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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	)	

REPORT OF MONITOR CONCERNING COMPLIANCE WITH INJUNCTION ORDERS

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BACKGROUND

The Court has entered several orders regarding the *Rasho* matter. On October 30, 2018, the Court granted Plaintiffs' Motion for Permanent injunction and entered an Order finding that Defendants have been deliberately indifferent to the mental health needs of mentally ill inmates in custody of the Illinois Department of Corrections in violation of the Eighth Amendment to the United States Constitution. The Court deferred entering specific injunctive relief, instead allowing Defendants an opportunity to submit a proposal to address their constitutional deficiencies. On November 13, 2018, Defendants submitted their proposed remedy order. On November 20, 2018, Plaintiffs submitted their memorandum in support of their proposed remedy order. On December 4, 2018 Defendants submitted their reply. On December 13, 2018, the above motions and proposed orders came before the Court for oral argument. The Court entered an order on December 20, 2018 specifying five areas of constitutional violation:

- Staffing requirements at the Illinois Department of Corrections
- Class members who are placed on mental health crisis watch
- Class members who are placed in segregation
- Class members who are prescribed psychotropic medication
- Treatment plans

The Court also ordered "The appointed independent monitor, Dr. Pablo Stewart, will monitor the Defendants' compliance with this Order consistent with the monitor's existing duties and functions." This report is submitted to comply with this portion of the Court's Order.

The Court has subsequently entered several Orders regarding this matter: February 26, 2019; March 19, 2019, and; March 28, 2019. The Seventh Circuit issued an order on April 15, 2019. Finally, the Court issued an Order on April 23, 2019 "to memorialize the Court's Orders dated October 30, 2018, December 20, 2018 and February 26, 2019. This report follows the requirements listed in the April 23, 2019 Order.

METHODOLOGY / MONITORING ACTIVITIES

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

To accomplish the monitoring obligations, the monitoring team sought information in a variety of ways. The monitoring team conducted 18 site visits of 15 different IDOC facilities, where interviews of administrators, staff, and offenders were conducted. While on site, the monitoring team would meet with the administrative and clinical leadership of the facility and then tour the facility. The tour would include observing general population units, segregated housing units, crisis care units, infirmary areas including medical records and restraint rooms, working spaces for the clinical staff, group therapy areas (if present), as well as any other area associated with the provision of mental health services. The monitoring team also toured the Residential Treatment Units at Logan, Joliet and Dixon. The team also requested and analyzed systemwide data, and a sampling of health care or master file records, as to some requirements.

1.	Danville	2/13/19	Ms. Gibson
2.	Decatur	4/2/19	Ms. Gibson
3.	Dixon	2/7-2/8/19	Dr. Kapoor
4.	East Moline	4/8/19	Ms. Gibson
5.	Elgin	1/16/19	Dr. Stewart
6.	Graham	2/22/19	Ms. Gibson & Dr. Stewart
7.	Illinois River	3/4-3/6/19	Ms. Morrison
8.	Joliet	3/22/19	Dr. Stewart
9.	Logan	12/27/18	Ms. Gibson & Dr. Stewart
10.	Menard	1/8/19	Ms. Gibson & Dr. Stewart
11.	Robinson	3/6/19	Ms. Gibson
12.	NRC	3/21/19	Ms. Gibson & Dr. Stewart
13.	Western	1/28/19	Ms. Gibson & Dr. Stewart
14.	Pinckneyville	6/13/19	Ms. Gibson
15.	Pontiac	12/28/18	Dr. Stewart
		1/22-1/24/19	Ms. Morrison
		3/22/19	Dr. Stewart
		6/25/19	Ms. Gibson

COMPLIANCE RATINGS

The following compliance ratings will be applied in this report:

- Substantial Compliance: The defendants will be in substantial compliance with the terms of the Court Orders if they perform its essential, material components even in the absence of strict compliance with the exacts terms of the Court Orders. Substantial compliance shall refer to instances in which any violations are minor or occasional and are neither systemic nor serious. Substantial compliance will be found only for the Department as a whole and not for individual facilities.

- Partial Compliance: "Partial Compliance" is defined as making substantial progress on a particular requirement without fully meeting the rigorous obligations of the Court Orders.

- Non-Compliance: This rating will be applied if the defendants' do not satisfy the definitions of substantial compliance or partial compliance.

EXECUTIVE SUMMARY

This report covers the period from 12/20/18 through 6/20/19. The Department is found to be non-compliant in the following areas: staffing, crisis watch, segregation and treatment plans. The major contributing factor to these non-compliance ratings is the lack of an adequate number of staff. The following is a summary of the findings for crisis watch, segregation, treatment plans

and medications:

- Crisis Watch: Crisis watches are being used for the correct patient population but the stays are not consistently employed for the shortest duration possible. Appropriate mental health treatment to protect against decompensation is still lacking. A daily, 20-minute visit with an MHP, when it occurs, is not sufficient to protect against decompensation given the austere nature of crisis watches. Reasonable treatment reevaluations were generally not occurring. Daily, confidential meetings with an MHP are becoming more common although certain facilities still struggle to consistently meet this requirement. Reviewing the treatment plan with the patient is occurring more consistently but the content of these discharge treatment plans doesn't always contain the required elements. Significant numbers of patients exceed an acceptable length of stay without a plan for transfer to a higher level of care. Sufficient, documented out-of-cell time does not consistently occur. Finally, excessive delays in accomplishing an actual transfer remain a problem when an offender is referred to a higher level of care.

- Segregation: The Department is more consistently performing evaluations of class members who are transferred to segregation. Reviewing treatment plans of class members who are transferred to segregation is not consistently occurring throughout the Department. Weekly rounds are generally occurring although plaintiffs' counsel expressed their concerns regarding the professional level of the staff who are actually performing the rounds. Continuation of class members' mental health treatment plan with such treatment as necessary to protect from any decompensation is not occurring.

- Treatment plans: Treatment planning continues to be a problematic area for the Department. Although some improvement in treatment planning has occurred, the Department remains very far from meeting the requirements of the Court's Orders. A major impediment is the fact that there still is a backlog of uncompleted treatment plans. Treatment planning is very staff intensive. The ongoing lack of an adequate number of mental health staff prevents the Department from ever being substantially compliant with this requirement.

  Mental health evaluations are equally problematic. Backlogs exist and the Department's largest Receiving and Classification Unit, NRC, is unable to perform all necessary mental health evaluations due to a lack of staff.

- Psychotropic Medication: Timely psychiatric follow up for class members prescribed psychotropic medications is not consistently occurring. A significant contributing factor to this deficiency is the presence of a backlog of psychiatric follow up visits at certain facilities. Medication distribution remains problematic, notwithstanding the Department's efforts to improve it. The charting of side effects, medication efficacy, laboratory monitoring and compliance monitoring is improved over previous reviews but much more improvement is needed to be in substantial compliance. Although the overall tenor of this

summary sounds very negative, the Department is much improved in this area since monitoring began in May 2016.

The rating for the psychotropic medication section falls somewhere between non-compliance and partial compliance. The overall quality of psychiatric care regarding the use of psychotropic medication continues to improve under the leader of the Chief of Psychiatry, Dr. Puga.

Of note, the Department is meeting all of the requirements of section 6, Compliance Requirements.

The Monitor has met with Director Jeffries and has been assured that the Department will be creating corrective action plans based on the findings of the Monitoring Team's reports. As Monitor, I am confident that this new approach will greatly hasten the Department's progress in meeting the requirements of the Court's Orders.

A summary of compliance findings is as follows:

Requirement	Compliance Status
1: STAFFING REQUIREMENTS AT THE ILLINOIS DEPARTMENT OF CORRECTIONS 1(a) 1(b) 1(c) 1(d)	Overall: Non-compliance Subfindings supporting overall findings: Non-compliance Non-compliance Substantial compliance No rating assigned
2: CLASS MEMBERS WHO ARE PLACED ONA MENTAL HEALTH CRISIS WATCH 2(a) 2(b) 2(c) 2(d) 2(e) 2(f) 2(g)	Overall: Non-compliance Subfindings supporting overall findings: Partial compliance Non-compliance Non-compliance Partial compliance Partial compliance Non-compliance Partial compliance
3: CLASS MEMBERS WHO ARE PLACED IN SEGREGATION	Overall: Non-compliance

	Subfindings supporting overall findings:
3(a)	Partial compliance
3(b)	Non-compliance
3(c)	Partial compliance
3(d)(i)	Non-compliance
3(d)(ii)	Partial compliance
3(d)(iii)	Partial compliance
3(d)(iv)	Non-compliance
3(d)(v)	Substantial compliance
3(d)(vi)	Non-Compliance
3(e)	Non-compliance
3(f)	Partial compliance
3(g)	Non-compliance
4: CLASS MEMBERS WHO ARE PRESCRIBED PSYCHOTROPIC MEDICATION	Overall: Non-compliance/partial compliance Subfindings supporting overall findings:
4(a)	Non-compliance
4(b)(i)	Non-compliance
4(b)(ii)	Partial compliance
4(b)(iii)	Partial compliance
4(b)(iv)	Partial compliance
4(b)(v)	No rating
4(b)(vi)	Non-compliance
5: TREATMENT PLANS	Overall: Non-compliance Subfindings supporting overall findings:
5(a)	Non-compliance
5(b)	Non-compliance
5(c)	Partial compliance
6: COMPLIANCE REQUIREMENTS	Overall: Substantial Compliance Subfindings supporting overall findings:
6(a)	Substantial compliance
6(b)	Substantial compliance
6(c)	Substantial compliance

1: STAFFING REQUIREMENTS AT THE ILLINOIS DEPARTMENT OF CORRECTIONS

Summary: The lack of adequate numbers of mental health staff prevents the Department from fully meeting the requirements of the April 23, 2019 Order. Per the requirements of this Order, the Department is only compliant with submitting a proposed amended staffing plan to the parties, Monitor and the Court. The Monitoring Team is also aware that a professional staffing analysis is underway in the Department. The Monitoring Team is working very closely with the professional staffing analysis personnel and will be reviewing their findings before it is submitted to the Court. Finally, the Monitoring Team is aware that negotiations regarding staffing are ongoing between the parties.

1(a): Specific requirement: Within 90 days of this order, Defendants must employ additional staff sufficient to meet the staffing requirements of their 2014 Remedial Staffing Plan.

Finding: The Defendants submitted a report to the Court on April 23, 2019 pursuant to paragraph 6(a) of the Court's Order dated December 20, 2018. In this report, Defendants outline their opinions regarding their obligations to and compliance with the Court Order of December 20, 2018. Regarding 1(a) the Defendants report:

> "The Order requires the defendants to employ staffing to the level of the "2014 Remedial Staffing Plan" within 90 days of the Order. Defendants have noted that the full "2014 Remedial Staffing Plan" is not in evidence and particular staffing levels from the 2014 Staffing Plan are not contained in the Court's Order. Defendants believe the 2014 Staffing Plan called for 450.75 full-time equivalent (FTE) mental health positions through the Department's facilities. The Department works with its vendor, Wexford, to assign the appropriate number of mental health staff to its facilities. As of March 31, 2019, Wexford employed 373.27 FTEs, in additional to prn (as needed) staff."

IDOC has not met the requirements of 1(a). Within 90 days of the Court's Order, IDOC has not employed 450.75 FTE mental health positions as called for in the 2014 Remedial Staffing Plan. A rating of non-compliance will be assigned to this subsection.

1(b): Specific requirement: Within 120 days of this order, Defendants shall evaluate whether their staffing plan is sufficient to provide mental health treatment consistent with constitutional law in the areas of treatment planning, medication management, mental health care on crisis watches, mental health care in segregation, and mental health evaluations.

Finding: The Defendants submitted a report to the Court on April 23, 2019 pursuant to paragraph 6(a) of the Court's Order dated December 20, 2018. In this report, Defendants outline their opinions regarding their obligations to and compliance with the Court Order of December 20, 2018. Regarding 1(b) the Defendants report:

> "Although the Department believes it has the staffing and procedures in place to protect mentally ill prisoners from substantial harm and to comply with minimal constitutional requirements, the Department and Wexford have complied with this portion of the

> Court's Order by conducting a detailed evaluation of current mental health staffing levels to identify the number of additional positions the Department would like to have in place to enhance its delivery of constitutional care and make it easier for staff to meet not only minimal constitutional requirements, but also to meet all of the requirements provided in the Department's Standard Operating Procedures Manual and Administrative Directives pertaining to mental health care."

IDOC has not complied with 1(b). In their April 23, 2019 response to the Court, the Department refers to "minimal constitutional requirements" as well as meeting the requirements of the Standard Operating Procedures Manual and Administrative Directives. No specific mention is made about providing mental health treatment consistent with constitutional law in the areas of treatment planning, medication management, mental health care on crisis watches, mental health care in segregation, and mental health evaluations. Of note, the backlog data as of June 14, 2019 reveals:

- 479 treatment plans backlogged
- 679 medication visits backlogged
- 387 mental health evaluations backlogged
- The Department does not provide backlog data for:
    - Mental health care on crisis watches
    - Mental health care in segregation

The presence of this backlog contradicts the Department's opinion that "it has staffing and procedures in place to protect mentally ill prisoners from substantial harm and to comply with minimal constitutional requirements.

IDOC will be found non-compliant with 1(b) until such time as they address the backlogs that exist and the specific concerns of the Court.

1(c): Specific requirement: Within 180 days of this order, Defendants shall report their findings and submit a proposed amended staffing plan to the Court, the monitor and Plaintiffs' counsel.

Finding: The Defendants submitted a report to the Court on April 23, 2019 pursuant to paragraph 6(a) of the Court's Order dated December 20, 2018. In this report, Defendants outline their opinions regarding their obligations to and compliance with the Court Order of December 20, 2018. Regarding 1(c) the Defendants report:

> "The Court ordered IDOC to provide its findings and proposed staffing plan to the Court, monitor and parties within 180 days of the order. The Department provided its new staffing plan to the appellate court mediator and plaintiffs' counsel on April 5, 2019. The plan was provided to the monitor on April 9, 2019.
>
> The defendants have met the requirements of 1(c). Please note, a rating of substantial compliance does not imply approval of the Department's proposed staffing plan.

1(d): Specific requirement: After the report, the Court will consider if any modification to the Defendants' staffing is necessary.

Finding: No rating assigned.

2: CLASS MEMBERS WHO ARE PLACED ON A MENTAL HEALTH CRISIS WATCH

Summary: Crisis watches are being used for the correct patient population but the stays are not consistently employed for the shortest duration possible. Appropriate mental health treatment to protect against decompensation is still lacking. A daily, 20-minute visit with an MHP, when it occurs, is not sufficient to protect against decompensation given the austere nature of crisis watches. Reasonable treatment reevaluations were generally not occurring. Daily, confidential meetings with an MHP are becoming more common although certain facilities still struggle to consistently meet this requirement. Reviewing the treatment plan with the patient is occurring more consistently but the content of these discharge treatment plans doesn't always contain the required elements. Significant numbers of patients exceed an acceptable length of stay without a plan for transfer to a higher level of care. Sufficient, documented out-of-cell time does not consistently occur. Finally, excessive delays in accomplishing an actual transfer remain a problem when an offender is referred to a higher level of care.

2(a): Specific requirement: Crisis watches should only be used for patients exhibiting behavior dangerous to self or others as a result of mental illness and may only be ordered upon a finding by an appropriately trained and licensed mental health professional that no other less restrictive treatment is appropriate. When used, crisis watches are to be employed for the shortest duration possible.

Finding: It is the monitoring team's experience that crisis watches are consistently used for patients exhibiting dangerousness to themselves or others, or who are gravely disabled. An admission is always ordered by an MHP; the monitoring team has not encountered examples of crisis watch being used when less restrictive treatment would have been preferable.

In a substantial number of cases, however, it is not clear that the duration of the crisis watch was the shortest possible. The Settlement Agreement sets an expectation that these admissions will be 10 days or less, a threshold commonly used by prison systems for this type of treatment setting. Crisis watch logs indicate that 14% of crisis watches exceeded that threshold.[1] There are circumstances in which this is reasonable for some patients, but it is one factor to consider when deciding whether stays are the shortest duration possible.

A few of these were explained by patients waiting for a higher-level care after staff made a timely referral. There was another subset, however, where staff did not initiate referrals until weeks or months into the crisis admission; these stays were problematic and certainly not the shortest duration possible.[2] See below for more discussion of referrals.

[1] This analysis is based on a review of 4 months (January through April 2019) of crisis watch logs from all IDOC institutions except Elgin. Thus, this analysis considered 2,145 crisis watches. It seems unlikely that Elgin should be expected to keep its crisis watches to 10 days since there is no higher level of care to which Elgin can refer. It is not feasible to assess, at any scale, whether stays less than 10 days are the shortest possible for those individuals.

[2] Times to referral ranged from 1 to 58 days. In 14 cases, the time to initiate exceeded two weeks and the most typical times fell in the 3- to 5-week range.

Most disturbing were the 61 people who stayed in crisis watch one month or more; these presumptively fail to meet the standard set in 2(a) and are an inappropriate use of this treatment setting. Rather, these patients require a higher level of care. This practice was widespread, occurring at 12 institutions, though it was most prevalent at Dixon, Pontiac, and Stateville. Shockingly, among that group, 8 patients were in this setting for 3 months to more than 1 year.

Thus, 3% of the crisis watches in this period definitely were not the shortest duration possible—indeed, most were very troubling lengths—and there are indicia that this population could be as much as 14%.

2(b): Specific requirement: IDOC shall provide appropriate mental health treatment to stabilize the symptoms and protect against decompensation.

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

IDOC has also brought attention to increasing psychiatry contacts during crisis watch, a welcome addition. In the systemwide, four-month crisis watch study cited above, 28% of patients saw a psychiatric provider by the day after admission, the standard the Monitor would expect for a crisis setting. Another 34% were seen within one week. There were indications that other patients were not seen until weeks into the admission, or had no contact at all, but this could not be quantified.[3] At some institutions,[4] psychiatric contact appeared only to occur at the discharge decision, so did not seemingly affect the course of care in crisis watch.

Treatment planning did not do much to support the provision of treatment to stabilize symptoms and protect against decompensation. IDOC has put significant work into treatment planning in the last year and improvement is evident, but there is further to go. The monitoring team reviewed treatment plans during each site visit. Additionally, the team conducted a systemwide study of 299 recent crisis watch treatment plans.[5] It revealed that nearly every patient received a new treatment plan on admission, but these were not decided by a multidisciplinary team, a minority identified patient-specific problems and goals, and, for treatment, nearly all merely named the standard number of contacts but said nothing about what the treatment would be or how the clinician and patient would move toward meeting the goals. Multidisciplinary

[3] A great deal of the admissions could not be analyzed because this data was not captured or the log recorded information from outside the crisis watch period.

[4] This was particularly evident at East Moline, Menard, and Shawnee.

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

engagement in treatment planning improved to over half in those crisis watches lasting more than one week, though documents had the same content problems.

2(c): Specific requirement: Reevaluations of treatment and medication will occur as needed and mental health treatment shall be determined and any necessary interventions to stabilize individuals shall occur.

Finding: In the 299-treatment plan study described above, the approaches did not appear to change over time, nor to respond to the fact that the patient had been in this acute setting for weeks or months (in applicable cases). In onsite chart reviews, MHP progress notes almost never captured reevaluations of treatment for patients with extended stays. Psychiatric reevaluations were evident more often, though they were in the minority as well. [6]

2(d): Specific requirement: Daily assessment in a confidential setting of the patient's progress to determine if the patient is moving towards stability, whether other or additional treatments are indicated, or if transfer to a higher level of care is required.

Finding: Daily MHP meetings continue with the patients.[7] The monitoring team's review of 11 facilities[8] determined that the overwhelming majority of daily crisis contacts were conducted in confidential settings. The monitoring team has noted a decrease in cell side contacts, which previously were an accepted method for delivering mental health services. Menard has installed glass doors/windows in the interview rooms which greatly facilitates confidentiality between the mentally ill offenders and the mental health staff.

The meetings the team observed do tend to take the form of assessment, and progress notes were nearly universal in noting whether the patient was moving toward stability. Consideration of additional treatment needs, or methods used to address them, were much less common in the documentation, and progress notes almost never showed consideration of a higher level of care.

2(e): Specific requirement: Prior to discharge from crisis watch, a multidisciplinary team (with the patient) shall review and update the treatment plan.

Finding: Requirement removed in the February 2019 Order.

2(e): Specific requirement: *No later than at the time of discharge from crisis watch*, an appropriate mental health professional (with the patient) shall review and update the treatment plan which will apply after discharge from crisis watch. The updated treatment plan will address causes which led to the deterioration and the plan for risk management to prevent relapse.

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[6] This is based on stays of 8 days or more, assuming that reevaluations may not have been necessary in stays shorter than that.

[7] Notably, there were gaps in the daily contacts for half of the reviewed admissions at Illinois River, and in 20% of those reviewed at Pontiac.

[8] East Moline, Menard, Stateville-NRC, Dixon, Pontiac, Western, Robinson, Graham, Decatur, Illinois River, and Danville. These are the institutions visited since this Order was issued.

Finding: The language of this requirement was updated, as indicated in italics, in the February 2019 Order. For the most part, staff updated treatment plans for discharge, but there were notable exceptions. In the systemwide study described above, 12% of discharged patients apparently had no plans created at that time.

In terms of addressing the causes of admission and preventing relapse, there is some improvement but there is further to go. On **problems and goals**, 32% of the plans captured these well.[9] Another 28% were adequate but had minimal content and minimal tailoring to the patient. Fully 40% were insufficient. These reflected issues such as missing a key problem of the patient's, omitting goals altogether, content that appeared unrelated to the patient, and boilerplate that would not appear to assist in treating the patient. The **interventions** described in the plans lagged much further behind. Here, only 19% in the study captured these well, and another 7% were adequate. The vast majority were insufficient. This principally took the form of naming the *Rasho*-required contacts but not discussing what treatment would take place during them. Some omitted one or more of the problems that led to the crisis watch, contained content inapplicable to that patient, or omitted interventions altogether.

The monitoring team used onsite chart reviews to assess whether staff reviewed the updated plans with the patients. It appeared that patients universally were informed of their discharge treatment plans, based on the monitoring team observing the patient's participation, a progress note describing it, and/or the patient's signature on the plan.

2(f): Specific requirement: For anyone who does not stabilize sufficiently to be discharged from crisis watch, the treatment team must establish a plan to provide a higher level of care, which may include transfer to a higher level of care facility, or explain in writing why establishing such a plan is not appropriate.

Finding: Crisis watch logs indicate that 14% of crisis watches exceeded 10 days--an approximate measure established in the Settlement Agreement to signal the timing for stability or a higher level of care decision. Disturbingly, 61 of those patients stayed in crisis watch one month or more. Yet few were referred to a higher level of care.[10] Those referrals can be summarized as:

Length of stay	Number of people	Referred to higher level of care
11-29 days	242	26
1 – 3 months	53	12
3 months - >1 year	8	0

Multiple crisis watches, close in time, may also implicate questions of stability and the need to consider a higher level of care.

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

[10] According to the monitoring team's review of logs from all institutions showing referrals to RTU and Elgin for the same period, January through April 2019.

There is also an indication that these cases are *not* fully explained as a deliberate judgment that a higher level of care is not needed. In a complementary study of treatment plans in crisis watches exceeding 10 days, only 19% contained any documented consideration of another level of care.[11]

2(g): Specific requirement: Out of cell time for confidential counseling and groups, psychiatric care, therapeutic activities, and recreational or leisure activities, *unless contraindicated.*

Finding: The language of this requirement was updated, as indicated in italics, in the February 2019 Order. In the monitoring team's onsite reviews, patients often received confidential counseling and psychiatric care out of cell. Occasionally, group was provided.[12] It appears no other therapeutic activities were offered. The monitoring team did not review the provision of recreational or leisure activities during this monitoring period.

3: CLASS MEMBERS WHO ARE PLACED IN SEGREGATION

Summary: The Department is more consistently performing evaluations of class members who are transferred to segregation. Reviewing treatment plans of class members who are transferred to segregation is not consistently occurring throughout the Department. Weekly rounds are generally occurring although plaintiffs' counsel expressed their concerns regarding the professional level of the staff who are actually performing the rounds. Continuation of class members' mental health treatment plan with such treatment as necessary to protect from any decompensation is not occurring.

3(a): Specific requirement: Promptly after placement into segregation, a mental health professional shall assess the class member to establish a baseline against which any future decompensation can be measured. Such review shall be documented in the patient's mental health records in a manner that facilitates access and review by subsequent treatment staff.

Finding: The Department has brought attention to this important requirement and substantial improvement is evident. To accomplish this, IDOC has reported reconfiguring staff schedules; considering alternative staffing for the task; and incorporating this requirement in a major policy document, Departmental Rule 504, to reinforce its importance. This reconfiguration of staff schedules, however, has resulted in some unintended negative consequences, especially at the RTU located at Dixon. As reported on pages 34 & 35 of the 3rd Annual Report:

> "Dr. Kapoor has made six site visits to Dixon over the life of the Settlement Agreement. Her most recent visit occurred on February 7 & 8, 2019. Based on her experience and expertise, she is in a unique position to report on the status of RTU-level treatment at Dixon. Dr. Kapoor noted that short-staffing—particularly of psychiatrists—and high staff turnover remain significant problems

[11] This is a portion of the systemwide study of crisis watch treatment plans. Among the 26 patients with stays exceeding 10 days and for whom a treatment plan update was provided, only 19% made any mention of other levels of care. Progress notes were not part of this review, and this is not the same data set as the one used to identify crisis watches longer than 10 days, so this figure is not definitive, but it serves as one part of the picture.

[12] For example, among 19 crisis watches at IL River and Pontiac after this Court's Order, 4 showed the patient participating in 1 or 2 group sessions.

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

A systemwide sample in early 2019 showed 89% of the records contained a baseline assessment that was completed within 4 days, which the monitoring team considers prompt. Compliance would be 82% if one considers the Settlement Agreement's timeframe for this responsibility. Either way, this improvement is an impressive accomplishment.[13]

3(b): Specific requirement: A mental health professional shall review and recommend any clinically necessary modifications to the prisoner's individual treatment plan.

Finding: Dr. Kapoor reported that at Dixon, treatment plans were not updated upon entry into segregation for any offender, and the monitoring team finds that this is consistently the norm at other institutions. Illinois River had the best practice among the facilities reviewed, with an updated plan in essentially all monitored cases, but these were completed two to three weeks after placement.

3(c): Specific requirement: Rounds shall be conducted by appropriate mental health staff, which may include behavioral health technicians.

Finding: Rounds are well-established; during the monitoring team visits, all institutions have demonstrated that they have systems in place and designated staff to accomplish this. Nevertheless, interruptions to the system were occasionally observed, with gaps in the rounds' performance—either all patients missed for a week, or sporadic misses for individual patients.[14]

The plaintiffs' counsel has also raised a question about whether behavioral health technicians are sufficiently qualified to conduct these rounds.

3(d): Specific requirement: Class members who are in a Control Unit for periods of sixteen days or more shall receive care that includes, at a minimum:

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[13] The team reviewed a snapshot from February 2019. The sample totaled 161 new Segregation placements; these concentrate on SMI patients and were drawn from 23 institutions, exempting only those that had no such placements and one facility that appeared to misunderstand the request. Both the date of placement and the next mental health paperwork were provided for each person in the sample. For some institutions, all such placements were included; where there were large numbers of placements, IDOC provided a subset reportedly using random selection method. It is not practical to determine the total number of mental health caseload patients placed in segregation in a given period, so the sample percentage has not been determined, but this does provide a substantial sample of overall practice.

[14] This review controlled for patients who were not on the unit because they were in crisis watch.

(i): Continuation of their mental health treatment plan with such treatment as necessary to protect from any decompensation.

Findings: Several measures have been employed to assess IDOC's compliance with section 3(d)(i). These measures include an analysis of the backlog data, a multi-site chart review of offenders placed in segregation and Dr. Kapoor's review of Dixon. A recent review of the backlog data regarding treatment planning is as follows:

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

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

A chart review at Pontiac revealed that it generally could not be discerned whether the treatment plan was being continued while the offender was in segregation. This was due to the fact that the treatment plan was vague in its treatment recommendations or that the treatment only called for MHP contacts every 60 to 90 days and that time had not passed. In the handful of charts where a determination could be made, three did not continue the full treatment plan and only one did. There were similar findings at Illinois River, but there, it was clear that the MHP contacts had *not* fulfilled the treatment plan. In a few instances, there was no treatment plan in the chart with which to make an assessment. In her review of 3(d)(i) at Dixon, Dr. Kapoor noted "To the extent that any offender's treatment plan is continued, it would occur either by chance or by habit, as no concerted effort to assess the offender's needs is made." Reviews at other institutions have yielded similar results.

Based on these measures IDOC is non-compliant with 3(d)(i).

(ii): Rounds in every section of each Control Unit at least every seven days by appropriate mental health staff.

Findings: Please refer to the findings of 3(c), above.

(iii): Pharmacological treatment (if applicable).

Findings: Please refer to the findings of 4(a), below, for a discussion of the psychiatric backlog. This backlog means that a number of mentally ill offenders, some of whom are placed in segregation, who are prescribed psychotropic medications are not being evaluated by a psychiatric provider at regular intervals consistent with constitutional standards.

The Monitoring Team has found, however, notwithstanding the backlog, pharmacologic treatment generally does occur when an offender is placed in segregation. This finding reflects the

emphasis that the Department has placed upon meeting the requirements of the Settlement Agreement.

(iv): Meeting with MHP or multidisciplinary team meetings to the extent necessary.

Findings: The Monitoring Team found that this occurs episodically. When it does occur, it is usually for only 15-30 minutes monthly.

(v): MHP or mental health treatment team recommendations to post-segregation housing.

Findings: This is consistently occurring throughout the Department.

(vi): Structured and unstructured out of cell time sufficient to protect against decompensation. Structured out of cell time includes therapeutic, educational and recreational activities that involve active engagement by their participants for the duration of the activity.

Findings: Of note, all of the requirements in this section begin after **16 days.** The Department struggles to meet this requirement for class members assigned to a control unit for more than 60 days. (please see section 3(e) below for a discussion about this 60-day requirement. At the time of this report, the Department is not providing "Structured out of cell time sufficient to protect against decompensation." The Department performs slightly better with unstructured out of cell time. That is, yard and showers are offered on a more consistent basis than structured activities. Even in the area of unstructured activities, showers and yard are not necessarily offered to the degree "sufficient to protect against decompensation."

3(e): Specific requirement: Class members in any Control Unit for periods longer than sixty days shall be provided with structured and unstructured out of cell time sufficient to protect against decompensation unless clinically contraindicated. If an inmate refuses out of cell time, an MHP shall follow-up with the inmate to determine whether or not there is a risk of further decompensation.

Finding: At this time, the Settlement Agreement requires at least 8 hours of structured and 8 hours of unstructured activities per week for mentally ill offenders housed in a control unit for longer than 60 days. This could be considered a measure for what is commonly needed to protect against decompensation.

It is consistently the case that 12 or fewer institutions house patients in a control unit for this length of time and thus are subject to this requirement. The monitoring team analyzed IDOC's systemwide tracking of out-of-cell time for this population.[15] According to these logs, the ***average*** hours **offered** were exactly what they should be – 8 hours of structured and 8 hours of unstructured activities per week. Similarly, the April IDOC Quarterly Report provides a list showing the hours

[15] The team analyzed the logs for February 2019. Where feasible, the review included all relevant cases for an institution. Where the relevant population is larger, the reviewer employed random selection method of every 4th, 6th, 10th, or 15th case, depending on the population size. In total, 63 cases were reviewed. The analysis controls for length of time each patient was in a control unit during the reviewed month, adjusting for releases to general population and time off unit for writs, crisis watch, etc.

offered at each institution, with each meeting or exceeding the requirement, with one exception. That list was not consistent with logs maintained and provided by IDOC, for unknown reasons.[16]

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

IDOC also has a very high rate of refusals for all types of out-of-cell time. In total, only 4 patients in the sample, or 7%, actually received the required number of hours. And when the hours fell short, they did *not* just miss the mark; on average, patients received *half* of the requirements. Incremental improvement over previous reviews was evident in structured therapeutic time to, on average, 4.3 hours per week,[17] a welcome advance.

IDOC indicates that MHPs meet with patients who refuse and document the reasons for the file. The monitoring team has noted refusal forms but these contained nothing about the patient and give the impression that they are only used to collect the patient's signature. The team has not encountered anything approximating the Court's order to determine whether there is risk of further decompensation.

No correctional system can guarantee full attendance in programming and patients will invariably refuse some programming. However, when 93% are either not being offered, or are refusing so often, that they commonly receive only half of the required hours, this is a systemic problem that IDOC is obligated to work on to reduce. Of note, in the Monitor's experience, this elevated percentage of refusals strongly suggests that the structure out-of-cell activities are not considered helpful to the class members and should be reviewed for their clinical efficacy.

3(f): Specific requirement: Mental health staff shall assess class members in Control Units to determine if a higher level of care is necessary and if so, to make proper recommendations to facility authority.

Finding: This is a complex issue for the Department. Mental health staff do assess class members in control units to determine if a higher level of care is necessary. The fact remains, however, it is difficult to actually move a decompensated class member from segregated housing to an RTU facility. The major source of the difficulty is that the RTU units at Joliet are only

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

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

operating at approximately one-third of their required capacity. So, the mental health staff often assess class members in control units to determine if a higher level of care is necessary, but functionally there is no place to send them in a timely manner.

The RTUs at Logan and Dixon are located in the same facility as the segregate housing units. The above-described problem doesn't exist at this facility.

3(g): Specific requirement: Continued treatment by mental health professional and/or psychiatric provider to the extent clinically indicated.

Finding: The challenges facing the Department in meeting this requirement are detailed in 3(d)(iii), (iv), (vi) and 3(e). The only consistent treatment that is continued is psychotropic medication.

4: CLASS MEMBERS WHO ARE PRESCRIBED PSYCHOTROPIC MEDICATION

Summary: Timely psychiatric follow up for class members prescribed psychotropic medications is not consistently occurring. A significant contributing factor to this deficiency is the presence of a backlog of psychiatric follow up visits at certain facilities. Medication distribution remains problematic, notwithstanding the Department's efforts to improve it. The charting of side effects, medication efficacy, laboratory monitoring and compliance monitoring is improved over previous reviews but much more improvement is needed to be in substantial compliance. Although the overall tenor of this summary sounds very negative, the Department is much improved in this area since monitoring began in May 2016.

4(a): Specific requirement: Class members who are prescribed psychotropic medication shall be evaluated by a psychiatric provider at regular intervals consistent with constitutional standards.

Finding: The psychiatric backlog data must be taken into consideration when evaluating IDOC's performance regarding 4(a). The following is the total number of psychiatric visits backlogged throughout the Department:

- 1/18/19 1558
- 2/15/19 1126
- 3/15/19 793
- 4/12/19 752
- 5/17/19 696
- 6/14/19 679

The current backlog of 679 represents 7% of the total psychiatric case load. This 7% total is somewhat deceiving in that some facilities have little to no psychiatric backlog while others have a very large psychiatric backlog. For example, Dixon is a facility that houses a large number of SMI offenders, many of whom are assigned to the RTU level of care. The following is the total number of psychiatric visits backlogged at Dixon during the same time period:

- 1/18/19 265
- 2/15/19 215
- 3/15/19 234

- 4/12/19 320
- 5/17/19 220 out of a total psychiatric caseload of 888 (25%)[18]
- 6/14/19 121 out of a total psychiatric caseload of 893 (14%)

Backlog, however, is only one indication of IDOC's performance regarding this requirement. The Monitoring Team conducted a data-driven analysis of IDOC's performance in meeting the requirements of 4(a). This consisted of chart reviews for 68 mentally ill offenders from seven facilities[19] who were prescribed psychotropic medication. This analysis revealed that only 35 of the 68 charts reviewed demonstrated that the mentally ill offenders were evaluated by a psychiatric provider at regular intervals consistent with constitutional standards, as measured by the intervals required by the Settlement Agreement. This was a compliance rate of only 51%. The most common deficiency was that 90-day follow ups were occurring without the patient being psychiatrically stable.

Given the problems associated with the psychiatric backlog and that only 51% of the reviewed charts demonstrated timely psychiatric follow up, a rating of non-compliance will be assigned.

4(b): Specific requirement: IDOC shall accomplish the following in psychiatric services:

(i): Administer medications to all class members in a manner that provides reasonable assurance that prescribed psychotropic medications are actually being delivered to, and taken by, the offenders as prescribed.

Findings: Some institutions showed difficulty with delivering medication timely. In chart reviews at Illinois River and Pontiac, for example, more than half of the patients had interruptions when orders lapsed, or when 3 to 10 days elapsed between writing the order and delivering the medication.

As I reported in the 3rd Annual Report, I have been very critical of IDOC's lack of progress regarding this specific requirement in the past.[20] Since this midyear report, however, IDOC has made a concerted effort to address this critical issue. These endeavors include:

- IDOC reports that facilities actively identify those mentally ill offenders who have a history of "cheeking" medication. Hill is offered as an example of such a facility and a robust procedure is described. The monitoring team looks forward to learning about other facilities undertaking similar practices.
- Using better lighting to inspect the mouths of offenders in restricted housing settings. Almost half of institutions report upgrading in-cell lighting and/or using flashlights.
- Pulling patients out of their cells—either on to the tier, in a holding cell, at an officer's desk, or in the health care unit or other pill window--where they can be

[18] IDOC has only recently been reporting the psychiatric case load numbers.
[19] Elgin, Western, Graham, Logan, Stateville NRC, Illinois River, and Pontiac
[20] Midyear Report, dated 11/30/18, page 48.

better observed while taking their medications. Seven institutions have instituted this as routine practice, and another seven employ this method when necessary.

- Illinois River and Shawnee utilize a "crush and float" method of medication administration.
- Changing the formulary to address this issue (i.e. introducing oral-disintegrating tablets of the antipsychotic and mood stabilizer, Zyprexa; moving to daily dosing of certain medications.)

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

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

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

The efforts of IDOC to address this very difficult issue are duly noted and appreciated, however, this efforts are not enough to warrant a rating partial compliance.

(ii): The regular charting of medication efficacy and side effects.

Findings: The Monitoring Team conducted a data-driven analysis of IDOC's performance in meeting the requirements of 4(b)(ii). This consisted of chart reviews for 68 mentally ill offenders from seven facilities[21] who were prescribed psychotropic medication. This analysis revealed that 50 of 68 (74%) charts reviewed had evidence of "the regular charting of medication efficacy and side effects."

This finding is generally consistent with an aggregate of three studies conducted by the Monitoring Team during year three of the Settlement Agreement. In those studies, 94 of 153 charts reviewed (63%) had evidence of "the regular charting of medication efficacy and side effects." The data from these aggregate studies will not be used to determine IDOC's performance of 4(b)(II) as some of the data predated the December 20, 2018 Court Order.

Solely based on the 2019 data of 74% compliance, the Department will be assigned a rating of partial compliance. The Department will be found in substantial compliance when they can document a compliance rate of 85% for at least two consecutive monitoring periods.

[21] Elgin, Western, Graham, Logan, Stateville NRC, Illinois River, and Pontiac.

(iii): Take necessary steps to ascertain side effects.

Findings: As reported for 4(b)(ii), the Monitoring Team determined, through a chart review from seven facilities, IDOC has a 74% compliance rate for this subsection. As in 4(b)(ii), the Department will receive a rating of partial compliance.

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

Findings: A review of 69 charts from seven facilities[22] revealed that "the timely performance of lab work for these side effects and timely reporting on results" occurred in 52 of the charts reviewed (75%). This 75% compliance rate represents an improvement over the past three years. This rate, however, can only result in a finding of partial compliance.

(v): The class members for whom psychotropic drugs are prescribed receive timely explanations from appropriate medical staff 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: 4(b)(v) is a challenging item to accurately monitor. The Department has implemented an omnibus consent form aimed at addressing this issue. The Monitoring Team, however, frequently encounters psychiatric providers utilizing outdated forms to obtain informed consent. There is also a "check box" on the psychiatric progress note form which also is designed to address the requirements of 4(b)(v). Providers do typically check that box, and sometimes include a sentence indicating they have had the conversation. Notwithstanding the use of these forms, the Monitoring Team regularly interviews mentally ill offenders who are prescribed psychotropic medications who are unaware of what medications they are taking or what symptoms the medications are meant to address. At this time, no rating will be given for 4(b)(v).

(vi): That class members, including offenders in a Control Unit who experience medication noncompliance, as defined herein, are visited by an MHP. If, after discussing the reasons for the offender's medication noncompliance said noncompliance remains unresolved, the MHP shall refer the offender to a psychiatric provider.

Findings: As in its response to the requirements of 4(b)(v), the Department has placed a "check box" on the psychiatric progress note form to partially address this concern. This check box only indicates, however, if the psychiatric provider has reviewed the patient's most current Medication Administration Record (MAR). This is meant to inform the psychiatric provider if their patient has been compliant with their psychotropic medications. In a review of 29 charts from Stateville-NRC, Western, Graham, and Logan, the Monitoring Team found that only 16 of the 29 had the "compliance box" checked. This is a rate of 55%.

[22] Elgin, Western, Graham, Logan, Stateville NRC, Illinois River, and Pontiac.

In the charts reviewed at those institutions, Illinois River, and Pontiac, there were only eight examples of medication non-compliance that would cause the MHP to get involved. Nearly all contained problems.

- *Referral*: in three cases it appeared no referral was made to Mental Health staff and in another case the referral was made only after a lengthy period of non-adherence.
- *MHP follow-up*: in two of the cases, the MHP involved did not follow up with their non-compliant patient.
- *Referral to psychiatry*: in one case, the MHP did follow up with their non-compliant patient but did not refer the patient to the psychiatric provider when the non-compliance continued. In two other cases, the psychiatry response was timely.

The Department will be assigned a rating of non-compliance for 4(b)(vi).

5: TREATMENT PLANS

Summary: Treatment planning continues to be a problematic area for the Department. Although some improvement in treatment planning has occurred, the Department remains very far from meeting the requirements of the Court's Orders. A major impediment is the fact that there still is a backlog of uncompleted treatment plans. Treatment planning is very staff intensive. The ongoing lack of an adequate number of mental health staff prevents the Department from ever being substantially compliant with this requirement.

Mental health evaluations are equally problematic. Backlogs exist and the Department's largest Receiving and Classification Unit, NRC, is unable to perform all necessary mental health evaluations due to a lack of staff.

5(a): Specific requirement: All class members shall have a treatment plan that is individualized and particularized based on the patient's specific needs, including long and short-term objectives, updated and reviewed with the collaboration of the patient to the fullest extent possible.

Finding: An analysis of the treatment planning backlog data must occur before a discussion regarding treatment plans being "individualized, particularized, including short and long-term goals, and updated and reviewed with the collaboration of the patient to the fullest extent possible" can occur. Basically, if treatment plans are backlogged, then those affected mentally ill offenders are without any up to date documents that direct their care. These mentally ill offenders, without an up to date treatment plan, are without plans that are "individualized, particularized, including short and long-term goals, and updated and reviewed with the collaboration of the patient to the fullest extent possible."

A sample of the treatment planning backlog data for 2019 follows:

- 1/18 508 treatment plans backlogged throughout the Department
  - Illinois River 46
  - Pinckneyville 18
  - Pontiac 214
- 2/15 523 treatment plans backlogged throughout the Department

  - Illinois River 61
  - Pinckneyville 29
  - Pontiac 174
- 3/15 572 treatment plans backlogged throughout the Department
  - Illinois River 77
  - Pinckneyville 33
  - Pontiac 156
- 4/12 544 treatment plans backlogged throughout the Department
  - Illinois River 125
  - Pinckneyville 50
  - Pontiac 176
- 5/17 463 treatment plans were backlogged throughout the Department
  - Illinois River 100
  - Pinckneyville 55
  - Pontiac 123
- 6/14 479 treatment plans were backlogged throughout the Department
  - Illinois River 105
  - Pinckneyville 48
  - Pontiac 65

As reported in the 3rd Annual Report, the overall assessment of the status of treatment planning within the Department is that the Monitoring Team has noted some improvement but more work is needed to meet the requirements of 5(a). There still exists treatment plans created only by the psychiatric provider which only list medications. Similarly, MHP-only treatment plans were noted in which no reference was made to medication management. The Monitoring Team did encounter well-prepared treatment plans at the RTUs at Logan and Joliet as well as the STC at Dixon. Of note, these are relatively well staffed facilities. This demonstrates that if the Department were appropriately staffed, good quality, multidisciplinary treatment plans would be the norm.

As for crisis watch treatment plans, clinicians do, for the most part, use a form formatted to call for goals, frequency and duration of treatment activities, and the staff responsible. Rarely in the systemwide sample, staff instead offered a progress note to demonstrate their treatment planning. In that study, Illinois River and Jacksonville seemed to have the strongest practice. Hill, Sheridan, and Vandalia showed the greatest need to improve.

IDOC training has emphasized the need to complete these fields and the monitoring team observes some improvement in this regard. The greatest improvement is evident in recording patients' **problems and goals**: in the systemwide study, 34% of the plans captured these well.[23] Another 22% were adequate but had minimal content and minimal tailoring to the patient. Fully 23% were insufficient. These reflected issues such as missing a key problem of the patient's,

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

omitting goals altogether, content that appeared unrelated to the patient, and boilerplate that would not appear to assist in treating the patient.[24]

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

5(b): Specific requirement: Mental health evaluations shall be conducted in a timely manner to ensure that individuals in need of treatment, or re-evaluation of existing treatment, are evaluated without undue delay.

Finding: A persistent backlog of uncompleted mental health evaluations continues to impair the Department's ability to satisfy the requirements of 5(b). The following is a sample of the backlog data for 2019:

- 1/25 308 backlogged throughout the Department 177>14 days late (57%)
- 2/22 300 backlogged throughout the Department 152>14 days late (51%)
- 3/29 292 backlogged throughout the Department 174>14 days late (60%)
- 4/26 395 backlogged throughout the Department 256>14 days late (65%)
- 5/24 297 backlogged throughout the Department 197>14 days late (66%)
- 6/21 414 backlogged throughout the Department 217>14 days late (52%)
- Total 2006 1173>14 days late (58%)

Over the first six months of 2019 there were over 2000 mental health evaluations backlogged with the majority of them being more than 14 days late.

As reported in the 3rd Annual Report[25], it is important to note that mental health evaluations are not routinely completed at the NRC. This is due to their tremendous workload of new intakes and having to house a large number of offenders on writs. While workload may make this understandable, it is a significant compliance issue. IDOC's April Quarterly Report states that offenders stay at the NRC for an average of 18 days if they do not have pending court or medical matters. What it does not say is that those exceptions involve hundreds of people.

In a visit on October 10 & 11, 2018, the team analyzed caseload lengths of stay for the population onsite at the time. Using IDOC's data and applying very conservative measures,[26] 169 people had been at NRC longer than the stated average that week, and staff said there was nothing

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

[25] Pages 18 & 19

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

unusual about the population at the time. Over a year's time, of course, this total would multiply. Staff appropriately attempted to prioritize higher acuity patients for evaluations, to mitigate these circumstances, but were only successful in a slight majority of such cases onsite at the time. Of note, this data was collected prior to the Court's order of December 20, 2018. A follow up visit to the NRC on March 21, 2019 confirmed that this October 2018 data was still valid in 2019.

The mental health evaluation backlog data for 2019 combined with the problems encountered at the NRC demonstrate that the Department is not meeting the requirements of 5(b).

5(c): Specific requirement: Treatment plans shall be reviewed and updated at regular intervals as clinically necessary to assess the progress of the documented treatment goal and update the plan accordingly.

Finding: As reported in 5(a) above, persistent problems with treatment planning backlogs impair the Department's ability to meet the requirements of 5(c).

The Department has the responsibility of reviewing and updating treatment planning for mentally ill offenders in a variety of clinical settings. These include outpatient, crisis, inpatient, RTU and segregation:

- Outpatient: The Monitoring Team determined that treatment plans for mentally ill offenders assigned to the outpatient level of care are generally "reviewed and updated at regular intervals as clinically necessary." These plans, however, tend to be more generic and boiler plate in nature and do not generally "assess the progress of the documented treat goal(s)."
- Crisis: The Monitoring Team determined that treatment plans for mentally ill offenders assigned to the crisis level of care are overwhelmingly "reviewed and updated" upon admission to crisis care. Only a minority of these plans are "reviewed and updated at regular intervals as clinically necessary to assess the progress of the documented treatment goal(s) and update the plan accordingly."
- Inpatient: The staff at the inpatient unit at Elgin are 100% in compliance with the requirements of 5(c).
- RTU: The staff at the RTU's at Logan, Joliet and the STC at Dixon are meeting the requirements of 5(c). The RTU located in the X-house at Dixon is not meeting these requirements.
- Segregation: The Monitoring Team determined that for those mentally ill offenders assigned to segregation, their treatment plans were not "reviewed and updated at regular intervals as clinically necessary to assess the progress of the documented treatment goal(s) and update the plan accordingly." A minority of the cases reviewed demonstrated that the treatment plans were updated and reviewed upon entrance into segregation and even fewer had their plans reviewed and updated at regular intervals.

The inability of the Department to consistently meet the requirements of 5(c) is due to having an insufficient number of mental health staff. Taking the inpatient unit at Elgin as an example, this unit is appropriately staffed. The requirements of 5(c) are being met without fail. My opinion as Monitor is that 5(c), as well as other staff-intensive requirements of the Court's December 20, 2018, would be easily met with the proper amount and type of mental health staff.

6. COMPLIANCE REQUIREMENTS

6(a): Specific requirement: A quarterly report created by IDOC shall certify each facility's compliance with the above requirements.

Findings: The Department created and distributed its first quarterly report on April 23, 2019. The next quarterly report is scheduled for distribution the week of July 22, 2019.

6(b): Specific requirement: On a regular basis (no less than every 90 days). Defendants shall provide the results of their own quality assurance audit. These results shall include an accompanying certification of the Defendants' CQI Manager of whether compliance has been reached with Defendants' quality assurance requirements.

Findings: The Department is meeting this requirement. Their quality assurance audit and certification by the Defendants' CQI Manager appeared as Attachment four to the quarterly report of April 23, 2019.

6(c): The appointed independent monitor, Dr. Pablo Stewart, will monitor the Defendants' compliance with this Order consistent with the monitor's existing duties and functions.

Findings: This report is the result of monitoring accomplished by the independent monitor and his staff.

CONCLUSIONS

As noted in the body of this report, the Department still has a long way to go to be in substantial compliance with the Court's Orders. Staffing remains a critical roadblock to the Department's ability to be in substantial compliance. I meet with Director Jeffries and am encouraged that this change in leadership will hasten the Department's meeting the requirements of the Court's Orders.

Respectfully submitted,

/s/ Pablo Stewart, M.D.

Pablo Stewart, M.D.
Rasho Monitor