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JHA's Summary and Guide to IDOC's Mental Health Settlement in *Rasho*

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The John Howard Association of Illinois (JHA) independently monitors policies and practices within the Illinois Department of Corrections (IDOC). In May 2016, a settlement agreement was reached in the ongoing litigation, *Rasho v. Baldwin* (*Rasho*),[1] a case brought in response to allegations of inadequate mental health treatment for IDOC inmates. This memo distills the complexities of the 32-page *Rasho* settlement agreement (the Agreement) into more understandable terms and clarifies the timelines for implementing certain changes so that the public has the information needed to understand IDOC's responsibilities under the Agreement's terms.[2] JHA believes the Agreement will bring about beneficial changes, but there are ongoing challenges to its implementation as well. We believe educating legislators, state agency leaders, stakeholders, and the public on successes and challenges under the Agreement is critical to achieve lasting change and ensuring public accountability.

MOST NOTABLE IMPROVEMENTS

1. Recognizing the need to improve mental health care, setting new standards to improve the quality of care, and beginning necessary staff trainings
2. Mandating minimum out-of-cell time for inmates identified as having a mental illness
3. Requiring an agreement with Department of Human Services (DHS) to provide inpatient level of care services for inmates in DHS treatment facilities
4. Requiring input from mental health professionals in disciplinary decisions
5. Hiring a specialized court-appointed mental health Monitor to oversee compliance with the Agreement

[1] *Rasho v. Baldwin*, 07-cv-1298 (C.D. Ill., Judge Mihm).

[2] The *Rasho* May 20, 2016 Amended Settlement Agreement is organized into sections detailing requirements for mental health care provisions including: III. General Provisions, IV. Initial (Intake) Mental Health Services: Screening, V. Mental Health Evaluation and Referrals, VI. Mental Health Services Orientation, VII. Treatment Plan and Continuing Review, VIII. Transition of Offenders from Specialized Treatment Settings, IX. Additional Mental Health Staff, X. Bed/Treatment Space, XI. Administrative Staffing, XII. Medication, XIII. Offender Forced Medication, XIV. Housing Assignments, XV. Segregation, XVI. Suicide Prevention, XVII. Physical Restraints for Mental Health Purposes, XVIII. Medical Records, XIX. Confidentiality, XX. Change of SMI Designation, XXI. Staff Training, XXII. Participation in Prison Programs, XXIII. Transfer of Seriously Mentally Ill Offenders from Facility-to-Facility, XXIV. Use of Force and Verbal Abuse, XXV. Discipline of Seriously Mentally Ill Offenders, XXVI. Continuing Quality Improvement Programs (CQI), and XXVII. Monitoring. For more on the Agreement's explicit provisions and current required timeframes for implementation, see the Appendix. Note that these timeframes are subject to change.

SIGNIFICANT ONGOING CHALLENGES

1. Lack of budget and appropriations
2. Ability to hire and retain required licensed Mental Health Professionals
3. Ability to improve record keeping/continuity of care due to limitations of existing system capacity
4. Creating consistency for uniform application and expectations around changes to rules and timely implementation of changes where necessary resources are not yet in place
5. Prisons remain largely unsuitable environments for the provision of therapeutic care and mental health interventions are still primarily crisis-oriented

REVISING POLICY AND PRACTICE

Defining "Serious Mental Illness" (SMI) and Standardizing Associated Procedures

Provisions for improving mental health care and accommodations within IDOC—and related changes to staff hiring, prison construction, inmate screening, referrals, confidentiality, education, continuity of care, and documentation processes—are all required under the *Rasho* Agreement. IDOC represents they have already made progress with:

> implementation of a definition of serious mental illness (SMI);[3] development of an evaluation and referral process; increased staffing of licensed mental health professionals [MHPs] and behavioral technicians; construction and space retrofits to create four (4) residential treatment units [RTUs]; revised mental health protocols and policies including incorporation of clinical mental health input into disciplinary system; central committee review of SMI inmates who are segregated more than sixty (60) days; and enhanced

[3] In short, to be categorized as "SMI" an inmate must have a combination of diagnosis or significant signs and symptoms of a mental disorder, and an impaired level of functioning as determined by an IDOC MHP. Key terms are set forth in the Agreement's Definitions section, p. 3-6, and some of the definitions are quite lengthy and painstakingly detailed. For example the term "SMI" is defined at p. 5 in the following paragraph; "an IDOC offender is "seriously mentally ill" ("SMI") if he or she, as a result of a mental disorder as defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders ("DSM") of the American Psychiatric Association, exhibits impaired emotional, cognitive, or behavioral functioning that interferes seriously with his or her ability to function adequately except with supportive treatment or services. These individuals also must either currently have, or have had within the past year, a diagnosed mental disorder, or must currently exhibit significant signs and symptoms of a mental disorder. A diagnosis of alcoholism or drug addiction, of developmental disorders, or of any form of sexual disorder shall not, by itself, render an individual seriously mentally ill. The combination of either a diagnosis or significant signs and symptoms of a mental disorder and an impaired level of functioning, as outlines above, is necessary for one to be considered seriously mentally ill. Whether a person meets the criteria of seriously mentally ill is initially determined by a comprehensive, professional clinical assessment by an IDOC Mental Health Professional in order to 1) determine if the individual has a diagnosable mental disorder as defined by the current DSM and 2) to establish the person's overall level of functioning. The appropriate threshold to establish level of functioning that equates to a serious mental illness includes serious impairments in capacity to recognize reality, in work environments, school or learning environments, frequent problems with authority/rules, occasional combative behavior, serious impairments in relationships with friends and family, serious impairments in judgment, thinking, and mood, and serious impairment due to anxiety. These aforementioned disturbances must be observed in at least one of the areas listed above."

> clinical contacts, programming and out-cell-time for the most seriously mentally ill offenders.[4]

Over the past few years, JHA has observed IDOC facilities struggle with understanding and adopting the SMI definition and changing practices. Recently, however, we have observed some improvements at several facilities and an encouraging increased uniformity of practice within the agency. JHA expects improvements to continue as the May 2016 Agreement is implemented and the new court-appointed *Rasho* Monitor, as well as new hires at the agency and facility levels, begin their work. JHA had the opportunity to observe a newly required two-day staff training presented by IDOC in partnership with the National Alliance on Mental Illness (NAMI). The training, which is described as "Mental Health 101," was rolled out earlier this year, and all IDOC staff are expected to complete it by the end of 2016. As of the end of July 2016, nearly 7,600 IDOC staff have been through this course. Some staff shared that it was a positive experience for them and provided training that they had not been exposed to before. Additional tangible benefits that have resulted from recently instituted changes include greater provision of mental health services and group treatment, additional space for treatment, and some SMI individuals leaving restrictive housing settings after periods of years.

On July 1, 2016, IDOC filed notice of requested rule changes that, in part, incorporate changes from the *Rasho* litigation into the Administrative Code.[5] Generally the proposed rule changes represent improvements not just for inmates affected by the *Rasho* settlement, but also for all others. JHA continues to believe that the *Rasho* changes present a new floor in Illinois for minimum practices, while national best practices have and continue to evolve to provide clarity and even greater protections for inmates in restrictive housing, particularly those who are considered to be vulnerable.[6] While we recognize that Illinois faces many challenges relating to staffing, physical plant, and budget that will make providing even greater out-of-cell time and treatment difficult, it is important that IDOC strive with best practice ideals in mind.

IDOC's proposed rule changes based on *Rasho* include defining SMI, requiring consideration of SMI status as a factor for determining disciplinary sanctions, requiring that SMI inmates be reviewed by a mental health professional (MHP) within 48 hours when placed in segregation or investigation status, requiring that a MHP's recommendation be considered in a determination of continued segregation placement, and requiring a MHP to conduct rounds every seven days in segregation.[7] JHA believes the better practice would be to institute a uniform rule requiring a mental health review of *any* inmate placed in segregation, have this review occur within a shorter timeframe, and require more frequent rounds by mental health staff, and, ideally, generally cease

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[4] Agreement, p. 2.

[5] *See* Illinois Register, Vol. 40, Issue 27, Pages 8,628-8,879 (July 1, 2016), http://www.cyberdriveillinois.com/departments/index/register/register_volume40_issue27.pdf.

[6] *See e.g.* the Department of Justice's (DOJ) January 2016 *Guiding Principles for use of Restrictive Housing*, (Guiding Principles), https://www.justice.gov/dag/file/815556/download.

[7] Note that the Agreement requires that a mental health professional review "any mentally ill offender," not just offenders already designated as SMI, within 48 hours of a restrictive placement. Thus, IDOC's proposed rule change seems to create a rebuttable presumption that any inmate identified as mentally ill also will demonstrate the necessary impaired level of functioning to be classified as SMI if they find themselves in a restrictive status. Several of the Agreement's provisions are similarly unclear regarding their application. Oversight and guidance by the Monitor should help to facilitate greater clarity and uniformity in the application of the new rules at facilities.

housing SMI inmates in restrictive settings, as this would comport with best practice.[8] Importantly, these proposed rule changes would also make crucial changes to eliminate the use of segregation as a sanction for minor disciplinary offenses (or "tickets") for all inmates, as JHA and other advocacy groups have recommended for years.[9]

The Agreement makes explicit that IDOC shall not bar an inmate from participating in programs based on illness or taking psychotropic medication, unless counter-indicated by a MHP.[10] JHA has consistently criticized blanket policies barring inmate participation in certain programs solely based on their mental health treatment because this runs afoul of the Americans with Disabilities Act (ADA). Individualized determinations of eligibility for programs are needed to prevent unfair discrimination. Further, the Agreement states that all inmates on the mental health caseload must have treatment plans[11] that continue even if the inmate is in restrictive housing.[12] Additionally, under the terms of the Agreement, MHPs must be given notice regarding any housing changes for individuals on their caseload and alert security staff if they have concerns regarding housing assignments. Further, where security staff reject an MHP's housing recommendation for SMI individuals in treatment or restrictive housing settings, the reason must be documented.[13]

Another improvement is a provision of the Agreement that requires IDOC to develop, within 18 months of the settlement approval date, a method for non-staff, third-party sources (including other inmates or family members) to refer inmates for mental health evaluation and to keep records related to this.[14] JHA is frequently contacted by family members with concerns about

[8] *See e.g.* DOJ Guiding Principles, https://www.justice.gov/dag/file/815556/download (stating "Generally, inmates with serious mental illness (SMI) should not be placed in restrictive housing," with some limited exceptions (p. 6-8), and setting out other standards regarding restrictive housing that provide greater protection for all inmates).

[9] One aspect of the *Rasho* Agreement required that segregation terms for minor disciplinary incidents, classified as 300 or 400 level tickets, be thrown out for SMI inmates. Agreement, XV, p. 18. This created an unfair disparity in that inmates classified as SMI did not have to serve segregation terms for minor offenses, while other non-SMI inmates did, generating confusion and resentment in facilities, as well as a perceived incentive to being labeled SMI. This proposed rule change would correct this inequity and bring IDOC more in line with national best practices of reserving segregation for all offenders for serious offenses. In 2011, the Vera Institute of Justice published a study, *Quantitative Findings on Use and Outcomes of Segregation in IL DOC*, which found in IDOC only 15 percent of violations resulting in segregation time were for "major" tickets, or 100 or 200 series violations. See IDOC January 30, 2012 Advisory Board Minutes, https://www2.illinois.gov/idoc/aboutus/advisoryboard/Pages/default.aspx.

[10] Agreement XXII., p. 24.

[11] Agreement, VII., p. 9-10.

[12] For example, the Agreement at XV., p. 17-20, states that IDOC shall ensure that mentally ill offenders in AD, disciplinary segregation, or investigative status/temporary confinement *for more than 16 days* receive: (1) Continuation of their Individual Treatment Plan (ITP) with enhanced therapy as necessary to protect from decompensation, (2) Rounds minimally every seven days by MHP documented on Form 380, (3) Pharmacological treatment if applicable, (4) supportive counseling by an MHP as indicated in the ITP, (5) Participation in multidisciplinary teaming meetings once established, (6) MHP or treatment team recommendation for post-segregation housing, (7) Documentation of clinical contacts in the medical record, and (8) Weekly unstructured out-of-cell time equal or greater than the normal segregation time as indicated by the ITP, which if refused, shall be documented.

[13] Agreement, XIV., p. 16. For example, if a MHP recommends moving an inmate from segregation to a crisis cell or RTU, any non-compliance with this recommendation must be documented and justified as to why security concerns are of sufficient magnitude to overrule the MHP's professional judgment. Agreement, XV., p. 18.

[14] Agreement, V.(e), p. 8.

loved ones' mental health deterioration. Having a means for such concerns to uniformly trigger a mental health response at facilities will be beneficial.[15]

JHA applauds all of this progress, but also recognizes there are ongoing concerns and challenges in implementing reforms safely and fairly in over-populated, under-resourced environments.

Housing and Out-of-Cell Time

The Agreement stipulates that, within the three months from the settlement approval date, IDOC will enter into an intergovernmental agreement with the Department of Human Services (DHS) to provide bed space for a total of 22 male and 22 female inmates who require an inpatient level of care in DHS treatment facilities. However, the agreement notes that "[t]he necessary funding to complete this construction is dependent upon additional appropriations," so the actual availability of bedspace under the intergovernmental agreement is contingent on budget and may be rolled out over years.[16]

IDOC is also required by the Agreement to build more Residential Treatment Units (RTU) bedspace, again contingent on appropriations. Importantly, IDOC has also been required to remove all crisis cells from segregation units.[17] The counter-therapeutic environment inherent in such settings, the questionable practice of housing those in acute mental distress proximate to inmates with disciplinary/acting out issues, and fact that these units can be very high-stress environments has been frequently noted.

Ultimately, after a budget is passed and construction is completed, IDOC will have approximately 1,150 male RTU beds available and 108 RTU beds for women.[18] Notably, under the terms of the Agreement, inmates in RTUs must receive at least 10 hours out-of-cell structured treatment and 10 hours out-of-cell unstructured time a week. This new mandate works out to, on average, a little less than three hours out-of-cell activity a day over seven days.

Pursuant to the Agreement, IDOC has been reviewing SMI inmates in segregation status and reducing the length of their segregation terms based on changes to disciplinary practices negotiated under the *Rasho* litigation. In addition, input from mental health professionals now will be considered by IDOC in disciplinary decisions. For mentally ill inmates[19] still housed in Control Unit[20] settings out-of-cell time will be incrementally increased.[21]

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[15] While some facilities are already good at recognizing that such input is valuable from a safety and security and facility management perspective, others may be less inclined to be responsive to this input coming from non-professionals absent an official policy requiring particular handling as called for in the Agreement.

[16] Agreement, X.(e), p. 13.

[17] Pontiac is not required to comply with this requirement until a year after the settlement period. Agreement, p. 13.

[18] Agreement, X.(b), p. 12.

[19] Agreement, p. 4, "Mentally Ill Offenders: Persons now or in the future in the custody of IDOC who are identified or should have been identified by the IDOC's mental health professionals as in need of mental health treatment as defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. A diagnosis of alcoholism, drug addiction, developmental disorders, or any form of sexual disorder shall not, by itself, render an individual mentally ill for the purpose of this class definition."

[20] Agreement, p. 3, "Control (or segregation) Unit: An area within a correctional facility for housing offenders on segregation status. Segregation status included temporary confinement pending a disciplinary hearing or investigation, disciplinary segregation resulting from a hearing or investigation, and Administrative Detention.

Currently, agency rules mandate only a minimum of five hours out-of-cell time per week for inmates in segregation status.[22] Under the provisions of the Agreement, out-of-cell time for mentally ill inmates housed in a Control Unit *for longer than 60 days* will be increased. By 2019, IDOC must have procedures in place to ensure that mentally ill inmates who are in Control Unit settings or segregation for more than 60 days have a minimum of 20 hours out-of-cell time each week. The Agreement currently dictates that mentally ill inmates in Control Units must be provided with four hours of structured out-of-cell time and four hours of unstructured time out-of-cell time weekly (for a total of eight hours). Thus, the Agreement essentially grants IDOC a grace period of several years to meet the 20 hour out-of-cell time requirement, during which out-of-cell time will be increased by two hours each year.[23] However, IDOC could implement this requirement sooner or provide all inmates with more out-of-cell time than the minimums under the Agreement. JHA has repeatedly advised that IDOC should use *Rasho* as an opportunity to make necessary increases to out-of-cell time for all inmates.

Staffing

The requirements of the Agreement cannot be met without adequate staffing. The importance of increasing the amount of staff and staff training are critical elements to the success of this Agreement. Mental health professionals will now have considerably more influence over the housing and treatment decisions for inmates under their care. However, JHA has serious concerns regarding IDOC's ability to fill required mental health positions. For the most part, the Agreement requires that MHPs be licensed in Illinois. This reduces the pool of eligible job candidates, as licensure requires significant on-the-job supervised experiential learning hours.[24]

Wexford Health Services (Wexford), the private company contracted to provide the majority of mental health services within IDOC, had numerous job openings at facilities for MHPs, as of the time of drafting this report. These job openings included at least 63 mental health positions

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Segregation status does not include offenders in protective custody. Segregation areas include the segregation unit or any cell, living area, or other area designated by the Chief Administrative Officer to house offenders who are in segregation status."

[21] Agreement, p. 4, "Mentally Ill Offenders: Persons now or in the future in the custody of IDOC who are identified or should have been identified by the IDOC's mental health professionals as in need of mental health treatment as defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. A diagnosis of alcoholism, drug addiction, developmental disorders, or any form of sexual disorder shall not, by itself, render an individual mentally ill for the purpose of this class definition."

[22] IDOC submitted proposed rule changes in July 2016 making the minimum five hours of weekly recreation time for recreation apply from the outset of segregation place, instead of the current practice where this minimum only applies after a stay of more than 90daysin segregation, and the current policy mandates that for inmates in segregation for less than 90 days to recreate outside their cells for a minimum of one hour a week. 20 Ill. Admin. Code 504.670, Recreation for Persons in Segregation Status.

[23] Agreement, XV. (c), p. 20.

[24] Under the Agreement, to be a MHP an individual must be licensed in Illinois and must be licensed as a physician (who is licensed to practice medicine and is board-certified in psychiatry by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Psychiatry and Neurology, or has completed four years of an accredited post-graduate training program in psychiatry), a clinical psychologist (with Ph.D./Psy.D.), a psychiatric nurse, a clinical social worker, or a mental health service provider (with at minimum a master's degree in psychology, counseling, social work, or similar degree program).

requiring licensure. In addition, 27 job openings were listed for behavioral health technicians to assist licensed MHPs.[25] Behavioral health technicians do not require licensure, but must possess a Bachelor's degree in psychology, social work or a related field. JHA again encourages IDOC to minimally increase recruitment efforts within Illinois mental health professional programs, offering greater internship and other shadowing opportunities to individuals who may be interested in working in State corrections. JHA has observed, as with many areas for new hires,[26] IDOC has not been able to review and accept professional student interns in a timely fashion, resulting in them accepting other placements. Additionally, attrition of potential supervising mental health professional staff and turnover at all levels at facilities has impeded successful onsite student training programs. Having more dedicated agency mental health administrative staff, as required under *Rasho*, could help to facilitate field placements and put in place a more solid program. As set out below, the court-appointed Monitor to be employed by IDOC under *Rasho* is also charged with advising IDOC on how to meet staffing goals.

Additionally, for mental health services to be adequately provided in secured settings, security staff levels must be maintained at levels sufficient to ensure inmate movement occurs, for example escorting an inmate to an interview area to meet with a MHP with appropriate privacy and security, and to maintain safety. Effective training for new procedures is also critical to uphold inmates' rights, set proper expectations, create staff buy-in, and keep everyone safer. Best practices for ensuring appropriate inmate treatment as well as facility security, include security staff being made aware of the requirements of appropriate mental health treatment response, and mental health staff must be trained to understand the security needs and responsibilities of the facility.

Monitoring Required by the Agreement

The Agreement sets out specific requirements relating to documentation and timelines for the provision of mental health care. Thus, the court-appointed Monitor, and facility administrators and staff have the benefit of clear standards for evaluating performance and compliance with the Agreement, and conducting quality improvement reviews and audits.[27] The Monitor agreed upon by the parties and named by the Court to evaluate compliance with the Agreement and report to the Court is Dr. Pablo Stewart, a physician who is licensed in California, specializing in clinical and forensic psychiatry, and is an experienced expert in correctional litigation.[28] During the first two years of the Agreement, IDOC is expected to prepare quarterly reports based on the

[25] *See* http://www.wexfordhealth.com/Careers, visited July 4, 2016.

[26] *See e.g.*, JHA's 2015 report, *State Hiring Practices and Illinois' Corrections: A Complex Problem in Need of Straightforward Solutions*, http://thejha.org/sites/default/files/State%20Hiring%20Practices%20and%20Illinois'%20Corrections.pdf

[27] For example, all inmates receiving any ongoing mental health services must have a mental health treatment plan that states the goals, frequency and duration of intervention/treatment activities and the staff responsible. This plan must be reviewed annually or more frequently when clinically indicated. Additionally, inmates on psychotropics generally shall be evaluated by a psychiatrist every 30 days. However, the length of time between evaluations may be extended to 90 days for inmates who are stable and receiving outpatient level services, and 60 days for inmates in residential treatment unit care who are stable.

[28] A January 2013 version of Dr. Stewart's CV is available in a court filing for Coleman v. Brown, (90-cv-520, E.D. Ca., March 14, 2013), Document 4381, Expert Declaration of Pablo Stewart, M.D., Exhibit A, p. 252-273, http://rbgg.com/wp-content/uploads/Coleman-Decl-of-Stewart-in-Opposition-to-Motion-to-Terminate-Dkt-4381-3-14-2.pdf. The Agreement's provision regarding Monitoring are set out in section XXVII, p. 25-28.

Monitor's requests for specific data relevant to the Agreement, and twice-yearly reports thereafter. Also, the Monitor will have unfettered access during announced facility visits, where at least 48 hours' notice is given to IDOC's legal office. Onsite monitoring visits are limited to five days, four times a year, unless otherwise approved.[29] The Agreement also requires that IDOC give quarterly progress reports on hiring to the Monitor to determine if staffing targets are being met and to propose "reasonable techniques to achieve hiring goals."[30] Where hiring targets are not met, the parties may negotiate for time extensions.[31] While Plaintiffs' counsel will have confidential access to materials given to the Monitor, the Agreement does not explicitly provide for IDOC's reports to be made publicly available. While some information is rightly privileged to protect patients' confidentiality,[32] generally JHA believes that increased transparency over agency practices and compliance with litigation would be appropriate.

Importantly, the newly-hired *Rasho* Monitor will likely be recommending further changes, as is within his authority under the Agreement. For example, the Monitor is given specific authority to recommend changes to standard forms, staffing levels, architectural plans, etc.[33] JHA believes such input is essential and should begin as quickly as possible. The Monitor will submit annual reports to the Federal Court.

Costs and Budget

The costs of implementing the settlement are estimated at $40 million for prison construction, and an additional $40 million annually to pay for increased mental health and security staff. The maximum fees recoverable by plaintiffs' attorneys cannot exceed $6 million, and the unspecified costs of ongoing monitoring of the Agreement's implementation are to be negotiated between the *Rasho* Monitor and IDOC. From a taxpayer perspective, IDOC's adherence to the terms of the Agreement furthers the public interest by limiting the State's liability for attorney fees, which increase exponentially the longer litigation persists. For example, between 1997 and 2009, California taxpayers incurred more than $38 million debt for plaintiffs' attorneys' fees and legal costs in the ongoing litigation over unconstitutional prison conditions in *Brown v. Plata* (*Plata*).[34] The ultimate outcome of *Plata* was that the United States Supreme Court ordered

[29] Agreement, p. 25, provides that "The Monitor may retain such appropriate staff with the approval of IDOC including clinical and administrative experts as are necessary to conduct the requisite monitoring. IDOC agrees to pay for all agreed upon costs associated with said monitoring pursuant to a reasonable budget to be agreed upon by and between the IDOC and the Monitor." Plaintiffs' counsel are also permitted to visit areas of facilities where mentally ill prisoners are housed and treated. p. 28.

[30] As detailed in JHA's 2015 report, time-consuming procedures and inefficient practices in state hiring can frustrate IDOC efforts to timely fill staff vacancies. See *State Hiring Practices and Illinois' Corrections: A Complex Problem in Need of Straightforward Solutions*, http://thejha.org/sites/default/files/State%20Hiring%20Practices%20and%20Illinois'%20Corrections.pdf.

[31] Agreement, p. 11-12.

[32] For example, the Plaintiffs' Expert report filed in this case remains under a court-ordered seal. JHA believes it is important for the public to appreciate what the Expert observed to gauge future progress and that the document could likely be appropriately redacted to remove identifying inmate information.

[33] Agreement, p. 14. Construction has already begun in some areas. Thoughtful planning and consideration of how architectural design impacts mental health and the delivery of services is critical to fulfilling the goals of the Agreement. For example, after construction of one RTU unit at Logan was completed the design in the next unit was modified so that cell windows were realigned to allow better visual access to the sky and trees for therapeutic purposes, this was not taken into consideration prior to construction the first RTU unit at this facility.

[34] *See* Heather MacDonald, "*California's Prison-Litigation Nightmare*" City Journal Magazine (Autumn 2013),

California to make a population reduction requiring the release of about 40,000 inmates (at that time the California prison population was approximately 150,000). Illinois could still avoid paying significantly more later by immediately making some needed costly changes.

The reality is that the more crowded facilities are, the harder it will be to meet terms of settlement. JHA strongly urges Illinois to focus on immediately reducing the population of the adult prison system, so that staffing set under the Agreement and realties of filling positions could more closely, and quickly, align appropriately with population and treatment need. To reduce population, there are still many relatively simple steps that could be taken at the Agency, Legislative, and Executive levels in our state, as well as other steps that may be more challenging.[35] Some of these changes would not release large numbers of inmates, but could make significant facility management differences, for example, an effective compassionate or medical release program could let out inmates who are difficult for staff to manage and do not pose a threat to others, particularly where loved ones are prepared to care for this individual instead of continuing to add up costs of staff time and medical care on top of the inevitable costs Illinois will continue to pay for the tolls of mass incarceration.[36] Notably after California was ordered to reduce the prison population, violence crime did not increase.[37]

IDOC's ability to implement necessary changes to meet minimum constitutional standards of care ultimately depends on the Legislature and Governor appropriating sufficient funds to implement the terms of the Agreement. If the Legislature and the Governor fail to approve adequate funding, the Agreement is effectively rendered a nullity. Therefore, it is imperative that the Legislature and Governor work cooperatively to fund necessary changes under the Agreement to avoid the costs of prolonged litigation and to reduce harm to prisoners.

It remains unclear what effects the Governor and Legislature's recent stop-gap budget will have on the rollout of mental health improvements within IDOC. Many of the important provisions within the Agreement have a "Budget Contingent Approval Date" meaning they have a timeline triggered by the date the State of Illinois passes a budget.[38] IDOC appears committed to moving forward with changes whenever there are funds allocated, and there are mechanisms within the Agreement that allow for modification if significant time elapses. JHA will continue to independently monitor these developments under the settlement and advocate for more fair and humane treatment in the criminal justice system.

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http://www.city-journal.org/html/california%E2%80%99s-prison-litigation-nightmare-13604.html.

[35] The Illinois State Commission on Criminal Justice and Sentencing Reform has been working on this issue with the goal of reducing the Illinois prison population 25% over ten years; they have issued several recommendations, *see* http://www.icjia.state.il.us/cjreform2015/index.html.

[36] While not part of the Agreement, JHA again encourages IDOC to make better use of available tools for low-risk inmates such as maximizing use of Supplemental Sentencing Credits to the extent permissible under the law and to publicly report the number of inmates effected by utilizing this program more fully.

[37] *See e.g.*, https://www.washingtonpost.com/news/true-crime/wp/2016/05/18/mass-release-of-california-prisoners-didnt-cause-rise-in-crime-two-studies-find/.

[38] Agreement, Definitions, p. 3.

This report was written by JHA staff. Media inquiries should be directed to JHA's Executive Director, Jennifer Vollen Katz, at (312) 291-9555 or jvollen@thejha.org.

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Since 1901, JHA has provided public oversight of Illinois' juvenile and adult correctional facilities. Every year, JHA staff and trained volunteers inspect prisons, jails and detention centers throughout the state. Based on these inspections, JHA regularly issues reports that are instrumental in improving prison conditions.

JHA's work on healthcare in IDOC is made possible through a generous grant by the Michael Reese Health Trust.

APPENDIX

PLEASE NOTE THE BELOW DETAILS ARE SUBJECT TO CHANGE.

Budget Contingent Dates

Importantly, for all budget contingent dates, after engaging in dispute resolution as set out in the Agreement, Plaintiffs may ask that the Court intervene if a necessary appropriation is not made within 15 months of the start of Fiscal Year 2016 (*i.e*. by October 2016) and within six months of the start of subsequent fiscal years. The Court's jurisdiction will end three years after the budget contingent approval date or if the Court finds Defendants to not be in substantial compliance, for two years subsequent to that finding. Agreement, p. 29-30.

Within six months of there being a budget

- Dixon and Logan have hired to levels set out in the Approved Remedial Plan (or modification of this staffing plan if put forth and approved). IX., p. 11.
- Dixon has RTU space for approximately 625 men. X., p. 12.
- Logan has RTU bed and programming space for 80 women. X., p. 13.

Within nine months of there being a budget

- IDOC shall complete construction and improvements to make at least 22 beds for female inmates available within an existing DHS facility. X., p. 13.

Within a year of there being a budget

- Pontiac has hired to levels set out in the Approved Remedial Plan (or modification of this staffing plan if put forth and approved). IX., p. 11.
- Dixon and Logan have additional treatment and administrative office space. X., p. 12.
- Pontiac has RTU bed and programming space for 169 men. X., p. 12.
- Logan has RTU bed and programming space for an additional 28 women. X., p. 13.
- A MHP shall review a mentally ill inmate placed in Investigatory Status/Temporary Confinement within 48 hours with documentation. XV., p. 19.

Within 15 months of there being a budget

- Joliet has RTU space for 360 men. X., p. 12.

Within 16 months of there being a budget

- IDOC shall complete construction and improvements to make at least 22 beds for male inmates available within an existing DHS facility. X., p. 13.

Within 18 months of there being a budget

- Pontiac has additional treatment and administrative office space. X., p. 14.

Within 21 months of there being a budget

- Joliet has additional treatment and administrative office space. X., p. 14.[39]

Non-Budget Contingent Dates

As of the approval date of the settlement agreement, May 23, 2016

- Any SMI inmates with 60 days of remaining segregation time as of the approval date of the settlement agreement will be reviewed by a Review Committee comprised of attorneys, security

[39] Note: for any RTU or outpatient treatment location other than the four specified above (Dixon, Logan, Joliet, and Pontiac), there is a provision in the Agreement contemplating that modifications may be determined needed, however, the timeframe is unclear. X., p. 14.

professionals, and MHPs.[40] The Warden has authority to reduce segregation time as recommended by the Committee. XV., 18-19.

- Mentally ill inmates in a Control Unit setting longer than 60 days receive minimally four hours structured out-of-cell time and four hours unstructured out-of-cell time a week (eight hours total). XV., 20.

Within 30 days of approval of the settlement agreement, June 23, 2016

- IDOC will have hired two regional directors who are licensed psychologists or psychiatrists to assist the Chief of Mental Health Services. XI., p. 14.
- IDOC will have designated at least one qualified state employee (PSA-8K, Clinical Psychologist, Social Worker IV or appropriately licensed MHP) at each facility to provide supervision and assessment of staff involved in delivery of mental health services. If the state employee leaves, an interim designee may be vendor staff. XI., p. 14.

Within 60 days of approval of the settlement agreement, July 23, 2016

- IDOC shall fully implement the use of the standardized forms. XVIII., p. 21.
- IDOC shall ensure informed consent policy is followed and ensure that the MHPs who have a treatment relationship with an inmate disclose the following to the inmate before proceeding: the professional's position and agency, the purpose of the meeting, the uses to which information may be put, and shall "indicate a willingness to explain the potential risks associated with the offender's disclosures." XIX., p. 22.

Within 90 days of approval of the settlement agreement, August 23, 2016

- Defendants may propose an amended staffing plan, which Plaintiffs and Monitor will have 45 days to review, to be resolved through the dispute resolution process. IX., p. 11.
- IDOC shall enter an intergovernmental agreement with DHS to secure 22 beds for female and 22 beds for male inmates in an existing mental health facility – however, although the agreement is due within 3 months, implementation requires construction on separate schedule. X., p. 13.
- IDOC will comply with provisions of section XII Medication, including providing inmates with information regarding medication effects, monitoring, documentation, and referral for medication refusals. XII., p. 15-16.
- IDOC shall fully comply with policy requiring an inmate's medical record, including any needed medication, to be transferred to any facility with the inmate. XVIII., p. 21.
- Within 30 days of the first calendar quarter after the settlement approval date, IDOC shall submit to Plaintiffs' counsel and the Monitor the first quarterly report. XXVIII., p. 28.

Within six months of approval of the settlement agreement, November 23, 2016

- IDOC shall comply with policy for confidentiality of mental health records and develop policies and procedures on confidentiality requiring mental health consultations are conducted with sound confidentiality. Trainings for staff on such policies and procedures shall be included in conventional staff training so that all prison staff understand and respect the need for privacy. If confidential inmate mental health information is required to be disclosed it shall only be used only in furtherance of the security of the institution, treatment, or as required by law, and in no other case. XIX., p. 22.
- IDOC in consultation with the Monitor and IDOC's designated expert, shall develop and implement a pilot Behavior Treatment Program (BTP) at Pontiac for SMI inmates currently sanctioned for serious disciplinary infractions. IDOC will review the pilot and consider for other facilities. XXV., p. 25.

[40] Factors to be examined by the Committee in considering modifications to major ticket segregation terms shall include: 1. the seriousness of the offense; 2. safety and security; 3. the inmate's behavioral, medical, mental health and disciplinary; 4. reports and recommendations concerning the inmate; 5. The inmate's current mental health; and 6. "other legitimate penological interests."

- Defendants may ask Plaintiffs' counsel to review a proposed modification to any portion of the Settlement Agreement. XXXI., p. 31.

Within nine months of approval of the settlement agreement, February 23, 2017

- IDOC has hired a state employee statewide Quality Improvement (QI) Manager–this individual is charged with implementing specific Quality Improvement Programs and Peer Review Process as set out in the Agreement with a particular focus on ensuring deficiencies identified are the basis of further actions to improve quality of mental health care at each facility and throughout IDOC. XI., p. 14 and XXVI, p. 25.
- All reviews of SMI inmates with 60 days of remaining segregation time as of the approval date of the settlement agreement by Committee completed. XV., p. 19.
- IDOC shall submit to Plaintiffs' counsel and the Monitor a second quarterly report. XXVIII., p. 28.

Within a year of approval of the settlement agreement, May 23, 2017

- Information regarding self-referral to be included in orientation manual and information about access to mental health care is to be incorporated in facility orientation, and written policies and procedures to this effect. VI., p. 9.
- Crisis cells at Pontiac must be relocated from control units (segregation) to protective custody. X., p. 13.
- Mentally ill inmates in a Control Unit setting longer than 60 days receive minimally six hours structured out-of-cell time and six hours unstructured out-of-cell time a week (12 total). XV., p. 20.
- Policies, procedures, and record-keeping for identifying and responding to suicidal inmates are implemented and followed at all facilities. XVI., p. 21.
- Physical restraints policies, procedures, and recordkeeping provisions of the agreement fully implemented. XVII., p. 21.
- Mental Health Administrative Staff shall develop a written plan and program for staff training. XXI., p. 23.
- Mental Health Administrative Staff shall develop a written plan for the orientation, continuing education and training of all mental health services staff. XXI., p. 23-24.
- IDOC shall make best efforts to ensure that the inmate's treating MHP is consulted prior to transfer (unless a SMI inmate is being transferred for clinical reasons), if no consultation is possible prior to transfer, the MHP shall be consulted no more than 72 hours after. If the transfer is made for security reasons only, the reasons and consultation shall be documented and placed in the inmate's mental health file. XXIII., p. 24.
- The sending institution for a SMI inmate's transfer shall notify the receiving institution of pending transfer and any mental health treatment needs using the most expeditions means available. XXIII., p. 24.
- IDOC in consultation with the Monitor shall develop and implement policies and procedures to provide that for mentally ill inmates punishment is prohibited for: 1. self-injurious behavior, 2. reporting feelings or intentions of self-injury or suicide, and 3. behavior directly related to self-injurious behavior, e.g. destruction of property, unless it results in the creation of a weapon or possession of contraband. XXV., p. 24-25.
- For inmates in RTU or inpatient treatment, the disciplinary process will be carried out within a mental health treatment context. Discipline may include loss of privileges or confinement to cell on the treatment unit for a specified period but may not entail ejecting from treatment program. XXV., p. 25.
- IDOC shall submit to Plaintiffs' counsel and the Monitor quarterly reports. XXVIII., p. 28.
- The Monitor shall submit first annual report to the parties and the Court that shall evaluate relevant provisions of the settlement agreement for IDOC's substantial compliance or non-compliance. XXVII., p. 27.

Within 18-months of approval of the settlement agreement, November 23, 2017

- Provisions of the Mental Health Evaluation and Referrals section in place. V., p. 8-9.
- Joliet RTU has hired to levels set out in the Approved Remedial Plan or modification of this staffing plan if put forth and approved. IX, p. 11.
- IDOC has hired 10 central office staff to implement the policies and record-keeping requirements of the Settlement Agreement. XI., p. 15.
- IDOC shall continue to submit to Plaintiffs' counsel and the Monitor quarterly reports. XXVIII., p. 28
- Monitor to submit to the parties a status report six months post annual report re IDOC progress on Settlement Agreement. XXVII., p. 28.

Within two years of approval of the settlement agreement, May 23, 2018

- Mental health screenings at reception and classification centers are to be sound confidential. IV (d), p. 7.
- Mentally ill inmates in a Control Unit setting longer than 60 days receive minimally eight hours structured out-of-cell time and eight hours unstructured out-of-cell time a week (16 total). XV., p. 20.
- All IDOC and vendor staff who interact with inmates shall receive training and continuing education regarding recognition of mental and emotional disorders -- including information about the frequency and seriousness of mental illness, how to treat persons who have mental illness or manifesting symptoms. In addition to training on confidentially, training shall include:1. Recognition of signs and symptoms of mental and emotional disorders most frequently found in the inmate population, 2. Recognition of Chemical dependency and symptoms of narcotic and alcohol withdrawal, 3. Recognition of Adverse reactions to psychotropic medication, 4. Recognition of Developmental disability, particularly intellectual disability, 5. Types of potential mental health emergencies and how to approach inmates to intervene in these crises, 6. Suicide prevention, 7. Obligation to refer inmates with mental health problems or needing care, appropriate channels for immediate referral to mental health services for further evaluation and procedures governing such referrals. XXI., p. 23.
- IDOC shall continue to submit to Plaintiffs' counsel and the Monitor quarterly reports. XXVIII., p. 28.
- The Monitor shall submit second annual report to the parties and the Court as to IDOC's substantial compliance. XXVII., p. 27.

Within 30 months of approval of the settlement agreement, November 23, 2018

- IDOC will transition to assuming control or ownership of the existing DHS facility and provide approximately 60 additional beds and programming space for separate housing of male and female inmates in need of inpatient care and consult with the Monitor and expert to develop policies and procedures, and programming and treatment space, appropriate for a forensic hospital. X., p. 13.
- Monitor to submit to the parties a status report six months post annual report re IDOC progress on Settlement Agreement. XXVII., p. 28.

Within 36 months of approval of the settlement agreement, May 23, 2019

- Mentally ill inmates in a Control Unit setting longer than 60 days receive minimally ten hours structured out-of-cell time and ten hours unstructured out-of-cell time a week (20 total). This is to be in effect *no later than four years* after the approval of the settlement agreement, i.e. May 23, 2020. XV., 20-21.
- The Monitor shall submit third annual report to the parties and the Court as to IDOC's substantial compliance. XXVII., p. 27.

No later than four years after approval of the settlement agreement, May 23, 2020

- Provisions of the Segregation Section to be fully implemented. XV., p. 21.