
Facility Report



Joliet & Elgin Treatment Centers 2019-20

JHA's Inaugural Report on IDOC's Specialized
Mental Health Treatment Facilities

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Executive Summary

JHA has made several visits to the Joliet Treatment Center (JTC), most recently in December 2019. JTC is the parent facility for Elgin Treatment Center (Elgin), which is a special IDOC unit providing in-patient level mental health treatment located within the grounds of the Department of Health and Human Services (DHS) Elgin Mental Health facility, about an hour's drive north of JTC. JHA staff visited Elgin in February 2019, and a brief summary of that visit is included at the end of this report.

A new 200-bed hospital that is being constructed on the JTC grounds and anticipated to open in fall 2021 will be a much-needed resource for the Department.



JTC was closed as a juvenile prison in 2013 and began housing adults in October 2017. One of the reasons advocates pushed for closure of this facility for juveniles was because this facility seemed more like an adult prison in both its operations and physical characteristics. It contained a larger population within an abundance of surrounding razor wire and had a more punitive outlook, due in part to housing higher security youth. JTC, however, like Kewanee (which ceased to operate as a higher security youth facility within the Illinois Department of Juvenile Justice (IDJJ) in 2016 and reopened as an IDOC treatment-focused adult facility in 2017), represents a smaller and relatively well-programmed adult facility and new direction within IDOC. Poignantly, JHA spoke with several men now housed at JTC for mental health treatment as adult prisoners who previously were incarcerated there as youth when JTC was a juvenile prison.

JHA appreciated administrators' frankness that IDOC is not so much changing the mental healthcare provision within the Department as creating it, because Illinois' prisons are still behind the times in many respects with regard to best practices in mental healthcare. JHA believes that the policies and practices that make these treatment settings more successful (i.e. respectful treatment, productive activity, reentry planning, increased out-of-cell time, and other improved conditions) should extend to all prisons and not be limited to specialized treatment facilities. Further, making all of Illinois' prisons more humane and treatment-oriented would make the demands on these small specialized facilities less urgent.

Generally, JHA visitors have been impressed by the treatment vs. punishment philosophy evident in these specialized mental health facilities, made possible in part by increased education for staff and better staffing ratios. As is publicly reported on IDOC's webpage in its Quarterly Reports, JTC and Elgin are the only facilities with a ratio of less than one prisoner to each security staff member, and ratios of 4:1 total staff to person incarcerated at Elgin and 2:1 at JTC. Additionally, both population numbers and housing units at these facilities are smaller and more manageable than most adult prisons, and individuals are single-celled, which is also

rare in IDOC. For example, one security staff member will oversee at most 16 people on a JTC wing, compared to one staff member making rounds overseeing a hundred or more people in a unit of an IDOC correctional facility. Hence, these specialized facilities are far more expensive to operate than other prisons. All officers employed at these facilities as Correctional Treatment Officers (CTOs) must have a college degree (as is also now required for line staff within the IDJJ) and undergo specialized training to work with individuals with mental health issues, including an additional two weeks of training and instruction on using verbal de-escalation to avoid the use of force.

Many people who are incarcerated at JTC expressed that this facility was better than other mental health settings and IDOC housing they had been in previously. JHA visitors were impressed by many people's awareness and articulation of their own mental health issues, past traumas, and needs. We attribute the ability and openness of people to having such conversations to the more relaxed and productive treatment environment. One man described how he could not sleep for days after transferring from Pontiac because it was so quiet at JTC. Others talked about how being at JTC helped relieve the stress of being incarcerated elsewhere. Some people who had been housed at the now closed Tamms supermax prison were doing particularly well at JTC, as were some men that JHA has come to know over the years from various encounters and correspondence during their stays at other facilities in more traumatic settings. We were encouraged hearing more future-orientation and positivity from many. One man we spoke with had reportedly earned a 110-year segregation cut as a result of positive behavioral changes he had made during his stay at JTC. JHA had the opportunity to talk with several people who were much better mentally, emotionally, and socially adjusted to engage in daily life and, importantly, better prepared for their impending release dates, having been housed at this facility.

During JHA's December 2019 visit to JTC, we also were particularly pleased with administrators' emphasis on promoting family engagement and outside connection. Administrators noted that although they are

JTC and Elgin are the only IDOC facilities with a ratio of less than one prisoner to security staff member (a ratio of 4:1 total staff to person incarcerated at Elgin and a ratio of 2:1 at JTC).

generous with visitation for the treatment population, it has not posed a space problem because many people are alienated from their families or lack outside supports. One man we spoke to was anticipating his first visit from his mother in nearly two decades. We believe that other facilities could benefit from following JTC's example by increasing or not punitively restricting visits and phone calls to motivate positive behavior, and we have frequently made this recommendation to IDOC officials. Additionally, JTC was effectively using a state loan television incentive, where individuals without funds to purchase a television on commissary can earn one through good behavior, as JHA has also recommended. We believe and continue to recommend that both institutional safety and people's well-being could be increased by implementing positive incentive programs, like those used at JTC, at other IDOC facilities.

In providing a setting for effective mental health treatment, positive social engagement and supports are also critical to recovery. Mental health is improved by reliable assistance from others, caring relationships, stable environments, autonomy or opportunity for self-improvement, and productive activity. Efforts at JTC to make the facility a more positive and motivating environment were evident from the use of positive imagery in murals to having desirable Leisure Time Services (LTS) offerings. Administrators also were willing to use peer mentoring and were soliciting the input of a resident committee to identify ways to improve the facility. Incarcerated individuals reported to JHA specific positive interactions with staff and noted that staff interacted positively with their families as well. One man said that security staff at JTC care about how they are doing, in contrast to staff at other places within IDOC. Another man stated that security staff at JTC are "not aggressive" and are "helpful." That this comment was unique and of note as an indicator of widespread distrust and perceptions of unfair treatment. We were also told of an instance at JTC where staff actually apologized to an incarcerated man after an incident where the staff member was in the wrong.

Some incarcerated individuals opined of JTC that increased out-of-cell time is the most important factor to improving people's functioning. JHA agrees and has long recommended that increasing out-of-cell time should be a top priority throughout IDOC. Importantly, people incarcerated at JTC reported that there were opportunities and "second chances," e.g. to demonstrate improved behavior or rehabilitation and earn back privileges, that were available for them at JTC that were not available in other prisons. JHA believes that such opportunities should exist consistently throughout the Department.

IDOC's Mental Health Bed Space

JTC and Elgin, as dedicated specialized facilities designed for mental health treatment, housed less than half a percent of the total IDOC population (0.49%).

As of February 15, 2020, JTC housed 171 people for mental health treatment, out of a purported rated capacity of 422, with 29 additional people housed in non-treatment bed space (which had a reported capacity of 64). As of that date, Elgin had seven of a purported 22 bed spaces for women filled and eight of 22 male bed spaces. These specialized mental health treatment facilities housed less than half a percent of the total IDOC population (0.49%). At maximum purported capacity, they would have housed a bit more than one percent of the IDOC population. However, as

discussed below, there are reasons to believe that rated capacities for these facilities are unachievable.

As of the end of 2019, there were 4,756 people identified within IDOC as Seriously Mentally Ill (SMI), about 13% of the total IDOC population. While most of these people may not need specialized mental health housing, or either in-patient or Residential Treatment Unit (RTU) levels of care, such care must be available as needed, and all IDOC facilities, not just specialized treatment facilities, must provide adequate mental health treatment. Moreover, there should be uniformity in treatment and response throughout the Agency.

In addition to housing at JTC, RTU space is available at Logan Correctional Center for women and in a maximum-security setting at Pontiac and both medium and maximum-security settings at Dixon Correctional Centers for men. Under the terms of the 2016 *Rasho* mental health class action litigation settlement agreement (No. 7-CV-1298 (C.D. Ill.)) there were supposed to be 108 RTU beds for women at Logan and approximately 1,150 for men with 625 beds at Dixon, 169 beds at Pontiac, and 360 at JTC, with 44 inpatient beds at Elgin, 22 for men and 22 for women. IDOC administrators reported that as of June 2020, there are 1,287 total RTU beds, with 146 for women at Logan and 1,141 for men (with 676 beds at Dixon, 300 at JTC, and 165 at Pontiac), in addition to the Elgin inpatient bed space.¹ As of May 15, 2020 IDOC reported the RTU census was 847 people, or 65.8%, with 86 at Logan, 518 at Dixon, 168 at JTC, and 75 at Pontiac; the inpatient census at Elgin was 16 people, or 36%, with 10 men and 6 women. IDOC administrators noted that COVID-19 had impacted movement.

¹ IDOC administrators were provided with a draft of this report 2/27/20, but due to the COVID-19 pandemic draft review was not conducted until 6/24/20.

Mental Health Bed Space Capacity and Census at IDOC Facilities

	Totals	Logan	Dixon	JTC	Pontiac	Elgin
# of beds	1,331	146	676	300	165	44
Type	RTU & In-Patient	RTU Female	RTU Male	RTU Male	RTU Male	In-Patient 22 Male/ 22 Female
5/15/20 Census	863	86	518	168	75	16 10 men/6 women
% of Reported Capacity	64.8%	58.9%	76.6%	56.0%	45.4%	36.3% 45.4% male/27.2% female

JTC could be thought of as housing three populations. First is a higher security area of two housing units. This area houses individuals who are identified as Seriously Mentally Ill (SMI) who are participating in a Behavioral Management Unit (BMU) program, which consists of phases where someone can earn privileges through program participation and work their way out of the more restrictive housing back to general population. Secondly, there is the treatment or therapeutic community population, where individuals receive Residential Treatment Unit (RTU) level care. Within the treatment population, there is orientation, segregation, and a housing unit wing where individuals requiring greater accommodations are housed. Third, there is a non-treatment population, who are considered the workforce of the facility, although increasingly, the treatment population is involved in work activities as they are able. JHA commends the creation of these work opportunities. As of June 2020, administrators reported there were 189 people total at JTC, with 123 housed in the RTU, 42 in the BMU, and 24 in the non-treatment general population. The population is down from before the COVID-19 pandemic; on March 15, 2020, JTC housed 205 people, with 30 non-treatment and 175 in treatment.

Ideally, the Elgin and JTC dedicated specialized mental health treatment settings will model best practices and be used for stabilization of individuals with the greatest needs, facilitating smooth reintegration into other settings without compromising individuals' care, mental stability, and well-being. This will require intensive individualized treatment planning and enhanced communication. Effective transition between facilities was questionable. JHA continues to stress that these specialized treatment facilities do not operate in isolation and must be thought of as part of a greater healthcare system and continuum, involving both other IDOC facilities and community care.

Treatment Capacity and Transition Concerns

During JHA's December 2019 visit, we were informed that the projected capacity of JTC could not be realized. Administrators stated that they believed they could not double-cell individuals due to physical space requirements at the facility, possibly based on state health, not correctional, regulations. Additionally, treatment capacity must consider both staffing and physical space. Both of these areas presented challenges, even at JTC, which was theoretically redesigned for this purpose. Because of the low population, JHA did not hear as many treatment access issues as at other facilities, but there were still some concerns. At other facilities, we have been told that it is impossible to have the number of required mental health groups because they do not have the staff or space available, sometimes because they are unable to have certain people safely in group together or that one disruption to the schedule throws off the entire schedule. JHA frequently speaks with people who are identified as SMI in segregation units throughout IDOC who report they do not have the required mental health contacts or group participation and out-of-cell time. Often staff resources are directed first to crisis management, without fully appreciating that consistent treatment can be preventative care. JHA believes that IDOC must realistically reevaluate bed space capacity at facilities, considering the operational and programmatic needs of the population, and make this information public.

JHA continues to have concerns regarding the capacity of specialized housing to meet demand and how individuals are supposed to transition between JTC and Elgin and other facilities. Many individuals who would benefit from settings with more treatment simply do not have access. It is clear that JTC and Elgin do not have the capacity to house all individuals in IDOC who have acute mental healthcare needs. Administrators at other facilities with RTUs have expressed that they were not able to place people they believed would be better off housed in more intensive mental health treatment setting at these facilities. We were told by various administrators that some particular high-need individuals could not be placed at JTC or Elgin because they were considered too disruptive or dangerous to themselves or others. Placement at JTC seems to require treatment participation, which suggests some ability to conform behavior to rules and to comply with medication regimens. However, people who have decompensated severely as a result of serious mental illness may be unwilling or unable to participate, causing greater isolation, exacerbation of mental illness, and more destructive behavior. At various prisons, JHA has been told that some people do not want to come out-of-cells to participate in group or even for showers. Gradually, some facilities seem to be introducing incentives and one-on-one attention to facilitate greater participation.

JHA has interviewed individuals housed at Pontiac who were returned from JTC for behavioral issues. We were told by staff elsewhere that the absence of a tactical unit at JTC and Elgin makes them inappropriate

setting for some individuals; however, administrators reported JTC has had a tactical team since 2019 and that this team would also cover Elgin's needs. Certain individuals will even be sent to prisons out of state by IDOC if they believe they are unmanageable. JHA also does not know whether JTC or Elgin have capacity to accommodate people who have Limited English Proficiency in treatment. We were contacted by one individual who was Spanish speaking who reported issues with receiving treatment and assistance. All such limitations and participation criteria should be acknowledged and planned for in considering how the Department will meet the mental healthcare needs of people with mental illness. These specialized treatment facilities alone cannot serve the needs of the entire Department, so other facilities must be empowered and properly staffed and resourced to treat people and appropriately prioritize referrals. JHA believes the Department should more carefully consider how they will classify and transition people to different settings both within and outside IDOC. The current Departmental leadership appears receptive to this and intends to rollout a new risk and needs assessment tool, Ohio Risk Assessment System (ORAS), in 2020 and reevaluate classification. It is worth considering where JTC best meets the population's needs, e.g. should it be used to help people with greater mental health needs in general or those with significant needs with approaching release dates, or should people go here earlier in their stays to stabilize them and provide them with the means to more positively adjust to and withstand the trauma of incarceration.

Movement to and from enhanced treatment settings is still opaque and appears to be a major planning problem that remains to be addressed by IDOC. This was an issue that was anticipated by JHA and others: if you build a better mental health treatment facility with a limited number of beds (and beds are now limited even beyond initial capacity estimates), you must choose who you will treat. By creating a more therapeutic, "kinder, gentler" treatment-intensive prison, you create a setting people will not want to leave. Consequently, people, as a function of survival and self-protection, may regress to prolong their stay at the facility (if improved mental stability triggers transfer) or, upon being transferred back to the traumatizing, punitive environment of a typical prison, may once more deteriorate mentally. JHA was told by administrators that about a third of the JTC population was anticipated to remain at the facility, but it was unclear what criteria those individuals must meet. The process to meet the stated goal of placing people in more intensive mental health treatment, stabilizing them, and transitioning them back into less intensive treatment settings, general population or the community, is still being developed. However, lack of information and communication regarding these transitions heightens people's anxieties in treatment and should be addressed in treatment planning.

Structure, predictability, and normative routines are important to all peoples' sense of stability and well-being, especially people with mental illness in treatment settings. It is incumbent on IDOC to create and communicate a rational and therapeutic mechanism for people to smoothly transition out of the JTC to other settings when making space for others who will also benefit from the treatment setting. Having and communicating set limits and goals for treatment plans and standards for transitioning people to other settings

will be helpful for everyone to understand expectations and relieve the anxiety of total uncertainty about stays. If the expectation for Elgin is for short one or two month stays, or for JTC is for people to stay 12-24 months until stabilized and move elsewhere, people receiving treatment need to be told this, and this needs to be part of their treatment and transition planning. JHA requested more information about length of stay at the specialized treatment facilities now that they have been in operation for over two years. Some information about transfers into and out of facilities is publicly available in IDOC Quarterly reports and did not seem to show much movement; however, this is not adequate information to look into issues regarding lengths of stay. Administrators responded in June 2020 that the average length of stay at Elgin is 16 weeks, while the average length of stay at JTC is 13 months. Administrators also reported that since the beginning of 2020, there have been seven "door violations," or instances of people remaining incarcerated past their projected parole date because they cannot be released on mandatory supervised release (MSR, or parole) due to lack of suitable community mental health care or housing. However, administrators reported that some of these seven have since been released.

In June 2020, the average length of stay at Elgin was reported to be 16 weeks, while the average stay at JTC was 13 months.

Another barrier to proper treatment and transitional care between facilities has been the use of paper medical records, which physically move with the incarcerated patient. While electronic medical records (EMRs) were piloted in female facilities and facilitated women's treatment at Elgin, EMR is still largely not available for men within IDOC. As part of the *Lippert* class action consent decree, the Department is now on a deadline to implement EMR by 2022. Many mental healthcare providers throughout IDOC have reported that paper records impede their work and that paperwork required to show compliance with litigation requirements is taking time away from providing more direct patient contact and treatment. They also expressed concerns regarding lack of end-user staff involvement and input in ongoing litigation. JHA strongly encourages more communication regarding compliance and treatment goals with frontline staff.

Joliet Treatment Center

Behavioral Management Unit

IDOC BMUs were located at JTC, Illinois River, and Pontiac for men; one was planned for women at Logan.

In 2019, JTC established a Behavioral Management Unit (BMU) in housing units 7 and 8, which have a purported combined bed space capacity for 100 people. However, again, population in this area has never been nearly this high, peaking at around 40. As of March 2020, other BMUs exist within IDOC at Illinois River (which JHA visited May 2019) and Pontiac (visited February 2020), and one was planned for women at Logan. These units use phases and incentives for people to earn their way out of restrictive status, e.g. segregation cuts and privilege restoration, while

attempting to keep individuals who are identified as SMI and who are exhibiting disruptive behaviors together. It is unclear if the BMUs throughout IDOC follow the same methodology. The target population at JTC's BMU is described in program materials as residents who present a potential safety risk to themselves or staff, who would benefit from participation. JTC's BMU program is Dialectical Behavior Therapy-based (DBT), and people can earn points to redeem for various privileges or benefits, similar to programs used within IDJJ, and earn their way through phases. This program uses a multidisciplinary team to assess progress. Individuals may regress and repeat phases in the program. During our first visit to this unit, as during our visit at Illinois River's BMU, it was clear that people were happy being in this setting compared to Pontiac, and one man even requested his friends get transferred. However, during our more recent visit, some people expressed frustrations and concerns regarding their lack of progression in the program. Nonetheless, other people acknowledged the helpfulness of the BMU groups and that it gave them "a way out."

Administrators described the JTC BMU as housing more of the people with personality disorders within the SMI designation, e.g. antisocial or borderline diagnoses. Some of the BMU residents are serving segregation time, while others are not. Segregation is referred to as "Transformation" in this unit. JHA has heard from staff that individuals housed in BMUs often in a RTU environment will influence or target other more vulnerable residents. At other facilities, we have heard that mirroring undesirable behaviors is common and difficult for staff to manage, e.g. yelling, self-harm, spitting, splashing, or other assaultive behaviors. Staff reported that there is a lot of self-harm on this unit. Staff described how some men in the BMU when they began the program had managed to climb up onto various common area ledges far off the

floor, where they had to be talked down. After these incidents, barriers were installed to prevent people from climbing onto the ledges.

Several of the individuals housed in the male BMUs have a history of “masturbating” or exposing their genitals in inappropriate settings, which is commonly referred to by the disciplinary ticket number of 107 for the Departmental Rule prohibiting sexual misconduct. IDOC is now making information about staff assaults and prisoner sexual misconduct, as well as other data points, regularly publicly available on their webpage in Quarterly Reports, as advocated for by JHA and others.

Male facilities with RTUs thus far seem to have the highest number of incidents, although location of incidents within the facilities is not published. Some individuals report that their compulsion to expose their genitals in front of staff or others in cells or in groups relates to their mental illness. Some staff disagree that the behavior is compulsive and not willful, noting that some incentives and consequences have been successful in motivating some people to cease the behavior. Staff at other facilities reported they have not had luck with trying to prevent inappropriate sexual displays by modifying prisoner uniforms. Staff at JTC reported that tinting windows so that people cannot see out from BMU dayrooms reduced incidents.

In May 2020, IDOC reported 131 Sexual Misconduct tickets. 10% (13) were at JTC. Nearly half were at the 3 male facilities with RTUs: JTC, Dixon, or Pontiac (46.5%).

107. SEXUAL MISCONDUCT

Engaging in sexual intercourse, sexual conduct, or gesturing, fondling or touching done to sexually arouse, intimidate or harass either or both persons, or engaging in any of these activities with an animal. However, private masturbation in the offender's living area, excluding a deliberate display of the act or to affront others, shall not be considered sexual misconduct.

Interestingly, a highly experienced operational staff member at another facility suggested body cameras may be effective at deterring the behavior, which seems an idea worth considering for facility safety generally given concerns also about staff conduct and accountability. This type of misbehavior has been a growing issue within both Cook County Jail and IDOC, resulting in litigation being brought by some staff working with the incarcerated.

During our December JTC visit, we were pleased to see the number of people in the most restrictive BMU phase lowered and to hear about some remarkable successes from that area, including substantial segregation time cuts. However, we did encounter a few people still housed in the BMU after nearly a year, suggesting insufficient progress with treatment and likely a need for greater individualized treatment planning or ability to try alternative methods or settings. We have met people who have been unsuccessful at JTC and returned to other facilities. According to administrators and BMU program materials, individuals will be given multiple chances to participate in the Phase program before they are sent elsewhere due to treatment noncompliance, and they may try again after a period of time. JHA recommends data about program criteria, selection methods, participant characteristics, and treatment success or program completion be made publicly available.

JHA continues to advocate for holistic review of consequences for people who have a significant disciplinary history. Not only should people be reviewed for segregation cuts, but privilege grades should be restored, good time returned, restitution debt eliminated or revisited, etc. One man reported that IDOC was still taking all of his money for restitution; usually debts should be assessed only at a percentage of a person's income. Segregation terms often also practically preclude people from future job or school assignments. Behavioral incentive programs must try to use individualized responses to restore appropriate means for a person to succeed going forward. Departmentally, JHA continues to encourage systemic review of overly harsh historic sanctions and strongly encourages use of automatic restoration where possible, as many people cannot effectively self-advocate within their circumstances.

During our visits to JTC several people housed in the BMU expressed that they had no idea why they came to JTC, and some believed it was a setback in their segregation cut programs at other prisons (e.g. they had been in some programming at Pontiac and felt they were making progress and earning privileges but forced to start over upon moving to JTC's BMU). While some individuals may not have full pictures of their progress in other settings and while there may be some legitimate clinical reasons to start people at the beginning of a program to orient and get to know the individual, the perception of arbitrariness appeared counterproductive to effective treatment and created an impression of lack of procedural justice. The apparent lack of communication with patients regarding their placement in various programs was not particularly conducive to treatment success, obtaining appropriate consent and buy-in, or promoting autonomy.

In general, JHA continues to recommend that IDOC make a concerted effort to make treatment environments and treatment plans a cohesive continuum and to communicate these plans to people in treatment. While we understand the benefit of trying different methods as treatment milieus are created, insofar as different facilities have RTUs and BMUs, policy, programming, and practices should be conformed across facilities.

Some people in the BMU felt they were not completing the program due to lack of available other treatment bed space at JTC. Individuals reported to JHA that they had spent 60-120 days in Phase 4. One individual particularly wanted to go to the treatment side so that he could eat at dietary and not in his cell. Lack of movement diminishes the effect of use of incentives as behavioral motivators. For example, people reported individuals conformed their behavior because they knew they could move to the treatment side of JTC and participate in basketball tournaments; however, resentment built when this did not occur and no reason was given for the decision. Incentives must be actually available, clearly communicated, and provided to people as promised when they successfully achieve realistic benchmarks in order to be effective. Furthermore, a swift and certain response is most likely to incentivize appropriate behavior and disincentivize inappropriate behavior. JHA recommended a more appropriate, realistic, and available incentive might be to tell BMU residents that they could play basketball in the gym on the BMU side of the facility if they reached the highest phase, instead of holding out a remote, unmet promise that they would be allowed to play basketball when and if they transitioned to the treatment side. During our first visit to the BMU, people expressed that having to go long periods without a ticket for a particular incentive was too difficult for them and that shorter-term motivators are needed.

Concerningly, multiple individuals in the BMU reported not having a treatment plan, or not knowing of one, over a period of months. This is an issue that other individuals who are identified as SMI in segregation or other restrictive housing status throughout IDOC continue to raise. One man reported not having a treatment conference in four months and requested a treatment team meeting. JHA recommends that all residents be given copies of their treatment plans, including aftercare planning used for all transitions, e.g. to other units, facilities, or release. There also was a concern among residents and JHA visitors about mental health regression from being housed in, or upon transition to, more restrictive environments, such as the maximum-security setting of Dixon or Pontiac RTUs. Ideally, providing specialized treatment should facilitate greater social functioning, recovery, and normalization of behavior, which, in turn, should reduce security concerns and allow people to return to general population settings or to Dixon's Special Treatment Unit, with mental health supports in place. Currently, only JTC's RTU seems to fulfill its function as a true and appropriate earned step-down setting among the RTU options.

Some people in the BMU reported concerns regarding lockdowns and wanted more group and individual counseling. They also requested more activities like workouts, music-based activities, and reading materials. JHA visitors expressed concerns that the BMU is still a very restrictive environment. Individuals in the BMU were supposed to be provided with 15 hours unstructured and 15 hours structured time out-of-cell weekly. We were not provided with schedules; however, on prior visits we noted that there seemed to be a lot of in-cell study time.

Other Special Housing

JTC houses some people who are identified as having greater needs and lower functioning on a particular housing unit wing. Residents in this area have meals brought to the unit. JHA was also told that this unit housed people stepping down from Elgin, but the specifics surrounding this process were unclear. JHA visitors appreciated staff knowledge and apparent concern for people housed in this area. Nonetheless, we believe a prison setting is an inappropriate place to house very high need, low functioning people who are not likely to be a threat to the public as opposed to a non-carceral setting such as a hospital. Some men on that unit did not seem capable of appreciating their surroundings or communicating, and others appeared gravely physically impaired. However, encouragingly, the people we spoke with did not present as being in distress, even where they were not oriented to reality or were experiencing paranoid thoughts. We continue to encourage IDOC and Illinois to be proactive in seeking appropriate release mechanisms for people with serious physical and mental disabilities. The new hospital is much needed but will not be available soon enough and will not be a sufficient solution to meet the foreseeable needs of the Department.

Some visitors felt that the medical needs of some residents were too great for JTC, which lacks an infirmary. People felt that there should be more consideration of dual mental health and medical health needs of the population in placement. However, we are aware of the overall dearth of appropriate bed space to address such need. Dixon is perhaps the best equipped for such housing, but it also is struggling to meet people's needs, and some JTC treatment residents opined that this facility is "way better" than Dixon.

Staffing

Although JHA was not provided with requested staff demographic data, it was apparent that staffing in these specialized facilities benefited not only from greater mental health staffing but from higher racial diversity and more female employees than most IDOC facilities. Northern and urban facilities in Illinois tend to have diverse staff, more closely approximating the racial makeup of the prison population. At JTC, we were impressed by several staff member's knowledge of the people they worked with and that they appeared to show exceptional pride in their work and caring about the individuals in their charge.

A significant concern noted on our December 2019 JTC visit was that some key leadership and administrative/clerical support staff positions were vacant, and there is a lack of consistency in leadership. IDOC has acknowledged this as a Departmental need. Although we were not provided with requested detailed staffing data at JTC at the time of our visit (perhaps due to the facility's lack of administrative support staff), a notable absence was the facility lacked any Assistant Wardens. The Warden at the time of the visit was a Licensed Clinical Social Worker and had a background with a large jail, which many JHA visitors believed brought valuable perspective regarding mental health treatment and community

reintegration to the facility. Since our visit, the facility has a new Warden, who previously oversaw Elgin, and the Assistant Warden positions were filled. During draft review in June 2020, administrators reported staffing had improved, noting in addition to Warden positions, all Unit Director positions have been filled.

During JHA's visit, administrators and staff noted that the burdensome state hiring process impedes the ability to timely fill vacancies and that there is a lack of succession planning and training for new positions or promotions throughout the Department. Staff also suggested that there should be more opportunities for new or promoted staff to do on the job shadowing of veteran staff to better learn their roles. This has also been a reported need at other facilities. In addition to training for particular job roles, JHA feels that it is important for staff within IDOC, particularly leadership and treatment staff, to have at least some understanding of the other facilities and varied carceral environments that the incarcerated population may have come from or may be transferred back to prior to their release. We believe IDOC staff decisionmakers and mental health staff should minimally tour the other RTUs to have better context for people's experiences coming into JTC and their concerns regarding leaving if the plan remains to transition people out of JTC to other settings once they are stabilized. There are many benefits at JTC and Elgin that are not present in other IDOC facilities. Again, we would not be surprised to see people regress in their treatment to avoid movement to another facility or in an attempt to come back to JTC. We also believe that regression, for some, is an involuntary and not unforeseeable response to being moved to a different and less supportive environment.

Staff and people incarcerated felt the facility would benefit from even more mental health staff and counselors to increase offerings, allow staff to be more proactive and not reactive, and to provide more one-on-one treatment. Some people in treatment reported that they did not find mental health groups helpful for their treatment or reported they were not comfortable participating in group treatment given the lack of confidentiality, making individual treatment necessary. Turnover of mental health staff, although perhaps better at these facilities than elsewhere, was also reported as a challenge to ensure that patients have a stable environment and continuity in relationships with mental health staff for treatment success.

Additional Concerns Reported

Mental Health Treatment Concerns

People incarcerated within JTC reported that they felt a need for more group and individual counseling, with some reporting that group treatment was distracting.

In addition to the mental health treatment concerns discussed in the BMU section above, individuals throughout JTC reported to JHA that they wanted more group and individual counseling. Some people felt the in-depth treatment they needed could not be addressed in groups, which were reportedly distracting. One man requested that we observe groups at JTC on future visits. Some people reported and expressed dissatisfaction their treatment groups were clustered on a few days and not spread over the week. Some residents reported that daily community group meetings of residents in particular housing areas were not

particularly helpful or were conducted too often, instead of having more helpful structured group treatment time. Some people felt that security staff presence during groups did not allow for appropriate confidentiality. Staff should explain confidentiality expectations to treatment participants and allow for some confidential forum for people to have one-on-one treatment related communications.

As mentioned above, JHA spoke to several individuals who had been housed at JTC when they were youth before the facility was repurposed into a treatment center. Some mentioned having particular trauma associated with these incarcerations and expressed that this was on their minds. Staff should be mindful of these issues and try to identify them at intake and address them with individuals in holistic treatment.

JHA visitors had concerns and questions regarding the use of four-point restraints and whether alternatives such as short-term monitored use of restraint chairs which would allow for greater mobility and participation were appropriately considered before being rejected in treatment planning.

Additionally, we continue to have concerns regarding significant periods of reported stays on crisis watch. One person stated he had been crisis watch for months and was told that he would need to have disciplinary tickets heard before he could come off of the watch. Given what was reported, it seemed that isolating the person through an extended stay on crisis watch was of questionable efficacy and that a more intensive treatment intervention was indicated. Extended stays on watch have been a concern raised repeatedly by JHA and also noted by the *Rasho* Court Monitor. Administrators responded that what was reported is not procedure, and people do not need to have disciplinary tickets heard prior to coming off of watches.

Programming and Productive Activity Concerns

Several people requested more structured out-of-cell time, which could include non-mental health structured time. Many people requested increased educational programming, including college classes and vocational activities. JHA believes more volunteer or peer-led activities or mentoring would also be beneficial, and administrators seemed receptive to this possibility. People also specifically requested access to substance use disorder treatment. In addition, some people wanted more access to the larger yard/quad area and functional gym equipment or weights. There was also a request for more Muslim services.

Incarcerated Worker Issues

There were some concerns regarding workers being overworked with numerous jobs with no choice and low pay. When JTC first opened, JHA received numerous complaints from incarcerated workers regarding conditions and lack of amenities compared to other facilities, including access to the law library, yard opportunities, cable television (for more than six months), programming through which to receive sentencing credit, commissary or item availability, shorter visitation time, temperature concerns and lack of vending products in the visitation room, concerns

about their living area being too crowded and the possible introduction of more people, and delays in payment for work, etc. at the new facility. One man described it as being a “guinea pig.” Typically, people who are incarcerated in a facility when it is starting up will face hardships. People also reported that they were not allowed to have particular items allowed at other facilities, such as hot pots, because of the mixed security classifications and populations at this facility. In addition, workers reported they had trouble getting administrative responses to their concerns and grievances as they were told the focus was on the treatment population at JTC and not workers at the facility. However, some of these concerns seem to have improved over time. We continue to stress the importance of having equivalent privileges for similarly classified people across facilities and more uniformity throughout the Department. Additionally, we continue to encourage IDOC to award discretionary sentencing credit for satisfactory work performance and other good efforts beyond program participation given programming scarcity. JHA was pleased to hear from some workers that they are given appropriate protective equipment for cleaning bodily fluids, which has been an issue in the past and at other facilities.

Because JTC was a newly opened facility, one individual described the experience of being an incarcerated worker as feeling like a “guinea pig.”

Issues with Staff Reported

JHA visitors felt staff should receive more training regarding incarcerated people's rights to assistance. Several people incarcerated at JTC reported that certain staff seemed non-responsive to their concerns. Some people said that appropriate signs were not always used on cell doors, e.g. for crisis watches or for identifying someone as hard of hearing, etc. There were a few reports of staff inattention, even of staff sleeping, and of some staff bringing frustrations and problems in their home life to work, negatively impacting their professionalism. Staff wellness and professionalism should be emphasized, as it affects everyone.

JHA received a few specific reports regarding concerns about staff use of force and lack of timely, appropriate follow up on reports made under the Prison Rape Elimination Act (PREA) both at JTC and at other facilities where individuals had been previously incarcerated prior to JTC. In addition, we have heard some concerns regarding lack of appropriate staff response to threats or violence between prisoners. JHA believes all claims should be thoroughly and impartially investigated and that IDOC should work to ensure that there is no retaliation or impression of retaliation for reports made in good faith.

As reported in IDOC's Quarterly Report, there were a total of 33 instances of Staff Use of Force at JTC between March and May 2020.

Some people reported harming themselves and infrequent monitoring of this in cells by staff. Others reported there has been an increase in the use of chemical agents (Oleoresin Capsicum, OC) and a decrease in use of verbal de-escalation. IDOC is now making information about use of OC, as well as other data points, including data on crisis watches, regularly publicly available on their webpage in Operations and Management Reports and Quarterly Reports, as advocated for by JHA. Some people reported they had to resort to self-harm to get crisis attention. JHA unfortunately has heard that lack of attentiveness to requests for care and crisis intervention is a problematic area at many IDOC facilities. Again, we reiterate that people should be closely monitored and receive preventative care before a crisis emerges, not just emergency mental health responses. Staff attentiveness in monitoring people's mental health and timely responding to their needs proactively would decrease urgent demand for crisis responses. There were reports of line staff having to get a senior staff member to respond to crises, delaying responses. All staff at these specialized facilities should be crisis trained and able to respond effectively without undue delay.

Concerns were also raised over conflicts of interest where staff alleged to have engaged in misconduct were involved in reviewing grievances brought against them. There have also been complaints regarding harsher sanctions for minor tickets, unevenness in sanctions given to different people, use of ancient prior disciplinary tickets used to elevate sanctions, and of staff serving in the dual role of both counselor and grievance officer, depriving people of the benefit of two levels of grievance review. JHA has long recommended IDOC review disciplinary practices to promote uniformity, and we disagree that an individual's disciplinary history that is years or incarcerations ago and stale should have bearing on contemporary sanctions. Others reported that their grievances were not responded to or were not treated as emergencies as they believed them to be. JHA continues to strongly recommend improving the grievance process by shortening response time in IDOC, including objective and independent parties in the review process, and providing more transparency around the issues being grieved and the outcomes.

As JHA has observed and reported on throughout IDOC, since the change to the new polo shirt uniforms for staff, there are complaints regarding staff not having visible identification at JTC and, more worrisomely, of not providing their name when requested. It was also reported that administrators were not responsive to such concerns. JHA continues to recommend that people be informed that they can grieve staff conduct without staff names by referring instead to the time and place that an incident occurred, and administrators should be sure they track where employees are posted within the facility given this widespread concern of which they have been notified. IDOC has plans to embroider staff shirts with names using Illinois Correctional Industry (ICI); however, this will not be a quick fix.

Phone Concerns

Reportedly individuals at JTC, as has been reported on at other facilities, are trading or taking advantage of vulnerable individuals by filling out others' phone lists and using others' Personal Identification Numbers (PINs) to make more phone calls, particularly where people are placed on C Grade prohibiting phone calls. JHA opposes this restriction on communication as a discipline measure. JHA recommends that staff ensure they receive phone lists from the individual themselves and be vigilant regarding manipulation of others. We were concerned to hear from a person that when such issues were reported to staff, the reporter was told essentially to just mind his own business.

Access to Information Issues

Housing wings and units were observed to not have consistent informational postings available. JHA recommends postings be regularly reviewed throughout facility to make sure they are accessible and current. Several individuals reported to JHA that they did not have access to orientation manuals. Updated versions of orientation manuals should be readily available in facility libraries and accessible on housing units. One man reported that mail delays have caused him issues with his legal case and that he did not

have enough access to the law library. During June 2020 draft review, administrators reported that they are caught up on mail and always ensure the mailroom is staffed, noting that during the COVID-19 crisis additional precautions are in place in the mailroom with staff wearing full personal protective equipment. Others reported difficulty obtaining particular materials through the library, such as information about how to quash a warrant in another state.

Healthcare Concerns

JHA has received some complaints regarding insufficient medical response at this facility. Some people who believed they were being given wrong medications said they were not being listened to when they mentioned the side effects of drugs they were being given. Others stated that they felt that medical staff were not recording their issues when they reported them. One man reported waiting more than five months for a particular medication that he believed he needed. People said there was inconsistency regarding certain medications being permissible, both over time for the same individual and amongst different individuals, resulting in perceptions of arbitrariness and unfairness without further communication or documentation being provided for individuals explaining the medical rationale for the difference. A man reported to a JHA visitor that he had been spitting out his medication and requested to see the doctor. JHA is hopeful with the *Rasho* and *Lippert* court-appointed monitors IDOC formularies will be reviewed and better communication between healthcare providers and patients can be promoted and increase medication compliance.²

Better communication between healthcare providers and patients should be promoted. One individual at JTC reported he had been waiting more than five months for a medication he believed he needed.

General Issues

JHA did not receive as many physical plant concerns as at other facilities, in part likely due to the facility being fairly recently reopened and in part due to there being greater productive activity, programming, and out-of-cell time. We heard concerns regarding lack of adequate ventilation in cells and windows not opening. There was a report of some power outages. Some cells at the ends of the wings reportedly were very cold. Some people requested emergency call buttons in cells. Residents do not have property boxes. There were some water concerns, including that a housing unit did not have hot water for a period of several

² Class action case documents, including Monitor reports, re available on plaintiffs' counsels' webpage, <https://www.uplcchicago.org/what-we-do/prison/class-action-lawsuits.html>.

days, and problems with water discoloration, including some reports of facility laundry discoloring people's white clothing. As elsewhere, people reported that \$10 a month state pay was not sufficient to meet their needs and that this amount had not been increased in decades while prices have grown. Individuals do not receive any state pay when they are in segregation, so those who have recently earned significant segregation cuts are often without sufficient funds if they lack outside financial support. Notably, we did not receive complaints about food.

Americans with Disabilities Act (ADA) Issues Reported

Some people requiring ADA hearing accommodations reported difficulty at JTC. Some people wanted to be housed closer to the front of their housing unit so that they could have a better sense of what was going on than when they were housed towards the back of wings. One man said he recently had TTY phone use taken away but that he was not provided a reason why and that he had waited three months for hearing aids. Others reported delays or that they were not getting appropriate assistive headphones, in some cases having to buy them on commissary when they were supposed to be provided by IDOC for free. In February 2020 at Pontiac, JHA was told by administrators that many young men are now requesting and failing hearing tests, which has challenged IDOC's ability to keep up with demand for assistive equipment that is provided at State expense and making prioritization based on need difficult.

Elgin

JHA staff visited Elgin in February 2019. However, during that visit we primarily spoke with staff and administrators because the individuals housed at the facility were either in treatment or not particularly communicative, perhaps due to illness or medication effects. Elgin began housing women from IDOC in April 2018 and men in October 2018. At Elgin, men and women are housed on different wings and do not mix. People reportedly have free movement from their room to dayroom areas during the day and are confined to their cells/rooms no more than 12 hours per day. JHA requested but was not provided with schedules. Food and laundry for the population are handled by the Department of Human Services.

Administrators said that while security factors such as high escape risk, history of violence, offense type, predatory behavior, etc., do not automatically preclude someone's placement at Elgin, such factors are weighed in the placement decision. Committing offense types appear to be diverse, and this information is regularly publicly reported in IDOC's Quarterly Reports made available on their webpage. Administrators reported weekly multidisciplinary team conference calls, including mental health and operations staff, were held to discuss admissions of inpatient referrals from other facilities. Clinical needs and level of care needs reportedly take precedence and drive placement decisions over other considerations such as security level or diagnosis. Administrators stated that it was not the policy that individuals could only be transferred to Elgin when stable, which was the impression JHA was given by staff at some sending facilities regarding why individuals on extended crisis watches would not be transferred to a more intensive treatment setting. Clarification of policy around transfer to Elgin, including facility priorities and what levels of need and care among the prisoner population can be accepted, should be provided to all IDOC facilities and administrators.

Elgin is intended to be an intensive treatment setting that stabilizes patients and reduces their needed level of care, although administrators stated that the hospital level of care would remain the appropriate level of care for some. Patients are intended to step down to a Residential Treatment Unit (RTU) level of care in

As of May 31, 2020, Offense Types of people housed at Elgin were reported as:

- **68.75% (11) Person**
- **18.75% (3) Sex**
- **12.5% (2) Property**
- **0% Drug**

Offense Classes were:

- **31.25% (5) Murder**
- **18.75% (3) Class X**
- **6.25% (1) Class 1**
- **31.25% (5) Class 2**
- **12.5% (2) Class 3**

30-60 days on average. It was not clear whether that was occurring. Administrators reported that segregation is not used at Elgin and that this had not been a problem.

When JHA asked what administrators needed to get to purported capacity of 22 women and 22 men, we were informed that they were being cautious because they want to be successful and have to allow for the newness of the staff and treatment. There was reportedly no waitlist for placement.

At the time of our February 2019 visit, staff reported patients have many more mental health interactions and contacts with higher-level practitioners than in other treatment settings. A high percentage of the population was on enforced medication. Staff are able to work one-on-one with people who are reluctant to come out of their rooms or participate in group. Elgin administrators reported staff success with using de-escalation techniques and using incentives to promote good behavior with a level system of privileges and points given to purchase items like hygiene products as a reward for positive conduct like group participation. Under the incentive system, people can earn other rewards including snacks, extra phone calls, lunch with staff, or “glamour time,” where a patient gets her makeup and nails done. Elgin uses a soothing room with a pleasant sensory environment where people can go to calm down. Because of greater staffing, people who are on crisis watch reportedly can at times continue to participate in programming at Elgin, which seems to be good practice.

Next Steps

JHA hopes on subsequent visits to observe more programming and interview more people at these facilities to get a fuller impression. Going forward, we hope that IDOC will be able to articulate the relationship between treatment settings and how individuals are placed in particular settings. It is no surprise that smaller, better resourced settings result in more humane treatment, but the lessons to be learned and extrapolated from them departmentally remain to be seen. We celebrate the efforts of everyone involved in the creation and success of these facilities to date but encourage pushing beyond comfort in terms of available bed space, amount of mental healthcare contact, and prioritizing positive incentives over discipline for the good of the many people within IDOC who still lack adequate assistance.



This report was written by JHA staff. Media inquiries should be directed to JHA's Executive Director Jennifer Vollen-Katz at (312) 291-9555 x205 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 humbly thanks everyone who graciously shared their experiences and insights with us.

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