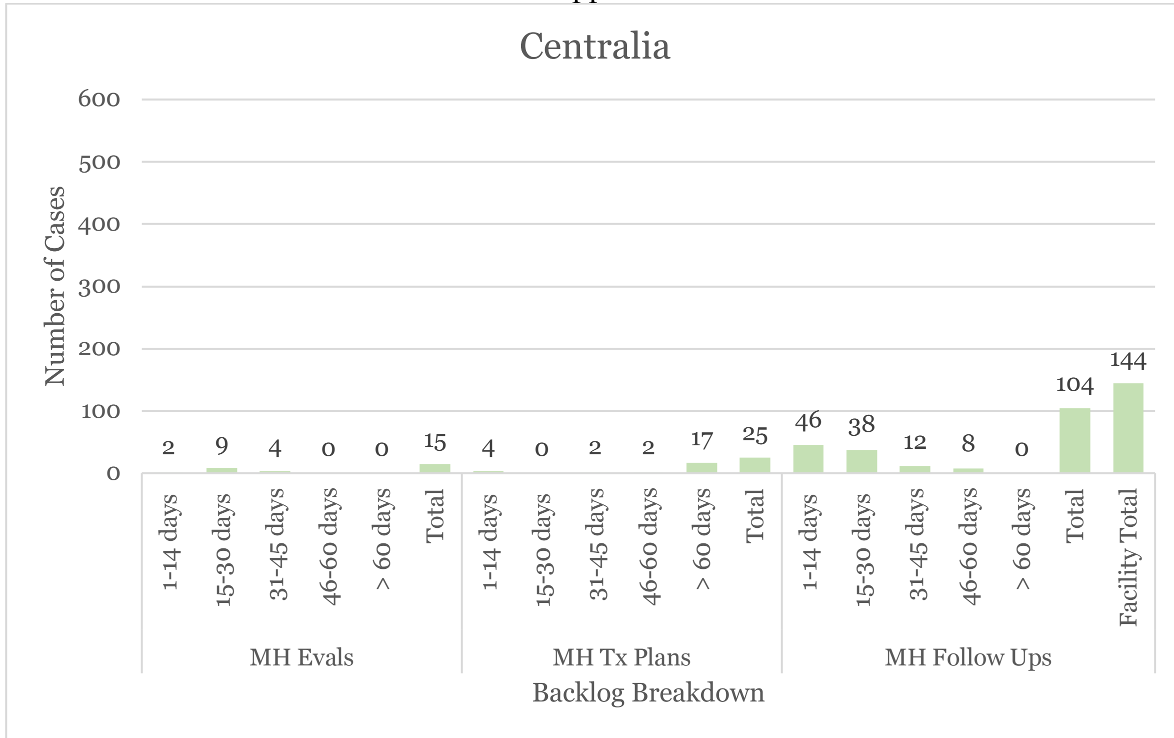

Figure 38. Centralia Total MHP Backlog – Low/No Level of FTE Vacancies.

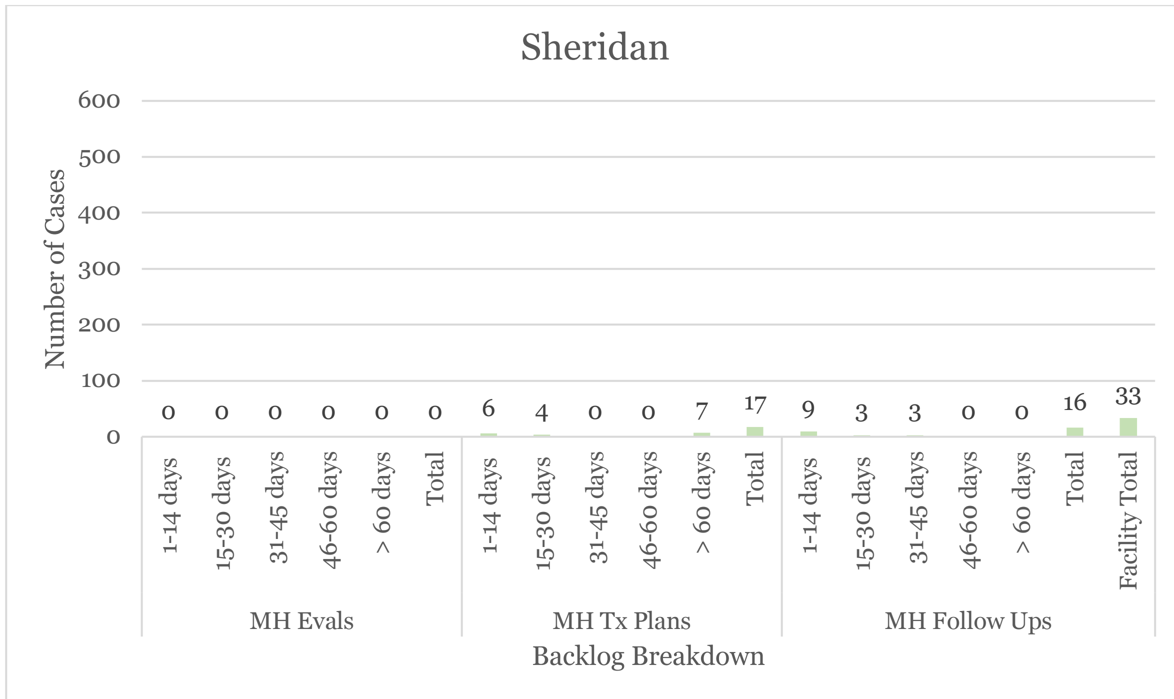

Figure 39. Sheridan Total MHP Backlog – Low/No Level of FTE Vacancies.

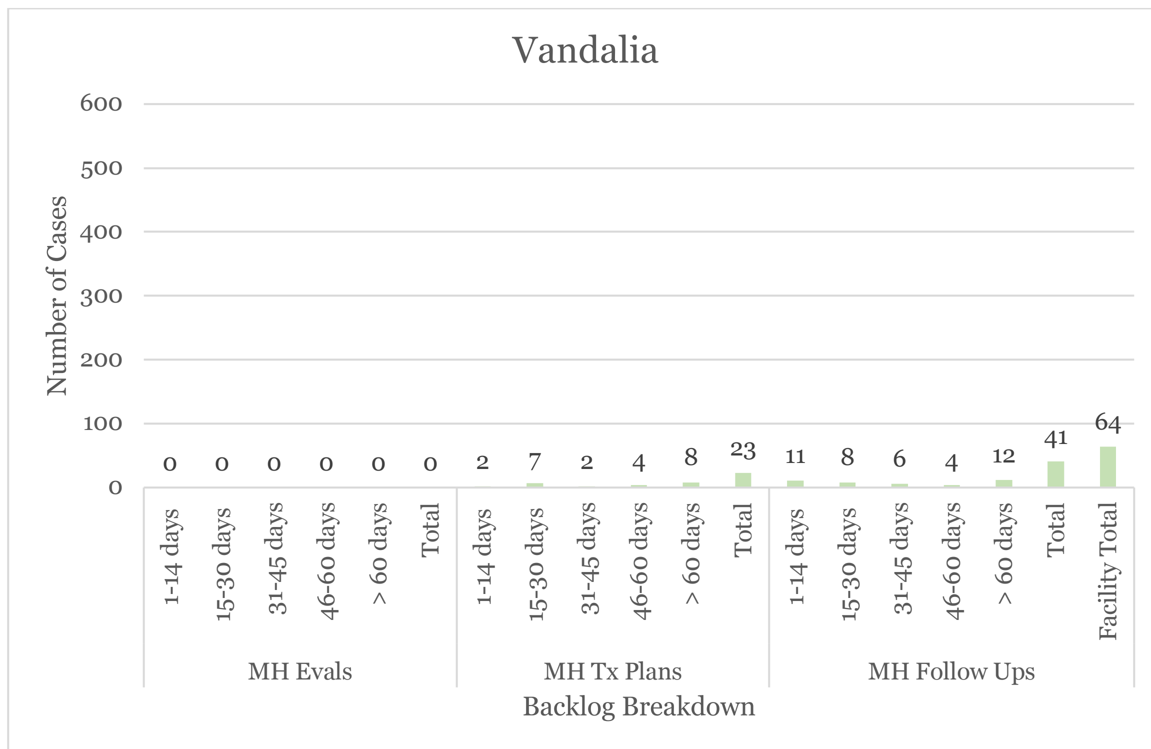

Figure 40. Vandalia Total MHP Backlog – Low Level/No of FTE Vacancies.

APPENDIX 2

Implementing Gender-Responsive and Trauma-Informed Practices:

Explanation and Justification

Executive Summary

- Women are generally a low-risk, high need offending population with individual and case characteristics that are much different than the average male offending population.

- Approximately 73 percent of incarcerated women exhibit mental health problems, with many of these women struggling with substance abuse issues as well. The preferred treatment method involves a holistic, integrated approach that targets criminogenic risk/needs, mental health, and substance abuse issues simultaneously.

- A vast majority of incarcerated women report experiencing trauma prior to entering prison. Trauma and one's response to trauma plays a heavy role in incarcerated women's lives and should play a central role in informing institutional practices and policies.

- Gender-responsive practices involve acknowledging the differing social and political structures between men and women, high rates of violence and other trauma experienced by women, differing pathways to crime, and the unique interaction of trauma, mental health, substance use and abuse, and criminal activity in the female offending population. Further, gender-responsive principles form assessment, classification, treatment, and custodial polices through this gender-informed lens in order to provide optimal care.

- Many traditional assessment and classification instruments are inappropriate to use with female offenders as they were developed for men and validated with male samples. These tools tend to over-classify women. A gender-responsive and trauma-informed assessment that has been validated with female populations is optimal.

- Adequate mental health treatment must be responsive to women's unique needs, pathways to crime, trauma, and family responsibilities. Equal treatment services for men and women offenders does not necessarily result in equal treatment outcomes. Strength-based approaches are essential for delivering gender-responsive treatment for women offenders.

- Women tend to present a lower institutional security risk than male offenders and are at high risk of being re-traumatized during security-related practices (e.g., searching, secluding, restraining, and monitoring). Thus, these traditional practices may be inappropriate for vulnerable women incarcerated populations.

- Implementing a quality assurance tool would provide a guideline for assessing and maintaining the institution's therapeutic fidelity to gender-responsive practices.

- Legal considerations incorporating the Settlement Agreement, Administrative Directive, 730 ILCS 5/3-2-5.5, and the literature described below is presented.

Implementing Gender-Responsive and Trauma-Informed Practices:

Explanation and Justification

Women offenders are a growing population in the United States criminal justice system. While they make up a small portion of the incarcerated population relative to male offenders, the female offending population is growing at twice the rate of male offenders (Blanchette & Brown, 2006). Between 1995 and 2004, the United States saw a 34 percent increase in the female incarceration rate (47 per 100,000 to 63 per 100,000; Harrison & Beck, 2005). The male incarceration rate also rose, but at a rate of only 17 percent (789 per 100,000 to 923 per 100,000; Harrison & Beck, 2005). While the female offending population is growing, their commission of violent crimes is not (Van Voorhis & Salisbury, 2014). Instead, women are more likely to commit drug and property crimes (Javdani, Sadeh, & Verona, 2012; Van Voorhis & Salsibury, 2014). Thus, generally, women are a low-risk, high-need offending population with individual and case characteristics that are much different than the average male offending population (Van Voorhis & Salisbury, 2014).

Mental Health Needs of Women

Prevalence of Needs

Female offenders often present mental health needs that differ from male offenders. Female offenders tend to have higher levels of anxiety, depression, and borderline personality disorder than their male counterparts (Bloom, Owen, & Covington, 2003; Howells, Heseltine, Sarre, Davey, & Day, 2004; Veysey, 2003). According to the United States Department of Justice, approximately 73 percent of incarcerated women exhibit mental health problems, while

55 percent of incarcerated men exhibit these symptoms (James & Glaze, 2006). Women often have multiple, co-occurring mental health needs and substance abuse needs (Bloom & Covingtion, 2003; Bloom et al., 2003; Howells et al., 2004). James and Glaze (2006) report that 75 percent of women incarcerated in state prisons with a mental health disorder also struggle with substance abuse issues. To further complicate the situation, it is often difficult to parse apart these needs and determine which psychiatric issue or substance abuse issue existed first (Bloom & Covington, 2009). Thus, researchers recommend that a holistic, integrated approach to treatment that is delivered concurrently is the most effective (e.g., treating substance abuse and mental health issues simultaneously rather than sequentially) (Bloom & Covington, 2003; Bloom & Covington, 2009; Bloom et al., 2003; Howells et al., 2004). Bloom and Covington (2009) also stress that these needs must be addressed through a trauma-informed lens.

Trauma

Messina and Grella (2006) summarized the existing research on traumatic histories of female offenders and concluded that between 77 percent and 90 percent of incarcerated women have experienced some form of abuse in their life. The premier resource of mental health providers, *The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition,* defines trauma as:

"Exposure to actual or threatened death, serious injury or sexual violence in one (or more) of the following ways:

- Directly experiencing the traumatic event(s)
- Witnessing in person, the event(s) as it occurs to others
- Learning that the traumatic event(s) occurred to a close family member or close friend

- Experiencing repeated or extreme exposure to aversive details of the traumatic event(s)[47]" (American Psychiatric Association, 2013, p. 271).

Female offenders tend to report experiencing trauma at a higher rate than women in the community and incarcerated men (James & Glaze, 2006; McClellend, Farabee, & Crouch, 1997; Messina, Burdon, Hagopian, Prendergast, 2006; Ryder, Langley, & Brownstein, 2009). Most notably, this trauma includes physical, sexual, and emotional abuse (Messina et al., 2006). One study of randomly-sampled women in a Georgia prison found that nearly all participants had experienced at least one traumatic event in their lifetime, and that 81 percent of participants had experienced five or more events (Cook, Smith, Tusher, & Raiford, 2005). Trauma may include physical abuse, sexual abuse, or neglect. This high exposure to various forms of trauma substantially increases their risk for Posttraumatic Stress Disorder, depression, and substance abuse (Horwitz, Widom, & White, 2001). Messina and Grella (2006) notes in their study of incarcerated women that a strong link exists between childhood or adult trauma and behavioral problems (including criminal activity), substance dependence, and mental health problems.

A history of trauma is an important factor to consider in the context of female offending and may inform unique pathways to crime for women. English, Widom, and Brandford (2001) compared women with a history of abuse and neglect to a control group who did not report these experiences to examine the effect of trauma on criminal behavior. These researchers found that women who had experienced trauma were four times more likely to be arrested in their youth, twice as likely to be arrested in adulthood, and seven times as likely to be arrested in adulthood for a violent crime (English et al., 2001). This indicates that trauma plays a heavy role in the

[47] This last criterion is related to the work of first responders.

lives of female offenders and offers an explanation for the need for trauma-informed policies and practices when handling and caring for women offenders.

Basic Principles of Offender Classification: Risk, Need, and Responsivity

Risk

An offender's risk to recidivate is paramount to the assessment, classification, and treatment process. One's risk level should match the level of services provided to them (Andrews & Bonta, 2003). For example, a high risk offender should be provided with a higher level of services. A high level or services for a low risk offender would be inappropriate. An offender may possess static (e.g., age, criminal history, childhood upbringing) or dynamic risk factors (the "Big Eight"; Andrews & Bonta, 2003, 2010; Gendreau, Little, & Goggin, 1996). Though static predictors are very important in determining risk, they cannot change and thus should not be the target of recidivism-reducing interventions (Blanchette & Brown, 2006). A large body of research identifies eight criminogenic risk/need factors (the "Big Eight") that influence criminal behavior (Andrews & Bonta, 2010). Andrews and Bonta (2010) list the "Big Eight" as: 1) antisocial behavior; 2) antisocial personality; 3) antisocial attitudes; 4) antisocial associates; 5) dysfunctional family and/or marital circumstances; 6) problematic school and/or work circumstances; 7) lack of positive leisure activities; 8) substance abuse. These factors are changeable attributes and are suitable targets for intervention.

Need

An offender's needs refer to criminogenic needs should be addressed during interventions to reduce their likelihood of recidivism. These include characteristics of the offender, their personal history, and their social situation that are directly related to their risk of recidivism (Blanchette & Brown, 2006). An individual may have non-criminogenic needs such as physical

health problems or psychological distress. However, criminogenic needs such as antisocial attitudes, antisocial associates, low self-control, substance abuse issues, lack of education or vocational skills, lack of family supports or dysfunctional familial relationships, and poor use of leisure time should be the primary focus of interventions intended to mitigate criminal re-offending (Andrews & Bonta, 2003; Blanchette & Brown, 2006).

Responsivity

The responsivity principle asserts that intervention results are optimal when the intervention service is delivered in a way that best suits the ability and learning style of the offender (Blanchette & Brown, 2006). Essentially, this principle focuses on how the intervention should be delivered in order to achieve an optimal treatment response (e.g., reduction in recidivism). This principle is made up of broad and specific responsivity. An intervention incorporating broad responsivity principles involves a structured intervention curriculum (e.g., cognitive behavioral therapies), warm and empathetic delivery, and a firm but fair approach (Blanchette & Brown, 2006). Specific responsivity is achieved when considerations are made for the gender, ethnicity, literacy, and intelligence of the offenders intended to receive the intervention (Blanchette & Brown, 2006).

Gender-Responsive and Trauma-Informed Principles and Practices

Due to the growing body of evidence detailing the differences between men and women in the correctional system, and most notably the inappropriateness of classifying, securing, and treating women the same as male offenders, many state and federal agencies are moving toward gender-responsive practices and programming (Bloom et al., 2005; Harris & Lurigio, 2009; Van Voorhis & Salisbury, 2014). Bloom and Covington (2009) and Salisbury and Van Voorhis (2009) state that gender-responsivity involves acknowledging the differing social and political

structures between men and women, high rates of violence and other trauma experienced by women, differing pathways to crime between men and women, and the unique interaction of trauma, mental health, substance use and abuse, and criminal activity in the female offending population. Advocates for gender-responsivity emphasize using a 'gendered' lens when developing correctional polices and taking extra care to account for trauma and other social issues faced by female offenders (Bloom et al., 2005; Harris & Lurigio, 2009; Van Voorhis & Salisbury, 2014). It should be noted that gender-responsive assessment, classification, and treatment goes beyond simply having a female caseload managed by a female staff member (Van Voorhis & Salisbury, 2014).

Strategies Toward Gender-Responsivity

Bloom and colleagues (2003, 2005) developed a gender-responsive strategy for women offenders during a three-year study commissioned by the United States National Institute of Corrections. First, the institution holding the responsibility of incarcerating female offenders must acknowledge that men and women offenders are different in terms of presence and magnitude of specific risks and needs, pathways to offending, responses to security, and risk to reoffend. Second, behavioral change is most likely to be achieved when the change can be facilitated in a safe and respectful environment preventing them from being re-victimized or re-traumatized. Third, policies and programs that incorporate family, children, and spouses/significant others are most likely to be effective in promoting prosocial change. Fourth, a holistic approach should be incorporated to address mental health issues, trauma, and substance abuse in an integrated, simultaneous fashion. The fifth principle advocates for offering education and vocational training to female offenders to remove barriers that may prevent them from being crime-free. Sixth, efforts should be made to collaborate with community and institutional

resources to foster a strong support system upon release (e.g., reentry services, community mental health care centers, family service agencies, emergency shelters, self-help groups, etc.).

Offender Assessment and Classification

The assessment and classification of offenders is an important tool used by institutions for the primary purpose of risk management, but also serves to identify treatment needs, inform security designations, release decision-making, and advise other correctional decisions (Blanchette & Brown, 2006). Austin (1986) discussed the necessity of these tools by stating "a properly functioning classification system is the "brain" of prison management as it governs inmate movement, housing and program participation, which in turn heavily influence fiscal decisions on staffing levels and future budget needs" (p. 304).

But, Do Current Assessment Tools Apply to Women?

A vast majority of offender assessment and classification instruments are "gender-neutral" (Blanchette & Brown, 2006). These measures were developed using male offender samples, then were later applied to women. "Gender-neutral" measures are intended to be impartial to gender; however, the normative standard for these measures is male (Brennan, 1998). Many researchers have concluded that this is inappropriate for female offenders because traditional risk-based classification tools over-classify women (e.g., categorize women at higher levels of risk than they actually are; Blanchette & Brown, 2006; Bloom, 2000). Improper classification leads to the over-supervision and improper custody placement of women and delivering services that are not actually meeting their needs (Handyman, 2001).

Olson, Alderdan, and Lurigio (2003) examined various traditional predictor variables of committing future offenses. The researchers' compared the predictive accuracy of these predictors of the male sample and female sample. Their findings indicate that fewer predictor

variables accurately predicted re-arrest for the female-only sample than the male-only sample. Further, the magnitude and effect direction of several of the predictor variables was different for male and female samples (Olson et al., 2003). Brown and Motiuk (2005) also note that it is not the current criminogenic risk or need principles in general that contribute to the inappropriate classification of women offenders, but *which* risk and need variables are emphasized in traditional assessment measures. For example, family contact, relationships, current or prior mental health issues, economic marginality, self-injury, and child abuse or other victimization are much more salient variables for women's security classification and risk prediction than men (Blanchette, 2005; Gido, 2009; Hardyman & Van Voorhis, 2004).

Toward Effective Gender-Responsive Assessment

An effective assessment for female offenders should be centered around empirically-supported criminogenic risk factors, but also incorporate the context of female-specific risks, needs, and identify histories of trauma. Traumatic experiences may complicate adjustment to the prison environment, complicate engagement in therapeutic efforts, and more accurately inform staff and service providers of their unique needs (Harris & Lurigio, 2009). The assessment must also incorporate strength-based areas including abilities, skills, and protective factors. Importantly, assessments should be built with a female-only population in mind (incorporating appropriate risks/needs and strengths) and validated with female-only samples (Harris & Lurigio, 2009).

To obtain an accurate assessment and minimize any potential harm or re-traumatization, staff responsible for conducting the assessment must undergo gender-responsive and trauma-informed training (Wright, Van Voorhis, Salisbury, & Bauman, 2012). Training should include educating staff members on the differences between male and female offenders, motivational

interviewing, gender-specific case management, building rapport and trust with the women, and approaching all assessment, treatment, and custodial duties with sensitivity (Wright et al., 2012).

Women's Risk Need Assessment. One example of a gender-responsive risk/needs assessment tool for women offenders is the *Women's Risk Need Assessment* instrument. This tool was developed by researchers at the University of Cincinnati and the National Institute of Corrections in light of the strong evidence supporting the need for an effective assessment measure that incorporates the unique criminogenic needs and life experiences of female offenders, as well as empirically-supported gender-neutral criminogenic risk factors (Van Voorhis, Salisbury, Wright, & Bauman, 2008; Van Voorhis, Wright, Salisbury, & Bauman, 2010). Topics such as abuse, victimization, mental health issues, dysfunctional interpersonal relationships, child care issues, self-esteem, and self-efficacy are included to provide a more holistic look at the individual's life and presenting needs and strengths. The *Women's Risk Need Assessment* has been validated in several jurisdictions across the United States and with several types of women offenders (e.g., inmates, probationers, and parolees (Van Voorhis & Salisbury, 2014; Van Voorhis et al., 2008; Van Voorhis et al., 2010).

Service Planning Instrument for Women. The *Service Planning Instrument (SPIn*) is an assessment and case management tool originally designed for male offenders. A gender-responsive version of this assessment, the *Service Planning Instrument for Women (SPIn-W)* was developed in order to be more sensitive to women's risks and needs (Van Voorhis & Salibury, 2014). This assessment tool contains 11 domains to measure women's risk, criminogenic needs, and strengths. The *SPIn* and *SPIn-W* have exhibited moderate to high levels of predictive validity (Jones & Robinson, 2017). Further, Jones and Robinson (2017) notes that the inclusion of

women's strengths in the *SPIn-W* improves the assessment's predictive validity above risk/needs-only assessments (Jones & Robinson, 2017).

Gender-Responsive and Trauma-Informed Mental Health Treatment

Bloom, Owen, and Covington (2003) assert that the recognition and incorporation of traumatic experiences into women's treatment plans is one of the most significant developments in female mental health care in the past several decades. It is of the utmost importance for practitioners to be sensitive to these experiences and incorporate trauma treatment into other interventions (e.g., mental health or addiction; Bloom & Covington, 2009). Bloom and Covington (2009), Elliot, Bjelajac, Fallot, Markoff, and Reed (2005), and Harris and Fallot (2001) note that it is necessary for service providers to be trauma-informed and to deliver trauma-informed services for the intervention to be effective. In fact, Elliot and colleagues (2005) assert that gender-responsive and trauma-informed services are so critical to the effective care and rehabilitation of offenders that organizations that do not adhere to these principles should be considered "trauma-denied".

Tenants of Best Practices

Harris and Fallot (2001) advise that trauma-informed services must: take the traumatic experiences into account, avoid triggering or re-traumatizing the individual, alter the service provider and organization's behavior to support the individual's coping capacity, support successful trauma-management so the individual can benefit from all rehabilitative services. Similarly, Bloom and Covington (2009) offer the following steps for delivering trauma-informed treatment: educate women on various types of trauma, how to identify these experiences, how to identify symptoms of PTSD, validate women's reactions and express to them that they are

normal reactions considering their situation, and recommend coping techniques (e.g., breathing and relaxation exercises; Bloom & Covington, 2009).

Strength-based approaches are also crucial to implementing an effective treatment program. These approaches shift the focus from managing risk and avoiding harm to enhancing the abilities of the offender (Blanchette & Brown, 2006). Sorbello and colleagues (2002) also emphasizes the need for identifying and addressing internal and external obstacles that women face that may better inform their pathway to crime. Obstacles may include skill deficits, maladaptive attitudes, and inadequate social supports. These needs must be addressed through rehabilitative efforts by identifying ways the offender may lead stable and rewarding lives, while considering their individual abilities, temperament, skills, commitment to change, and support networks (Sorbello et al., 2002). Bloom and Covington (2009) note that an emphasis should be placed on supporting the women through identifying and addressing their symptoms and other problems, not on confrontation.

Bloom and Covington (2009) advocate for women-facilitated therapy groups. These researches summarize that a large body of literature indicates that group therapy (e.g., mental health groups) comprised of women is best delivered when led by a woman due to responsivity principles. Women may be uncomfortable discussing their mental health issues, addiction issues, sexual histories, prior abuse and other trauma, childcare concerns, and other personal issues with men present (even as a trained facilitator; Bloom & Covington, 2009). Facilitating a safe environment is essential for effective, trauma-informed treatment that adheres to gender-responsive principles (Bloom 2003, 2005; Center for Mental Health Services, 2005).

Psychotropic Medication Management

The landmark case of *Ruiz v. Estelle*, 503 F.Supp. 1265 (S.D. Tex. 1980), established several elements of minimal mental health care including proper screening and evaluation, treatment that is more substantive than seclusion or supervision, treatment delivered by mental health professionals, accurate record-keeping, suicide prevention programs, and guidelines for the use of psychotropic medications. Institutional staff tasked with administering psychotropic medication must take extra care in safeguarding against inappropriate and excessive use (Harris & Lurigio, 2009). Women offenders are especially vulnerable to overmedication as a form of behavioral control (Harris & Lurigio, 2009). American Psychiatric Association standards for adequate care maintain that all correctional institutions must have a full range of psychotropic medication on site that is on par with community mental health standards of care (Harris & Lurigio, 2009). Further, institutions serving women must allocate sufficient resources to serve these offenders with mental illness (e.g., lower psychiatrist-to-offender ratio than found in male institutions; Harris & Lurigio, 2009).

Security Concerns

Traditional searching, secluding, restraining, monitoring, and other security-related practices that are typically implemented identically for male and female incarcerated populations may be inappropriate for women (Bloom et al., 2003; Van Voorhis & Salisbury, 2014). Not only do women tend to present lower levels of violence and thus pose a lower institutional security risk, but these practices may also cause harm by traumatizing or re-traumatizing women in custody (Bloom & Covington, 2009; Farr, 2000; Hardyman & Van Voorhis, 2004). The Center for Mental Health Services (2005) recommends training security staff in trauma-informed practices and reducing the amount of seclusion and restraint used with female offenders.

Offenders and staff report an increased sense of safety when this reduction is implemented (Center for Mental Health Services, 2005).

The American Psychological Association also notes that staff must be cautious in using seclusion and restraint with women due to the significant effect of trauma in women offender's lives and potential for re-traumatization (Weinstein, 2000). Further, Daniel (2006) and Harris and Lurigio (2009) caution that isolation may also put female offenders at an elevated risk of self-harm or suicide. Dirks (2004) notes that the mere presence of male correctional officers' in women's facilities may re-traumatize female offenders and perpetuate the existing power imbalances. This may be particularly relevant for especially vulnerable incarcerated women, such as those with a serious mental illness or who pose a high risk for suicide. Promoting a safe and secure environment is paramount to avoiding re-traumatization and managing female offenders with gender-responsive principles (Bloom & Covington, 2009).

Some practices, such as strip searches, may also re-traumatize female offenders particularly if a woman has a history of sexual abuse (Easteal, 2001). While abolishing strip searches entirely would be unreasonable as they are a primary strategy in fighting against transporting contraband, these practices should be mitigated and only used when completely necessary. An investigation by Davies and Cook (1998) on the use and findings of these searches revealed that one Australian prison conducted 506 strip searches in one month with none of these searches turning up any contraband. Several months later, this prison conducted 595 strip searches and discovered two cigarettes during the month (Davies & Cook, 1998). This finding provides evidence for potential over-use of this strategy and an unnecessary invasion of privacy.

Quality Assurance in Gender-Responsive Principles

The Gender-Informed Practices Assessment (GIPA) is a tool for assessing an institution or program's therapeutic fidelity to gender-responsive principles developed by the National Institute of Corrections and the Center for Effective Public Policy (Van Voorhis & Salisbury, 2014). This instrument contains 12 domains consistent with evidence-based gender-responsive principles. The GIPA is intended to assist institutions in developing and maintaining practices that are grounded in empirically-driven gender-responsive elements (Van Voorhis & Salisbury, 2014). The assessment covers the following domains: leadership and philosophy, external support, facility, management and operations, staffing and training, facility culture, offender management, assessment and classification, case and transitional planning, research-based program areas, services, quality assurance and evaluation.

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APPENDIX

Legal Considerations

730 ILCS 5/3-2-5.5 Women's Division.

Gender-Responsive Practices

730 ILCS 5/3-2-5.5 (a) states that "gender-responsive" is defined as taking into account gender specific differences identified in women-centered research including "socialization, psychological development, strengths, risk factors, pathways through systems, responses to treatment intervention and other unique gender specific needs facing justice-involved women."

Further, "Gender-responsive policies, practices, programs, and services shall be implemented in a manner that is considered relational, culturally competent, family-centered, holistic, strength-based, and trauma-informed."

Trauma-Informed Practices

730 ILCS 5/3-2-5.5 (a) also defines “trauma-informed practices” as those “incorporating gender violence research and the impact of all forms of trauma in designing and implementing policies, practices, processes, programs, and services that involve understanding, recognizing, and responding to the effects of all types of trauma with emphasis on physical, psychological, and emotional safety.”

Authority of the Women’s Division

In accordance with 730 ILCS 5/3-2-5.5 (b)(2), (3) and (4), the Women’s Division is tasked with implementing evidence-based, gender-responsive, trauma-informed practices for the operations and programs under the jurisdiction of the Women’s Division. This includes training, orientation, and curriculum.

730 ILCS 5/3-2-5.5 (b)(5) and (6) grants the Women’s Division authority to implement validated gender-responsive assessment/classification tools and a case management system that properly covers risk, needs, and assets.

Settlement Agreement

Offender’s Orientation

According to Settlement Agreement § VI(a), information regarding access to mental health care shall be incorporated as part of every offender’s orientation process upon initial reception to IDOC facilities. Thus, special efforts should be made to emphasize gender-responsive and trauma-informed services and treatment available for female offenders. The orientation should be tailored to their needs.

Screening and Evaluation

Settlement Agreement § IV(g) and (h) states that all offenders admitted to an IDOC facility must see a Mental Health Professional within 48 hours and complete a Mental Health Screening, DOC 0372 and an interview to identify mental health needs, suicidal ideation/intent, current or past self-injurious behavior, or current or past use of psychotropic medications, or any conditions requiring immediate intervention. Further, If the Mental Health Professional feels it is clinically necessary, the offender must undergo a second interview and the completion of the Mental Health Evaluation, DOC 0374 with a Mental Health Offender. There is no indication that a separate process is available for female offenders. Per the literature, a gender-responsive assessment that is sensitive to the unique needs of women is crucial. Thus, "adequate mental health services" (Administrative Directive 04.04.100 § I(B)) must include gender-specific intake and evaluation tool.

Treatment Plan

According to Settlement Agreement § VII(a) and (b), offenders in the on-going outpatient, inpatient or residential mental health services shall have a mental health treatment plan. This shall include treatment goals, frequency and duration of intervention/treatment activities, and the staff conducting the treatment activities. These components must be recorded in Mental Health Treatment Plan, IDOC Form 0284 or its equivalent. There is no specific indication that treatment must differ between male and female offenders, but the literature suggests that gender-responsive and trauma-informed treatment that incorporates a strength-based approach is the most effective. Thus, "adequate mental health services" (Administrative Directive 04.04.100 § I(B)) must include these practices.

Housing Placement of SMI Offenders

Settlement Agreement § XIV(a) states that "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." In order to provide "adequate mental health services" (Administrative Directive 04.04.100 § I(B)), special care should be taken to mitigate inappropriate and unnecessary usage of searching, secluding, restraining, and monitoring female SMI offenders as described in the literature. Further, a large body of research concludes that women tend to present a lower institutional security risk than men.

AD 04.04.100

Staff Training

According to AD 04.04.100 § II(G)(1), "Training on identification of mental health issues and the procedures for referring offenders to the facility's Office of Mental Health Management shall be included in pre-service training for all new facility employees and shall be reviewed annually during cycle training. Training curricula shall be developed in consultation with the Chief of Mental Health and approved by the Office of Staff Development and Training." Through authority of 730 ILCS 5/3-2-5.5(b)(4), the Women's Division should be included in the last sentence. Also, 730 ILCS 5/3-2-5.5(b)(4) grants authority to mandate that gender-responsive and trauma-informed training be required for all new facility employees.