E-FILED
Friday, 23 October, 2020 06:50:51 PM
Clerk, U.S. District Court, ILCD

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

ASHOOR RASHO, et al.,	)	
	)	
Plaintiffs,	)	No. 1:07-CV-1298-MMM-JEH
	)	
v.	)	Judge Michael M. Mihm
	)	
ROB JEFFREYS, et al.,	)	
	)	
Defendants.	)	

PLAINTIFFS' SECOND RENEWED MOTION AND MEMORANDUM REQUESTING THAT DEFENDANTS' BE FOUND IN CONTEMPT FOR VIOLATIONS OF THE COURT'S APRIL 2019 INJUNCTION ORDER

Plaintiffs submit this renewed motion for trial on Defendants' continued failure to comply with this Court's permanent injunction order. Plaintiffs move for a finding of contempt as to the following sections of this Court's April 23, 2019 Injunction Order:

- Section 1 (a)-(c) (Staffing)
- Section 2(a), (b), (c), (e), (f), and (g) (Crisis Care)
- Section 3(a), (d)(i) and (vi), (e) and (f) (Segregation)
- Section 5(a) (Treatment Planning) (b) (Initial Evaluations)

While Defendants have also failed to fully comply with other areas of the Court's Order, as well as the Settlement Agreement, this motion is limited to seeking additional civil sanctions to coerce compliance due to Defendants' failure to take the urgent steps necessary to comply with these specific terms. These failures are causing substantial and ongoing harm to the Plaintiff class including exacerbation of symptoms such as depression, anxiety, paranoia, delusions, and mania, which in turn is met by the Department with further isolation, leading to additional deterioration, behavioral acting out, self-harm and more. Without the interventions ordered by the Court more than one year ago, the cycle of deterioration and harm continues.

It is impossible to quantify the injury to the Plaintiff class caused by Defendants' contempt of the Court's order, but that contempt has saved roughly $15 million in wages over the course of their noncompliance and saves at least $1 million per month for as long as the contempt persists.

I. Legal Standard for Contempt

A party may be held in civil contempt when there is clear and convincing evidence that (1) the Court's Order sets forth an unambiguous command; (2) Defendants violated that command; (3) the violation was significant, meaning that it did not substantially comply with the Order; and (4) Defendants failed to take steps to reasonably and diligently comply with the Order. *See Bailey v. Roob*, 567 F.3d 930, 935 (7th Cir. 2009).

Absent a stay, a party compelled by a court order must obey that order regardless of any disagreement its terms. Unlike Defendants' unkept promises throughout the first decade of this litigation, a party's failure to comply with a court order risks being held in contempt. The obligation to comply is so serious that contempt may properly issue even where the party believes it to be incorrect and, indeed, even if the order is ultimately held to be incorrect. *Maness v. Meyers*, 419 U.S. 449, 458 (1975) ("We begin with the basic proposition that all orders and judgments of courts must be complied with promptly ... Persons who make private determinations of the law and refuse to obey an order generally risk criminal contempt even if the order is ultimately ruled incorrect."). As the Seventh Circuit explained in *McNaughton v. Harmelech*, 932 F3d 558, 565 (7th Cir. 2019), "regardless of whether MacNaughton agreed with the Holderman Order, he had to follow it unless and until it was undone through proper channels, such as reconsideration by the district judge or vacatur by us … . MacNaughton served as his own attorney but not as his own judge."

The parties' settlement agreement contemplates the failure to comply with an enforcement order may be met with a finding of contempt:

> If Plaintiffs contend that defendants have not complied with an order entered under the preceding paragraph, they may, after reasonable notice and a meeting with defendants, move for further relief from the Court to obtain compliance with the Court's prior orders.

Amended Settlement Agreement, Sect. XXIX (i).

Courts have "inherent power to enforce compliance with their lawful orders through civil contempt," *Spallone v. United States*, 492 U.S. 265, 276 (1990), and district courts have great discretion in both ordering contempt and fashioning the necessary relief, particularly in areas where the court, as here, has overseen complex litigation involving systemic constitutional reforms. *See Rufo v. Inmates of Suffolk County Jail,* 502 U.S. 367, (1992) (O'Connor, J., concurring); *see also Hutto v. Finney,* 437 U.S. 678, 688 (1978) (substantial deference given to district court's "years of experience with the problem at hand"). "A court that invokes equity's power to remedy a constitutional violation by an injunction mandating systemic changes to an institution has the continuing duty and responsibility to assess the efficacy and consequences of its order." *Brown v. Plata*, 563 U.S. 493, 542 (2011).

The question of whether Defendants' efforts have been "reasonably diligent" is a factual assessment under an objective standard, not premised on intent but how the efforts measure against the needs at hand. *Taggart v. Lorenzen,* 139 S. Ct. 1795, 1802 (2019). The Supreme Court explained that contempt may be equally available where a party acted in bad faith with a "record of continuing and persistent violations" or, on flip side, where the party acted in good faith to comply but failed to adequately do so. *Id.* Plaintiffs need not demonstrate that Defendants' failure to comply was willful if Defendants have not been reasonably diligent and energetic in their attempts to comply. *Bailey v. Roob*, 567 F.3d at 935.

In *Shakman v. Democratic Org. of Cook County,* 533 F.2d 344 (1976), for example, the Seventh Circuit rejected the City's argument that its directives to employees to comply with the court's order was sufficient. "The orders of the Court must be obeyed, and to absolve a large or small corporate defendant from its responsibilities simply because the corporation has ordered compliance but has not sufficiently policed same, would be to open the door for wholesale disobedience of the Court." *Id.* at n.13. As demonstrated below, the same is true here. IDOC may have informed its facilities of the Court's order, but it has once again failed to turn policy into practice. This failure to implement the Court's order requires a contempt finding.

Plaintiffs are thus entitled to both remedial relief that compensates them for the losses sustained as a result of Defendants' failure to comply with this Court's injunction, as well as relief geared at coercing them into compliance. *See Shakman v. Democratic Org. of Cook Cty.,* 533 F.2d 344, 349 (7th Cir. 1976). In determining compensatory relief, a court typically considers evidence of the Plaintiffs' actual losses and awards a fine, payable to the Plaintiff, accordingly. As for coercive relief, a court has broad discretion to fashion relief based on its consideration of "the character and magnitude of the harm threatened by continued contumacy, and the probable effectiveness of any suggested sanction in bringing about the result desired." *United States v. United Mine Workers of Am*., 330 U.S. 258, 304 (1947).

Here, Defendants' failure to comply has caused real harm to the Class due to lack of adequate care, though calculating that ongoing suffering is impossible. The nearest proxy is the amount of wages Defendants have been able to save by flouting this Court's staffing requirements. We therefore request that the Court order Defendants to pay into the Registry of the Court a monthly fee equivalent to the cost of clinical staffing that Defendants fail to provide to Class Members.

II. An Order of Contempt is Required to Coerce Compliance with this Court's Order.

Here, the Court's commands were unambiguous. The evidence is clear and convincing. As elaborated below, the Monitor's reports, data produced by Defendants, and Defendants' own self-certifications demonstrate continuing violations of this Court's order, not the least of which is Defendants failure to hire the staff they were required to within 90 days of the April 2019 order.[1] As to the substantive care requirements, throughout their quarterly reports, Defendants continue to cite to the same policies in crisis and segregation care that were in place when this Court found that they were failing to comply with constitutional standards, as evidence that they are somehow now in compliance. Defendants have obstinately refused to even acknowledge that their staffing has been and continues to be inadequate despite that it is thousands fewer hours than Defendants themselves have contracted for with their vendor. Meanwhile, at the largest receiving center in the state, Defendants have failed to increase staffing and do not even collect data on the backlogs of initial treatment evaluations at this single facility, where most initial mental health evaluations should take place.

And while Defendants, we assume, will point to reductions in backlogs of evaluations and treatment plans as evidence of their good efforts, the reality is that the treatment plans being generated still tend to be boilerplate, generic pieces of paper that are not even being implemented in many facilities, rather than meaningful, individualized plans to provide substantive care—exactly the situation that the Court found failed to meet constitutional requirements. As to the backlog reduction, the unprecedented drop that occurred early in the COVID-19 lockdowns was both temporary (as the numbers started to increase dramatically in August), and is not an

[1] In fact, Defendants failed to reach the staffing numbers ordered in this Court's original permanent injunction order, issued in December 2018, within 90 days of that order. They similarly failed to comply within 90 days of the re-issued order in April 2019 order.

indication of care actually being provided. Instead, just the opposite is true—the reductions merely reflect that forms were being completed and boxes were being checked through cell-front contacts, which did not constitute any substantive care for Class Members.

A. Defendants Have Not Complied with the Court's Order to Conduct Timely Evaluations at the Northern Reception Center

Stateville's Northern Reception Center (NRC) is by far the largest receiving system in the state, processing approximately 66% of the system's intakes. Although not designed for long term care, many Class Members remain at NRC for weeks to months prior to being transferred to a parent facility. Despite this reality, NRC has routinely failed to conduct the mental health evaluations that are needed to understand and provide for the individual's treatment needs. The Court's order, Section 5(b), however, requires that, "Mental health evaluations shall be conducted in a timely manner to ensure that individuals in need of treatment, or re-evaluation of existing treatment, are evaluated without undue delay."

Shockingly, to date the IDOC has not even *kept* data on the backlog of mental health evaluations at the NRC. This is alarming, given that the NRC is where the majority of new intakes enter the IDOC system and where the majority of initial evaluations should take place.

In February, prior to the pandemic, the Monitor visited NRC and found that it had approximately 285 backlogged evaluations. Defendants continue to leave NRC out of their backlog reporting; its inclusion in February would have doubled the system's total backlog. ECF No. 3038, Monitor's June 2020 Report at 16, 17-18. Unsurprisingly, the Monitor has pointed out that IDOC's staffing plan for NRC calls for an insufficient number of QMHPs to fulfil that facility's vital function as the primary receiving center for the state. For example, in just two months, December and January, NRC processed 2,336 new intakes, all of whom would have had the initial screening for mental illness at intake. Hundreds of those individuals will then require

more in-depth mental health evaluations, treatment planning, and substantive mental health treatment during their stay at NRC, as do the many Class Members housed at NRC temporarily for court or medical writs. IDOC's staffing plan, however, provides for 6 QMHPS and no staff psychologists. ECF No. 3093 July 2020 Qtly Report (Agreement) Att. 2 at 68; ECF No. 2977, IDOC's April 2020 Qtly. Report (Agreement) Att. 2 at 69. Six QMHPs are simply insufficient to perform the daily intake responsibilities, and also conduct evaluations and provide treatment for those in its population. ECF No. 3038, Fourth Annual Report at 18 ("The solution is very straightforward. That is, provide NRC with an adequate number of QMHPs.").

Despite the Monitor pointing out the flaw in NRC's approach to initial evaluations back in February, the IDOC still does not report backlog numbers for initial evaluations at NRC. And, since the onset of the coronavirus pandemic, individuals have spent far longer in "intake status" at NRC than is typical due to restrictions on inter-facility transfers. The result is untold numbers of individuals languishing in a facility not built or staffed to provide mental health care, without evaluation, without a treatment plan, and without any meaningful mental health treatment.

While NRC falsely claims a compliance rate of 75-85% in their self-certifications, the narrative section actually admits that it is in fact not complying the evaluations requirement as a matter of course:

> All offenders transferred to NRC, including those with a known mental illness, are assessed by a qualified mental health professional (QMHP) utilizing the DOC 0372 (Mental Health *Screening*) within 24 hours of their admission to the facility. Those identified needing mental health services are referred for *psychiatric services* upon this assessment and are seen within the appropriate clinical timeframe (with 30 days being the latest follow-up date). When the offender comes in on psychotropic medications from county jail, the medications are continued and the offender is seen by psychiatry, with a full evaluation completed by the psychiatrist, within 30 days of admission.

ECF No. 3092, July 2020 Qtly Report, Att. 3 at 150 (emphasis added). First and foremost, a

mental health screening is not equivalent to the mental health *evaluation*. The *screening* is a short assessment done immediately at intake to identify individuals for whom mental health services are needed. A mental health *evaluation* is conducted to assess the individual's mental illness and treatment needs. From the evaluation, the staff have an understanding of the person's mental illness and how it affects them. It is only following that evaluation that their treatment needs (separate from medications) can be assessed and provided for.

The NRC instead relies on a cursory screening, which is used to identify individuals who need to see a psychiatrist to get their medications continued—by the facility's own admission, no other mental health treatment is initiated or provided as a result of the mental health screening. Nor do the psychiatric "evaluations" referred to in NRC's self-certifications initiate any treatment planning or treatment provision—these are merely evaluations to determine psychiatric medications, and are not equivalent to the mental health evaluations ordered by this Court.

B. Crisis Care

Defendants continue to overuse and understaff these 24-hour-a-day placements, where Class Members are put in a stripped-out cell with little-to-no property or clothing, resulting in extensive harm to Class Members, as this Court has repeatedly found. Defendants continue to rely on the same protocols that they developed in response to this Court's preliminary injunction (which this Court found insufficient to provide constitutional care at the permanent injunction hearing). Indeed, Defendants have not changed their approach to crisis watch in any meaningful way, nor are they likely to make any meaningful change without significant increases in staffing.

The purpose of crisis placement is to observe people when they are acutely at risk of harm to themselves or others *while* providing immediate, intense interventions to stabilize sufficiently to move to an appropriate level of care setting. The watch should occur in a

therapeutic setting with mental health staff continuously available to provide the care required to stabilize the patient enough that they can be placed in a less intrusive setting and receive the treatment they need for stability. When patients fail to stabilize enough to reduce the imminent risk of harm, they need to be immediately placed in inpatient care (i.e., hospitalization).

The Monitor found that the IDOC has not complied with any of the six terms of the Court's Order on crisis care. ECF No. 2841, Monitor's Jan. 2020 Report at 12-18; ECF. No. 2715, Monitor's July 2019 Report at 10-14. With this Motion, Plaintiffs move for a finding of contempt in all subsections of Section 2 of the Court's Order except for Subsection (d) (requiring that daily assessments be conducted confidentially).

(a) Defendants Continue to Hold Patients on Crisis Watch for Far Too Long Instead of Transitioning to Appropriate Models of Acute Care, in Violation of Sect. 2(a)

Defendants were ordered to ensure that crisis watches were used for the shortest duration possible, where no less restrictive treatment is available, and, for those who do not stabilize, provide a plan for transfer to a higher level of care. Order, Sect. 2(a), (f). Defendants have failed to comply with these orders.

Crisis watches (or, seclusion) should be measured in *hours not days,* as it is only meant to be used during the moment of acute threat of harm to self or others. This intervention should only occur for longer periods in extraordinary circumstances, yet in the IDOC, patients on crisis watch are only assessed for progress and stability once per day—meaning that the shortest possible duration is, at minimum, 24 hours, regardless of the individual patient's needs. Inherent to crisis watch is an extreme level of isolation and deprivation that itself is harmful and contraindicated for mental illness. The dangers presented by sustained crisis placement are the reason such long placements are abjured in other systems.

Yet the Monitor has concluded that IDOC continues to place people on crisis watch when it could be avoided by proper use of psychotropic medications and keeps people on watch far longer than necessary. ECF No. 3097, Monitor's July 2020 Compliance Report at 12-14; ECF No. 2841, Monitor's Jan. 2020 Report at 12. This year, the Monitor reviewed data from 2,499 crisis watch placements (in June, September, February, and April) and found that 21% exceeded 10-days. ECF No. 3097, Monitor's July 2020 Compliance Report at 12. Only 34 of the 526 patients who were on watch for longer than 10 days were there because they were waiting to be transferred to a higher level of care after a timely referral was made. *Id.* at 17. And of course, as noted above, ***all*** of those 2,499 people remained on watch for at least 24 hours—which itself is longer than is acceptable in most instances.

In fact, the Monitor's most recent report found that the number of crisis watch placements lasting over a month has ***almost tripled*** in the last year. ECF No. 3097, Monitor's July 2020 Compliance Report at 17. The Monitor has consistently warned that crisis watch placements lasting more than a month are an inherently inappropriate use of that treatment setting, and yet 163 patients in the sample reviewed in July 2020 had been on crisis watch for one month or more. *Id.* Of those, 23 had been on watch for 3 months to one year. ECF No. 3097, Monitor's July 2020 Compliance Report at 12.

Many of the individuals on crisis watch for these excessive periods are not referred for a higher level of care. ECF No. 3097 Monitor's July 2020 Compliance Report at 17. No. 2841, Monitor's Jan. 2020 Report at 13. For these individuals, a prolonged need for crisis watch placement indicates that they are not stabilizing and therefore require further interventions (ie, a higher level of care). While the Monitor noted slight improvement in referrals, only 16% of individuals who spent more than 10 days but less than a month on crisis watches (59 out of 363)

were referred to a higher level of care, such as a residential treatment unit or inpatient treatment. Shockingly, of those who ***a month or more*** in the extremely isolated setting of crisis watch, only 30% were referred to a higher level of care. ECF No. 3097 Monitor's July 2020 Compliance Report at 17. As the Monitor explains, "[q]uite a number of other patients whose stays exceeded 10 days should also have been referred, but in cases of one month or more there is no doubt." *Id.*

For those who are referred for transfer to a higher level of care facility, significant delays ensue. Of the 96 individuals referred to a higher level of care in the 11-month period leading up to the Monitor's July 2020 report, only 20% of patients were transferred within a week of referral. ECF No. 3097 Monitor's July 2020 Compliance Report at 19. Worse, 15 of the 96 individuals referred waited 3 to 10 ***months*** for a disposition of their referral. *Id.*

Meanwhile, Elgin Treatment Center, which was opened specifically for the purpose of providing a higher level of care for this population, has less than half of its beds in use with only 17 residents. Those 17 patients are staffed by 2 full time psychiatrists, 3 psychologists, 5 CNAs, and at least 4 state-employed QMHPs. And, yet, IDOC has continuously refused to move Class Members in need of hospitalization to Elgin Treatment Center.

(b) Defendants Are Not Providing Appropriate and Individualized Treatment, Interventions, or Out-of-Cell Time to Stabilize Class Members on Crisis Watch

Whether due to a lack of sufficient staffing, or simply an unwillingness to admit to the unconstitutionality of its practices, Defendants have not implemented the necessary changes to provide the treatment, interventions, and out-of-cell time that are required for a patient in acute mental health crisis, as required by Section 2(b), (c), and (g). These sections require the IDOC to "provide appropriate mental health treatment to stabilize the symptoms and protect against decompensation" (Sect. 2(b)); "reevaluat[e] treatment and medications as needed" and provide

necessary interventions (Sect. 2(c)), and provide "out of cell time for confidential counseling and groups, psychiatric care, therapeutic activities, and recreational or leisure activities unless clinically contra-indicted" (Sect. 2(g)).

Instead of implementing the requirements of the Court's order, the IDOC has continued the same crisis care protocol—put forward in response to the preliminary injunction proceedings—that the Court and the Monitor have previously found unacceptable. Pursuant to that protocol, all Class Members on crisis watch are to be (1) seen once per day by a QMHP out-of-cell session (generally for 15 minutes) for both assessment and therapeutic interventions; (2) referred for psychiatric care; and (3) considered for out-of-cell time only once they have spent 10 days on crisis watch. Additionally, their treatment plans are to be updated with their crisis status. This same schedule of standardized care was found inadequate—at both the preliminary and permanent injunction hearings—to fulfill either the requirements of the Settlement Agreement or the Eight Amendment of the Constitution. Having maintained these practices, Defendants have defied the Court's Order. The Monitor has repeatedly explained that the minimal care under IDOC's crisis protocol is insufficient for the needs of Class Members in acute crisis. ECF No. 3097, Monitor's July 2020 Compliance Report at 12; ECF No. 3038, Monitor's June 2020 Report at 40; ECF No. 2841, Monitor's January 2020 Report at 13; ECF No. 2798, Monitor's Dec. 2019 Report at 39; ECF No. 2715, Monitor's July 2019 Report at 10.

The single daily session required by IDOC's policy is most often the *only* treatment and out-of-cell time provided on crisis watch, aside from a brief psychiatric visit for most (but not all). ECF No. 3097, Monitor's July 2020 Compliance Report at 14 ("In an eight-facility study of 45 mentally ill offenders on a crisis watch, the monitoring team found that there is no additional treatment offered except brief daily checks, possibly a psychiatric visit and treatment

planning."); *see also* ECF No. 2841, Monitor's Jan. 2020 Report at 13. Many of the QMHP daily contacts are limited to the daily assessment, and do not include the additional therapeutic interventions, despite having been specifically ordered by the Court. ECF No. 3038, Monitor's June 2020 Report at 40; *see also* ECF No. 2841, Monitor's Jan. 2020 Report at 13 ("many still resembled an assessment alone"). Without treatment and therapeutic activities, those experiencing decompensation are unlikely to stabilize as they sit alone in an isolated cell for 23.5 hours a day or more.

Further, the psychiatric care referrals previously touted by Defendants frequently are not timely relative to the urgent need presented by crisis. In the Monitor's most recent review of 2,499 crisis watches, only 41% of individuals saw a psychiatric provider within the first day of watch—"the standard the Monitor would expect for a crisis setting." ECF No. 3097, Monitor's July 2020 Compliance Report at 14. Another 13% did not see a psychiatric provider *at all* during their crisis placement—this number frequently was not explained by a very short crisis stay. *Id.* This reality has, unfortunately, remained consistent throughout the year and half of the court order. *See* ECF No. 3038, Monitor's June 2020 Report at 40 (Monitor found that a full 15% of sampled crisis watch files showed no psychiatric contact at all during watch placement, particularly at Lawrence, Illinois River, Graham, Hill, Menard, Pontiac, and Lincoln); *see also* ECF No. 2851, Monitor's Jan. 2020 Report at 14 ("Fully 14% appeared to have no psychiatric contact; frequently, this was *not* explained by a very short crisis stay.").

Likewise, the Monitor has found that treatment planning for those in crisis does not provide support for stabilizing symptoms and protecting against decompensation. A study of crisis watch treatment plans found that nearly half of the treatment plans reviewed did not individualize the problems, goals or interventions for the patient." ECF No. 3097, Monitor's July

2020 Compliance Report at 15; *see also* ECF No. 2841, Monitor's Jan. 2020 Report at 14 (Monitor's finding that many of the plans during this crucial period (where acute care should be provided) missed key problems, were irrelevant to the patient, or did not contain discernible information regarding the patient, instead only listing "the *Rasho*-required contacts" (i.e., daily assessments, treatment plan updates and psychiatric referral)).

Moreover, the treatment provided during watch placement does not change over the duration of the watch, meaning that Defendants are failing to reevaluate patients' needs and provide appropriate interventions as required by Section 2(c). As the Monitor has found, psychiatric reevaluations of medications still occur only in the minority of cases and extended stays on watch are not met with the reevaluations to find the effective treatment to stabilize. ECF No. 2841, Monitor's Jan. 2020 Report at 14-15; ECF No. 2715, Monitor's July 2019 Report at 12. In one study of 64 crisis watches across eight facilities, the Monitor found that only half of the crisis patients had their medications reevaluated while on watch. ECF No. 2841, Monitor's Jan. 2020 Report at 14-15. As to reevaluation of other treatment during the watch, the Monitor reports that in a review of 22 crisis placements that exceeded one week, only a minority (18%) had documentation of reevaluation of treatment.

With regard to out-of-cell activities, the Court ordered Defendants to provide "[o]ut of cell time for confidential counseling and groups, psychiatric care, therapeutic activities, and recreational or leisure activities *unless clinically contra-indicted.*" Section 2(g) (emphasis added). But IDOC's Quarterly Report claims compliance with its own protocol instead of with the terms of the Order. *See* ECF 2978, Quarterly Report, at 10 (stating that only those on watch **for longer than 10 consecutive days** are to have "one hour out of cell time on both first and

second shift respectively, **if clinically appropriate**.).[2] That protocol, however, is for the daily QMHP assessment sessions—it does not provide for any "groups, [], therapeutic activities, and recreational or leisure activities." Even the two-hours out-of-cell time that it does allow for is only *considered* once the patient has been on watch for ten days (an extraordinary amount of time in isolation). It is further limited by requiring a finding that it is clinically appropriate. The language of the Court's order is the opposite—"unless clinically contraindicated" means that the presumption is that the patients will receive the out-of-cell time.

The Monitor continues to find a lack of groups, therapeutic activities, and recreational and leisure activities offered. ECF No. 3097, Monitor's July 2020 Compliance Report at 20. Indeed, the Monitor found that only one facility was providing any group therapy for patients on crisis watch, and only two facilities were providing other additional out-of-cell leisure time, consisting of one hour of time in a "bullpen cage." *Id.* Far from providing the appropriate mental health treatment to stabilize and prevent decompensation as ordered by this Court, Defendants continue to subject Class Members to this extreme form of isolation, 23.5 hours a day, or more, with no engagement, treatment or activity. This is cruelty in the guise of care.

(c) Defendants Do Not Provide the Treatment Planning Upon Discharge from Crisis Watch As Ordered by the Court

Section 2(e) of the Court Order requires that:

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

[2] This two hours of out-of-cell time is not consistently provided. When it is, it typically consists of the patient spending time alone in a different space (often the corridor, yard cage, holding cell, or shackled to a table in the gallery).

The failure to conduct adequate treatment planning for people discharging from crisis watch has persisted despite the Court's Order. The Monitor has consistently found non-compliance with the requirements of Sect. 2(e). ECF No. 3097, Monitor's July 2020 Compliance Report at 16-17; ECF No. 2841, Monitor's Jan. 2020 Report at 16; ECF No. 2798, Monitor's Dec. 2019 Report at 26; ECF No. 2715, Monitor's July 2019 Report at 13. While the Monitor's most recent report noted improvement in the ***completion*** of the forms,[3] the contents of the plans are still quite problematic, and patients are sometimes excluded from the process, particularly at Joliet, Sheridan, and Elgin.

For most, the problem is one of quality and substance. The treatment plans simply lack the meaningful individualization, including to "address causes which led to the deterioration and the plan for risk management to prevent relapse." Order, Sect. 2(e). The Monitor has continuously found, since the issuance of the Order, that the discharge treatment plans most often do not appropriately capture the problems faced by the patient, their treatment goals, or the interventions needed.

> On problems and goals, 36% of the plans captured these well, and an equal number were adequate but had minimal content and minimal tailoring to the patient; 28% were insufficient. The interventions were of greater concern. The majority were insufficient, though 18% captured these well, and another 21% were adequate. The nature of the deficiencies in the problems, goals, and interventions is described in section 2(b), above. At Joliet, in every case, staff wrote that no update was needed on admission and discharge—so the outpatient treatment plan was maintained during and after the crisis watch—which appears contrary to this provision of the Court's orders.

ECF No. 2841, Monitor's Jan. 2020 Report at 16; *see also* ECF No. 3097, Monitor's July 2020

[3] The Monitor's findings in both the January 2020 and the Midyear 2019 reports found that 12% of crisis discharges did not have an updated treatment plan at all. ECF No. 2841, Monitor's Jan. 2020 Report at 15; ECF No. 2798, Monitor's Dec. 2019 Report at 25-26. In the July 2020 Compliance report, he calculates a 94% completion rate while noting that the logs produced by the Department indicated a higher rate of completion than he could verify through his review of the sample provided to the monitoring team. ECF No. 3097, Monitor's July 2020 Compliance Report at 16.

Compliance Report at 17 ("The greater difficulty was whether the contents of the plans constitutes addressing the causes which led to the deterioration and the plan for risk management to prevent relapse. While a form was completed, the content was problematic fairly often.").

In their self-certifications of compliance—documents that Plaintiffs, as a general matter, object to as being without foundation, baseless and inadmissible—three facilities admit to non-compliance with this Court ordered requirement. In April and in July of this year, Illinois River, Lawrence and Western all rated themselves as 50-75% partial compliance only, with Illinois River and Wester both citing short staffing as a barrier. Att. 3 to ECF No. 2978, IDOC's April 2020 Qtly Report at 111, 127 and 191; Att. 3. To ECF No. 3092, IDOC's July 2020 Qtly Report at 100, 112 and 160.

While review of the treatment plans from other facilities demonstrates that the problem is more widespread than these three admissions, they are—even standing alone—damning. In July 2020, these three facilities had 97 crisis watches.

C. Defendants Have Failed to Implement Changes to Segregation Care Required to Prevent or Respond to Decompensation

The Monitor has repeatedly explained that, as a matter of mental health and psychiatry, "*any* amount of time spent in segregation by mentally ill offenders is detrimental to their mental health." *See e.g.,* ECF No. 3038, Monitor's June 2020 Report at 54. Therefore, whenever segregation is utilized, IDOC must strictly adhere to the requirements for assessments, treatment, and out-of-cell time in order to "minimize the unnecessary harm inflicted upon this cohort." *Id*. IDOC's failure to do so continues, and so too does the harm inflicted upon these Class Members. Violations of nearly all of the Court's Order under Section 3 continue to occur. However, because of recent changes to the Department's segregation policy (which may bring some reductions in the use of segregation), this motion for contempt focuses on four of the Order's

requirements relating to the treatment required for those in segregation to prevent and respond to decompensation: Sect. 3(a) (assessment to establish a baseline upon placement); Sect. 3(d)(i) and (vi) (treatment to protect from decompensation, including structured and unstructured out-of-cell time for class members in segregation longer than 16 days); and Sect. 3(f) (determinations of when a higher level of care is necessary).

(a) Defendants Fail to Conduct Court-Ordered Assessments for Class Members in Segregation

Section 3(a) of the Court's Order requires a mental health professional to assess Class Members who are placed in segregation "to establish a baseline against which any future decompensation can be measured." The assessment is to be documented in a manner that facilitates access and review by subsequent treatment staff. In the Monitor's July 2020 Compliance Report, the Monitor analyzed 933 placements in restrictive housing and found violations in 27% of the cases. 15% of cases reviewed had no evidence of the baseline assessment occurring and in another 8% the assessment was completed unreasonably late—up to two weeks after placement. ECF No. 3097, Monitor's July 2020 Compliance Report at 21.

The finding that baseline assessments were not completed timely in 27% of new segregation placements is significant in itself, but is not fully representative of the ongoing failure to comply with this term in a meaningful way. The compliance rating is based on whether or not documentation is contained in treatment files (often via IDOC's new segregation screening form).[4] But it appears that the assessments, when documented, do not result in the removal of patients from segregation even where deterioration is documented at the time of the assessment or thereafter during the segregation placement. This suggests that these assessments

[4] *See* ECF 2978, April Qtly. Report, at 11 (citing to the new form and the presence of documentation as the basis for claiming compliance with the requirement for a mental health review and recommendations for treatment).

are formulaic and are not being used as intended—to review and respond to signs of decompensation before more harm occurs.

Putting aside the quality concerns, in IDOC's proffered "certifications" attached to the Quarterly Report, five facilities continue to admit to non-compliance with IDOC's procedure related to this requirement. ECF No. 3092 IDOC's July 2020 Qtly Report at p. 11 and Att. 3 at 98 (Hill), 101 (Illinois River), 128 (Pinckneyville), 152 (Taylorville) and 161 (Western.). These same facilities reported noncompliance in April 2020 as well, along with Graham and Lawrence. ECF No. 2978, IDOC's April 2020 Qtly Report at 12 and Att. 3 at 104 (Graham), 108 (Hill), 112 (Illinois River), 128 (Lawrence), 180 (Taylorville), 148 (Pinckneyville), and 192 (Western). As of the most recent segregation population data that Plaintiffs received this summer, these seven facilities housed 136 prisoners with mental illness in segregation. And these numbers, as disturbing as they are, significantly undercount the number of people harmed by Defendants' failure to comply with the Court's order, as they are just a "snapshot"—that is, the number of people in segregation on a single day. Many more people would have come in and out of segregation over the months that defendants have been defying the Court's order.

Section 3(f) of the Order requires that, "Mental health staff shall assess class members in Control Units to determine if a higher level of care is necessary and if so, to make proper recommendations to facility authority." Although these types of assessment occur, the recommendations are not made at sufficient numbers relative to the needs of the severely mentally ill prisoners in segregation.

The Monitor awards Defendants a "no rating" on this term, explaining that "[r]eferrals to a higher level of care from Control Units is not a metric for which IDOC provides data. ECF No. 3097, Monitor's July 2020 Compliance Report at 26. The fact that compliance with this

requirement evades review does not make it unimportant, and the Monitor has explained that, in his experience, when a patient decompensates in a Control Unit, they sometimes are admitted to a crisis watch, but often times are left in the Control Unit. Referrals to levels of care beyond crisis are often made only once the patient is referred to crisis.

(b) Defendants Fail to Provide Care Sufficient to Protect Class Members in Segregation For 16 or More Days from Decompensation

For Class Members who remain in segregation for 16 days or more, Section 3(d)(i) requires "continuation of their mental health treatment plan with such treatment as necessary to protect from any decompensation." The Monitor continues to report this to be a problematic requirement for the purpose of monitoring compliance as it assumes the existence of a relevant treatment plan prior to the individual going into segregation. As a general matter, "the generally inadequate treatment plans may be continued while a mentally ill offender is assigned to segregated housing." ECF No. 3038, Monitor's June 2020 Report, at 56, 58.

However, the reality is that there is often not a relevant treatment plan to be continued. *Id. See also* ECF No. 2841, Monitor's Jan. 2020 Report at 20-21. In fact, four facilities admitted to non-compliance with this requirement in their self-certifications in both April and July of this year. *See* ECF 2978, IDOC's April 2020 Qtly Report at 13 and Att. 3 at 108 (Hill), 140 (Menard), 152 (Pontiac) and 192 (Western); ECF No. 3092, IDOC's July 2020 Qtly Report at 12 at Att. 3 at 122 (Menard), 131 Pinckneyville), 146 (Stateville), and 161 (Western); *see also* ECF 2978, IDOC's April 2020 Qtly Report at 13 and Att. 3 at 108 (Hill), 140 (Menard), 152 (Pontiac) and 192 (Western).

The Monitor has questioned the self-certifications of the remaining facilities reporting compliance with this term, noting treatment planning backlogs at facilities that house a large number of individuals with mental illness in segregation. ECF No. 3097, Monitor's July 2020

Compliance Report at 24. In one review of segregation placements, the monitoring team found that "only 50% of the segregation cases had evidence of treatment plans being reviewed" upon placement in segregation. *Id.* In another review of 52 segregation files, the monitoring team found that only 33 (or 63.5%) had their treatment plan reviewed and updated. *Id.*

Moreover, even when the treatment plan forms are utilized—timely or not—meaningful treatment planning is rarely provided. Segregation treatment planning is "very non-specific, generic and inadequate to address the serious mental health needs of this patient cohort." ECF No. 3038, Monitor's June 2020 Report, at 56; *see also* ECF No. 3097, Monitor's July 2020 Compliance Report at 24 ("[T]he interventions listed on the treatment plans overall were usually vague and not necessarily individualized for the treatment needs of the offender."). For example, all Class Members in outpatient segregation at Pontiac have the same treatment plan—each week they receive two movie groups and one clinical group, an individual follow-up with a QMHP every 30-60 days, and medication as indicated. ECF No. 3038, Monitor's June 2020 Report, at 56.

(c) Defendants Fail to Provide Sufficient Out-of-Cell Time to Protect Class Members in Segregation For 16 or More Days from Decompensation

The IDOC admits that it has failed to implement Section 3(d)(vi) requiring structured and unstructured out-of-cell time for those in segregation longer than 16 days. IDOC's Quarterly Reports state: "Without guidance or a requirement in the Order for a specific amount of time offenders should receive for structured and unstructured time in this area, the facilities utilized the time currently required in the Agreement in gauging compliance." *See* ECF No. 3092, IDOC's July 2020 Qtly Report at 14; ECF No. 2978, IDOC's April 2020 Qtly Report at 15; ECF No. 2782, Oct. 2019 Qtly Report at 11-12. In other words, IDOC failed to give guidance or

instruction on how to implement this requirement of the Court's order, and the facilities, in turn, failed to abide by it. *See, e.g.* ECF No. 3092, IDOC's July 2020 Qtly Report Att. 3, at 116 (Lincoln responded "other" in their certification to this term, noting "No policy for offenders in control unit for 16 days have been distributed. Please note policies for longer than 60 days have been distributed and implemented.")

However, the Court's requirement is in fact clear: provide as much out-of-cell time as is needed to prevent worsening of a patient's mental illness. To do so, staff must conduct regular assessments of patients while they are in segregation. If they are struggling or symptoms are increasing, the amount of out-of-cell time must be increased. The prerequisite to fulfilling this requirement, however, is the regular and timely assessments, which as described above, are not happening. While no quantitative data exists, scores of prisoners continue to report deterioration while in segregation. This frequently includes experiences such feeling that the walls were closing in on them, increased depression and anxiety, and even hallucinations. While they have often asked for help from mental health staff, help has rarely been provided, and certainly has not been provided to the extent needed to prevent further decompensation.

The self-certifications submitted by IDOC with its Quarterly Reports make plain that IDOC failed to require facilities to implement this provision of the Court's Order. Indeed, it is unclear what exactly the facilities are certifying. For example, in the April 2020 certifications, Pinckneyville self-certifies substantial compliance but then gives an explanation of non-compliance: it "is understaffed and we are unable to see offenders in segregation sooner than 55 days," and, even then, the explanation states that the groups are only provided to those designated as SMI (and not all Class Members in segregation more than 55 days)
Att. 3 to ECF 2978, IDOC's April 2020 Qtly Report at 148.Vandalia's April 2020 self-

certification of substantial compliance states that those in segregation between 16-55 days receive the same out-of-cell time as they received out of segregation, which entirely fails to provide any enhanced treatment called to protect against decompensation. *Id.* at 184.[5] Graham's July 2020 self-certification notes that offenders in segregation are offered yard at least two times a week, but no indication of the length of yard time is given. ECF No. 3092, IDOC's July 2020 Qtly Report, Att. 3 at 95.

Despite the lack of standards, nine facilities actually admit their lack of compliance with this requirement:

- Dixon: "Barriers to completing this task include lack of mental health staff, lack of security staff and lack of space given the large number of offenders this would apply to." ECF No. 3092, IDOC's July 2020 Qtly Report at Att. 3 at 86; ECF No. 2978, IDOC's April 2020 Qtly Report Att. 3 at 92.

- Joliet Treatment Center: Citing "administrative and medical quarantine precautions due to positive COVID case in institution." ECF No. 3092, IDOC's July 2020 Qtly Report at Att. 3 at 107.

- Lawrence: Citing compliance less than 50% of the time due to COVID restrictions. ECF No. 3092, IDOC's July 2020 Qtly Report at Att. 3 at 113.

- Lincoln: "No policy for offenders in control unit for 16 days have been distributed. Please note policies for longer than 60 days have been distributed and implemented." ECF 2978, IDOC's 2020 Qtly Report, Att. 3 at 132.

- Logan: "Medical quarantines/Level 1 Lockdowns due to the COVID-19 Pandemic necessitated cell-front contacts being made for a significant amount of time during this period." ECF No. 3092, IDOC's July 2020 Qtly Report at Att. 3 at 119.

- Menard: "Covid19 social distancing and flu/covid19 quartines/level 1 lock down impacted available space for groups and yard access over the last month." ECF No. 3092, IDOC's July 2020 Qtly Report

[5] Because most out-of-cell time in general population is through work assignments, school, and dining that is not allowed for those in segregation, this reference is presumably to out of cell time for mental health treatment activities.

at Att. 3 at 122

- Stateville: "Due to the COVID-19 pandemic, the CDC, WHO and Office of Health Services guidelines required social distancing does not allow for group activities to take place. Upon the lifting of the medical quarantine, group activities will resume when appropriate." ECF No. 3092, IDOC's July 2020 Qtly Report at Att. 3 at 146

- Stateville NRC: "Due to current mental health staffing, at this time at NRC Offenders in restrictive housing 16-55 days are not offered structured out-of-cell time." ECF 2978, IDOC's 2020 Qtly Report, Att. 3 at 176; *see also* ECF No. 3092, IDOC's July 2020 Qtly Report at Att. 3 at 146 (again explaining that 10 hours of out-of-cell time is only offered to those who have been in segregation for 55 days or more).

- Western: Cites to staffing and space constraints for non-compliance, "Request additional assistance - increase MH staffing levels; competing with group room (VRS per Holmes lawsuit)." ECF 2978, IDOC's April 2020 Qtly Report, Att. 3 at 192; ECF No. 3092, IDOC's July 2020 Qtly Report at Att. 3 at 161 ("compliance low due to inadequate MHP staff").

All of the Monitor's reports since the Court's Order have found non-compliance with this requirement. ECF No. 3097, Monitor's July 2020 Compliance Report at 25; ECF No. 3038, Monitor's June 2020 Report at 60; ECF No. 2841, Monitor's Jan. 2020 Report at 22; ECF No. 2798, Nov. 2019 Midyear Report at 54; ECF No. 2715, Monitor's July 2019 Report at 13-14. Defendants have been recalcitrant in their unwillingness to implement this requirement throughout the life of the Court's Order.

(d) Necessary Structured and Unstructured Out-of-Cell Time to Protect Against Decompensation for Class Members in Segregation More Than 60 Days

Section 3(e) applies to Class Members in segregation for more than 60 days, requiring "structured and unstructured out-of-cell time sufficient to protect against decompensation unless clinically contraindicated. If an inmate refuses out-of-cell time, a MHP shall follow-up with the

inmate to determine whether or not there is a risk of further decompensation."

The Monitor's review has consistently found violations with this requirement. The most recent compliance report includes a data-driven analysis showing that Class Members in segregation more than 60 days received out of cell time well below the accepted standard of 10 and 10 hours as a minimum required to protect against decompensation:

	Structured Hours Received	Unstructured Hours Received
October 2019	2.79	6.21
January 2020	5.48	4.04
April 2020	1.55	2.1

ECF No. 3097, Monitor's July 2020 Compliance Report at 26. The data, provided by IDOC contends that ten hours of unstructured out of cell time was generally "offered" in October and January, but even that number dropped down to 3.18 in April with the COVID-19 lockdowns. As to the structured time "offered," IDOC's update reports 8-9 hours per week in October and January, and only 2.96 offered in April.

The Court's Order required IDOC to specifically follow-up on refusals in order to respond to decompensation, but their failure to take this important action persists. Although staff, by IDOC policy, have patients sign refusal forms, the Monitor found no indication of the assessments required by the Court's Order." ECF No. 2715, Monitor's July 2019 Report at 18. ("The team has not encountered anything approximating the Court's order to determine whether there is risk of further decompensation.").

Both issues—the lack of out of cell time and the failure to follow-up on refusals—have worsened during the pandemic, causing great harm to Class Members. The IDOC's out-of-cell time trackers show that most facilities significantly reduced both structured and unstructured out-

of-cell time for Class Members in segregation since mid-March. During this period of intensified isolation due to COVID-19 restrictions, the rate of refusals for the little out-of-cell time offered is significant. Unfortunately, the MHP follow-up on refusals required by the Court's Order remains absent. Class Members report increasingly visible rates of depression and anxiety within their housing units, with some refusing to come out of the cells entirely. Instead of QMHPs conducting individualized follow-up and working to engage the patient, it is frequently left to the bachelor's level BHTs who continue to conduct the segregation rounds. These rounds should include a verbal and visual clinical assessment for signs of decompensation, but instead are reported by Class Members to be a quick walk-through. As long as the individual says, "I'm ok" when asked—regardless of all indications to the contrary—the BHT keeps moving through the unit. There is no MHP follow-up with those individuals who are refusing out-of-cell time, even if all other indicators are that they are not, in fact, ok.

D. Treatment Planning

Section 5(a) of the Court's Order, on treatment planning, requires that:

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

The Monitor has repeatedly found that Defendants have not complied with this requirement. ECF No. 3097, Monitor's July 2020 Compliance Report at 33-35; ECF No. 2841, Monitor's Jan. 2020 Report at 28-30; ECF. No. 3038, Monitor's June 2020 Report at 21-25; ECF No. 2715, Monitor's July 2019 Report at 23-26.

Defendants still have not provided individualized and particularized treatment plans for class members. While treatment planning forms are generally filled out, the substance of the documents created is usually meaningless. It takes significant staff time to dig into a patient's

history, needs, and treatment goals in order to create a treatment plan that is truly tailored to the individual—staff resources Defendants do not have (because they have not complied with the Court's order requiring additional staff). Thus, Defendants continue to resort to generic, boilerplate plans that generally do not provide for any mental health contacts beyond those that are required by the Rasho Settlement Agreement and Court Order.

In other words, IDOC continues to approach treatment planning as a formulaic documentation requirement instead of a process to provide care based on individual need. ECF No. 3097, Monitor's July 2020 Compliance Report at 34-35; ECF No. 2851, Jan. 2020 Qtly. Report at 29-30; ECF. No. 2715, Monitor's July 2019 Report at 23-26. In the Monitor's most recent report assessing compliance with this section of the Court Order, the Monitor found that "many treatment plans did not appear to be individualized or particularized based on the person or their specific needs. Even if a problem or treatment issue was identified, objectives were often vague." ECF No. 3097, Monitor's July 2020 Compliance Report at 34; *see also* ECF No. 3038, Monitor's June 2020 Report at 23 (finding that, while the form including long and short term goals is generally filled out, "[t]he content in those fields, however, is not always genuinely a goal or a treatment activity that would advance that goal.").

Specific to outpatient treatment plans, the Monitor explained that the correct forms, with the required elements, are utilized "but they tended to be very generic and not especially individualized. There was a paucity of actual treatment provided…typically for the patient to receive one 15- to 30-minute individual session with an MHP every 30, 60 or 90 days." ECF No. 3038, Monitor's June 2020 Report at 23-24. In the Monitor's July 2020 report on compliance with the Order, the Monitor further explained that the interventions listed in non-crisis treatment plans "were predominately only the requirements set by the *Rasho* Settlement Agreement and

Order" and "[t]he prescribed interventions typically did not specify what treatment should focus on in order to obtain the treatment objectives of the treatment plan." ECF No. 3097, Monitor's July 2020 Compliance Report at 35.

Five facilities admitted to their own failure to comply with this requirement in the July 2020 self-certifications. Illinois River explained that its own backlog was due to short staffing, ECF No. 3092, July 2020 Qtly Report, Att. 3 at 102. Similarly, Lawrence cited their large caseloads and insufficient staff time as a barrier to compliance, "With high case levels and number of assigned duties, continuing is challenge for individualizing treatment plans. Staff strives for individualizing with some noted improvement, however, when caseloads are above 100, more of a challenge exists for doing so." *Id.* at 114. Stateville, Stateville NRC, and Western all admitted to being compliant only 75-85% of the time, but did not elaborate on the explanation. *Id.* at 147 (Stateville); 150 (NRC), and 162 (Western).[6]

In their Quarterly Reports, Defendants focus on the timeliness of treatment planning and point to reductions in backlog numbers. ECF No. 3092, July 2020 Qtly Report at 19-20. But filling out a form on time means nothing if the contents of the form lack quality and individualization, and if there is no follow-through on the care prescribed. Even where facilities have certified compliance based on backlog reduction, the reality is that the quality of treatment plans are frequently insufficient to provide constitutional care to class members.

III. Defendants Have Not Complied with the Court Order's Staffing Requirements

Defendants are out of compliance with all subsections of the Court's order on Staffing.

[6] Plaintiffs note that the lack of specific treatment plans is particularly problematic in light of the significant turnover of treatment providers. A newly hired QMHP would not have the needed guidance as to their patient's treatment needs or progress. Instead, each new hire needs to start from scratch with every patient. This is not only inefficient; it means that the patients need to reestablish trust, and retraumatize themselves by reviewing their entire history each time a new QMHP is hired.

First, in Section 1(a), Defendants were ordered to obtain specific numbers of clinical staff, based on the Department's own 2014 Staffing Plan, within 90 days of the Court's Order. The Order was initially entered on December 20, 2018 (ECF No. 2516). In February, the Court made minor modifications to the Order at Defendants' request (ECF No. 2540). The Seventh Circuit then remanded Defendants' appeal of the injunction because the order failed to comply with the single document rule, and the Order was re-issued on April 22, 2019 (ECF No. 2633). Effectively, Defendants were given an extra five months to bring themselves into compliance with the Court's mandates. Even so, as detailed below, Defendants failed to reach those numbers within 90 days and *still* have not reached those numbers over a year and a half later.

Importantly, the Court's Order did not stop at requiring Defendants to meet the 2014 staffing levels. Rather, the 2014 staffing plan was a *starting* point, intended to spur Defendants to toward the higher levels now needed for the Department to provide constitutionally adequate mental health care. The Court's opinion explained that the 2014 levels would not likely be sufficient given the higher caseload that exists today. See ECF No. 2633, Order, at 54 ("The Court recognizes this staffing mandate may not be enough.") citing ECF No. 2122 at 10, Second Annual Report of Monitor ("It has become painfully clear to the monitoring team over the first two years of the Settlement Agreement that the staffing levels of the Approved Remedial Plan are totally inadequate to meet the mental health and psychiatric needs of the mentally ill offender population of the Department."). The mental health caseload—and the percentage of SMI prisoners on the caseload—has increased substantially since 2014, requiring in turn substantially higher staffing levels. DX-63; ECF No. 2406 ¶ 25.

For that reason, the Court also ordered Defendants, in Subsection 1(b), to evaluate whether their staffing plan was sufficient to provide ***constitutionally adequate*** mental health care

in the five substantive care areas of segregation, crisis placement, treatment planning, evaluations, and medication management. In Subsection 1(c), the Court ordered Defendants to report the findings from their staffing evaluation and submit a proposed amended staffing plan to the Court, monitor, and Plaintiffs' Counsel. Defendants have failed to do either.

A. Defendants have Not Met the Court-Ordered Staffing Numbers

Defendants did not meet the required staffing levels within 90 days of this Court's order, as demonstrated in the table below. Indeed, they *still* have not met those levels, over a year and a half later.

Clinical Staff Position[7]	**Court Order**	**April 2019** (90 days from Court's Dec. 2018 Order)	**July 2019** (90 days from Court's April 2019 order)	**Oct. 2019** (180 days from Court's April 2019 Order)		**Jan. 2020** (270 days from Court's April 2019 Order)	**April 2020** (1 year from Court's April 2019 Order)		**July 2020**
Site Mental Health Service Directors	**7**	**7**	**7**	**6**	**Plaintiffs' first contempt motion filed 11/15/2019**	**6**	**6**	**Plaintiffs' Second Contempt Motion filed 7/10/2020**	**7**
Mental Health Unit Directors	**12**	**4**	**5**	**8**		**6**	**9**		**8**
Staff Psychologists	**16**	**13.025**	**13.525**	**11.1**		**11.6**	**10.8**		**10**
Qualified Mental Health Professionals	**142.5**	**110**	**106**	**108**		**112**	**111**		**132**
Behavioral Health Technicians	**102**	**70**	**76**	**89**		**89**	**86**		**95**
Registered Nurses - Mental Health	**54.5**	**23**	**22**	**30**		**33**	**31.55**		**29.75**
Psychiatric Providers	**85.5**	**58.145**	**55.813**	**59.238**		**61.463**	**64.363**		**65.488**
Recreational Therapists	**5**	**5**	**5**	**5**		**6**	**6**		**6**
Total MH Staff	**424.5**	**290.17**	**290.338**	**316.338**		**325.063**	**324.713**		**353.238**

[7] This table uses the numbers of WHS staff reported in IDOC's quarterly report on compliance with the order, attachment 5 (WHS MH Fill by Position). Plaintiffs dispute that the IDOC staff put forward by Defendants in their reporting and briefing should be counted for the Court's order on clinical care provider staffing. This table also lists only clinical staff positions, meaning positions that provide direct care to Class Members. It excludes staff assistants, which are clerical positions that do not provide care. IDOC has more than met the Court-ordered number of clerical staff, and currently employs 60 (whereas 24 were ordered by the Court). This table also does not list the Director of Psychiatric Nursing position, of which one is ordered and has been filled.

For the last year and a half, the Department has largely failed to fill the positions ordered by the Court. Only after Plaintiffs filed their first and second motions for contempt did the Department begin to comply—and only with regards to half of the clinical staff positions included in the Court's order. This continued failure to hire needed staff has made it impossible for the Department to provide the care required by the other terms of the Court order—and has saved the Department millions of dollars in wages over the last year and a half.

B. Defendants have Not Conducted the Evaluation or Provided the Staffing Plan Required by Court Order

While setting out initial staffing benchmarks based on the Defendants' 2014 staffing plan, this Court also required Defendants to conduct their own evaluation to update the staffing plan to provide adequate care to the current population. Order, Sect. 1(b), (c).

In the Defendants' April 2019 Quarterly Report (Doc. 2638, Att. 2), they did provide a new staffing plan, but refused to provide the evaluation of their staffing needs or the plan ordered by the Court. Instead, Defendants insisted on their belief that the Department "has the staffing and procedures in place to protect mentally ill prisoners from substantial harm and to comply with minimal constitutional requirements"—in defiance of this Court's findings to the contrary. Doc. 2638, IDOC's April 2019 Qtly Report at 2. Rather than propose a remedy, as the Court ordered, Defendants decided to instead simply repeat the arguments that the Court had already rejected. In that Report and every Quarterly Report since then, Defendants continue to characterize this plan as one that is not associated with the need to achieve constitutional care:

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

See IDOC's July 23, 2020 Quarterly Report, ECF No. 3092 at p. 5. Defendants obstinately refuse to accept this Court's findings that their staffing is, or ever was, insufficient to provide constitutionally adequate care.

But this Court assigned Defendants the task of a plan for the staffing numbers necessary to provide constitutional care. Thus, Defendants' 2019 staffing plan either is a demonstration of the minimum staff needed to provide constitutional care, or the Defendants are in violation of Sections 1(b) and (c) of this Court's order requiring them to submit such a plan. *See* ECF No. 3097, Monitor's July 2020 Compliance Report at 11 ("[A]s Monitor, I completely disagree with their proposition that IDOC has sufficient staff to provide mental health treatment consistent with constitutional standards. So, in my opinion, IDOC's evaluation of their staffing plan is extremely inadequate and does not fulfill the requirements of 1(b).").

(a) Defendants' 2019 Staffing Plan is Inadequate to Provide Constitutional Care

While the Monitor begrudgingly found Defendants in compliance with Subsection 1(b) and (c), insofar as Defendants had updated it, the Monitor also found Defendants' April 2019 Staffing Plan to be "extremely inadequate." ECF No. 3097, Monitor's July 2020 Compliance Report at 11.

Following receipt of the new Staffing Plan, on April 24, 2019 (referred to as the April 2019 plan), the Monitor submitted a facility- by-facility analysis of IDOC's plan and recommended additional staff. On May 14, 2019, Plaintiffs submitted their position and objections to parts of IDOC's 2019 Staffing Plan based on review of the plan together with the Monitor's recommendations and all available facility data. *See* ECF. No. 2739-1.

The inadequacy of the Defendants' 2019 plan becomes clear when you look at the actual needs of the Plaintiff class. For example, at Dixon, which had an SMI population of 697 in March 2019 and a total mental health caseload of 964, Defendants' 2019 plan actually ***reduced*** the number of psychologists from 5 to 1, while the Monitor suggested ***increasing*** the number of psychologists to 6 and to adding another 2 psychiatrists (to reach a total of 12 psychiatric providers). At the time of Defendants' 2019 plan and continuing to today, that facility has been largely unable to provide much-needed individual counseling for its complex patient population, yet Defendants went ahead with this reduction in staffing despite objections from Plaintiffs' counsel and the Monitor.

IDOC's 2019 staffing plan also failed to increase the number of budgeted staff at facilities that were obviously struggling and in need of additional staffing. For example, Joliet Treatment Center seems to have budgeted an insufficient number of staff given the fact that it houses some of the most complex patients in the IDOC system, including many residents of their Behavior Modification Unit who are largely coming from spending years in segregation and, as a result, have very high needs as they work to overcome its impact. Heading into trial on the permanent injunction, JTC appeared to be doing well while keeping its population very low. But as the population of JTC grew, it exposed many problems that were already evident at the time of Defendants' April 2019 staffing plan. JTC was then, and continues to be, struggling to provide care. For over a year, JTC has provided very little individual counseling to patients who need that form treatment to overcome significant histories of trauma; groups are frequently run by BHTs who do not have the skills to meet the population's complex needs; and, even those groups are often canceled and/or schedules are inconsistent (causing distress for SMI patients). Based on Class Member reports to Plaintiffs' counsel, there has been an increase self-harm incidents and crisis watch placements even before the pandemic, and the situation has only gotten worse with

medical quarantines and administrative lockdowns over the past several months. Given that JTC is only populated at about one-third of its intended population, it appears that the staffing levels budgeted by Defendants continues to be insufficient.

Similarly, at Stateville NRC, Defendants generally have been able to hire staff to fill their budgeted positions, yet, as detailed above, NRC remains unable to complete initial evaluations for untold numbers of Class Members, delaying their care for weeks or months while they wait for transfer to a parent facility.

Defendants have not addressed these concerns or the many other objections raised related to the 2019 Staffing Plan. Moreover, Defendants have not filed a motion under the section 1(d) to modify the staffing requirements of the Order. IDOC has likewise failed to engage with the Monitor on staffing. The Fourth Annual Report details that IDOC has not responded to the Monitor's objections to the staffing plan, suggestions for improvements, his offer to hold a "staffing summit" to work with IDOC to address staffing, or his request to add a staffing expert to the Monitoring team. ECF No. 3038, Monitor's June 2020 Report at 33. Although IDOC hired VitalCore to evaluate the retention problem, IDOC and its vendor, Wexford, have failed to sufficiently act on the recommendations made by that independent consultant. *Id.* As a result, turnover remains a huge problem (*see, e.g.,* ECF No. 3097, Monitor's July 2020 Compliance Report at 10 (noting rapid turnover rate of MHPs at Dixon)), making the inadequate number of staff much worse.

(b) Even if Defendants' 2019 Staffing Plan Was Sufficient to Provide Adequate Care, Defendants Still Have Not Reached the Staffing Numbers Required by that Plan

As is evident from the chart below, Defendants continue to fall far short of their own April 2019 staffing plan—the plan they submitted in response to this Court's order that they

create a staffing plan sufficient to provide constitutionally adequate care. The Department has contracted for the staff it needs to provide necessary care for those in its custody—any contention that it is paying for excess staff defies credibility—and so the Department's April 2019 plan should be seen as a benchmark for the staffing needed to provide adequate care.

Position	**Filled as of September 30, 2020**	**April 2019 Plan**
MH Unit Directors	11	12
Staff Psychologists	10	19
Qualified Mental Health Professionals (QMHPs)	138	172
Behavioral Health Technicians (BHTs)	92	99
Registered Nurses – Mental Health	25.55	48.65
Psychiatric Providers	68.338	75.2

Defendants are short 34 QMHPs—that translates to roughly 5,500 hours of that were not provided just in the month of September 2020—or 68,000 hours per year (34 x 2000). That is over 100,000 hours of QMHP care that the Department has failed to provide since this Court ordered it to increase staffing immediately, over a year and a half ago. They have nearly half as many mental health RNs and staff psychologists as they require and are short by at least seven psychiatric providers (note, the Department's plan calls for 10.3 *fewer* psychiatric providers than this Court ordered). These positions are crucial providing care to class members in segregation and on crisis watch. Without filling these positions, the Department has no hope of ensuring that mental health evaluations are done timely and that individualized treatment can be provided. Defendants will continue to fall short of meeting the Court ordered substantive care requirements until they hire sufficient mental health staff.

B. Any Recent Backlog Reductions Are Not Evidence of Sufficient Staffing or Adequate Care

The backlog rates often emphasized in this litigation are not measures of the core issues of quality or adequacy of care provided, but can reflect the timely delivery of some types of care by the existing staff. Mental health backlogs persisted under the Court's Order. Over 1000 mental health treatment sessions due as of May 29, 2020 were backlogged in the three tracked categories (evaluations, treatment plans, and follow-up). That is only slightly less than the low of 1109 reached the week of Nov. 2, 2018, shortly after the trial. Moreover, for the year following the Court's Order, the mental health backlog fluctuated at high rates, between 1546 and 3169. These high numbers of backlogged evaluations, treatment plans, and follow-ups demonstrate the lack of sufficient numbers of QMHPs to fulfill all the functions of their positions.

It is also important to note that these numbers (high as they are) do ***not*** include evaluations which are supposed to be done at the Northern Reception Center—where the vast majority of prisoners first enter the system. IDOC does not bother to count these evaluations, and thus the real number of people who did not receive timely evaluations (and thus did not receive treatment) is hundreds, if not thousands, more than reported.

Defendants will inevitably point to recently reduced backlogs to argue that their staffing is sufficient, and that adequate care is being provided. But the current lower backlog is a consequence of the highly contagious COVID-19, and the global pandemic, which has closed the IDOC system in several critical ways—by the Governor's order suspending new intakes from county jails and by IDOC stopping transfers between facilities in all but emergency situations. Facilities also went on medical quarantine status, a form of lock- down that limits congregating, movement, and activity within facilities. For Class Members, this has meant increased isolation with decreased quality and quantity of mental health treatment and out-of-cell activity. For

mental health treatment providers, it has meant more rounds (brief cell- front contacts) and fewer evaluations, reduced groups, and little individual counseling.

While these short cell-front checks (which lack confidentiality) do not provide meaningful treatment, Defendants nonetheless count them toward backlog reduction. The reduction to the mental health backlogs during this period of virtually total lockdown is thus grossly misleading.

The decrease in the mental health backlogs was achieved only with a significant reduction in duties required of the QMHPs due to the pandemic. The system is, however, starting to reopen, and backlogs have already begun to rise. As intakes from the county jails began trickling into the system in mid-August, the backlog immediately jumped: the total mental health backlog (including evaluations, treatment plans, and MHP follow-ups) was down to a low of 392 systemwide as of July 31, but rocketed up to 506 on August 7, and then 688 on August 14. They continued to hover in the 600s throughout the rest of August (the last month for which Plaintiffs currently have backlog data).

These numbers demonstrate that QMHPs are again struggling to provide the screening, evaluation and treatment required for new intakes, as well as the follow-ups required for current Class Members. This is true even while most, if not all, facilities are operating with reduced out-of-cell activity and mental health treatment, largely deferring treatment for thousands of Class Members and subjecting them to extreme levels of isolation for months on end. When the IDOC fully reopens, the QMHPs on staff will once again be inundated and the backlogs will inevitably continue to rise.

Conclusion

Despite repeated efforts to try to resolve this contempt motion, the Parties have failed to do so. The violations of this Court's Order are clear and have long persisted. The Defendants, unfortunately, refuse to conform their conduct to what the parties originally agreed to in resolving this class action, and Defendants' failures thereafter necessitated the Order. Despite assuring the Court that they would obey that Order—and despite that order never having been stayed—the order has not been obeyed. A party cannot take into his own hands the power to ignore a court's order. The only remedy for such unilateral temerity is contempt. The parties recognized that possibility in the Settlement Agreement. Defendants have had every chance to change their behavior and have not. Coercion is all that remains.

RESPECTFULLY SUBMITTED,

/s/ Samantha Reed
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CERTIFICATE OF SERVICE

I, Samantha R. Reed, an attorney, hereby certify that on October 23, 2020, I caused a copy of the foregoing document to be served on all counsel of record via the CM/ECF system.

/s/ Samantha R. Reed