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

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

PLAINTIFFS' MOTION TO ENFORCE THE SETTLEMENT AGREEMENT

Plaintiffs, by their attorneys, move this Court for enforcement of the Settlement Agreement, pursuant to Section XXIX of the Agreement, as follows.

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I. INTRODUCTION

> "[T]he overall quality of the psychiatric services provided to the mentally ill offenders of IDOC is exceedingly poor and often times dangerous. IDOC leadership is well aware of the problems related to the insufficient amount of psychiatric services and has taken decisive action to address this issue, but this has not yet been effective."

Dr. Pablo Stewart, Court Monitor, First Annual Report, May 22, 2017

> "Unfortunately, during the first four months of the 2nd year of the Settlement Agreement, the monitoring team has determined that the above-described conditions persist in the facilities inspected. ... I must reiterate that IDOC is in a state of emergency regarding its provision of psychiatric care."

Dr. Pablo Stewart, Court Monitor, letter to Dr. Hinton, October 1, 2017.

Dr. Stewart's declaration of a mental health emergency, followed by four months of inaction by the IDOC, leaves Plaintiffs no choice but to seek relief from this Court, as provided for by Paragraph XXIX(d) of the Settlement Agreement.

The *Rasho* Settlement Agreement should have impacted the lives of more than 12,000 Class Members by overhauling the mental health treatment system in Illinois prisons. A year and a half into the settlement, however, the required treatment system still has not been implemented. Defendants have failed to meet the Settlement Agreement's requirements of treatment planning, medication management, timely evaluations, and minimum standards of care for those in crisis and segregation. Instead, Class Members continue to be devastated by the lack of meaningful mental health treatment. The psychiatric appointment backlog is in the thousands; treatment plans do not comply with the Settlement Agreement in meaning or effect; mental health referrals are backlogged; and those in crisis and segregation continue to suffer without the treatment they need. Isolation—itself detrimental to mental health—remains the norm for those most at risk for decompensation.

In May of this year, the Monitor found IDOC out of compliance with more than half of the Agreement's requirements and found that Class Members were suffering harm. Despite this grim report, IDOC failed to prepare any plan to address the violations or protect the wellbeing of Class Members. On October 1, 2017, the Monitor issued a formal letter to IDOC declaring the psychiatric situation to be in a "state of emergency." The letter states that IDOC has failed to present a "viable plan …detailing an approach to deal with this critical problem." Ex. B (Monitor's letter). Defendants have proven themselves to be unable or unwilling to create an effective mental health treatment system. The Court's enforcement of the Settlement Agreement is required.

II. BACKGROUND

A. The Case

Plaintiffs are more than 12,000 people with mental illness incarcerated in the Illinois Department of Corrections (IDOC). The case was brought in 2007 to challenge to IDOC's punitive approach to mental illness and failure to provide necessary mental health treatment. The lead Plaintiff, Ashoor Rasho, spent years in segregation while struggling with the symptoms of serious mental illness, including auditory hallucinations, severe depression, agitation, self-mutilation, and suicide attempts. Mr. Rasho and his fellow Class Members have been isolated and restrained instead of receiving the mental health treatment that they desperately need.

IDOC's failure to adequately treat, house, and protect people with mental illness has resulted in untold human suffering and harm, including emotional suffering and distress, decompensation, physical injuries from self-harm, and far too many suicides. Bringing claims under the Eighth Amendment and the Americans with Disabilities Act, this case sought to

prevent further needless harm by requiring the State to build a functional mental health treatment system and to end its punitive response to mental illness.

B. The Settlement

The parties entered into Settlement Agreement in December of 2015. The 32-page Agreement provides for the establishment of a mental health system to facilitate timely, consistent, and individualized treatment. It includes strict timelines for the provision of care, including screening and evaluation, medication management, and for developing and updating treatment plans. These detailed requirements do not dictate the content of any individual's treatment, but provide the system necessary for adequate care. For example, anyone taking psychotropic medications must be seen by a psychiatrist every 30 days (with extensions no longer than 90 days if certain conditions are met); medication efficacy and side-effects must be strictly monitored; and practices of informed consent must be maintained.

Another example is that the Agreement ends the practice of discontinuing prior treatment modalities when a prisoner enters segregation. The Agreement mandates the continuation of prior treatment as the *minimum* level of treatment required in segregation, with increases as necessary to protect against the adverse impact of isolation. The Agreement requires that individual treatment plans be updated and reviewed throughout segregation placements. With minimum treatment standards and by mandating regular reviews, monitoring for decompensation, updating treatment plans, and providing minimum levels of out-of-cell time, the Agreement, if followed, provides for therapeutic responses and protects those in segregation.

Notice of the Proposed Settlement Agreement and its terms was given in January 2016. The Court soon began hearing from Class Members, hundreds of whom wrote detailed accounts of the devastating impacts of IDOC's ongoing failures to provide adequate mental health

treatment. Many Class Members opposed the Settlement Agreement because they believed – presciently – that IDOC would not implement the Agreement's terms.

The Court's Monitor, Dr. Patterson, echoed a similar concern, given the IDOC's failure to implement changes recommended by the monitors since the 2012 Cohen Report. "My only recommendation with regard to the proposed Settlement Agreement is that the Court establish clear consequences to the State should the State not meet its obligations within specific timeframes." *See* Dckt. No. 695, Letter of Raymond Patterson to the Court, dated May 9, 2016.

On May 13, 2016, the Court held a lengthy and detailed fairness hearing. Taking note of the urgent need for reform, and the lives of Class Members at stake, the Court granted approval of the Settlement Agreement.

C. Overview of the Current System

More than a quarter of Illinois's 44,817 prisoners have mental illness that requires treatment. The mental health caseload totals 12,052 prisoners. Of that caseload, 4,842 prisoners have been classified by IDOC as "seriously mentally ill." IDOC currently operates residential treatment units (RTUs) at Logan (80 beds) and Dixon (474 beds), and a mental health unit at Pontiac (approximately 76 beds). When the remaining inpatient and RTU facilities required under the Agreement are opened, about 11% of Class Members (around 1,280) will reside in specialized treatment units. Most Class Members will continue to be housed in General Population and Control units (*e.g.*, segregation), as they are today. *See* Ex. C (chart of caseload placement). For these Class Members, mental health treatment is supposed to be provided through psychiatric medication management, groups and/or one-on-one counseling by Qualified Mental Health Professionals.

Throughout IDOC's twenty-seven prisons, turnover and vacancies in mental health treatment staff positions continuously interfere with the provision of these mental health services. In 2014, IDOC agreed that the staffing ratios recommended in the Cohen Report were needed. Those ratios mean that IDOC needed approximately 80 psychiatrists. In 2015, IDOC had 75.75 budgeted positions for psychiatrists, but 60% of those budgeted psychiatry positions were vacant. Things have not improved over the last two years. Under the Amended 2016 staffing plan, there is a reduction in number of psychiatrists to 65.05 full time positions, of which only 34.18 are filled. In 2015, IDOC created the position of Director of Psychiatric Services in an effort oversee and manage the psychiatry program (psychiatrists are otherwise provided by the vendor, Wexford). That position, however, has been vacant for at least four months, leaving a major gap in any effort to improve the psychiatric program in any meaningful way. In the Monitor's October 1st letter to IDOC, he asked that IDOC take immediate steps to fill the position and take control of the psychiatric staffing. *See* Ex. B.

IDOC entered into the Settlement Agreement knowing that adequate staffing was required to fulfill its terms. Conducting timely and thorough mental health evaluations, treatment planning, medication monitoring, and counseling all require staff. These agreed upon requirements of a mental health system were not budget-contingent and do not require the creation of new positions beyond the already budgeted (albeit often vacant) mental health staff.[1]

III. DEFENDANTS' VIOLATIONS OF THE DECREE AT ISSUE IN THIS MOTION

There have been some areas of improvement under the Settlement Agreement, including the initial screening process at receiving facilities; reductions to the segregation sentences of

[1] The new specialized inpatient and RTU treatment units—and staffing for those units—required by the Agreement are not at issue here. The deadlines for those units were budget contingent and are not due until 2018.

seriously mentally ill Class Members in long-term segregation; the construction of new treatment facilities (*albeit* not opening of those new facilities); and the hiring of non-clinical staff. While important steps, they have not resulted in improvements to the mental health treatment of the vast majority of Class Members.

The Monitor has found that IDOC is in violation of most of the terms and obligations required by the Agreement. The Monitor's First Annual Report gives detailed findings of overall non-compliance in the areas of intake; mental health evaluation and referrals; treatment plan and continuing review; transition from specialized treatment settings; administrative staffing; medications; housing assignments; segregation; suicide prevention; medical records; confidentiality; use of force and verbal abuse; discipline of seriously mentally ill offenders; continuous quality improvement; and record keeping.

In the face such widespread, systemic non-compliance, Plaintiffs have identified five core areas in urgent need of enforcement. The IDOC is not in compliance with the Settlement Agreement in ***any*** of these areas:

> Sections VII(a)-(d), Treatment Plans
> Section V(f), Evaluations
> Sections (b)-(d), Medications
> Sections XV(a)(iii)-(vii), (c)(iii)-(iv), Segregation.
> Section II(e), VIII(b)(i), Crisis Treatment and Transitions

Plaintiffs chose to focus on these five areas as compliance with these requirements will (1) provide the most basic elements of mental health treatment to the Plaintiff Class as a whole, and (2) address the most severe deprivations for Class Members who continue to suffer in isolation --

through "crisis watches" or in controlled units, such as disciplinary segregation -- without necessary mental health treatment.[2]

These discrete terms of the Settlement Agreement interrelate and overlap to impact the mental health and conditions of Class Members in significant ways. The cumulative impact is illustrated by one Class Member's recent story. Henry's[3] mental health records showed that, while in segregation, he began complaining of depression and hearing voices without any meaningful response from mental health staff. When he eventually received a treatment plan, it was not followed, nor was it regularly reviewed or updated. Henry began asking to see a psychiatrist in early June with no response.

On June 20th, Henry attempted suicide. As a result, he was placed on crisis "watches" where he remained for most of the next three months. In the bare, stripped-out crisis cell -- without his clothes or property, and sometimes even without a mattress -- Henry was isolated even further than he had been in segregation. And still he did not see a psychiatrist for more than a month. During that three-month crisis placement, his treatment plan was never updated. Other than seeing the psychiatrist once, Henry received no mental health treatment while on crisis watches. The only interaction he had was a daily check-in by a mental health professional for a few minutes at his cell door. The notes from those brief checks reflect that Henry was increasingly incoherent, confused, and actively hallucinating. According to Henry's own reports, he would spread feces over the cell and himself because he believed it would ward off the demons. In September he received a disciplinary ticket, resulting in a loss of privileges, for

[2] Other areas of non-compliance, not set forth in this Motion, are also significant. Plaintiffs have limited this Motion to these areas with the hope of achieving meaningful results that benefit Class Members as soon as possible. However, Plaintiffs have not waived any right to pursue court enforcement on the other areas of non-compliance.

[3] This is a pseudonym, used to protect the actual prisoner's identity.

smearing feces in his cell. At the disciplinary hearing in August, Henry was said to have pleaded guilty by stating, "You use it for protection. Smearing feces keeps the voices down."

This isolation and complete lack of mental health treatment is far from the aggressive treatment required for those in crisis. It is likewise far below the Agreement's treatment requirements for those who are decompensating in a segregation unit. Unfortunately, as the Monitor's Report details, Henry's case is far from an anomaly. Violations of these provisions of the Agreement are not only pervasive, they are the norm.

Each of the terms of the Settlement Agreement at issue in this Motion are set forth below, along with the Monitor's findings.

A. Treatment Planning

Treatment Plans, §VII (a) & (b)	As required by IDOC Administrative Directive 04.04.101, § 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.
Treatment Plans, §VII (b)	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.

The Monitor found that, while the treatment plan form created by IDOC does contain the required fields and is now in the file of most Class Members, it is not being used consistently with the purpose and requirements of the treatment planning provisions. Ex. A, Report at 28-29. The Settlement Agreement provides that Class Members have a treatment plan; not just the form, but a substantive plan developed by the Class Member together with his or her treaters with individualized needs, goals, and treatment activities.

> Overall at the facilities monitored, the treatment plans, when completed, were "boiler plate" in nature. That is, almost all the treatment plans reviewed contained the same generic language regardless of the

> psychiatric condition of the offender. The treatment plans were not routinely prepared collectively by the offender's treating mental health team. Rather, an individual staff person completed them without apparent input from other members of the treatment team. That is, at times an MHP completed the treatment plan without input from other staff. At other times, the psychiatrist would complete only the psychiatric portions of the treatment plan again without input from other staff. It became clear during the review of several hundred-treatment plans that these documents did not facilitate the delivery of mental health services. Rather, their appearance suggested they were viewed as yet another requirement imposed upon the mental health and psychiatric staff that needed to be "checked off."

Ex. A, Report at 28.

For example, even at Dixon's Special Treatment Unit ("STC")—the system's largest and most established RTU, which is generally in better compliance with the Agreement than other facilities—the Monitor found treatment plans that were mostly left blank or were not signed by critical team members. "Overall, it appeared that the plans were being completed by a mental health professional in a rote, 'cut and paste' manner" without specific recommendations or individualized goals. The Monitor cited an example of a prisoner in the Pontiac's mental health unit who was on three different psychotropic medications, but none were reflected in his treatment plan. The Monitor also cited to cases where individuals who were overtly psychotic, but whose treatment plans only reflected diagnosis for non-psychotic conditions.

Ex. A, Report at 28.

In segregation, regular treatment planning was meant to be a tool to protect against decompensation by individualizing assessments, goals, and activities. The Monitor found that the plans, when done, are "very non-specific, often using the identical treatment approaches regardless of the offenders' diagnoses." *Id.* at 57.

Treatment Plans, §VII (c)	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). 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. For those offenders receiving RTU care, treatment plans shall be reviewed and updated upon entrance and thereafter no less than once every two (2) months, or more frequently if clinically indicated, and upon discharge. 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. Reviews shall assess the progress of the documented treatment goals and be documented on the DOC 0284 or its equivalent and shall include the date of the review and the date on which the next review will be performed.

The Monitor found that IDOC is in compliance with the timing requirement for annual treatment planning only for Class Members who are at an outpatient level of care. "The current system of treatment planning is not working and needs to be completely rethought. IDOC has not been able to perform its required treatment plan reviews and updates for mentally ill offenders assigned to RTU, segregation or crisis housing." Ex. A, Report at 10.

1. Crisis

The Settlement Agreement requires treatment plans of those at a crisis level of care to be reviewed and updated upon the prisoner's entrance and weekly thereafter. The Monitor found that it is simply not done. Ex. A, Report at 30. The Monitor found Class Members on crisis watch for prolonged periods without an updated treatment plan. The Monitor cited an example of a woman at Logan who was psychotic and became suicidal. Instead of updating her treatment plan as required by the Agreement, "her previous plan was scanned into the record without any changes to address her worsening psychosis or her suicidality." Ex. A, Report at 30.

Defendants have admitted that they are not updating treatment plans for those on crisis watches. Instead, they are using form 377, which does contain the word "plan" among its contents but does not otherwise meet any of the Agreement's requirements for a treatment plan. Moreover, form 377 does not make adjustments to the individual's actual treatment plan in light

of the deteriorated condition that resulted in the crisis placement. Taking the example of Henry, discussed on Page 7 above, the only "plan" listed on his form 377 is the fact of his crisis watches and, at discharge, the required three-day follow-up. It does not address in any way actual mental health treatment, goals, or activities. In short, form 377 does not meet the requirements of a treatment plan.

2. Segregation

The Settlement requires that the treatment plans of those Class Members in segregation be reviewed and updated within seven days of placement and at least monthly thereafter. "This requirement is not being accomplished in any monitored IDOC Facilities." Ex. A, Report at 30. Defendants admit in their quarterly report that they are not reviewing and updating treatment plans for those in segregation.

3. *RTU Level of Care*

The Settlement requires that treatment plans of those at an RTU level of care be reviewed and updated every two months. The Monitor found that one facility, Logan, is in compliance with this requirement in its RTU. Ex. A, Report at 30. At Dixon, the RTU is updating the treatment plans monthly except for in its X-House, which is a maximum security level unit within the treatment unit (the X-house is sometimes referred to as the system's Disciplinary Psychiatric Unit). For Class Members with an RTU level of care who are not fortunate enough to actually reside in one of the two RTUs, the treatment plan reviews and updates are not happening as required. For example, at Menard, the Monitor found that they were only done at random intervals; mental health staff said that they did them "when they could." Ex. A, Report at 28.

B. Medication Management

The overall quality of psychiatric care is "extremely poor" and "often times dangerous." Ex. A, Report at 10. The failure to provide psychiatric care "contributes to IDOC being non-compliant in the vast majority of areas of the Settlement." In summary, the Monitor found:

> The frequency of psychiatric follow-up was variable but generally poor, including in situations calling for increased contact. Medication orders sometimes expired for weeks. The timing of medication passes is a major deterrent to medication compliance. Medication efficacy and side effects information often was not recorded, even where side effects were evident in prisoners the Monitor interviewed. Blood tests and neurological tests were sometimes conducted but do not appear to be routine practice. Informed consent reportedly is not practiced. Records do not seem to reflect a system for following up medication noncompliance.

Ex. A, Report at 46.

Medications, §XII(b)	Within ninety (90) days after the approval of this Settlement Agreement, IDOC shall also comply with the provisions of IDOC Administrative Directive 04.04.101, § 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, with extensions on follow-up care for those whose psychiatrist have found and documented that the offender has reached stability (outpatient level of care: not to exceed 90 days; RTU level of care: not to exceed 60 days.

In May 2017, data produced by IDOC showed a psychiatric backlog of 3,270. According to a recent letter by IDOC to the Monitor, the backlog has since grown to 3,552. *See* Ex. D, IDOC 10/2 letter. The May backlog numbers, broken down by facility, are included in the chart attached as Exhibit C.

Consistent with that backlog, the Monitoring team found that the 60-day requirement is not being met at facilities other than Dixon. Ex. A, Report at 47. The Monitor described that at

Logan "due to the lack of appropriate follow-up, a significant number of offenders just stopped taking their medications. Even when nurses noted significant medication non-compliance, a psychiatrist still not see the offender as required by XII(c)(vi)." *Id.* As to Pontiac, "among this cohort of offenders were numerous cases where there had been a new prescription for psychotropic medication. *Id.* Due to the extreme lack of competent psychiatrists at all facilities monitored, offenders who are prescribed psychotropic medications are not being seen every 30 days, or documented as stable and being seen every 60 to 90 days, as is required by AD 04.04.101, section II (F)(5)." *Id.*

Medications, §XII(c)(i)	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;

The Monitor found that when Class Members had a valid prescription, the medications would generally be available at the medication pass. However, the Monitor found two very significant problems with the administration of medications which interfere with the requirement that administration occur "so that there is a reasonable assurance" that psychotropic medications are both delivered and taken:

> The first was the often chaotic and unpredictable nature of the psychiatric care throughout IDOC. Medication orders often expired and the offender may or may not continue receiving his or her medication. This problem was noted at all the facilities monitored, with the exception of Dixon, but was especially prevalent at Pontiac and Menard. At Menard, psychotropic medication orders were allowed to expire, and often staff did not correct the problem until an inmate had already missed a week or two of medication. This can result in these offenders suffering needlessly from withdrawal symptoms as well as a worsening of psychiatric symptoms. The second aspect is that medications are passed at times that may be convenient for the staff but certainly not for the offender. For example, the morning medication pass at Graham was 2:00 am. This extremely inappropriate time to pass medications results in significant numbers of offenders refusing their "morning" dose of medication. This is not just a

> problem at Graham. The monitoring team noted inappropriate medication pass times throughout IDOC. This is a problem that requires immediate attention.

Ex. A, Report at 47.

Medications, §XII(c) (ii)	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 dyskenesia, high blood pressure, and liver function decline;

The Monitor found that this requirement is not being met except at Dixon:

> In the remainder of the facilities monitored, there were few examples of proper charting regarding medication efficacy and side effects. In the overwhelming majority of the cases reviewed, there was little to no attention paid to either the efficacy or the side effects of the prescribed medications. In a significant number of cases, the Monitor noted the offender to be displaying overt signs of medication side effects with no mention of this found in the medical record.

Ex. A, Report at 48.

Medications, §XII(c) (iii)	Adherence to standard protocols for ascertaining side effects, including client interviews, blood tests, blood pressure monitoring, and neurological evaluation; iv) The timely performance of lab work for these side effects and timely reporting on results;

The Monitor found "no evidence that adherence to standard protocols for ascertaining side effects was occurring on a regular basis." Ex. A, Report at 48.

Medications, §XII(c) (v)	That offenders for whom psychotropic drugs are prescribed receive timely explanations 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.

Again, the Monitor only found compliance with this provision in the Dixon STC, again with the exception of X-House. Ex. A, Report at 48. In other facilities, the Monitor found that

when psychiatry sessions do occur (given the psychiatric backlog in the thousands) they are rushed and very superficial. *Id.* at 48-49. In fact, the Monitor reported that the "overwhelming majority" of the hundreds of Class Members interviewed reported that they were not even able to ask questions of their psychiatrists. *Id.* at 49.

Medications, §XII(c)(vi)	That offenders, including offenders in a Control Unit, who experience Medication Non-Compliance, as defined herein, are visited by a 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.

The Monitor found "no evidence that this is occurring in IDOC. The monitoring team found numerous examples of medication noncompliance with offenders housed in control units for which nothing was done. That is, there was no documentation in the offenders' medical records that the MHP was aware of these noncompliance issues or that the offender was referred to a psychiatrist. In fact, there were examples of the psychiatrist discontinuing the offenders' medications without a visit if noncompliance was reported." Ex. A, Report at 49.

Medications – Informed Consent, § XIX (d)	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 IDOC Administrative Directive 04.04.101, § 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. The Manual requirements incorporated here relate to informed consent for psychotropic medications. (*See* Ex. A, Report at 88.)

The Monitor found that IDOC has not complied with this provision, and that little attention has been paid to its requirements by mental health and psychiatric staff. Ex. A, Report at 88.

> The lack of sufficient numbers of both mental health and psychiatric staff also contributes to the fact that the requirements of this subsection of the Settlement are not being met … Even when present, the documentation of these attempts at providing informed consent tend to be superficial. The problems are even worse for the psychiatrists. Due to the tremendous backlog of psychiatric visits, mentally ill offenders report they are not even given the opportunity to provide informed consent. In the cases where a psychiatrist sees mentally ill offenders, there is rarely documented evidence that informed consent was obtained in the manner specified in this subsection of the Settlement."

Id.

Treatment Plans, §VII (d)	Offenders who have been prescribed psychotropic medications shall be evaluated by a psychiatrist at least every thirty (30) days, subject to the following: (i) For offenders at an 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.

The Monitor found that Class Members are "at great risk of harm" as a result of IDOC's failure to conduct timely psychiatric evaluations of its mentally ill offenders who are prescribed psychotropic medications. Ex. A, Report at 31. In just the first year of the Settlement, "there have been thousands of psychiatric evaluations and follow-up appointments that have been delayed or just not completed."

At Pontiac, the Monitor found that prescriptions were being written for six months, without any psychiatric follow-up during that period. At other facilities, psychiatric visits "routinely exceeded the 30 day limit." *Id.* at 32. The Monitor cited an example of a prisoner on Crisis watches at Pontiac for two months without seeing a psychiatrist. Although the Settlement Agreement does allow for an extension on psychiatric follow-up for those who have achieved stability, none of the charts reviewed by the Monitor contained any such finding. And, certainly no one on crisis watches would meet that requirement.

At Menard, the Monitor found that most psychiatrists' notes would indicate a plan for follow-up in 30 days, but that two to three months would lapse between visits. Ex. A, Report at 32. At Menard, the problem was attributed to a lack of psychiatrists. Only 3.5 of the 6 budgeted psychiatry positions were filled. As with many of the requirements, Dixon's STC did better here with compliance than other facilities, with the exception—again—of X-House. Some of the system's most seriously mentally ill prisoners are housed at X-House, which includes segregation units, room restriction, and higher security level mental health housing. Approximately 149 seriously mentally ill prisoners are currently housed at X-House, including many of those considered by IDOC to require ongoing inpatient level of care. The continual failure of IDOC to carry the improvements made in the rest of the STC over to X-House is of serious concern.

Even with the Monitor's involvement on this issue since December 2016, IDOC's efforts to reduce the psychiatric backlog have been "insufficient." Ex. A, Report at 31. Although IDOC's only proposal for addressing this emergency situation is to use telepsychiatry (IDOC claims insurmountable barriers to hiring and retaining psychiatrists to work in prisons), even

facilities that already use telepsychiatry have significant backlogs. In fact, according to recent report by IDOC, about 60% of the outpatient backlog are for follow-up telepsychiatry.[4]

C. Timely Evaluations

Evaluation, § V(f)	Evaluations resulting from a referral for routine mental health services shall be completed within fourteen (14) days from the date of the referral (*see* IDOC Administrative Directives 04.04.100 § II(G)(2)(b) and 04.04.101 §II(F)(2)(c)).

Data produced by IDOC shows a backlog of 533 mental health evaluations of 30 days or more (largely at 7 facilities: Dixon, Pinckneyville, Pontiac, Western, Menard, and Graham). These are non-psychiatric mental health follow-ups. While the Monitor did not make a finding of non-compliance on this term, IDOC admits to the backlogs in these evaluations.

D. Mental Health Treatment in Segregation

"A significant majority of inmate suicides occur in segregation, as segregation itself imposes psychic stress, which can exacerbate depression and other potentially lethal psychiatric symptoms as well as creating psychiatric disorders de novo in offenders without pre-existing mental illness." Ex. A, Report at 63. The Monitor cited to the example of a Class Member in long-term segregation who described that her days consist of: waiting on her meal trays, waiting on the nurses, and going to sleep. She reported that "because I have nothing to do," she would often start thinking "crazy thoughts." *Id.* at 64. Another Class Member described that without meaningful contact in segregation, she was thinking about suicide. She described the detrimental effect of the screaming and other disturbing behaviors of prisoners in the segregation units.

Our system continues to rely on significant long-term segregation. *Id.* at 63 (noting segregation sentences up to 24 years, even after the reductions required by the Settlement Agreement). Although the American Psychiatric Association advises against segregation for

[4] The Monitor has many concerns about IDOC's reliance on telepsychiatry (Ex. A at 30), which are discussed further below.

more than two weeks due to the adverse harms, data produced by IDOC in March of this year, showed 383 seriously mentally ill prisoners in long-term segregation (more than 60 days). As a result, the Agreement places many requirements on the monitoring, treatment, and conditions of prisoners with mental illness in segregation.

§XV(a)iii)	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.
§XV(a)(vi), (c)(iii)	IDOC will ensure that mentally ill offenders who are in Administrative Detention, Disciplinary Segregation or Investigative Status/Temporary Confinement 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; with at least one hour or more of treatment per week for those on Investigatory Status. B) Rounds in every section of each segregated housing unit, at least once every seven (7) calendar days, by a 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; and H) Weekly unstructured out-of-cell time,
§XV (c)	Mentally ill offenders in a Control Unit for periods 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.

The Monitor found that "mentally ill offenders in segregation did not consistently continue to receive the treatment specified in their treatment plan." Ex. A, Report at 55. The Monitor confirmed the frequent complaint of Class Members that they do not receive counseling

in segregation. Record reviews showed that counseling visits occurred monthly at most, if at all. *Id.* at 59-60. This is a particular problem at Pontiac, where Class-Members find that the only way to speak individually with a mental health professional is through requests for the Crisis Intervention Team. *Id.* at 60.

The Monitor has found, and IDOC has admitted, that the requirements for structured out-of-cell time (generally provided through group therapy) are not being met. *Id.* at 61, 69. While some improvements have been made at every facility with long-term segregation to provide at least some structured programming, they still are not meeting the four-hour threshold requirement for the first year, let alone the six hours required since June of this year. *Id.* at 69. The Monitor notes this as being particularly problematic at Pontiac –the system's largest segregation facility. The Monitor's data found that, as of March 2017, nearly half the Class Members in North House received only one to 1.5 hours per week of structured out of cell time. Half of the Class Members in Pontiac's West House receive one to four hours per week. IDOC itself report that only zero to two hours of structured out of cell time is being provided to its segregation Class Members (with 5 hours of unstructured).

The unstructured out-of-cell time requirements are now largely being provided. However, facilities are not following up on refusals, which can be a significant indicator of mental deterioration. *Id.* at 60. Moreover, the monitoring team "found no evidence at any of the facilities monitored of mentally ill offenders receiving 'enhanced therapy as necessary to protect from decompensation that may be associated with segregation.'" *Id.* at 59.

At Pontiac, the Monitor received numerous reports of groups denied as a disciplinary measure. *Id.* at 57. Similarly, Plaintiffs' counsel and the Court have also received complaints of denied out of cell time, including yard and groups, as an informal punishment method. The

Monitor notes that, "[i]f this alleged action is accurate, it runs counter to good mental health treatment. That is, if an offender is acting out to such an extent that he is written up, then it is a strong indication that he requires more and not less treatment." *Id.* at 57.

As to pharmacological treatment, the Monitor found that: "As with other populations, poor handling of pharmacological treatment was evident in segregation cases reviewed. Offenders were not seen every 30 days as required by the Settlement. Medications were allowed to expire with the offenders going weeks at a time without their medications. Protocols regarding laboratory and side effect monitoring were not being followed." *Id.* at 59.

As to multidisciplinary team meetings, the Monitor reported that over the last year his team has not yet encountered a functioning multidisciplinary team in any segregation unit. *Id.* at 60.

§XV(a)(iv)	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.

IDOC reports that MHPs are not reviewing prisoners within 48 hours of placement. *Id.* at 58. IDOC states it is not meeting this requirement as a result of staffing shortages. However, this is not a budget contingent term.

§XV(a)(vii) and (c) (iv)	If, at any time, it is determined by a MHP that a mentally ill offender in a control unit 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 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.

The Monitor's findings:

> For the most part, there is no formal procedure for mental health staff to identify inmates for removal from segregation, other than through weekly segregation rounds and/or calls for a Crisis Intervention Team. This is particularly a problem in combination with no 48-hour, seven-day, or monthly reviews or treatment plan updates for new segregation placements. There is a heavy reliance on segregation rounds, which are extremely cursory and conducted at the cell front, and crisis placements.
>
> There are numerous instances of mentally ill offenders being removed from segregation into crisis watch for prolonged periods, only to be returned directly from crisis watch back into segregation. The vast majority of placements into crisis watch for ten or more days (ten out of 14 at Stateville and 19 out of 23 at Menard) were from segregation.

Ex. A, Report at 61.

The Monitor's report details how Class Members at Stateville and Menard cycle between segregation and crisis watches. In fact, the Monitor found that the vast majority of prolonged crisis placements (for 10 days or more) were from segregation and nearly all of them were sent back to segregation following the crisis watches. *Id.* at 61. At Pontiac, the Monitor found some recent improvement with the transitioning Class Members out of prolonged crisis watches through the Mental Health Unit (instead of returning them directly to segregation). *Id.* at 62. However, even there, staff were not removing Class Members from segregation until after they had deteriorated to the point of requiring crisis placement.

E. Mental Health Treatment for Class Members on Crisis Watches

§ II (e)	Beds that 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, as required by IDOC Administrative Directive 04.04.102, § II(F)(2).

The Monitor found "an absence of 'aggressive treatment' for mentally ill offenders assigned to a crisis level of care as the bulk of the treatment activities are limited to daily cell side visits by an MHP." Ex. A, Report at 10, 43. Even in crisis, medications are still not timely evaluated. *Id.* at 43. The Report describes an inmate on crisis watches for three months without any psychiatric evaluation. Another Class Member on crisis watch was found by the Monitor to be "overwhelmingly psychotic" but was only being treated for depression. *Id.* at 43. As noted above, given the lack of adequate treatment in both the isolated settings of segregation and crisis, Class Members seem to rotate between the two. *Id.* at 61-62.

The Monitor summarized this disturbing issue:

> Crisis beds are an integral part of a well-functioning correctional mental health treatment system. As stated in the Settlement, they are meant to provide an acute and aggressive level of care designed to rapidly stabilize mentally decompensated offenders. If, due to the severity of their mental illness, the offenders are not able to stabilize in a relatively short period of time, which is defined as "generally no longer than 10 days," then they need to be transferred to a higher level of care. In all fairness to IDOC, it currently does not have a well-functioning correctional mental health treatment system. The number of mentally ill offenders continues to overwhelm the resources available in the current mental health treatment system. Of note, there are no inpatient services available. This results in extremely ill offenders being housed in the RTUs, Control Units, General Population Units, and R&C Units. There are not sufficient services available to adequately address the needs of this extremely ill population. All of this results in seriously mentally ill offenders being placed in crisis beds, which represent the highest level of psychiatric care currently available to mentally ill offenders in the IDOC. The crisis beds have become *de facto* inpatient care.
>
> The level of services provided to offenders in crisis care is woefully inadequate to meet their treatment needs. Basically, offenders in crisis care only receive a non-confidential visit with an MHP on a daily basis. The only exception to this non-confidential MHP visit is at Pontiac, which began confidential visits in March 2017. A psychiatrist does not evaluate the offenders to determine if their medications should be adjusted or changed. These mentally ill offenders do not receive any "aggressive mental health" interventions.
>
> * * *

> Another egregious example of the inadequate care that mentally ill offenders receive while in crisis care occurred in Stateville proper. During the Monitor's January 31, 2017 tour of the crisis cells, the Monitor noted an offender covered in feces that was being "hosed off" by the custody staff. When the Monitor interviewed this offender, he said he had been covered in feces for over a week. He went on to state that the only reason staff cleaned him up was because "they heard you was coming." Also, all the mentally ill offenders in crisis cells that the Monitor interviewed stated the MHPs always just asked the same four questions on their daily cell front visits: are you suicidal, are you homicidal, do you have something in your cell to harm yourself, and are you taking your medication. These four questions were the extent of the visit.
>
> "Aggressive" intervention, required by the Settlement, cannot be provided simply by virtue of placement into a crisis cell and cell-side monitoring. This will not accomplish the aim of "reducing the acute, presenting symptoms and stabilizing the offender." Inmates in crisis watch need actual treatment, such as one-to-one and group therapies as well as an aggressive reevaluation of the patients' prescribed psychotropic medication. It seems offenders may receive more treatment in segregation than in crisis care, though additional out-of-cell time is provided for those in crisis for prolonged periods.

Ex. A, Report at 42-43.

The Monitor also found inappropriate use of crisis cells, such as with placements up to five months. *Id.* at 61-62. At Menard, RTU prisoners were held in crisis cells for months at a time with little mental health treatment while waiting for transfer to Dixon. *Id.* at 39.

§ VIII(b)(i)	Transitions from Specialized Settings. 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. 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.

The Monitor found that the required 5-day follow-ups were only being conducted at one of the facilities monitored, Stateville; they were not occurring at Pontiac, Dixon, Menard, Logan, Graham or Pinckneyville. Ex. A, Report at 33-34.

"At Pontiac, the monitoring team found that, while the suicide risk evaluation was being conducted within seven days of discharge from crisis care, the monthly evaluations were not occurring. At Logan, the seven-day follow evaluations were not being conducted, and while monthly evaluations were conducted for some period of time, they were not conducted each month for a full six months. Neither Dixon nor Menard had implemented policies required by provision (b)(i) of this section; suicide evaluations are not completed within seven days or monthly for six months." *Id.* at 34.

IV. DEFENDANTS FAILURE TO PROVIDE AN EFFECTIVE MENTAL HEALTH TREATMENT SYSTEM VIOLATES THE FEDERALLY PROTECTED RIGHTS OF PLAINTIFFS

The Settlement Agreement provides for a two-step process in the event Plaintiffs contend that Defendants have failed to comply with its terms. First, the Court must determine whether there has been "substantial non-compliance with the Settlement Agreement" (Dkt. 708-1, Sec. XXIX(d)). If the Court finds substantial non-compliance, then it must make findings required by the Prison Litigation Reform Act before granting additional relief (Dkt 708-1, Sec. XXIX(g)). In the sections above, Plaintiffs have set forth the facts which establish that Defendants are not in substantial compliance with the Settlement Agreement. We now turn to the requirement that the Court find that this non-compliance constitutes a violation of the federal rights of the Plaintiff Class.

A. Defendants' Noncompliance with the Settlement Agreement Violates the Right of the Plaintiff Class to Be Free from Cruel and Unusual Punishment Guaranteed by the Eighth Amendment

Under our Constitution, prisoners "retain the essence of human dignity inherent in all persons." *Brown v. Plata*, 563 U.S. 493, 510 (2011). It is respect for that dignity that "animates the Eighth Amendment prohibition against cruel and unusual punishment." *Id.* The Eighth

Amendment "proscribes more than physically barbarous punishments." *Estelle v. Gamble*, 429 U.S. 97, 102 (1976). It embodies "'broad and idealistic concepts of dignity, civilized standards, humanity, and decency . . .'" *Id.* at 103.

These principles "establish the government's obligation to provide medical care for those whom it is punishing by incarceration." The failure to provide such care "may actually produce physical 'torture or a lingering death'" or "may result in pain and suffering which no one suggests would serve any penological purpose." *Id.* at 103. Thus "deliberate indifference to serious medical needs of prisoners constitutes the 'unnecessary and wanton infliction of pain' proscribed by the Eighth Amendment." *Id.* at 104 (citations omitted).

To evaluate whether a claim of deliberate indifference to serious medical needs rises to the level of an Eighth Amendment violation, courts use a two-part test, looking both at the seriousness of the medical need and the conduct of the officials. The test contains both "an objective and a subjective component." *Greeno v. Daley*, 414 F. 3d 645, 653 (7th Cir. 2005). For a court to conclude that a medical need is serious, the prisoner must "demonstrate that his medical condition is 'objectively, sufficiently serious.'" *Id.* A medical need is considered "sufficiently serious if the inmate's condition 'has been diagnosed by a physician as mandating treatment or is so obvious that even a lay person would perceive the need for a doctor's attention.'" *Roe v. Elyea*, 631 F.3d 843, 857 (7th Cir. 2011). The medical condition need not be life-threatening to be serious. Rather, it need only be a condition that would result in significant injury or unnecessary and wanton infliction of pain if not treated. *Id.* Plaintiffs' psychiatric illnesses meet this test, as prisoners on IDOC's mental health case load have been diagnosed as requiring mental health treatment. *See, e.g., Wellman v. Faulkner*, 715 F.2d 269, 272 (7th Cir. 1983).

The subjective component is met where prison officials "know of and disregard an excessive risk to inmate health." *Greeno v. Daley,* 414 F. 3d at 653. Deliberate indifference may be found where "a prison official, having knowledge of a significant risk to inmate health or safety, administers 'blatantly inappropriate' medical treatment, acts in a manner contrary to the recommendation of specialists, or delays a prisoner's treatment for non-medical reasons, thereby exacerbating his pain and suffering." *Perez v. Fenoglio,* 792 F.2d 768, 777 (7th Cir. 2015).

Of most relevance here, deliberate indifference "can be demonstrated by proving there are such systemic and gross deficiencies in staffing, facilities, equipment, or procedures that the inmate population is effectively denied access to adequate medical care." *Wellman v. Faulkner*, 715 F.2d 269, 272 (7th Cir. 1983). Deliberate indifference exists where prison officials "have been confronted repeatedly with plain evidence of real suffering caused by systemic deficiencies of a constitutional magnitude" and "have failed to take reasonable steps to avert the obvious risk of harm to mentally ill inmates that from the failure to remedy those deficiencies." *Coleman v. Wilson*, 912 F. Supp. 1282, 1304, 1311 (E.D. Cal.1995). And "patently ineffective gestures purportedly directed towards remedying objectively unconstitutional conditions do not prove a lack of deliberate indifference, they demonstrate it." *Id.* at 1319. "When systematic deficiencies in staffing, facilities or procedures make unnecessary suffering inevitable, a court will not hesitate to use its injunctive powers." *Wellman*, 715 F.2d at 272, *citing Todaro v. Ward,* 565 F.2d 48, 52 (2d Cir. 1977).

Many federal courts have considered whether states' prison mental health systems violated the Eighth Amendment. In *Wellman v. Faulkner*, 715 F.2d 269 (7th Cir. 1983), the Court of Appeals reviewed the district court's decision regarding Indiana's Michigan City prison, including its provision of mental health services. In reversing the lower court's decision finding

against an Eighth Amendment violation, the Court held that "the record contains sufficient evidence of negligent medical treatment together with evidence of general systemic deficiencies to establish that there is deliberate indifference to serious medical needs such that unnecessary suffering is inevitable." *Id.* at 272.

The Court pointed specifically to the fact that the position of staff psychiatrist had been unfilled for two years, noting that, without proper psychiatric care, prisoners with mental illness could not be properly evaluated, treated during psychiatric emergencies, or supervised on psychotropic medication "to avoid the unnecessary suffering of acute episodes of mental illness." *Id.* at 272-73. While the district court found that the psychiatrist vacancy supported its finding of no constitutional violation, as the prison officials had been trying to fill the vacancy, the Court of Appeals found the opposite, stating: "We think this circumstance may weigh more heavily against the state than for it, since the position has remained vacant for two years and the authorized salary is, in the district court's words, 'woefully inadequate.'" *Id.* at 273.

In *Indiana Protection and Advocacy Services Commission v. Commissioner, Indiana Department of Corrections*, 2012 WL 6738517 (S.D. Ind. 2012), the mental health system in Indiana's prisons was once again at issue. The court held a bench trial, where it found that prisoners with mental illness in segregation lacked adequate treatment plans; proper medication monitoring; regular group and individual mental health treatment; privacy in treatment; adequate social contact; and adequate activity. The court found further that these conditions led to decompensation, which is a form of psychological pain. *Id.* at *16. The court concluded that "mentally ill prisoners within the IDOC segregation units are not receiving minimally adequate mental health care in terms of scope, intensity, and duration, and the IDOC has been deliberately indifferent." *Id.* at *23.

In assessing whether a prison mental health system violates the Eighth Amendment proscription against cruel and unusual punishment, many courts look for six components in the system, the absence of any one of which can support a finding of an Eighth Amendment violation. These factors were originally set forth in *Ruiz v. Estelle*, 503 F. Supp. 1265, 1339 (S.D. Tex. 1980) (Texas' mental health care program fell short of minimal adequacy and thereby violated the Eighth Amendment) and have subsequently been adopted by courts in other jurisdictions. *See, e.g.*, *Coleman v. Wilson*, 912 F. Supp. 1282, 1288 n.10, 1304 (E.D. Cal 1995) (finding deliberate indifference where "defendants have known for years of the gross deficiencies in the provision of mental health care to inmates … and have failed to take reasonable steps to aver the obvious risk of harm to mentally ill inmates that flows from the failure to remedy those deficiencies"); *Balla v. Idaho State Bd. of Corrections*, 595 F. Supp.1558, 1577 (D. Idaho 1984)(where psychiatric care consists almost solely of "[w]holesale prescription of psychiatric drugs," "[i]t represents a deliberate indifference to the serious medical needs of the inmates").

The six components are: (1) a systemic program for screening and evaluating inmates in order to identify those in need of mental health treatment; (2) a treatment program that involves more than segregation and close supervision of mentally ill inmates; (3) employment of a sufficient number of trained mental health professionals; (4) maintenance of accurate, complete and confidential mental health treatment records; (5) administration of psychotropic medication only with appropriate supervision and periodic evaluation; and (6) a basic program to identify, treat, and supervise inmates at risk for suicide. They create a useful framework for evaluating the constitutionality of prison mental health systems. In this case, the Monitor has found that failures in all of these six areas are harming Class Members.

B. Defendants' Noncompliance with the Settlement Agreement Violates the Americans with Disabilities Act

Title II of the ADA provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132. A "public entity" includes "any department, agency, special purpose district, or other instrumentality of a State or States or local government." 42 U.S.C. § 12131(1)(B). State prisons are public entities within the meaning of the ADA. *Pennsylvania Department of Corrections v. Yeskey*, 524 U.S. 206, 210 (1998).

Discrimination under the ADA may include a defendant's failure to make reasonable modifications to its programs, services, or activities to accommodate the needs of a person with a disability. 28 C.F.R. 35.130 (b) (7) ('A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability"). In the prison context, this includes the failure of prison officials to address the disability-related needs of prisoners where that results in the inability of the prisoner to participate in prison programs, services, or activities.

In *United States v. Georgia*, 546 U.S. 151 (2006), a prisoner with paraplegia alleged that the Georgia prison failed to accommodate his disability by confining him in a small cell where he could not maneuver his wheelchair or even attend to his own toileting needs. As a result, he was essentially unable to move for almost 24 hours per day and was often forced to sit in his own waste. In reversing the lower courts' dismissal of the ADA Title II claim, the Supreme Court found that "it is quite plausible that the alleged deliberate refusal of prison officials to

accommodate [plaintiff's] disability-related needs in such fundamentals as mobility, hygiene, medical care, and virtually all other prison programs constituted exclusion from participation in or …denial of the benefits of' the prison's services, programs or activities." *Id.* at 157 (internal quotation marks and brackets omitted). *See also Wright v. Texas Dep't of Criminal Justice*, 2013 WL 6578994, at *3-4. (N.D. Tex. 2013) (applying the *Georgia* analysis to find an ADA claim for failure to accommodate a prisoner with mental illness who committed suicide after being placed alone in a cell with tie-off points).

Here, in addition to failing to provide the required mental health treatment to prisoners with mental health disabilities, IDOC has also denied reasonable accommodations including the weekly structured out of cell time to Class Members in long-term segregation (more than 60 days). *See McCoy v. Tex. Dep't Crim. Justice*, 2006 WL 2331055, at *7 and n. 6 (S.D. Tex. Aug. 9, 2006) ("failure to make reasonable accommodations to the needs of a disabled prisoner may have the effect of discriminating against that prisoner because the lack of an accommodation may cause the disabled prisoner to suffer more pain and punishment than non-disabled prisoners.").

It is well established that prolonged segregation (defined by the American Psychiatric Association as more than 3-4 weeks) is harmful to mental health. *See Madrid v. Gomez*, 889 F. Supp.1146, 65-66 (N.D. Cal. 1995); *Ruiz v. Johnson*, 37 F. Supp. 2d 855, 915 (S.D. Tex. 1999). *See also* Ex. A, Monitor's First Annual Report at 63 ("segregation itself imposes psychic stress, which can exacerbate depression and other potentially lethal psychiatric symptoms as well as creating psychiatric disorders de novo in offenders without pre-existing mental illness.").

While the Settlement Agreement does not end segregation for those with mental illness, Defendants did agree to provide a number of accommodations to Class Members in long-term

segregation. Defendants agreed to 48-hour checks, monthly treatment planning, minimum requirements for treatment while in segregation, and out-of-cell time.

These accommodations are essential to protecting people with mental illness in segregation. As to the out-of-cell, although IDOC has increased the unstructured (yard) time out-of-cell, it has not meat the requirements for structured time. Time in the segregation yards is not a substitute for the required structured time. Segregation yard does not provide the socialization, meaningful engagement, and mental health treatment that is necessary to protect people with mental illness. *See* National Commission on Correctional Health Care, Position Statement on Solitary Confinement, April 10, 2016. The American Psychiatric Association, Position Statement on Segregation of Prisoners with Mental Illness, December 2012.[5]

In *Madrid v. Gomez*, 889 F. Supp.1146 (N.D. Cal. 1995), the court found that, while segregation in and of itself does not constitute cruel and unusual punishment, segregation for prisoners "at particularly high risk for suffering very severe injury to their mental health, including overt paranoia, psychotic breaks with reality, or massive exacerbations of existing mental illness" is indeed cruel and unusual punishment and akin to "putting an asthmatic in a place with little air to breathe." *Id.* at 1265-66. Defendants cannot justify the denial of this agreed-upon accommodation for Class Members in long-term segregation.

V. THE DESPUTE RESOLUTION PROCESS REQUIRED BY SECTION XXIX HAS NOT PRODUCED ANY MEANINGFUL RESULTS

Following the Monitor's First Annual report, Plaintiffs invoked the Dispute Resolution process pursuant to § XXIX of the Settlement Agreement. After substantial discussions

[5] The NCCHC Position Statement is available at: http://www.ncchc.org/solitary-confinement. The American Psychiatric Association's Position Statement is available at: https://www.psychiatry.org/psychiatrists/practice/helping-patients-access-care/position-statements

throughout the summer, including with the assistance of the Monitor, the parties have not been able to resolve these issues. *See* Group Ex. D (correspondence exchanged). Indeed, although multiple letters have been exchanged and meetings have been held, Defendants have not submitted a comprehensive plan to bring IDOC into compliance. Instead Defendants proposed three programmatic changes, none of which brings IDOC into substantial compliance with the Agreement or cures most of the ongoing violations of Class Members' rights. Each of the three components of IDOC's plan is discussed below.

A. Use of Behavioral Health Technicians (BHTs) to Conduct the Weekly Segregation Rounds, Thereby Freeing Up QMHPs to Offer Additional Mental Health Groups.

Under this plan, the parties have agreed to allow BHTs to perform the weekly segregation rounds (which the Agreement otherwise requires be done by Qualified Mental Health Professionals) until QMHP staffing can be increased to sufficient levels. This measure is a band-aid, not a solution, and a small one at that. IDOC admits this staffing change will not free up enough QMHP time to achieve compliance with the structured out of cell time requirements. IDOC states that this staffing change will allow for 20 new groups at seven facilities; each group consisting of 6-10 prisoners and meeting once weekly. These few groups will only put a small dent in the shortfall of groups necessary to meet the Agreement's requirements.

B. UIC Psychiatric Nurse at Logan Correctional Center.

At the last status hearing, Defendants reported that in an effort to deal with the ongoing difficulties hiring and retaining psychiatrists, they were collaborating with UIC to bring in psychiatric nurses to assist with mental health treatment and medication management. This potential collaboration has now been limited to only Logan Correctional Center. In response to questions from Plaintiffs—how many nurses will be working at Logan, when, in what capacity,

and which of the non-compliance terms will be addressed and how—Defendants responded, "Full details of this approach have not been finalized."

C. Expanded Use of Telepscyhiatry

IDOC reports that seven new psychiatrists will be providing psychiatric services at Centralia, Dixon, Hill, Menard, Robinson Taylorville and Western for the purpose of backlog reduction. It has authorized additional telepsychiatry and in-person psychiatric hours over the next two months with a plan to reduce the current backlog (of 3,553) by 2027 appointments by December 8, 2017. *See* Ex. D (10/2/17 IDOC letter to Dr. Stewart).

Because of the current crisis in psychiatric treatment, Plaintiffs have agreed with Defendants that an expansion of telepsychiatry—if done in a manner approved by the Monitor—is appropriate as a temporary emergency measure to address the backlog. However, the Monitor has raised serious concerns about IDOC's reliance on telepsychiatry. First, although all have agreed that it can be used in a limited fashion to help with the current crisis, it is not the long-term solution to the psychiatric and medication management problems in this system. Second, the Monitor has emphasized that while this may be an acceptable means of addressing the urgent psychiatric backlog of outpatient patients, it is not acceptable for initiating treatment; evaluating patients in crisis; or treating patients who require translation services or those who are deaf or have cognitive disabilities. *See* Ex. A, Report at 30; Ex. B, Oct. 1 letter.

Even if all goes according to plan, and the backlog is reduced by December, no plan is in place to prevent the still significant backlog of 1,525 from escalating again (nor is a backlog of 1,525 acceptable). Further, this plan does not include the some of the prisons that house the most Class Members, including Dixon, Pontiac, Logan, and Menard, all of which have psychiatric backlogs.

Mismanaged, sporadic and poor quality psychiatry has been so longstanding and pervasive in IDOC that reducing the existing backlog alone—without any plan for the provision of quality and consistent psychiatric treatment—cannot constitute a solution. Reducing the existing backlog by bringing in extra telepsychiatrists over a two month period to see an average of approximately 1.5-2 prisoners an hour,[6] all of whom are overdue for psychiatric care, is a not a plan to create a quality and consistent psychiatric program.

In the last two months, Plaintiffs' counsel have been visiting some of the facilities with the most serious psychiatric backlogs—Pontiac, Centralia, Hill, Pinckneyville, Big Muddy River, Danville, and Lawrence—speaking to more than five hundred Class Members. At each facility, the intensity of the psychiatric needs is profound. Countless individuals describe medication problems and unmonitored side-effects. Many have simply given up and stopped taking their medications without any psychiatric follow-up. Others desperately submit one unanswered request for help after another. At Pinckneyville, on September 25-26, of the relatively small random sample of prisoners that Plaintiffs' counsel spoke to, three reported taking Lithium, which requires monthly blood work to check to efficacy and side-effects. Of those three, two had not had the blood work done in months, and one in more than a year. One individual described having so many medication problems—including blood in his urine—go unresponded to for so long that he no longer trusts the psychiatrists for treatment.

Similarly, the Monitor found:

> These psychiatric services deficiencies include but are not limited to problems with the proper continuation of medications for offenders entering IDOC, lack of timely follow-up for offenders prescribed psychotropic medication, dangerous practices related to the use of psychotropic medications including those offenders on forced medication, lack of following standard protocols for ascertaining side effects, extreme delays in obtaining psychiatric evaluations, non-participation of

[6] This is based on the numbers of telepsychiatry hours IDOC proposes and its estimate for the reduction of the current backlog with these additional telepsychiatry hours.

> psychiatrists in the treatment planning process, lack of timely psychiatric follow up for offenders assigned to crisis beds, and problems related to those offenders designated as requiring inpatient level of psychiatric services. Of note, the overall quality of the psychiatric services provided to the mentally ill offenders of IDOC is exceedingly poor and often times dangerous.

Ex. A, Report at 10.

VI. THIS COURT SHOULD FIND DEFENDANTS OUT OF COMPLIANCE AND ENFORCE THE SETTLEMENT AGREEMENT

This Court and Plaintiffs have given Defendants countless opportunities to provide the care required by the Constitution and guaranteed by the Settlement Agreement. Each opportunity has been met with inaction by the Defendants, causing incalculable and unnecessary human suffering. Thousands of prisoners are experiencing the symptoms of untreated or inadequately treated mental illness, including paranoia, hallucinations, anger, withdrawal, confusion, agitation, anxiety, depression, self-harm, and suicidal ideation. To allow one human being unnecessarily to suffer these symptoms is unacceptable. To allow thousands to suffer is a moral and legal catastrophe. Court enforcement is imperative to ensure that prisoners receive the treatment that they are guaranteed and to limit the scope of this tragedy.

Plaintiffs seek relief from the Court under Section XXIX(d) to effectuate Defendants' substantial compliance with these terms of the Settlement Agreement. Under Section XXIX(g), and consistent with the Prison Litigation Reform Act, U.S.C. § 3626, any order from this Court to effectuate substantial compliance must include a finding that the relief sought is narrowly drawn, extends no further than is necessary to correct the violation of the federal right, and is the least intrusive means for doing so.

The federal rights at issue are set forth above. The scope of the relief to be ordered must take into consideration that Defendants have had many opportunities and many years to develop a functional mental health treatment system but time and again have failed to do so. None of the

issues raised in this Motion are new. They are the same core systemic problems that this case—through litigation, three independent experts, agreed orders and, now, the Settlement Agreement—has sought to address for the last decade.

In 2011, the parties came to an agreement in the course of settlement discussions that an independent expert would assess the treatment system and conditions for prisoners with mental illness. The resulting report, on March 6, 2012, by Fred Cohen and his team ("the Cohen Report") found glaring deficiencies in the system as a whole and at specific facilities. "The allegations of systemic failure and deliberate indifference in the Second Amended Complaint are essentially supported by our investigation." Cohen Report at 11. The Report continues, "we find that in every aspect of the provision of [mental health] care, the deficiencies are so great, and the care so lacking, inadequate or delayed that many class members suffer immediate, perhaps irreparable harm; that the longer systemic relief is delayed or denied, the more serious the psychological consequences and the more prolonged the needless suffering of class members … We could not identify a single step in the requisite continuum of care that was even minimally satisfactory." Cohen Report at 12.

The next independent monitor, Dr. Raymund Patterson, spent two years trying to get IDOC to build a mental health treatment system with the implementation of the Agreed Orders. Dr. Patterson's 2014 annual report concluded that IDOC "has an inadequate, insufficient, and ineffective mental health services delivery system. Indeed, there are serious and substantial flaws and deficiencies in the very basic elements of the mental health services delivery system including inadequate staffing, inadequate provision of a continuum of services and levels of care (more specifically with regard the unavailability of inpatient hospital services, the misuse of crisis cells, …and the sporadic and inconsistent outpatient services. The needs of mentally ill

inmates are not being adequately met." Ex. F, Patterson Report to the Court dated April 21, 2014, at 15.

Sections XXIX (d), (f), and (g) of the Settlement Agreement set forth the Court's broad enforcement authority. Under § (d), Plaintiffs may seek relief from the Court to "effect substantial compliance with the Settlement Agreement." Under § (f), "[i]f the Court finds that Defendants are not in substantial compliance with a provision or provisions of this Settlement Agreement, it may enter an order consistent with equitable and legal principles, but not an order of contempt, that is designed to achieve compliance."

These provisions are consistent with the broad remedial powers of district courts in enforcing parties' agreements. In *Duran v. Elrod*, 713 F.2d 292 (7th Cir. 1983), *cert. den.* 465 U.S. 1108 (1984), the Cook County Sheriff appealed the district court's order denying the Sheriff's motion to modify the consent decree by allowing double-bunking. The Sheriff also appealed the court's corresponding order on the detainees' enforcement motion to reduce jail overcrowding through a release program. In upholding both orders, the Court of Appeals found:

> The County officials made a free, deliberate choice when it agreed to settle this dispute and terminate the long costly litigation. The parties engaged in arms-length bargaining and the detainees have a justified expectation that the bargain freely entered into will be honored.

713 F.2d at 296-7 (7th Cir. 1983).

To the extent that enforcement should begin with the opportunity for Defendants to present another plan to remedy the non-compliance, the Court should give firm guidance for that plan, including deadlines for compliance that reflect the urgency of the violations and harms. *Armstrong v. Davis*, 275 F.3d 849, 873 (9th Cir. 2001) ("the court is entitled to give some guidance to the Board and set some deadlines for compliance. By her injunction, the thorough

and extremely patient district judge did not attempt to 'micro manage' the Board's activities, but rather to set clear objectives for it to attempt to attain, and, in most circumstances, general methods whereby it would attain them."). *See also Plata v. Schwarzenegger*, No. C01-1351 TEH, 2005 WL 2932253, at *24 (N.D. Cal. Oct. 3, 2005) ("In fashioning an appropriate remedy, the Court must exercise restraint, using the least possible power adequate to the remediation of constitutional violations … However, the Court is not required to restrict its powers to those means that have proven inadequate, or that show no promise of being fruitful.") (internal citation omitted).

RELIEF REQUESTED

Wherefore, as a result of Defendants' violations of the Settlement Agreement and the harm caused by those violations, Plaintiffs respectfully request the Court make the following findings and enter an Order as follows:

1. That a phone conference to set a briefing scheduling and hearing on this Motion be held on Thursday, October 12, 2017.

Plaintiffs respectfully request the Court make the following findings:

2. That Defendants are out of compliance with the following provisions of the Settlement Agreement: Sections VII(a)-(d), Treatment Plans; Section V(f), Evaluations; Sections (b)-(d), Medications; Sections XV(a)(iii)-(vii), (c)(iii)-(iv), Segregation; and Section II(e), VIII(b)(i), Crisis Treatment and Transitions.

3. That Defendants' failures to provide adequate and necessary mental health treatment violates the Eighth Amendment and that the Defendants' failure to provide reasonable accommodations to prisoners with mental health disabilities violates the Americans with Disabilities Act.

4. That the relief ordered is narrowly drawn, extends no further than necessary to correct the violations of federal rights, and is the least intrusive means necessary to correct the violations of the Eighth Amendment and the Americans with Disabilities Act.

Plaintiffs respectfully request the Court enter an Order for the following relief:

5. Defendants shall bring themselves into compliance the Settlement Agreement Sections VII(a)-(d), Treatment Plans; Section V(f), Evaluations; Sections (b)-(d), Medications; Sections XV(a)(iii)-(vii), (c)(iii)-(iv), Segregation; and Section II(e), VIII(b)(i), Crisis Treatment and Transitions.

6. Defendants shall fill the Director of Psychiatric Services position, which has been vacant since May, within 45 days. The Chief of Psychiatry shall report to the Court on the psychiatric issues raised in the motion within 30 days thereafter.

7. Defendants shall achieve and maintain staffing levels necessary to comply with the Settlement Agreement Sections VII(a)-(d), Treatment Plans; Section V(f), Evaluations; Sections (b)-(d), Medications; Sections XV(a)(iii)-(vii), (c)(iii)-(iv), Segregation; and Section II(e), VIII(b)(i), Crisis Treatment and Transitions.

8. Within 21 days, Defendants shall submit a detailed plan to fulfill the above-requirements.

    a. Within 7 days, Defendants shall confer with the Monitor regarding his recommendations for the content of the plan.

    b. For each area of non-compliance, the plan shall identify both short-term steps to be taken to protect the immediate wellbeing of Class Members and long-term actions to achieve compliance.

    c. The plan shall include specific timelines for each of the steps and actions to be taken and for achieving compliance, with measurable outcomes.

    d. The Plan shall include affirmative steps to be taken to address shortages and turnover in mental health staff, including psychiatrists. These steps must be in addition to the hiring efforts already underway.

9. Monitor and Plaintiffs shall have 7 days after Defendants submit a plan to submit comments to the Court and Defendants regarding the plan and the timelines for compliance.

10. In each Quarterly Report issued after the Court approves any compliance plan, Defendants shall provide a report describing their progress implementing the plan, including what specific steps have been taken by Defendants to assure Compliance with the plan and the Court's order, and the progress made toward meeting the specific numerical goals established in Defendant's plan.

11. The Monitor shall issue a report 120 days after approval of the plan which shall include specific findings as to whether Defendants have implemented each element of the plan, and whether Defendants have met the numeric goals of the

plan. The Monitor is authorized to hire, at Defendants' expense, such additional staff as is required to produce this report.

RESPECTFULLY SUBMITTED,

By: /s/ Amanda Antholt
One of the attorneys for Plaintiffs

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

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

CERTIFICATE OF SERVICE

I hereby certify that on October 10, 2017, I electronically filed **Plaintiffs' Motion to Enforce the Settlement Agreement** with the Clerk of Court using the CM/ECF system, which will send notification of such filing to all attorneys of record.

Respectfully submitted,

/s/Amanda Antholt
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