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 ROB JEFFREYS, 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 the 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
- Treatment for class members who are placed on mental health crisis watch
- Treatment for class members who are placed in segregation
- Treatment for class members who are prescribed psychotropic medication
- Treatment plans and evaluations

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, and Miranda Gibson, MA.

To accomplish these monitoring obligations, the monitoring team sought information in a variety of ways. The monitoring team conducted three virtual site visits of three different IDOC facilities, where interviews of administrators and staff were conducted. During these virtual site visits, the monitoring team would obtain information about staffing, the mental health and psychiatric case load, Covid-related issues, out-of-cell time, and the operations of crisis beds and segregated housing. These virtual site visits would be followed up by chart reviews of class members assigned to crisis beds and segregated housing.

Virtual Site visits:

1. Danville January 13, 2021
2. Big Muddy February 18, 2021
3. Centralia March 17, 2021

The monitoring team also conducted chart reviews for class members housed in crisis beds and segregated housing at an additional eight facilities.[1]

The monitoring team conducted on-site visits to following facilities:

1. Joliet	March 10, 2021	4. Pontiac	March 12, 2021
2. Stateville	March 11, 2021	5. Menard	June 28-30, 2021
3. Stateville-NRC	March 11, 2021		

During this activity, the monitoring team met with administration; mental health leadership and staff; regional mental health leadership; nursing, pharmacy, Internal Affairs, education, and counseling staff; and class members. Team members observed crisis watch case conferences, and medication distribution in medication lines and cell side settings, and reviewed medication administration records, medication-related discipline information, and use of force videos.

The monitoring team interviewed class members from five different facilities: Joliet, Pontiac, Stateville, Stateville-NRC, and Menard. The Monitor also reviewed 69 treatment plans and psychiatric progress notes for 88 class members from throughout the Department. The systemwide backlog reports, which are provided weekly, were reviewed. Drawing both on institutions' tracking and on health care charts additional to those above, the monitoring team analyzed the timeliness of evaluations, restrictive housing baseline assessments, and psychiatric contacts; the length of stay in crisis watch; and consideration of, and referrals to, RTU, BMU, and inpatient care. The team has also reviewed the Department's Quality Improvement audits covering the first quarter of 2021 and has integrated those findings where feasible.

COMPLIANCE RATINGS

Consistent with the obligations specified in the Settlement Agreement, 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 the essential, material components even in the absence of strict compliance with the exact 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.

- Noncompliance: This rating will be applied if the Defendants do not satisfy the definition of Substantial Compliance.

[1] Pontiac, Stateville, Menard, NRC, Sheridan, East Moline, Jacksonville and Taylorville

EXECUTIVE SUMMARY

This report covers the period from January 1, 2021 through June 30, 2021. The Monitoring Team found the Department to be in noncompliance with the following sections of the Court order:

1. Staffing: The Department has not met its staffing requirements throughout the life of the Court's orders in this matter. The Department's reporting is baffling in that they state that they are exceeding their staffing requirements, but the Wexford staffing report does not support this claim. It remains the opinion of the Monitor that the major impediment preventing the Department from meeting the requirements of the Court's orders is inadequate staffing. This lack of staffing applies to clinical and custody staff.

2. Crisis watch: The number of crisis watches decreased substantially, For the most part, crisis watch is used for the appropriate types of patients. IDOC continues to manage care through short daily contacts with MHPs, and some reviewed facilities provided additional types of care. Care was reevaluated in treatment plans and psychiatry appointments. In all these types of care, there were gaps between the intended amount and the actual amount delivered; the highest consistency was in the presence of treatment plans. Psychiatry was not available as much as it should be. There was a lower than acceptable rate of contacts occurring in a confidential, out of cell location, often because of Covid-19 precautions. Taken together, these treatments were not sufficient to stabilize the symptoms and protect against decompensation, demonstrated in part by the very long crisis watches in which the patients presumably were not stable.

   Stays are *not* for the shortest duration possible, though IDOC has made some improvement in lengthier stays. Defendants assert that they routinely consider a higher level of care in such cases, but a large, diverse study found almost no documentation describing the reasons such a placement was not warranted. Women were referred to a higher level of care at a rate of 50%, while less than 4% of men were referred.

3. Segregation: IDOC is delivering, to some extent, each of the elements in the Court's orders concerning restrictive housing (segregation). Compliance rates for the different responsibilities vary greatly, and only the continuation of the previous treatment plan, and recommendations for post-segregation housing, are performed sufficiently.

   The amounts of counseling and out of cell structured and unstructured time are far below what is needed and sufficient to protect against decompensation. Taken together, all of the care provided is less than is clinically indicated.

4. Medication: The parties will argue, and the Court will decide, the frequency of contact that is consistent with constitutional standards. To inform that, the monitoring team assessed whether psychiatry maintains the schedule specified in the Settlement Agreement – a reasonable standard of care – and found that psychiatric evaluations can take place at reasonable intervals, but not on a consistent, sustained basis, and confidentiality is not preserved often enough, generally because of Covid-19 limitations.

Psychiatric providers do consistently ascertain side effects, document efficacy and side effects, and record having informed patients about their medications and the possible effects. Lab work is ordered at a moderate rate, not yet sufficient for substantial compliance.

Defendants have well-established medication distribution systems but have offered no demonstration of whether IDOC practices provide reasonable assurance that psychotropic medications consistently are delivered to patients as planned. Quarterly reports respond to only 1 of the 9 issues the monitoring team has raised as common impediments. Neither have Defendants demonstrated the effectiveness of their policies concerning patients' nonadherence to medication regimens.

5. Treatment plans: All class members do not have a treatment plan that is individualized and particularized based on the patient's specific needs. This is due to the persistent backlog of treatment plans throughout the Department and the low completion rate of treatment plan reviews and updates when a class member is placed into restrictive housing. The treatment plans for class members assigned to the RTU and inpatient levels of care were of much better quality than those for class members assigned to outpatient and restrictive housing levels of care. The Department still struggles to meet its requirements for completing mental health evaluations in a timely manner. Finally, the Department doesn't consistently review and update class members' treatment plans per the requirements set out in the Settlement Agreement, a reasonable time frame for this requirement.

The results of the monitoring indicate that the Department's performance is as follows:

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

3(a), (b), (c) 3(d)(i) 3(d)(ii), (d)(iii), (d)(iv) 3(d)(v) 3(d)(vi), (e), (f), (g)	Noncompliance Substantial compliance Noncompliance Substantial compliance Noncompliance
4: CLASS MEMBERS WHO ARE PRESCRIBED PSYCHOTROPIC MEDICATION 4(a), (b)(i) 4(b)(ii), (iii) 4(b)(iv) 4(b)(v) 4(b)(vi)	Overall: Noncompliance Subfindings supporting overall findings: Noncompliance Substantial compliance Noncompliance Substantial compliance Noncompliance
5: TREATMENT PLANS 5(a) 5(b) 5(c)	Overall: Noncompliance Subfindings supporting overall findings: Noncompliance Noncompliance Noncompliance
6: COMPLIANCE REQUIREMENTS 6(a) 6(b) 6(c) and 6(d)	Overall: Substantial compliance Subfindings supporting overall findings: Substantial compliance Substantial compliance Not subject to compliance ratings

1: STAFFING REQUIREMENTS AT THE ILLINOIS DEPARTMENT OF CORRECTIONS

Summary: The Department has not met its staffing requirements throughout the life of the Court's orders in this matter. Their reporting is baffling in that they state that they are exceeding their staffing requirements, but the Wexford staffing report does not support this claim. It remains the opinion of the Monitor that the major impediment preventing the Department from meeting the requirements of the Court's orders is inadequate staffing. This lack of staffing applies to clinical and custody staff.

1(a): Specific requirement: Within 90 days of this order, Defendants must employ additional staff necessary to have the following system-wide levels in the following positions: 7 Site Mental Health Service Directors; 12 Mental Health Unit Directors; 16 Staff Psychologists; 142.5 Qualified Mental Health Professionals; 102 Behavioral Health Technicians; 54.5 Registered Nurses – Mental Health; 24 Staff Assistants; 85.5 Psychiatric Providers; 1 Director of Nursing – Psychiatric; 5 Recreational Therapists.

Finding: The monitoring team conducted a hand tally of the total number of staff in the various categories required by 1(a). This hand tally was based on the IDOC's, and Wexford's staffing updates contained in Attachment 1 of the Department's Quarterly Report of April 23, 2021. IDOC's staffing update was current as of April 15, 2021, and Wexford's as of March 19, 2021. Of note, the monitoring team's calculations considered Wexford's category of "Hired/Not Started" as vacant. The data follows:

	Required	Total	Difference
• Site Mental Health Service Directors	7.0	6.0	-1.0
• Mental Health Unit Directors	12.0	10.0	-2.0
• Staff Psychologists	16.0	15.0	-1.0
• QMHP	142.5	163.0	+20.5
• BHT	102.0	96.0	-6.0
• RN-Mental Health	54.5	36.75	-17.75
• Staff Assistant	24.0	61.0	+37.0
• Psychiatric Providers	85.5	68.438	-17.062
• Director of Nursing-Psychiatric	1.0	2.0	+1.0
• Recreation Therapists	5.0	7.0	+2.0

These numbers speak for themselves. The QMHP totals require additional explanation, however. The QMHP totals are based on the combination of Wexford staff, 132.0, and State staff, 31.0 for a total of 163.0, which is 20.5 full-time equivalents above their required minimum. This 163 number, however, flies in the face of the following facts, taken from the Wexford staffing report, current as March 19, 2021:

- Big Muddy -2.0 QMHPs
- Danville -1.0 QMHPs
- Dixon -10.0 QMHPs
- Graham -1.0 QMHPs
- Hill -2.0 QMHPs
- Joliet -1.0 QMHPs
- Lawrence -2.0 QMHPs
- Logan -8.0 QMHPs
- Menard -2.0 QMHPs
- Pontiac -9.0 QMHPs
- Robinson -1.0 QMHPs
- Shawnee -1.0 QMHPs
- Western -3.0 QMHPs
- Total **-43.0 QMHPs**

No matter what sleight of hand IDOC attempts to use to demonstrate compliance with 1(a), they remain significantly understaffed in a variety of job categories. A rating of noncompliance will be assigned to 1(a).

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: As previously reported, the Department did conduct this evaluation. In that regard they are in compliance with this requirement. The Monitor has consistently reported that the Department's staffing plan is grossly inadequate based on objective measures of performance. These measures demonstrate that the staffing is inadequate to provide a constitutional level of care in the areas of mental health evaluations, treatment planning, medication management, mental health care on crisis watches and segregation.

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: Department did report their findings to the Court, Monitor and Plaintiffs' counsel.

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

Finding: The Monitor is not aware of whether the Court has considered modifying the Defendant's staffing plan. No rating will be assigned.

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

Summary: The number of crisis watches decreased substantially, For the most part, crisis watch is used for the appropriate types of patients. IDOC continues to manage care through short daily contacts with MHPs, and some reviewed facilities provided additional types of care. Care was reevaluated in treatment plans and psychiatry appointments. In all these types of care, there were gaps between the intended amount and the actual amount delivered; the highest consistency was in the presence of treatment plans. Psychiatry was not available as much as it should be. There was a lower than acceptable rate of contacts occurring in a confidential, out of cell location, often because of Covid-19 precautions. Taken together, these treatments were not sufficient to stabilize the symptoms and protect against decompensation, demonstrated in part by the very long crisis watches in which the patients presumably were not stable.

Stays are *not* for the shortest duration possible, though IDOC has made some improvement in lengthier stays. Defendants assert that they routinely consider a higher level of care in such cases, but a large, diverse study found almost no documentation describing the reasons such a placement was not warranted. Women were referred to a higher level of care at a rate of 50%, while less than 4% of men were referred.

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: As an initial matter, it is notable that the usage of crisis watch has decreased substantially over the last year.[2] There are reasons to believe this is a positive development. Possible contributors include:

- with mental health personnel providing added cell side rounds during the pandemic, there were more opportunities to discuss mental health concerns before they escalated to a crisis, or before some patients felt the need to request crisis watch as a means to access an MHP
- the restrictive housing (segregation) policies, implemented in November 2020, aim to reduce the number of restrictive housing placements and shorten stays there; this may be resulting in fewer patients claiming they are in crisis as a means to escape, or protest, their restrictive housing placements
- after a year of pandemic quarantines and other limits, patients particularly value time out of their cells, and it may be that the confined conditions of crisis watch are unappealing to those who may previously have requested it for reasons other than crisis

[2] In the monitoring team's analysis one year ago, for example, there was an average of **625** crisis watches per month in the sampled IDOC tracking logs, which spanned summer 2019 through spring 2020. In the instant analysis, capturing 2021 practice, the monthly average was **457** crisis watches.

- staff believe that the coordinated efforts to improve crisis care, detailed in the last two Monitor's reports, are having an impact

As to the Court's order concerning the purposes of crisis watch, as indicated in the Monitor's report of January 31, 2021, "It is the Monitoring Team's experience that crisis watches are consistently used for patients exhibiting dangerousness to themselves or others, or who were 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." This statement remains consistent with the current use of crisis watches with the exception of the phrase "that no other less restrictive treatment is appropriate." It is the opinion of the Monitor that a portion of the crisis watch placements could be avoided by a greater involvement by the psychiatric practitioners. That is, if a class member is beginning to show signs of decompensating, a psychiatric practitioner needs to evaluate the class member prior to crisis placement, if possible, to determine if the use of emergency medications is appropriate. This practice could reduce the use of crisis watches.

For a substantial number of admissions, it does not appear that the duration was the shortest possible. To define this term, the monitoring team first looks to the Settlement Agreement, which employs a threshold commonly used by prison systems for this type of treatment setting. The agreement specifies that crisis beds are designed for short-term stays, which it defines as "generally no longer than ten (10) days." While this is not a firm deadline, the Settlement Agreement definition expects patients needing more care to be transferred to a "more…intensive care setting"; the definition indicates that patients who do not need a more intensive care setting are to be discharged. Thus, if Defendants have determined a patient does not need a higher level of care but the patient is also not discharged, then presumptively the additional time in crisis watch is excessive and not the shortest duration possible.

Crisis watch logs indicate that 19% of crisis watches in the monitoring round exceeded the ten-day threshold,[3] a frequency that is not "minor or occasional." There has been only minor fluctuation in this rate since the Court issued its consolidated Permanent Injunction Order.

There remains a disturbing practice of retaining patients in crisis watch far longer. **47 stays** were at least ***three times*** the length presumed by the Settlement Agreement to be appropriate.[4] The longest stays were found at Pontiac and Joliet:

- more than 3 months
- 4.5 months
- 10 months
- 1 year and 3 months, and continuing

[3] This analysis is based on all crisis watches on IDOC logs for February through April 2021 from all institutions at which a crisis watch occurred, except Elgin, a total of 1,372 admissions. Kewanee and Murphysboro reportedly had no crisis watches. Elgin was excluded as the highest level of care, such that transferring a patient to a higher level of care after ten days is not an option. It is not feasible to assess, at any scale, whether stays less than ten days are the shortest possible for those individuals.

[4] This includes five patients who had multiple stays in this short time, each lasting more than ten days and totaling 30 or more. It does *not* include other patients with multiple stays, some of which were shorter, but may also have totaled 30 or more. These were identified from only three months of logs. The number of stays of this length, per year, would be much higher.

- more than 6 months
- more than 8 months
- approximately 3 years and continuing

Each of these 47 presumptively fails to meet the standard set in 2(a) and are an inappropriate use of this treatment setting.[5] Rather, these patients require more care than can be provided in a crisis watch setting. On the other hand, these figures reflect improvement in that the number of stays over 30 days and over 90 days were meaningfully reduced over prior periods. There are fewer stays of these lengths[6] and it is occurring at fewer institutions.[7] Defendants have described efforts by headquarters and regional staff to guide institution staff in improved crisis care, treatment planning, and attention to patients with multiple or extended stays, and it appears to be having an impact.

IDOC's Quality Improvement system reviews the quality of care in crisis watch, and compliance with policy and the Settlement Agreement, but does not assess whether a less restrictive approach would have been appropriate or whether the stays were of the shortest duration possible.

The Monitor finds that there may have been cases where a less restrictive approach was appropriate, and a meaningful number of stays were not for the shortest duration possible. IDOC is thus Noncompliant with this requirement.

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

Finding: The consistent components of treatment that IDOC offers to class members placed on a crisis watch are daily, confidential contacts with an MHP; psychiatric evaluation; and treatment planning. Some facilities offer additional treatments. These facilities and the additional treatments they offer will be noted below.

The following data was obtained from a 11-facility[8] review of charts associated with 82 crisis placements:

- Daily, confidential checks with an MHP: Only 69 of the 82 crisis placements had evidence of a daily contact – 84.1%. Of these 69 stays that included daily MHP contacts, only 46 occurred in a confidential setting – 66.7%.

[5] This should not be read to imply that all stays up to 29 days are of the shortest duration possible. This discussion focuses on the longest stays, but many of the 221 stays between 11 and 29 days are also likely exceed the terms of this Court's order.

[6] The stays of 30 days or more represented 8% of crisis watches in 2019-2020. In 2021, they are 3% of the crisis watches. A subset of those—stays lasting 90 days or more—reduced from 22 people to 7 people in the instant analysis.

[7] In 2019-2020, this practice was observed at 16 institutions. In this 2021 review, it was evident at only 9 institutions.

[8] Pontiac, Stateville, Menard, Stateville-NRC, Sheridan, East Moline, Jacksonville, Taylorville, Danville, Centralia and Big Muddy

- Presence of treatment plans:
    - Upon admission: 77 of 82 – 94%
    - Upon discharge: 81 of 82 – 99%

- Additional treatments:
    - Pontiac – in-cell workbooks
    - Graham – additional cell front contacts by BHTs
    - Pinckneyville – one additional meeting with an MHP per week
    - Logan – psychoeducational meetings with BHTs
    - Stateville-NRC – offers the "ALIVE" curriculum once per week
    - Centralia and Big Muddy – two hours per day of unstructured out of cell time if patient is in crisis watch more than 10 days

- Seen by a psychiatric practitioner: 63 of 82 – 77%

Plaintiffs' counsel have also raised disturbing allegations about the safety of patients on crisis watch at Joliet, Pontiac, and Dixon, and possibly other institutions. Based on patient reports, health care records, video, and investigation records, Plaintiffs have identified patients possessing razors, metal, glass, and a cord in crisis watch cells, which are meant to be protected from access to such items, which the patients swallowed or used to cut themselves. The monitoring team has also noted such cases among incident reports reviewed. Plaintiffs gave five cases as examples and assert that this is more widespread. Some of the cited cases involved serious injury, with visible pooling of blood and/or outside hospital treatment. Plaintiffs also assert that some officers may not be consistently maintaining the observation that would prevent such self-injury, or catch it quickly, including one case where the officer documented he could not see into the cell for at least 40 minutes[9]; the parties disagree about whether real-time action was taken to remedy that.

IDOC describes a number of actions meant to address these issues. IDOC reports that it investigated the incidents noted above, and routinely investigates all self-harm incidents at Dixon and Joliet. Investigations identified at least two means through which patients obtained self-harming materials, leading to practice changes aimed at reducing the flow of such items. Reportedly, investigations examined both prisoner and officer conduct. IDOC indicates that Pontiac has increased the thoroughness of its crisis cell searches, and added more search methods, and Joliet has purchased chairs that should improve line of sight into cells. IDOC asserts that these actions have reduced the frequency of self-harm incidents in crisis watch. Looking to the future, a working group is considering how to enhance training for officers conducting observation, and Quality Improvement leaders are discussing means of expanding their reviews of crisis observation.

The Monitoring Team appreciates these actions, and because of the severity of this risk, these issues bear watching. If patients repeatedly self-harm in this setting, it cannot be said that the treatment is sufficiently serving to stabilize their symptoms and protect against decompensation.

[9] This is a very lengthy time if there are orders for continuous watch, or 10- or 15-minute checks, as is common. In this example, Plaintiffs provided a 40-minute section of the observation log for illustration; they also write that the full log shows this occurring for 1 hour and 50 minutes.

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: As noted above in 2(b), in an 11-facility sample, 94% of class members assigned to crisis care received a reevaluation of their treatment plans on crisis placement.[10] In the same sample, only 77% of class members were seen by a psychiatric provider who could reevaluate their medication during their crisis watch period.[11] There are also indications that far fewer patients see psychiatry in some institutions; for example, logs show that only 40% of crisis watches at Illinois River, Lawrence, and Robinson included a psychiatry contact.[12] Defendants have expressed a belief that patients not on the psychiatric caseload do not need to see a psychiatrist during crisis watch; this is incorrect based on the evolving community standard.

The treatment planning percentage of 94 is very encouraging. The fact that only 77% of reviewed class members were seen by psychiatric providers is inconsistent with a rating of substantial compliance.

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: Again, as noted in 2(b) above, daily assessments were occurring at a rate of 84.1% in the Monitoring Team's study. Out of this cohort, however, only 66.7% were confidential in nature. The monitoring team understands that this is a setback from previous accomplishments, caused primarily by Covid-19 precautions.[13] Reviewed notes do generally comment on whether the patient is moving towards stability. Much less often, notes discuss whether other or additional treatments are indicated. Consideration of the advisability of transfer to a higher level of care is recorded extremely rarely, as will be discussed in section 2(f) below.

As another resource, IDOC's Quality Improvement system also audited daily contacts, reviewing 165 patients who were on crisis watch in the first quarter of 2021. Their data show that 68% of sampled charts were fully compliant with daily, confidential MHP contacts.[14]

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[10] Although IDOC's Quality Improvement system audited crisis watch treatment plans, the recorded findings generally did not distinguish between plans on admission, updates, and discharge plans, so there is not additional material to add to this analysis.

[11] In IDOC's Quality Improvement audits, there were occasional findings that an expected psychiatric contact was absent. However, the audit method does not routinely record who is expected to see a psychiatrist, and who *was* seen, so it is not possible to put these findings into context.

[12] According to the Crisis Trackers for those institutions for January through April 2021

[13] In a separate, smaller review, among 21 crisis watch contacts at Joliet, Kewanee, Pontiac, and Shawnee, only 43% were clearly shown as occurring in a confidential setting. This may or may not be generalizable.

[14] The *Rasho* monitoring team calculated this percentage from the Quality Improvement auditors' raw data. Auditors' findings of violations that were of a clerical/administrative nature were NOT counted as noncompliant in the monitoring team analysis. More often, the Quality Improvement auditors' concerns had to do with missed contacts or related issues; confidentiality was found to be preserved well, with only 11% of the patient records showing a confidentiality deficiency.

Of note, the monitoring team found that only seven facilities among those in the team's study were offering any additional treatment to class members assigned to crisis care. This fact is demonstrative of a lack of uniformity in the Department's approach to providing appropriate services to class members assigned to crisis 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: This requirement was 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.

Finding: As noted in 2(b), 81 of the 82 (99%) crisis placements reviewed had evidence of a treatment plan being prepared upon discharge from crisis care.[15] This is not a comment on whether those plans meaningfully addressed causes which led to the deterioration and the plan for risk management to prevent relapse.

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 19% of the stays[16] exceeded ten days. As discussed above, ten days is an approximate measure established in the Settlement Agreement to signal the timing for stability or a higher level of care decision.

Defendants assert in each quarterly report that, for every patient in crisis watch ten days or more, mental health staff assess whether a higher level of care is needed and document this decisionmaking in the health care record. Defendants have not provided any studies demonstrating this and the Quality Improvement system does not assess this requirement. The monitoring team sought to substantiate this by reviewing relevant health care records sections.

The monitoring team collected this data within the 11-facility review referenced above. Additionally, the team conducted a second study whose characteristics were:

- 115 extended crisis watches experienced by 83 patients
- chosen from all 16 institutions that had very lengthy crisis watches
- sampled crisis watches lasted from 14 days to 15 months

[15] Although IDOC's Quality Improvement system audited crisis watch treatment plans, the recorded findings generally did not distinguish between plans on admission, updates, and discharge plans, so there is not additional material to add to this analysis.

[16] As described above, this is based on a review of the lengths of stay for all patients in crisis watch, except at Elgin, as shown on IDOC logs for February, March, and April 2021.

- the vast majority lasted one month or more
- each facility was asked to provide all "pages from the chart that show the consideration of a higher level of care" in the months in which these crisis watches took place.

Taking the studies together, ten extended crisis watches resulted in a referral to a higher level of care, and only 6 explained in writing why establishing such a plan is not appropriate, by, or not long after, ten days.[17] At a 13% compliance rate, IDOC is far from compliance with this Court order. There were also instances of weeks elapsing between decision and generating the referral, and further delays from approval to transfer.

A similar number of records showed a positive consideration of a higher level of care, but it was weeks or months later in the crisis watch[18] and almost half do not appear to have been finalized.

The monitoring team undertook a more comprehensive review of referrals made for this population, as well. Referrals to a higher level of care were the norm for women with extended crisis watches, but very rare for men. The latter *declined* during the current monitoring period.[19] Referrals might appropriately be made either to RTU, BMU, or inpatient care, depending on the patient's needs.

In this analysis:

	Patients with 1 or more crisis watches longer than 10 days	Patients referred to RTU or BMU	% Referred to RTU or BMU		Patients Referred to Inpatient	% Referred to Inpatient
Outpatients	81	9	12%		2	2%
RTU patients	112 men 10 women				2 5	<2% 50%

The patients with the longest stays were concentrated at the institutions with RTUs and one additional,[20] so it bears separate discussion of the referral practices at each one.

[17] These include all cases where the discussion and/or referral was recorded by Day 20 of crisis watch – double the length contemplated by the Settlement Agreement – and cases where a referral had already been initiated before the particular crisis watch.

[18] In 12 cases, the first mention occurred in Week 3 or later – up to 4.5 *months* into the crisis watch.

[19] While the Monitor's Fifth Annual Report notes a surge in RTU transfers in late 2020 and early 2021, these were *not* patients referred because of lengthy crisis watches. It appears that staff usually make RTU referrals for other reasons, but not in recognition of the insufficiency of crisis watch for extended care.

[20] Five other institutions each had one stay exceeding 30 days

Logan:

- Logan had only 13 stays exceeding ten days. Most were RTU patients, with only two outpatients in this position.
- There were *none* exceeding 30 days
- The longest stay was 19 days
- Among the extended stays, 5 were referred to higher level of care, and nearly all of the others had returned from inpatient care in recent months

Pontiac: Pontiac had the highest numbers, on all measures, of patients housed in crisis watch when more was needed, and only 1 referral.

- Pontiac had 76 stays exceeding ten days. There were about equal numbers of RTU patients and outpatients in this position.
- There were 17 stays exceeding 30 days
- An additional 5 patients had multiple lengthy stays totaling more than 30 days in the three months analyzed
- Of the above, 5 patients remained in crisis watch more than 90 days
- The longest stay was 1 year and 3 months[21]
- These included patients in restraints for lengthy periods and/or multiple episodes[22]
- Among all of these, only 1 patient was referred to a higher level of care

Joliet:

- Joliet had 51 stays exceeding ten days. All of its patients are RTU status.
- There were 8 stays exceeding 30 days
- Among those, 2 patients remained in crisis watch more than 90 days
- The longest stay was approximately 3 years[23]
- These included patients in restraints for lengthy periods and/or multiple episodes[24]
- Joliet made *no* referrals to higher level of care

Dixon:

- Dixon had 66 stays exceeding ten days. Most were RTU patients, with only six outpatients in this position.
- There were 8 stays exceeding 30 days
- The longest stay was 87 days

[21] That patient remained in crisis watch as of the time of analysis, so the actual length of stay is very likely greater

[22] The monitoring team does not have restraints use information for the entire monitoring period. However, in January alone, Pontiac had 2 patients held in restraints for more than 4 days, and 7 days, respectively.

[23] It appeared that that patient remained in crisis watch as of the time of analysis, so the actual length of stay is very likely greater

[24] The monitoring team does not have restraints use information for the entire monitoring period. However, in January alone, Joliet had 6 patients held in restraints for 1 to 2.5 days each.

- These included patients in restraints for lengthy periods and/or multiple episodes[25]
- Only 1 patient was referred to a higher level of care

Menard:

- Menard had 13 stays exceeding ten days. All were outpatients.
- There were 4 stays exceeding 30 days
- The longest stay was 61 days
- Menard referred 3 of these patients to RTU or BMU. The referrals did not always correspond to the longest stays

The foregoing indicates that there were substantial numbers of patients who did not stabilize sufficiently to be discharged from crisis watch, but no plan was established to provide a higher level of care, and explanations were limited as to why this would not be appropriate. Meanwhile, average censuses showed fewer than half of the inpatient beds were filled. This may be primarily because that facility adopted single-celling as a covid protection, though even single-celling would have permitted 2 to 7 more patients at different points in the monitoring period. Similarly, approximately half of the men's RTU beds required by the Settlement Agreement for Pontiac and Joliet stand empty.[26]

IDOC is Noncompliant with this provision of the Court's orders.

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: During the reporting period, the monitoring team discovered that although 84.1% of class members received daily counseling checks, only 66.7% of them occurred in an out-of-cell, confidential setting. A separate monitoring team study of crisis watch contacts by psychiatry and MHPs was similar, finding only 61% of reviewed contacts were clearly out of cell and confidential.[27] The IDOC Quality Improvement study, described above, found that 89% of the sampled patients had confidential counseling contacts.

Also, among the reviewed facilities, only Centralia and Big Muddy offered out-of-cell unstructured time to class members. IDOC asserts that it is policy to provide two hours per day for

[25] The monitoring team does not have restraints use information for the entire monitoring period. However, in January alone, Dixon had 4 patients held in restraints for more than 1 day to more than 5 days.

[26] The average census, based on numbers IDOC provides monthly to the monitoring team, shows a 47% vacancy rate in the beds required at Joliet and Pontiac. There were also empty beds at Dixon, but IDOC reported that the tracking was in error for some months, so a precise number could not be discerned. This discussion focuses on men because it has been established that Logan has constructed many more RTU beds than required, and that access to them and to the women's inpatient beds has been effective.

[27] This review consisted of 44 contacts from an accidental sample of 2021 crisis watches provided by Centralia, Dixon, Graham, Joliet, Kewanee, Lawrence, Pinckneyville, Pontiac, and Shawnee.

longer term crisis watches, and that the threshold was recently lowered so that unstructured time would begin on the seventh day in crisis watch.[28]

3: CLASS MEMBERS WHO ARE PLACED IN SEGREGATION

Summary: IDOC is delivering, to some extent, each of the elements in the Court's orders concerning restrictive housing (segregation). Compliance rates for the different responsibilities vary greatly, and only the continuation of the previous treatment plan, and recommendations for post-segregation housing, are performed sufficiently.

The amounts of counseling and out of cell structured and unstructured time are far below what is needed and sufficient to protect against decompensation. Taken together, all of the care provided is less than is clinically indicated.

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.

Findings: The monitoring team analyzed 321 placements in restrictive housing in 2021 for the presence of an MHP review. The Settlement Agreement specifies that such an assessment must take place within two days. Some other corrections systems require this within one day—the highest risk period for suicide—so the Settlement Agreement's two-day threshold may be a reasonable measure of promptness. Applying that measure, the compliance rate in these studies was 70%, or 81% if one includes the reviews completed by a Behavioral Health Technician, nurse, or custody staff member (not MHPs, as required by this order and the Settlement Agreement).[29]

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[28] See *Rasho v. Jeffreys* July 2021 Quarterly Report – Order, and previous quarterly reports

[29] This analysis aggregates two separate studies. Altogether, they reviewed 321 placements in restrictive housing from 17 institutions.

The first study reviewed chart sections from 103 charts of patients known to have been in restrictive housing, drawn from 11 facilities: Big Muddy, Centralia, Danville, East Moline, Jacksonville, Menard, Pontiac, Sheridan, Stateville proper, Stateville-NRC, and Taylorville.

For the second study, IDOC provides records of mental health caseload patients placed in control units. Where an institution has few placements, IDOC provides all SMI cases; among larger control unit populations, IDOC has been asked to provide a random selection of every 4th placement or every 10th placement of SMI patients. IDOC provides an evaluation form or another document demonstrating an MHP's first contact after placement, and the document is labeled with the date of placement. These cases were drawn from 9 institutions – Centralia, Dixon, Hill, Illinois River, Joliet, Lawrence, Menard, Pinckneyville, and Pontiac -- for the months of February and April 2021. Documents were not drawn from institutions already found to be in substantial compliance with the Settlement Agreement.

Timeliness was calculated from the date of physical arrival in restrictive housing; if a patient went to crisis watch within the first two days, timeliness was calculated based on his/her date of return to restrictive housing. Cases were omitted from the analysis if the patients were not present in restrictive housing for at least three or four days at the end of the month, as there may not have been sufficient time to complete and log a review. Documents completed while the patient was not in restrictive housing (for example, in crisis watch) were counted as noncompliant. Documents

This latter practice was found at six institutions.[30]

Among the noncompliant cases, some assessments were completed later; the lengths of time have improved over 2020. Other cases did not demonstrate that the required review was completed, and this was particularly prevalent at Dixon and Pontiac.

IDOC's Quality Improvement system reviewed the charts of 569 patients placed in restrictive housing during this monitoring period; their audits recorded a 91% compliance rate with this responsibility.[31]

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

Finding: In an 11-facility review conducted by the Monitor,[32] only 59 of the 98 class member placements in segregation (60%) had evidence of a mental health professional reviewing and recommending any clinically necessary modifications to a class member's individual treatment plan within seven days of placement.

In the IDOC Quality Improvement audits referenced above, the reviewers found 89% of the charts compliant with restrictive housing treatment planning.[33]

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

Finding: This 11-facility review looked at 104 class member placements in segregation for the presence of weekly rounds. Only 77 of the 104 cases reviewed demonstrated weekly rounds. This represents a completion rate of 74%.

In the IDOC Quality Improvement audits referenced above, the reviewers found 90% of

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that were essentially blank were counted as noncompliant if they did not contain information available to the reviewer (for example, the reviewer's observations).

[30] This appeared to be a pattern at Hill, Illinois River, and Pinckneyville; there were also instances at Joliet, Menard, and Taylorville.

[31] Some key differences, which likely contribute to the difference in results are: (1) the inclusion of all institutions (where the monitoring team studies employed a subset), and (2) the proportionate representation of institutions differed between the monitoring team's and IDOC's studies. While neither study strove to hue closely to each institution's proportion of the caseload, some institutions in each study were likely over- or underrepresented to an extent it could affect the outcome. The monitoring team's study underrepresented the omitted institutions and a couple of other institutions. The results of the IDOC study likely underrepresent Menard, Illinois River, and Hill, and overrepresent several institutions with smaller caseloads and fewer patients in restrictive housing.

[32] Danville, Centralia, Big Muddy, Pontiac, Stateville, Menard, Stateville-NRC, Sheridan, East Moline, Jacksonville and Taylorville.

[33] The monitoring team derived this from the audit tools, which record the violations that auditors detect. In these, auditors found a substantive concern – either a treatment plan was not updated or there was a problem in the contents – for 11% of the patients. The monitoring team did not include in this analysis any findings that were clerical concerns, and did not include more than one violation per person. That is, the calculation is *per patient* (the file is compliant or noncompliant), *not per treatment plan*.

the charts compliant with rounds being conducted weekly.[34]

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:

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

Findings: The following is an excerpt from the Fifth Annual Report to the Court dated May 31, 2021, page 41 **"**To assess IDOC's compliance with this requirement, the I reviewed 35 treatment plans of class members assigned to segregated housing. I also interviewed class members assigned to segregated housing during my site visits of Joliet, Stateville, Stateville-NRC and Pontiac. Based upon these efforts combined with my five years of experience with the operations of the IDOC, it is my opinion that mentally ill offenders in segregation continue to receive the treatment specified in their Individual Treatment Plans. The treatment, however, is not clinically sufficient to deal with the stresses that mentally ill offenders experience while in segregation. A typical treatment plan calls for an individual session with an MHP every 30-60 days. These sessions are listed as lasting from 15-30 minutes. Also, in many of the reviewed cases, weekly rounds are listed as a treatment. To be clear, weekly segregation rounds are not a treatment but rather a brief check on the psychiatric condition of mentally ill offenders in segregation. Having said all of that, I must assign a rating of substantial compliance due solely to the fact that the activities listed in the Individual Treatment Plans are continued while the patient is assigned to segregation."

The situation in the current reporting period is unchanged from that reported in the Fifth Annual Report to the Court. That is, the mental health treatment plans are continued, but the treatment offered is grossly insufficient to protect the class member from decompensation.

(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: Pharmacologic treatment does occur in segregation. The same problematic medication issues that affect the Department exist with class members in segregation. These issues will be discussed in Section Four, below. In general, there are inconsistent psychiatric follow-ups and extremely early medication distribution times, which contributes to poor medication adherence. Other issues are more fully discussed in section 4(b).

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

[34] The monitoring team derived this from the audit tools, calculating *per patient* (the file is compliant or noncompliant), *not* the number of times in which rounds did not occur timely. This calculation counted as noncompliant those instances when rounds reportedly did not occur and/or were not documented in the health care record; the analysis did *not* include omissions of signing a log.

Findings: As noted in 3(d)(i), above, class members in segregation meet with an MHP every 30-60 days. These sessions are listed as lasting 15-30 minutes. In IDOC's Quality Improvement study, auditors found that these contacts took place as expected in 99% of the reviewed charts.

These infrequent, extremely brief sessions, however, do not satisfy the requirement of "meetings to the extent necessary."

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

Findings: The Monitor has found that the Department is meeting this requirement. The recent IDOC Quality Improvement study supports this, finding only a handful of omissions at one institution.

(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: A data driven analysis was conducted for out-of-cell time, both structured and unstructured, for the months of January and April 2021. The data is reported in "hours per week." The following is the data for class members in segregation who have been there greater than 16 days but less than 60 days:

	Structured	Unstructured
January	offered – 1.77 received – 0.82	offered – 3.88 received – 1.10
April	offered – 2.06 received – 1.17	offered – 6.4 received – 3.01

This amount of out-of-cell time is not sufficient to protect class members 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: A data driven analysis was conducted for out-of-cell time, both structured and unstructured, for the months of January and April 2021. The data is reported in "hours per week." The following is the data for class members in segregation who have been there greater than 60 days:

	Structured	Unstructured
January	offered – 0.67 received – 0.28	offered – 2.59 received – 1.05
April	offered – 1.95 Received – 1.09	offered – 5.57 received – 2.81

This paltry amount of structured and unstructured out-of-cell time is not sufficient to protect class members against decompensation.[35]

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: In general, class members in Control Units are not routinely assessed. The mechanisms in place to assess class members in Control Units are weekly rounds and meetings with an MHP. As noted in 3(c), above, an 11-facility review looked at 104 class member placements in segregation for the presence of weekly rounds. Only 77 of the 104 cases reviewed demonstrated weekly rounds. This represents a completion rate of only 74%. So, weekly rounds don't occur in the required frequency. Also, as noted throughout this report, class members only meet with an MHP every 30-60 days and then for 15-30 minutes. Noting all of this, when class members in Control Units are moved to a higher level of care it usually due to the class member calling for the Crisis Intervention Team. If the Crisis Intervention Team responds to this request, then the class member is usually placed on a crisis watch. It is also my experience as Monitor that the Department keeps very seriously mentally ill class members in Control Units when in fact they should be moved to a higher level of care.

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

Finding: IDOC remains unable to provide continued treatment by a mental health professional and/or a psychiatric provider to the extent clinically indicated. Their deficiencies are noted in sections 3(a), 3(b), 3(c), 3(d)(i), 3(d)(ii), 3(d)(iii), 3(d)(iv), 3(d)(vi), 3(e) and 3(f).

[35] The IDOC Quality Improvement system does not assess 3(e), 3(f), and 3(g) of this Court's order.

4: CLASS MEMBERS WHO ARE PRESCRIBED PSYCHOTROPIC MEDICATION

Summary: The parties will argue, and the Court will decide, the frequency of contact that is consistent with constitutional standards. To inform that, the monitoring team assessed whether psychiatry maintains the schedule specified in the Settlement Agreement – a reasonable standard of care – and found that psychiatric evaluations can take place at reasonable intervals, but not on a consistent, sustained basis, and confidentiality is not preserved often enough, generally because of Covid-19 limitations.

Psychiatric providers do consistently ascertain side effects, document efficacy and side effects, and record having informed patients about their medications and the possible effects. Lab work is ordered at a moderate rate, not yet sufficient for substantial compliance.

Defendants have well-established medication distribution systems but have offered no demonstration of whether IDOC practices provide reasonable assurance that psychotropic medications consistently are delivered to patients as planned. Quarterly reports respond to only 1 of the 9 issues the monitoring team has raised as common impediments. Neither have Defendants demonstrated the effectiveness of their policies concerning patients' nonadherence to medication regimens.

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 Monitor reviewed 88 psychiatric progress notes to assess the adequacy of the class members visits with a psychiatric provider. These progress notes are of good quality in that they provide for a history of present illness, review medication compliance and side effects, arrive at a diagnosis, prescribe the appropriate psychotropic medications for the given diagnosis and obtain informed consent from the patient. The Department has tremendously improved in this area over the past five years of the Settlement Agreement.

To review the adequacy of the frequency of contact, the monitoring team used as a guide the related Settlement Agreement requirements, as they are consistent with psychiatric standards of care, and the Court may determine that they are also consistent with constitutional standards.

For **outpatients**, the monitoring team analyzed contacts for 451 psychiatric patients, drawn from across IDOC, for whom the timeliness of at least three appointments in the monitoring period could be discerned.[36] The review method employed both IDOC databases and sections of

[36] IDOC does not maintain a data system that can show a series of contacts, but relevant data can be extracted from its "Psych Database." The monitoring team reviewed a Psych Database from each institution with an outpatient psychiatric caseload for each month from December 2020 through April 2021. A sample was chosen generally by random selection method of every 10 patients, though there were exceptions if the caseload was small or for a few other reasons.

health care records.

It was rare for a patient to be seen *every* 30 days, or consistently within a longer interval the provider designated if the patient was more stable. Only 29% of reviewed patients were seen within those intervals every time. However, it was common for contacts to miss the mark only by a short time. The monitoring team considers a contact within an additional week to be reasonable. If that standard were to be adopted, compliance within the sample jumps to 63%. These percentages are similar to previous analyses.

Where there were longer times between contacts, two to four additional weeks was common and fewer than 20 appointments appeared to exceed that.[37] Appointments delayed two weeks, or more were concentrated at just eight institutions.

Practice was better with **RTU** patients. In a 40-patient study using the same method, 55% were seen consistently as planned – almost always at 30-day intervals – and 83% were consistently seen by that point or within an additional week.

Psychiatric care in crisis watch is discussed in Section 2 above. As for **inpatients**, IDOC reports that all Elgin patients see a psychiatric provider at least three times per week. The monitoring team did not review this practice, apart from noting the three-day follow-up plans indicated throughout Elgin's Psych Database.

As another source, IDOC's Quality Improvement system audited psychiatry practices, including whether appointments took place on the timeframe ordered by the provider. Auditors found that, in the 766 charts reviewed, 86% of the patients were seen according to the provider's expectations during the first quarter of 2021.[38] While the providers' plans may or may not be equivalent to constitutional standards, this is additional information to take into account.

A contact was counted as timely if it occurred within 30 days, even if the provider had ordered a return to clinic in a shorter period, because the Settlement Agreement only requires patients to be seen within 30 days (that is, the reviewer assessed whether the contact met the Settlement Agreement requirement, *not* whether the patient was seen within the time the psychiatric provider specified). If a provider ordered an appointment *more* than 30 days hence, the contact was counted as timely if completed within that time, and not exceeding 90 days. If a patient's series of contacts were timely or only one day late, that case was also counted as timely.

The monitoring team controls for the known difficulty of some contacts being displaced in the databases. For 117 of the patients, the reviewer cross-referenced a portion of the patient's health care record with the database information. Otherwise, where it was difficult to confidently discern the interval between two contacts, the contact in question was eliminated from this analysis. If there were not at least three contacts on which to make a judgment, the case was removed from the analysis; this may occur at some institutions more frequently than others, so the number of cases per institution is not always strictly proportionate to the caseload. Occasionally, where the patient was to be seen at extended intervals and it was not possible to have three contacts in the monitoring period, a case with two contacts was retained; it is unknown whether these cases would continue have a pattern of timeliness with a longer period of contacts reviewed.

[37] One patient had a verified gap in contact of 6.5 months, but every indication is that this is an anomaly. Apart from that, the longest times to appointment appeared approximately 2 months longer than planned.

[38] In a few cases, the auditor noted whether the contact was timely consistent with policy and Settlement Agreement mandates for medication changes; most, however, concerned the provider's return to clinic order. The audit tool entries do not expressly note the patient's level of care, and it is unknown whether all levels of care are represented.

It is a standard expectation that psychiatric contacts be confidential. The monitoring team reviewed 255 psychiatric contacts across different treatment programs. Health care records indicated that 78% of crisis watch contacts, and 83% from other programs, were held in confidential settings.[39]

Because these figures demonstrate that individual appointments can be kept timely, but that is not true on a consistent, sustained basis, it is the Monitor's opinion that this performance does not yet satisfy this Court's order.

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 persons in custody as prescribed.

Findings: The following is an excerpt from the Monitor's Fifth Annual Report regarding the provisions of this requirement. I repeat this information in this report as the situation hasn't changed since the end of May 2021: **"**From the Monitor's Fourth Annual Report forward, the monitoring team provided the following detail of typical components of 'reasonable efforts to ensure the medications are being taken by the persons in custody as prescribed': it is common for prisons to experience obstacles to patients receiving medication. These can include practices such as medications not being on formulary and being delayed in transmission to the facility; medications being restricted by policy and reasonable substitutes not being provided timely; delays between an order being written and nursing noting it, and/or the pharmacy filling the order; security staff preventing nursing staff from accessing housing units, or patients from attending the medication line; unreasonable and preventable disincentives such as distribution during normal sleeping hours or in conflict with essential activities such as meals, work, or school; nurses not consistently conducting directly observed therapy and patients thereafter "cheeking" and hoarding or selling medication; and medication errors. These are all potential impediments that IDOC must protect against, and staff must make a showing that these common obstacles are not affecting its medication delivery.

Prior to that writing, in early 2019, IDOC implemented practices intended to reduce "cheeking" and hoarding medication; the monitoring team has not seen studies about whether those practices resulted in improvements. The Monitoring Team was told there was a process study, through the Continuous Quality Improvement program, examining the length of time from a nurse receiving a medication order to the time the medication is dispensed. Defendants have not provided material demonstrating practice on these or any of the other aspects of medication distribution named above.

[39] Where the monitoring team pulled health care records for various purposes, those samples were aggregated for this review. This analysis drew from 109 patients' records, from 23 institutions, and from outpatient, RTU, and crisis care, though not in a proportionate fashion. It is unknown whether restrictive housing contacts were included.

Additionally, I am disappointed to note that several of the IDOC facilities with large numbers of class members persist with unacceptably early morning medication distribution times[40]. These include but are not limited to Graham, Logan, Menard, Pinckneyville, Pontiac, Vandalia and Western. The Quarterly Report of April 23, 2021, states "Adjusting the time of the med pass to appease the monitor would disrupt the movement throughout the facility for the entire day." I find this to be a very specious argument. Other IDOC facilities with large class member populations can offer much more reasonable morning medication distribution times without apparently disrupting "the movement throughout the facility for the entire day." These include, but are not limited to Big Muddy-7am, JTC-8am, Dixon-7:15am, Illinois River-6:30am and Stateville-NRC-8am.

These lingering early morning medication distribution times are a significant piece of the medication compliance puzzle. I am willing to consider this aspect resolved if IDOC can demonstrate, through conducting compliance rate studies, that these unacceptably early morning medication distribution times do not negatively affect psychotropic medication compliance.

This rating for this requirement will remain Noncompliant until IDOC demonstrates good practice on the issues outlined above."[41]

It is my opinion that these unacceptably early morning medication distribution times are done for the benefit of the staff as opposed to the class members. It is worth noting that where patients were interviewed at the early-distribution institutions during the monitoring period, most named the timing as a reason they are sometimes noncompliant with medications. Their medication administration records, and that of other patients, showed refusals of the morning dose only, which would tend to support their statements. The observed refusals tended to be intermittent, which undermines the effectiveness of medications that must build up to a therapeutic level, and the refusals would likely go without response because they fall short of the threshold of three consecutive days at which nursing is required to inform the mental health department.

This item will continue to receive a rating of noncompliance.

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

Findings: A review of 88 psychiatric progress notes from 15 different facilities[42] found 100% compliance with this requirement. IDOC's first quarter Quality Improvement studies of 766 patients on medication also showed 99.4% compliance. This provision is in substantial compliance.

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

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[40] These times range from 3:30 am through 5:30 am.

[41] Monitor's Fifth Annual Report, pages 33-34

[42] East Moline, Danville, Graham, Centralia, Kewanee, Robinson, Menard, Big Muddy, Pinckneyville, Lincoln, Joliet, Stateville-NRC, Stateville, Pontiac, and Decatur

Findings: The same 15-facility review found 100% compliance with this requirement, and the IDOC Quality Improvement studies found 99.4% compliance. This provision is in substantial compliance.

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

Findings: This monitoring team's same 15-facility review found 83% compliance with this requirement.[43]

(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: The Monitoring Team's same 15-facility review found 99% compliance with this requirement.[44]

(vi): That class members, including persons in custody 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: The Monitoring Team did not encounter a sufficient number of these types of cases to arrive at an opinion. A rating of "No Rating" will be assigned.

[43] In IDOC's Quality Improvement audits, there were double-digit findings of lab work not ordered. However, the audit method does not routinely record which patients were due for lab work, and the cases in which it was handled correctly, so it is not possible to put these findings into context.

[44] In IDOC's Quality Improvement audits, there were double-digit findings of lapses in the demonstration that informed consent took place. However, the audit method does not routinely record the cases in which an informed consent interaction would be expected during the quarter (as distinguished from those that had already taken place in previous contacts), and the cases in which it was handled correctly, so it is not possible to put these findings into context.

5: TREATMENT PLANS

Summary: All class members do not have a treatment plan that is individualized and particularized based on the patient's specific needs. This is due to the persistent backlog of treatment plans throughout the Department and the low completion rate of treatment plan reviews and updates when a class member is placed into restrictive housing. The treatment plans for class members assigned to the RTU and inpatient levels of care were much better than those for class members assigned to outpatient and restrictive housing levels of care. The Department still struggles to meet its requirements for completing mental health evaluations in a timely manner. Finally, the Department doesn't consistently review and update class members' treatment plans per the requirements set out in the Settlement Agreement, a reasonable time frame for this requirement.

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: To adequately discuss the Department's response to this requirement, a review of the treatment planning backlog for the reporting period is required. The following is a sampling of the actual number of treatment plans that have been backlogged from January through June 2021:

	total plans backlogged	plans backlogged greater than 14 days
1/15	273	152
2/12	225	149
3/12	401	282
4/16	210	149
5/14	262	148
6/12	302	222

These backlog numbers document that all class members do not have a current treatment plan. These backlog numbers represent less than 5% of the total mental health caseload. This fact is of little solace to those class members who do not have a written treatment plan which directs their mental health and psychiatric care. This is a very serious problem that warrants a rating of noncompliance.

To further evaluate the Department's response to this requirement, The Monitor reviewed 69 treatment plans from 10 different facilities[45]. This review included 23 outpatient plans, 13 RTU plans, 29 segregation plans and 4 inpatient plans.

[45] Centralia, Logan, Big Muddy, Pontiac, Dixon, Danville, Stateville, Elgin, Menard and NRC.

1. Outpatient plans: Of the 23 outpatient treatment plans reviewed, only two showed evidence of true multidisciplinary planning. These treatment plans were prepared by the QMHPs. A few of these plans omitted involvement by the psychiatrist and many of them were signed by the psychiatrist days or weeks after the date of preparation. The majority of these plans were not individualized to the patients' needs and were generic in nature.

2. RTU plans: Of the 13 RTU treatment plans reviewed, 9 showed evidence of true multidisciplinary planning. These RTU plans were much better than the outpatient plans in that they were more individualized to the patients' needs.

3. Segregation plans: As reported in 3(b), above, in an 11-facility review conducted by the Monitor,[46] only 59 of the 98 class member placements in segregation (60%) had evidence of a mental health professional reviewing and recommending any clinically necessary modifications to a class member's individual treatment plan within seven days of placement, a reasonable measure of timeliness set out in the Settlement Agreement.

   In addition, the Monitor reviewed 29 segregation treatment plans from 9 different facilities.[47] Of these 29 plans, 22 showed evidence of multidisciplinary planning. This multidisciplinary planning was based on the fact that the QMHP, psychiatric provider and patient all signed the plan on the same day. Upon closer scrutiny, however, it is clear to the Monitor that the QMHPs fill out the plan and the psychiatric provider merely signs the completed document. This opinion is based in part on the fact that the "Response to Medication section" was generally not completed. If these plans were truly completed in a multidisciplinary fashion, this section along with other references to medication would be prepared by the psychiatric practitioner. This was not the case. Also, these plans were very generic and not individualized to the patients' needs. For example, the charts reviewed listed meetings with the QMHP every 30-60 days for 15-30 minutes regardless of the diagnosis or clinical condition of the patient. Segregation rounds were routinely listed as a treatment intervention. Overall, these segregation plans were of poor quality.

4. Inpatient plans: These plans showed true multidisciplinary planning. They were individualized to meet the patients' needs. No problems noted with these inpatient plans.

Additionally, IDOC's Quality Improvement system reviewed 144 charts that contained 216 treatment plans created during the monitoring period. There were also indicia that auditors note where a treatment plan was due but appeared not to have been completed. Auditors recorded compliance with the elements of this order in 74% of the inpatient treatment plans and 82% of all other plans.[48] It is not clear whether all levels of care and treatment settings were included in this

[46] Danville, Centralia, Big Muddy, Pontiac, Stateville, Menard, Stateville-NRC, Sheridan, East Moline, Jacksonville and Taylorville.

[47] Centralia, Logan, Big Muddy, Pontiac, Dixon, Stateville, Menard and NRC.

[48] The monitoring team derived this from the completed audit tools. The auditing method includes selecting charts at random, as the term is used in everyday language; an entry without description signals a compliant document (for some responsibilities, other than treatment plans, it may indicate a compliant series of documents); and noncompliant documents are recorded with one or more entries showing predefined reasons for noncompliance. The monitoring team counted as noncompliant any findings about essential elements of a plan and multidisciplinary plan creation, but

study.

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.

Findings: The monitoring team reviewed 619 patients who had a need for an evaluation during the monitoring period.[49] Between 93% and 99% of the evaluations were completed,[50] but a large percentage were untimely.

The Settlement Agreement and IDOC policy call for evaluations to be completed within 14 days; this occurred in only 52% of the reviewed cases. It may be that the Court will employ a different timeframe to determine whether there was undue delay.

Another 16% of the sample was completed within one month of referral, double the Settlement Agreement's requirement.[51] Fully 31% took longer to complete; the *large majority of those were* ***one to five months later*** than the Settlement Agreement deadline. This was especially true where the need for evaluation arose in reception centers.[52] Where reception center prisoners transferred before an evaluation was conducted, receiving institutions did not appear to take the original referral date into account.

IDOC's Quality Improvement system also audited this responsibility. Reviewers noted 212 individuals with an evaluation in their health care records that was completed in the first quarter

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did *not* include noncompliance findings about late plans, clerical concerns, or other policy expectations. If there was more than one entry for a date, it was counted as one document, as the monitoring team is not aware of any situations in which more than one plan would be written in a day. If there was more than one entry showing different reasons of noncompliance for a given plan, it was counted as one noncompliant plan.

The IDOC sample included outpatient and RTU plans, and may have included crisis watch and restrictive housing plans, but this is unclear. It is not possible to determine whether those programs were proportionately represented within the sample. The expected frequency of inpatient plans is much higher, so they were analyzed separately so as not to skew the overall numbers. There was clear over- and underrepresentation of different institutions, in relation to their proportion of the system's caseload, so the collective compliance percentage may or may not be accurate.

[49] The auditor reviewed all cases that "MHP Databases" showed as referred and/or due during February 2021. This encompassed all institutions except Kewanee and Elgin, which showed no evaluations due that month. Most conclusions were drawn from the entries in the databases. Where an evaluation appeared not to have been completed, IDOC was given the opportunity to explain and provide documentation. Some cases were removed because an unintended effect of the database programming incorrectly showed an evaluation due when one had already been completed, and in a handful of cases where clear information could not be discerned. The remaining cases reviewed were a total of 619.

Among these, the reviewer tracked a large sample of those patients who came into a reception center but transferred to a parent facility before an initial evaluation was completed. Those cases require calculation combining information from the reception center database and the receiving institution database.

[50] Definitively, 1% of these evaluations were not completed. Databases do not record completion of another 6%; some or all of those may have been conducted, but those prisoners have paroled and IDOC does not provide archived records, so practice could not be verified.

[51] This is also a measure that IDOC employs in its backlog reports, determining whether a responsibility is overdue less than 14 days.

[52] Initial evaluations at Logan and Menard were generally timely. Evaluations at Stateville-NRC tended to be quite delayed, as were those at Graham, to a lesser extent.

of 2021. Reviewers audited according to a detailed "problem list," which guides them to check for good clinical practice, Settlement Agreement requirements for content and timelines, other policy requirements, and administrative accuracy and completeness. The method does not assess whether an evaluation should have been completed and is absent. The audit data showed 71% compliance for the content and timeliness of the evaluations.[53]

NRC has not been able to complete mental health evaluations by the standard set in the Settlement Agreement. During a site visit to NRC on March 11, 2021, staff informed me of a new effort to complete the mental health evaluations in a timely manner. They began reporting the backlog numbers on February 19, 2021. The NRC staff informed me that the mental health evaluation backlog numbers would be the best indicator of their new program's success. The following are the mental health evaluation backlog numbers from NRC for the period of February 19 through June 8, 2021:

2/19/21	402 backlogged evaluations	302 (75%) greater than 14 days late
3/19/21	384 backlogged evaluations	264 (69%) greater than 14 days late
4/16/21	171 backlogged evaluations	115 (67%) greater than 14 days late
5/21/21	86 backlogged evaluations	43 (50%) greater than 14 days late
6/8/21	74 backlogged evaluations	33 (45%) greater than 14 days late

Progress in eliminating the mental health evaluation backlog at NRC is being made. Of note, the numbers for July are as follows:

7/16/21	96 backlogged evaluations	42 (44%) greater than 14 days late

Based on the numbers reported, the Department in not in compliance with 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: There still remains a significant number of treatment plans that are backlogged. Please see 5(a), above, for details about this backlog of treatment plans. Also, as reported in 3(b), above, "In an 11-facility review conducted by the Monitor,[54] only 59 of the 98 class member placements in segregation (60%) had evidence of a mental health professional reviewing and recommending any clinically necessary modifications to a class member's individual treatment plan within seven days of placement."

[53] The *Rasho* monitoring team calculated this percentage using the Quality Improvement auditors' raw data, removing those cases that were outside the monitoring period, and counting as compliant any cases where the auditor found solely administrative violation(s).

[54] Danville, Centralia, Big Muddy, Pontiac, Stateville, Menard, Stateville-NRC, Sheridan, East Moline, Jacksonville and Taylorville.

Of note, while the IDOC Quality Improvement audits may be relevant to this provision, the presentation of findings lacks sufficient detail to be able to cite here. The findings do not indicate how many of the reviewed plans were updates, as opposed to initial plans. Reviewers note where the time to completion exceeds the deadlines in the Settlement Agreement; those may or may not be the measures the Court wishes to apply to determine whether the updates occur at regular intervals as clinically necessary, and the audit tools are not intended to capture how much time elapsed, the intervals, nor the match with clinical necessity, from which one could make a determination.

Based on these factors, the Department is not in compliance with the requirements of 5(c).

6. COMPLIANCE REQUIREMENTS

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

Findings: IDOC does distribute an extensive report quarterly. While it includes each institution certifying its compliance with the Court's orders, the certifications are broad statements without reference to the specific data, and sometimes essential details of the methods, that led to those conclusions. The Monitor and his team find that the bases for these conclusions are sometimes unclear, unsound, and/or at odds with Quality Improvement data.

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 Defendants' CQI Manager of whether compliance has been reached with Defendants' quality assurance audit requirements.

Findings: With each quarterly report, Defendants do provide summaries of the audit methods they have designed, as well as aggregate compliance numbers, derived from their Quality Improvement audits, for ten categories of service delivery. Most of the categories combine multiple Settlement Agreement requirements that are logically related. The summary tables do not specify a compliance percentage *per requirement* and do not indicate the number of health care records or documents on which each conclusion is based.[55]

While the summaries indicate that auditors assess compliance with the Settlement Agreement and the Permanent Injunction Orders, Defendants have noted that auditors are not generally tasked with assessing clinical judgment, and therefore have not separately assessed many of the elements of the Permanent Injunction Orders.[56] Rather, Defendants have asserted that the

[55] This is often much different from the number of charts reviewed, which *is* included in the audit method description. Some institutions have fewer restrictive housing patients, or fewer patients on crisis watch, than the standard number of charts pulled for an audit. More importantly, many requirements apply only to some patients (for example, medication nonadherence) or occur intermittently (as examples, an annual treatment plan update or a mental health evaluation on transfer between prisons), so they will not be present in every chart audited. It is thus important that audits indicate how many charts (or documents) underlie a finding on a requirement.

[56] That is, they have not directly assessed questions such as whether any treatment, less restrictive than crisis watch, is appropriate in the crisis watches reviewed; whether the crisis watches were employed for the shortest duration

frequency and type of contact necessarily reflects the treating staff's judgment that it was sufficient, and if care takes place in compliance with Settlement Agreement requirements, it also should be considered as satisfying the Permanent Injunction Orders.

Accompanying these summaries, the Statewide Mental Health Quality Improvement Manager certifies that compliance has been reached, at rates of 85% or better systemwide, as to all of the Permanent Injunction Orders. This threshold was chosen based on the recommendations of a national accreditation agency and is commonly, but not universally, used in US prison systems. In the monitoring team's experience, some systems choose different compliance percentages for different requirements, depending on a variety of factors. An across-the-board threshold of 85% has not been agreed upon as the standard in *Rasho.* While the monitoring team sees the Quality Improvement audits as very valuable, the team does not agree with several of the conclusions, as has been detailed in this report. IDOC also makes its audits available on request, which is an important contribution to the oversight of implementation. IDOC also requires and oversees corrective action plans for issues that do not meet its standards, whether they stem from court-ordered requirements, policy, or documentation or other expectations.

6(c): Specific Requirement: 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: The Monitor's reviews are documented in the reports submitted in July 2019, January 2020, July 2020, January 2021, and the instant report.

6(d): Nothing in this Order relieves the Defendants of their obligations under the Settlement Agreement.

Findings: The Monitor and parties acknowledge this and have taken it into account when delivering and monitoring mental health services.

possible; whether crisis watches provided appropriate mental health treatment to stabilize the symptoms and protect against decompensation; whether reevaluations of treatment and medication occurred as needed in crisis watch; whether necessary interventions to stabilize individuals occurred in crisis watch; whether clinicians determined if the crisis watch patients were moving towards stability, and whether other or additional treatments were indicated; whether out of cell activities were contraindicated for reviewed crisis watch patients; whether structured and unstructured out of cell time offered in restrictive housing was sufficient to protect against class members' decompensation, and whether out of cell time was clinically contraindicated for any of the reviewed patients; whether mental health staff assessed class members in Control Units to determine if a higher level of care was necessary and if so, made proper recommendations to a facility authority; whether treatment in restrictive housing by mental health professionals and/or psychiatry was provided to the extent clinically indicated; whether, in general, psychiatry provided service at regular intervals consistent with constitutional standards; whether IDOC administered medications to all class members in a manner that provided reasonable assurance that prescribed psychotropic medications were actually delivered to, and taken by, the persons in custody as prescribed (this also is not assessed as part of the Settlement Agreement reviews); and whether treatment plans were reviewed and updated as clinically necessary, assessed the progress toward the documented treatment goals, and made necessary adjustments.

CONCLUSIONS: The Department is once again unable to meet the requirements of the Court's orders. The overwhelming cause of this lack of performance, in the opinion of the Monitor, is lack of adequate clinical and custody staff. Until this vexing problem is addressed, the Department will unfortunately fall short of its responsibilities to the Rasho class members.

Respectfully submitted,

/s/ Pablo Stewart, M.D.

Pablo Stewart, M.D.
Rasho Monitor
July 30, 2021