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

ASHOOR RASHO, et al.,	)	
	)	
Plaintiff,	)	
	)	
v.	)	**No. 07-1298**
	)	
ROGER E. WALKER, *et al*.,	)	
	)	
Defendants.	)	

ORDER

This matter is before the Court on Plaintiffs' Motion for Permanent Injunction (ECF No. 2112) and Motion for Order on Payment of Deferred Attorneys' Fees (ECF No. 2233). For the reasons stated herein, the Motion for Permanent Injunction is GRANTED insofar as the Court finds permanent injunctive relief is necessary to address the constitutional deficiencies in the Defendants' care and treatment of mentally ill inmates. As previously scheduled, Defendants are given 14 days to submit their proposed action(s) to address the constitutional deficiencies outlined herein. (Minute Entry dated 9/28/2018). Plaintiffs have seven days thereafter to file their response to the Defendants' proposal. *Id*. Additionally, Plaintiffs' Motion for Order on Payment of Deferred Attorneys' Fees is DENIED without prejudice.

OVERVIEW OF THE ACTION

This case is a class action brought under 42 U.S.C § 1983 alleging violations of the Eighth Amendment of the United States Constitution, the Americans with Disabilities Act, 42 U.S.C. § 12101, *et seq*., and the Rehabilitation Act, 29 U.S.C. § 794. (ECF No. 711-1 at 1). Plaintiffs challenge the adequacy of the delivery of mental health services to mentally ill prisoners in the

physical custody and control of the Illinois Department of Corrections ("IDOC" or "Department"). *Id*.

On August 14, 2015, this Court certified a class in this case for purposes of litigation, and pursuant to Rule 23(b)(2) of the Federal Rules of Civil Procedure, as follows:

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

(ECF No. 252 at 7). As of June 21, 2018, there were approximately 40,237 inmates in the custody of the IDOC, of whom more than 12,228 are believed to be mentally ill. (ECF No. 2286 at 2; *see also* ECF No. 1758 at 50, testimony of Defendant Dr. Melvin Hinton ("Dr. Hinton")). Approximately 5,112 of these inmates are considered "seriously mentally ill ("SMI")." (*Id.*; ECF No. 1758 at 51, testimony of Dr. Hinton; *see also* ECF No. 1966-1 at 2, Plaintiffs place the number at 4,843). As of June 30, 2018, 9,576 of the inmates were on the IDOC psychiatric caseload. (ECF No. 2286 at 2). As of July 2018, 913 inmates on the IDOC mental health caseload were housed in segregation. *Id*. Ashoor Rasho, Patrice Daniels, Gerrodo Forrest, Keith Walker, Otis Arrington, Donald Collins, Joseph Herman, Henry Hersman, Rasheed McGee, Fredricka Lyles, Clara Plair, Desiree Hollis, and Crystal Stoneburner serve as the class representatives.

The Defendants are John Baldwin, the Acting Director of the IDOC, and Dr. Hinton, the Department's Chief of Mental Health Services and Addiction Recovery Services.

On December 17, 2015, the Parties announced they had entered into a comprehensive settlement agreement resolving the action set forth in the Plaintiffs' Third Amended Complaint, the operative complaint in this matter. (*See* Minute Entry dated 12/17/2015; ECF No. 711-1; and

ECF No. 260). Notice of the Settlement was given to the class members and a fairness hearing was held on May 13, 2016. (ECF No. 289; Minute Entry dated 5/13/2016). During the hearing, the Court found the agreement to be fair and reasonable, over the voluminous objections that were filed by various inmates[1]. *Id*. The executed Settlement Agreement can be found in this docket, and is referred to herein as the "Settlement Agreement." (ECF No. 711-1). The instant Motion is brought alleging violations of the Settlement Agreement and the Constitution. The procedural history is sufficiently captured in this Court's Order dated May 25, 2018, and will not be recited, provided however, the Court will detail the additional history occurring after the entry of its Preliminary Injunction Order. (ECF No. 2070 at 2-11).

On June 6, 2018, Plaintiffs filed their Motion for Permanent Injunction requesting that the Court hold a hearing on the merits of Plaintiffs' claims, and upon making the necessary merits determination, enter an order converting the Court's Preliminary Injunction Order to a permanent injunction. (ECF No. 2112).

On June 8, 2018, Dr. Pablo Stewart's Second Annual Report was docketed. (ECF No. 2122). In his Report, Dr. Stewart provides that "the Department is noncompliant with 18 of 25 [Settlement Agreement terms] and substantially compliant in only 3 [terms] (orientations, housing assignments and training) [and] [a]s is explained more fully in the body of the report, these noncompliance ratings are primarily due to inadequate staffing." (ECF No. 2122 at 9). It should also be noted that Dr. Stewart presented the Court with a Monitor Chart Review Report during the permanent injunction hearing. (Pl. Ex. 53). In the report, Dr. Stewart provided his assessment of the IDOC's compliance with the Court's Preliminary Injunction Order. His assessment included a review of mental health charts at several institutions. The general methodology used was to

[1] All objections have been filed in this docket.

assign a rating of "1, 2, or 3," with 1 being non-compliance, 2 being partial compliance, and 3 indicating compliance. During his testimony, however, certain information regarding the methodology was revealed that gave this Court pause in considering the data. Most notably, it was revealed that one of the assistant monitors collecting the data used a different methodology in her rating. Given that, the Court cannot give significant weight to the Monitor's findings in that regard.

On July 20, 2018, Plaintiffs filed their Motion for Order requesting that the Court enter an order enforcing their right to the fees previously awarded, but deferred, pursuant to the Settlement Agreement. (ECF No. 2233). On August 3, 2018, Defendants filed their Opposition to the Motion for Order. (ECF No. 2276). The Defendants argued, among other things, the Court had not made, by entry of the Preliminary Injunction Order, a finding of an actual violation of the Plaintiffs' federal rights. (ECF No. 2276 at 2).

Between August 27, 2018, and September 7, 2018, testimony and evidence were taken and arguments were made in support of the Parties' respective positions on the Motion for Permanent Injunction. The Parties were given the opportunity to submit post-hearing briefs in support of their positions. (ECF Nos. 2405, 2406, and 2407). The Parties were also given the opportunity to provide written submissions addressing the current status of the Settlement Agreement. (ECF Nos. 2424 and 2427). This Order follows.

SUMMARY OF DECISION

Under the Eighth Amendment, inmates suffering from serious mental illnesses are entitled to adequate medical care. To establish a constitutional violation, Plaintiffs must prove that Defendants have been deliberately indifferent to their serious medical needs, specifically in this case their mental health needs. "[D]eliberate indifference to serious medical needs of prisoners

constitutes the 'unnecessary and wanton infliction of pain' proscribed by the Eighth Amendment." *Estelle v. Gamble*, 429 U.S. 97, 104 (1976) (citations omitted). Having fully considered the evidence and testimony presented during the preliminary and permanent injunction hearings, the Court finds that Defendants have been deliberately indifferent to Plaintiff's medical needs in medication management, mental health treatment in segregation, mental health treatment on crisis watch, mental health evaluations, and mental health treatment plans within the meaning of the Eighth Amendment. In this case, the overwhelming evidence establishes that at the time of the preliminary injunction hearing, the Defendants were deliberately indifferent to the Plaintiffs' medical needs. Most notably, the evidence showed that there were systemic and gross deficiencies in staffing that effectively denied the Plaintiffs access to adequate medical care.

At the permanent injunction hearing, Defendants' evidence emphasized the changes to the delivery of mental health services that had been implemented by the IDOC after this Court's Order dated May 25, 2018. The Defendants have implemented policies and procedures that have created improvements in the overall delivery of mental health services. However, the record still shows there are systemic and gross deficiencies in the staffing of mental health providers that have a serious detrimental effect on the overall delivery of medical services to the Plaintiffs. Moreover, while there has been a decrease in the overall backlog of mental health contacts, the Defendants have relied heavily on the use of overtime to achieve these results. The testimony of the Defendants' own witnesses reveals this practice is unsustainable and there is no Plan B.

This litigation has unfolded for over a decade. In that time, some changes have been made to increase the quality of care for mentally ill inmates, but it is not enough. Despite the recent serious efforts by the Defendants, the Court finds that a permanent injunction is necessary to force

the Defendants to adequately staff their institutions with the necessary mental health providers and other personnel to provide the constitutionally required care.

SETTLEMENT AGREEMENT

On May 23, 2016, the last signature was acquired on the Settlement Agreement purportedly resolving the decade long dispute between the Parties. (ECF No. 711-1 at 33). The Settlement Agreement is a comprehensive document with the purpose of reaching an agreement that settled the litigation in a manner that is "fair, reasonable, and adequate to protect the interests of all parties." (ECF No. 711-1 at 2).

The Settlement Agreement allows for the Plaintiffs to seek relief from this Court if there is a dispute as to whether or not the Defendants are in substantial compliance with the terms contained therein. (ECF No. 711-1 at 29). The Settlement Agreement specifically provides:

> f) If the Court finds that Defendants are not in substantial compliance with a provision or provisions of this Settlement Agreement, it may enter an order consistent with equitable and legal principles, but not an order of contempt, that is designed to achieve compliance.
>
> g) to permit enforcement of the terms of this Settlement Agreement in federal court, the parties agree that, should it become necessary to seek the Court's assistance as to violations of this agreement, <u>any order granting such relief must include a finding that the relief sought is narrowly drawn, extends no further than is necessary to correct the violation of the federal right, and is the least intrusive means for doing so.</u>

(ECF No. 711-1 at 30) (emphasis added).

The Court has previously found that a preliminary injunctive hearing was an appropriate mechanism under the terms of the Parties' Settlement Agreement and the Prison Litigation Reform Act, 18 U.S.C. § 3626 ("PLRA"). Defendants objected to that procedure arguing Plaintiffs would never have the obligation of actually proving there had been a violation of federal law. (ECF No. 1709 at 2). The Court disagreed and noted that the Plaintiffs would ultimately need to seek

permanent relief at some point. That, of course, is what the Plaintiffs have done with the filing of their Motion for Permanent Injunction.

Moreover, the Plaintiffs specifically note they have not moved for enforcement of the Preliminary Injunction Order under Section XXIX(i) of the Settlement Agreement. (ECF No. 2424 at 2). Plaintiffs instead argue they are seeking relief under Section XXIX(d), (f), and (g). The Parties appear to generally agree an action under Section XXIX(d), (f), and (g) would not abrogate the Settlement Agreement. As for an action pursuant to Section XXIX(i), the answer appears more questionable. Section XXIX(i) provides:

> If Plaintiffs contend that Defendants have not complied with an order entered under the preceding paragraphs, they may, after reasonable notice and meeting with Defendants, move for further relief from the Court to obtain compliance with the Court's prior order. The Court may apply equitable principles and may use any appropriate equitable or remedial power available to it. This may include returning the case to the active docket and setting a trial date. The information gathered by the Monitor during the life of this Settlement Agreement, the Monitor's reports, including all reports and material supplied by Defendants, may be used in Plaintiffs' case at such a trial, along with the testimony of the Monitor, which may address ultimate issues in this case.

(ECF No. 711-1 at 30). Plaintiffs' current position is inconsistent with their previous position wherein they specifically relied on Section XXIX(i) to support their position that the Monitor's Second Annual Report was admissible. (ECF No. 2264 at 2, "Section XXIX(i) of the Settlement Agreement explicitly provides for the consideration of the Monitor's report and testimony as evidence during a trial in which Plaintiffs contend that Defendants have not complied with a court order enforcing the Settlement Agreement.") (Emphasis added). Moreover, Plaintiffs have asserted the position in their post-hearing brief that Defendants failed to adhere to the terms of this Court's May 25, 2018, Order, arguably invoking Section XXIX(i). (*See e.g.* ECF No. 2406 at 24).

Defendants, for their part, argue that "[o]nce the final judgment order is entered, that order will supersede the Settlement Agreement and will provide [P]laintiffs the relief necessary to

protect their rights under federal law." (ECF No. 2427 at 7). Defendants argue Plaintiffs have chosen to "reactivate" this case. Of course, the reality is, this case was limited to examining a limited area of the Settlement Agreement.

First and foremost, the Court finds that this Order is entered pursuant to Section XXIX(g) of the Parties' Settlement Agreement. This is the Order contemplated by the Parties under that provision. Nonetheless, whether the Plaintiffs' permanent injunction request is brought under XXIX(g) or XXIX(i), the Court finds the Settlement Agreement remains intact. The language of the Settlement Agreement does not address the status after either such hearing. Moreover, it has been clear to both Parties that this hearing was limited to addressing five areas. This was not a "full" trial on the merits on all of the claims; nor was it a situation where the Parties tore up the Settlement Agreement to have this Court decide the outcome on all matters.

Additionally, to be clear, this Court has jurisdiction over Plaintiffs' federal claims pursuant to 28 U.S.C. § 1331. There is no dispute as to the Court's jurisdiction. Furthermore, the Parties have specifically provided for a dispute resolution process under the terms of the Settlement Agreement. In order to find liability, the Court must find both a violation of the terms of the Settlement Agreement AND a violation of federal law. (ECF No. 711-1 at 29-30).

In that regard, as part of their preliminary injunction request, the Plaintiffs identified five areas where they challenged the adequacy of the mental health treatment and conditions for prisoners required under the terms of the Settlement Agreement and the U.S. Constitution. The five areas included: Mental Health Evaluations (ECF No. 711-1 at 8-9, Section V), Treatment Planning (ECF No. 711-1 at 9-10, Section VII), Medication Management (ECF No. 711-1 at 15-16, Section XII), Mental Health Treatment in Restricted Housing/Segregation (ECF No. 711-1 at

16-21, XV), and Mental Health Treatment on Crisis Watch (see e.g. ECF No. 711-1 at 3). Plaintiffs seek their permanent injunction based on violations of these same areas. (ECF No. 2286 at 2).

In this Court's previous Order, it found that the Plaintiffs had established all of the necessary requirements for a preliminary injunction to be issued. (ECF No. 2070). The record at that time contained ample evidence to meet the preliminary injunction standard that inmates with mental illness were receiving constitutionally inadequate treatment in the areas of Mental Health Evaluations, Treatment Planning, Medication Management, Mental Health Treatment in Restricted Housing/Segregation, and Mental Health Treatment on Crisis Watch. The Court specifically concluded that the testimony of almost all of the medical doctors at the preliminary injunction hearing established that, in one form or another, the system in place to treat mentally ill inmates at the IDOC was in a state of emergency. (ECF No. 2070 at 6). The Parties have agreed that all of the evidence presented in the preliminary injunction hearing is incorporated into the trial record for determination in this matter. (ECF No. 2286 at 2); *see also* Fed. R. Civ. P. 65(a)(2).

Now Plaintiffs move the Court to enter an order converting the Court's Preliminary Injunction Order to a permanent injunction. (ECF No. 2112). In determining whether a permanent injunction should issue, the analysis generally requires a court to consider: (1) whether the plaintiff has suffered or will suffer irreparable injury, (2) whether there are inadequate remedies available at law to compensate for the injury, (3) the balance of hardships, and (4) the public interest. *Sierra Club v. Franklin Cty. Power of Illinois, LLC*, 546 F.3d 918, 935 (7th Cir. 2008) *citing eBay Inc. v. MercExchange, L.L.C.,* 547 U.S. 388 (2006); *e360 Insight v. The Spamhaus Project,* 500 F.3d 594, 604 (7th Cir. 2007). This Court must also consider the parameters of the Parties' Settlement Agreement as noted above. In sum, in order for the Plaintiffs to establish that they suffered (or will suffer) irreparable injury, the Court finds that it must determine whether, by a preponderance

of the evidence, the Plaintiffs have proven that the violations of the Settlement Agreement have occurred, and that these violations of the Settlement Agreement establish a constitutional (or other federal right) violation.

DISCUSSION

> All parties and the Monitor recognize the immensity of the challenges facing the IDOC in providing constitutionally adequate mental health care.

(Pl. Ex. 9, IDOC's Proposed Remedial Plan dated April 17, 2014).

As noted above, the Plaintiffs argue the Defendants are not in compliance with the Settlement Agreement in the areas of Mental Health Evaluations, Treatment Planning, Medication Management, Mental Health Treatment in Restricted Housing/Segregation, and Mental Health Treatment on Crisis Watch. After the preliminary injunction hearing, the Defendants generally acknowledged they had not fully complied with the terms of the Settlement Agreement. (ECF No. 1965 at 5). At that point, the Defendants instead argued the evidence at the hearing was insufficient for this Court to make a finding that there has been a systemic lack of substantial compliance. (ECF No. 1965 at 5, Defendants argued "although the Court finds the Department has not fully complied with all aspects of the Settlement Agreement, a finding of a systemic lack of substantial compliance is not supported by the record.").

During the permanent injunction hearing, the Defendants primarily focused on what had changed between the preliminary injunction hearing and the permanent injunction hearing. It should be noted that after the permanent injunction hearing, Defendants again acknowledge they are not in full compliance with all of the terms of the Settlement Agreement. However, they argued that "the IDOC now has the leadership, staffing, facilities, and procedures and policies in place to ensure that mentally ill prisoners are reasonably protected against significant harm of decompensation, and are receiving the 'minimal civilized measures of life's necessities' that are

required to meet 'contemporary standards of decency' required to provide constitutionally adequate care. (ECF No. 2405 at 3).

In support of their case, Defendants offered the testimony of: (1) Baldwin (ECF No. 2370); (2) Jack Yen, M.D., Wexford Health Sources (ECF No. 2370); (3) Inna Mirsky, Ph.D. (ECF No. 2370); (4) Dr. Hinton (ECF Nos. 2371 and 2372); (5) William Puga, M.D. IDOC Chief of Psychiatry (ECF No. 2372); (6) Amy Mercer, Illinois Regional Mental Health Quality Assurance Coordinator for Wexford Health Sources (ECF No. 2373); (7) Elaine Gedman; Executive Vice President and Chief Administrative Officer at Wexford Health Sources (ECF No. 2373); (8) William Elliott, Ph.D., Regional Mental Health Director for Illinois at Wexford Health Sources (ECF Nos. 2373 and 2374); (9) Holly Andrilla, Defendants' Expert Witness (ECF No. 2375; *see also* Df. Ex. 62, CV of Andrilla); (10) Jeffrey Sim, Statewide Mental Health Quality Improvement Manager, IDOC (ECF No. 2375); (11) Melissa Stromberger, Ph.D., Psychologist Administrator for Hill Correctional Center (ECF No. 2376); (12) Kelly Ann Renzi, Ph.D., Psychologist Administrator at Pontiac Correctional Center (ECF No. 2376); (13) Al Doyle, M.D., Staff Psychiatrist at Dixon Correctional Center (ECF No. 2377); and (14) Cheri Laurent, Vice President of Special Projects for Wexford Health Sources (ECF No. 2377).

In support of their position, Plaintiffs called: (1) Pablo Stewart, M.D., Court Monitor (ECF No. 2374); (2) Joe Champ, inmate at Pontiac Correctional Center (ECF No. 2376); (3) Ralph Kings, inmate at Pontiac Correctional Center (ECF No. 236); and (4) Anthony Gay, former inmate within the IDOC (ECF No. 2376). In addition to the testimony taken during the permanent injunction hearing, the Court has also considered the testimony taking during the preliminary injunction hearing, including the testimony of: (1) Dr. Stewart (ECF Nos. 1757, 1758, 1903 and 1905); (2) Michael Dempsey, M.D., former staff psychiatrist for Wexford Health Sources from

January of 2013 until September 2015, located at Pontiac Correctional Center, former Acting Chief of Health Services, Illinois Department of Corrections, and former Chief of Psychiatry, Illinois Department of Corrections (ECF No. 1757; *see also* Pl. Ex. 28, CV of Dr. Dempsey); (3) Samuel Span, inmate at Pontiac Correctional Center (ECF No. 1758); Dr. Hinton (ECF Nos. 1758 and 1906); Corrie Singleton, inmate at Pontiac Correctional Center (ECF No. 1758); Gedman (ECF No. 1903); Gladyse Taylor, Assistant Director, IDOC (ECF No. 1904), Marcus Hardy, Executive Assistant to the Director of the IDOC (ECF No. 1904); Sandra Funk, Chief of Operations, IDOC (ECF No. 1904), Sim (ECF No. 1904), Mercer (*nee* Cantorna) (ECF No. 1904); and Dr. Puga (ECF No. 1905).

The Court will address the areas of Mental Health Evaluations, Treatment Planning, Medication Management, Mental Health Treatment in Restricted Housing/Segregation, and Mental Health Treatment on Crisis Watch in turn. However, the Court initially notes that, having fully considered all of the testimony and evidence, it still concludes that the IDOC has failed to maintain adequate staffing levels to provide adequate mental health treatment in compliance with the Constitution. The Court further finds that the deficiencies in several of the areas identified have greatly improved in certain locations within the IDOC. Indeed, Defendants also provide that, particularly since the execution of the Settlement Agreement, the IDOC has continued to build and enhance an entirely new mental health care system. (ECF No. 2405 at 4). In that regard, the Defendants noted, and the Court acknowledges, the IDOC has invested more than $45 million to build new facilities and rehabilitate existing facilities to provide mental health services to the inmates. (ECF No. 1904 at 16). In addition, the IDOC notes that it has obtained funds to build a new $150 million inpatient facility at Joliet. (ECF No. 2405 at 13; ECF No. 1904 at 16, 77). These facilities will ultimately improve the care of mentally ill inmates.

The IDOC's inability to properly staff the institutions with psychiatrists has been a persistent problem. (ECF No. 1716, Pl. Ex. 23, providing summary staffing levels for Nov. 2015, Sept. 2016, and June 2017). At the preliminary injunction hearing, Dr. Hinton acknowledged that the IDOC had only 29 psychiatrists available, with a system-wide need of 65 psychiatrists. (ECF No. 1758 at 48). That number has increased, and Dr. Hinton testified that Wexford is now delivering between 50 to 55 psychiatrists for their use in the correctional centers. (ECF No. 2372 at 10). Dr. Hinton maintained that Wexford has made substantial improvements in the delivery of full-time equivalents since the preliminary injunction hearing. (ECF No. 2372 at 10). Dr. Hinton also noted that the IDOC has authorized the use of unlimited overtime, use of psychologists on weekends, second shifts, telepsychiatry services at Dixon Correctional Center, and partnering with Southern Illinois University to provide additional psychiatric services at Pontiac Correctional Center and Logan Correctional Center. (ECF No. 2372 at 11, 35, 36, and 42-48). This Court agrees some improvements have been made. Nonetheless, there is still a serious deficiency in the delivery of mental health treatment, and the improvements are driven by an unsustainable use of overtime. Again, the delivery of mental health services will be discussed in the five areas below.

To be clear, the Court finds that the record presented establishes by a preponderance of the evidence, there was insufficient staffing at the IDOC at the time of the preliminary injunction. The Defendants have not generally disputed the Court's findings on this issue. The evidence was detailed in this Court's Preliminary Injunction Order but reiterated here for the sake of completeness.

First, when asked directly about the ability to provide psychiatric care with such a deficiency in staffing, Dr. Hinton's testimony at the preliminary injunction hearing was clear – the IDOC cannot deliver the required level of care. Dr. Hinton testified as follows:

> Q. You know today you can't deliver the care—the psychiatric care that is required for the 12,000 patients because you don't have enough psychiatrists?
>
> A. Correct.

(ECF No. 1758 at 50).

Dr. Hinton was also asked about the dangers the lack of appropriate staffing can have on an individual who is taking psychotropic medicine. His testimony went as follows:

> Q. And you've heard all the ills that can come if somebody is on psychotropic medicine and it's not being monitored, right?
>
> A. Correct.
>
> Q. And you know that's dangerous, don't you?
>
> A. Correct.
>
> Q. And you know that the 6,000 people are being endangered every day they're not seen correctly; isn't that right?
>
> A. Certainly is a concern, yes.
>
> Q. It's more than a concern. It's your responsibility that they get that care; isn't that right?
>
> A. Correct.
>
> Q. And you know they're not getting it?
>
> A. Correct.

(ECF No. 1758 at 52-53).

Dr. Hinton's testimony at the preliminary injunction hearing regarding inmates who are in segregation was extremely troublesome. Dr. Hinton explained:

> Q. [ ]. Why do you have so many mentally ill people in segregation and so few regular population people in segregation?
>
> A. I think, in general, the percentage of folks who are mentally ill tend to have more behavioral issues, in part because of their mental illness.

Q. So, you've got so many of them in segregation because they do -- they don't follow the rules well, right?

A. In part.

Q. And has anyone, to your knowledge, wondered whether or not putting mentally ill people in segregation is good for them?

A. Yes.

Q. Who's done that?

A. I have.

Q. And what's your view?

A. My view is there's nothing -- there's nothing that is a good thing about being in segregation. We need to make sure that they have proper access to treatment.

Q. Now, I believe your testimony the last time I took it on that subject was it won't hurt them if we treat them with the treatment they need, right?

A. Access to treatment, correct.

Q. But how do you know they're getting the treatment they need if they're in segregation?

A. That's why we have to make sure that there are no barriers to the access to treatment.

Q. But you don't have enough people?

A. Correct.

Q. So, you know they're not getting the right treatment?

A. We know that there's significant staffing shortages.

Q. They're not getting the right kind of psychiatric care, right?

A. We don't have -- correct, we don't have the right staffing requirements.

Q. They're not getting enough groups because you don't have enough people to run the groups?

A. Correct.

> Q. And you know from your own personal judgment that if you're not doing that for people in segregation, they're going to get worse; isn't that right?
>
> A. Across the board.

(ECF No. 1758 at 81-82) (emphasis added).

Second, Dr. Michael Dempsey, M.D., staff psychiatrist for Wexford Health Sources from January 2013, until September 2015, who was physically located at Pontiac Correctional Center, also testified about the lack of psychiatric staffing at the IDOC in the following manner:

> Yeah, we don't have enough psychiatrists to treat the patients. We just don't. If I remember correctly, IDOC had projected that they needed 66-1/2 full-time-equivalent psychiatrists to provide care for the population within the IDOC. I'm not sure if we've reached 25 full-time-equivalents at this point since I haven't been working there for the last six months. I know it's not 66.

(ECF No. 1757 at 197). Dr. Dempsey further explained the problems associated with the lack of staffing are as follows:

> I believe that we didn't have enough psychiatrists with the kind of expertise that is necessary to understand the correctional system.
>
> Corrections is a unique environment. It takes into account the fact that a person with a serious mental illness who is not in a natural environment is somehow expected, without the kind of supports they need, to function adequately, to understand the rules, the regulations.
>
> And when you have patients who are seriously mentally ill, who may be psychotic, who have impaired reality testing, and you put them in an environment where they're segregated, where they're not treated to any appropriate degree or subtherapeutically, and their options are limited, and they have to make important decisions, I find it becomes an emergent situation.

(ECF No. 1757 at 199).

Finally, when discussing the psychiatric and mental health backlog (more fully discussed below), Dr. Stewart explained during the preliminary injunction hearing:

> Well, you know -- again, that backlog can't be taken in isolation. You gotta look at the overall system. So, here we're talking about, you know, increased use of crisis

> cells, increased use of restraints, increased use of force, people suffering because of untreated mental illness. All of that has to -- is linked in some way with the fact that patients aren't being seen frequently enough or seen at all.

(ECF No. 1757 at 260)(Emphasis added). In his Mid-Year Report, Dr. Stewart further explained:

> IDOC leadership has been well aware of the problems related to the insufficient amount of psychiatric services and yet has been unable to adequately solve this issue. At the time of the submission of this midyear report, however, the lack and quality of psychiatric services continues to negatively impact all aspects of the Settlement and contributes to IDOC being non-compliant in the vast majority of areas of the Settlement. Of note, these deficiencies regarding psychiatric services were reported in the First Annual Report. The Monitor personally met with Director Baldwin on 6/26/17 to discuss this problem. To date, IDOC is yet to effectively address this emergency.

(ECF No. 1646 at 9).

The record leaves no question there was constitutionally deficient care being provided by the Defendants at the time of the preliminary injunction hearing. The Court also finds for reasons stated herein, that despite the good efforts of the Defendants, constitutionally deficient care is still being provided. The Court's finding is based generally on the fact that there is insufficient mental health staffing at the IDOC. Moreover, to the extent there have been improvements in the delivery of mental health services, the record is clear those measures are unsustainable.

As noted above, Dr. Hinton testified at the preliminary injunction hearing as follows:

> Q. You know today you can't deliver the care—the psychiatric care that is required for the 12,000 patients because you don't have enough psychiatrists?
>
> A. Correct.

(ECF No. 1758 at 50). Dr. Hinton testified at the permanent injunction hearing that the IDOC is now providing adequate care to mentally ill inmates. (ECF No. 2372 at 31). The Court does not doubt the sincerity of Dr. Hinton's current assessment. However, his current position is in stark contrast with the evidence presented at the preliminary injunction hearing only three months earlier, and therefore is viewed with considerable caution. (*See* ECF No. 2070, *ad passim*; *see*

also ECF No. 2070 at 16-18, Order capturing portions of Dr. Hinton's testimony; *supra*, p. 13-17). Importantly, it appears Dr. Hinton's assessment is based largely on the fact that the IDOC has the "proper procedures in place to provide adequate treatment," and not based on the actual care being given to inmates. (ECF No. 2375 at 5, Dr. Hinton, testifying in a deposition dated August 17, 2018, avoided addressing whether inmates were being given adequate care, instead testifying "[i]t is my testimony that we have the proper procedures in place to provide adequate treatment to all of our population.")(Emphasis added). Additionally, it should be noted that Defendants maintain they now have the leadership, staffing, and procedures in place to provide the necessary constitutional care. (ECF No. 2405 at 16). Dr. Hinton also explained that he did not have anything to do with the certification from the IDOC that they were in compliance with the Court's May 25, 2018, Order. (ECF No. 2372 at 18). Dr. Hinton specifically explained he was not at every prison for the "day-to-day activit[ies]." *Id*. It is clear the IDOC is concerned with the staffing levels of mental health providers. Baldwin testified that the IDOC continues to ask Wexford for additional mental health staff. (*See also* ECF No. 2370 at 95, Baldwin acknowledges that he understood that the staff Wexford is supposed to provide is the amount necessary to provide the required service). Both Baldwin and Dr. Hinton testified about expanding the relationship with Southern Illinois University and the University of Illinois to provide additional mentally health hours but at present this is *de minimis*. Baldwin testified about the IDOC continuing to engage in recruitment fairs.

Like Dr. Hinton, Baldwin also maintains the opinion that the IDOC has enough staff on board to provide adequate medical treatment to the mental ill inmates. (ECF NO. 2453 at 70). However, Baldwin also lacks an adequate basis for his position as it is based on the fact that the IDOC has made progress in its hiring, yet he acknowledges that he does not know to what level the hiring has been made. *Id*. Additionally, Baldwin testified that he "believe[s] [ ] right now [the

IDOC] ha[s] an adequate number of psychiatrist[s], and as we get our whole structure in place, [they will] need to increase staff [ ]." *Id*. The fact that the IDOC does not have all the necessary structures in place further demonstrates the problems with the current care for mentally ill inmates. Moreover, the current status of the structures suggests more staff is necessary to compensate for the current deficiencies. (*See also* ECF No. 2354 at 50, Baldwin acknowledging that buildings by themselves do not treat the inmates).

Moreover, it is generally undisputed that adequate staffing is necessary to deliver adequate care. In his Second Annual Report of Monitor, Dr. Stewart made it clear that non-compliance with the Settlement Agreement is a direct result of inadequate staffing. (ECF No. 2122 at 9). Even given his change in position, Dr. Hinton acknowledged that it takes the right number of people to provide the required care. (EFC No. 2372 at 31). When pressed regarding the situation at Dixon, Dr. Hinton's position was most telling:

> Q. So, psychiatrists, 1255, psychologist, 692, QMHPs, 1272, BHTs, 607. That comes to roughly 3700 [hours].
>
> You got more people vacant – oh, no. You managed to cut the vacancies from 3700 to 3000 hours. Is that adequate?
>
> A. It's an improvement.
>
> Q. Is it adequate?
>
> A. Well, I think – I can't answer that yes or no, so –

(ECF No. 2372 at 49).

In July 2018, Defendants submitted their staffing plan. (Pl. Ex. 48A; Df. Ex. 55B). Notably, Defendants' staffing plan provides for the equivalent of 65.75 psychiatrists. (Pl. Ex. 48A; Df. Ex. 55B). The actual number of on-staff psychiatrists sits somewhere between 50-55. *See supra*, p. 13. It should also be noted that the staffing shortage is not limited to psychiatrists.

Defendants' staffing of Mental Health Directors, Psychologists, Behavioral Health Technicians, and other Mental Health Employees is also deficient. (Pl. Ex. 48A; *see also* Df. Ex. 6 and Df. Ex. 38; after the Settlement Agreement was signed in May 2016, the IDOC increased its mental health staffing from 80 FTEs to 453.6 FTEs. In January 2018, the overall headcount was 364.).

Again, the testimony at the preliminary injunction hearing clearly established that the mentally ill inmates were receiving inadequate care. As noted above, Dr. Hinton, Dr. Dempsey, and Dr. Stewart each testified about the deficiencies in mental health staff and the impact on the inmates. Dr. Hinton acknowledged at the preliminary injunction hearing that given the deficiencies in staffing, inmates in segregation were getting worse "across the board." Dr. Stewart called the situation an "emergency." Even with the additional mental health staff hired after the preliminary injunction hearing, the numbers associated with mental health providers are deficient to provide the constitutionally required care. In fact, the June 2018 monthly facility performance report showed Wexford had failed to supply more than 10,000 hours of required clinical staff for that month. (Pl. Ex. 51; ECF No. 2376 at 290, Renzi's testimony).

The Court has given little weight to the testimony of Holly Andrilla, Defendants' expert, who opined that, statistically, given the public in general, the IDOC has more than enough psychiatrists to treat its mentally ill population. (ECF No. 2375 at 59, Andrilla concluded, among other things, "[e]very facility except Vienna, the ratio of psychiatrists per seriously mentally ill people exceeds the ratio of the general population [ ]."). Andrilla is a research scientist with the WWAMI Rural Helath Research Center and the Center for Health Workforce Studies in the Department of Family Medicine at the University of Washington School of Medicine. (Df. Ex. 62). The Court takes no issue with the expert's credentials or even her general methodology. However, the Court finds the expert's analysis is inapplicable because her analysis compares the

non-prison population with the prison population. (*See* ECF No. 2375 at 82-83, Andrilla explained the source of her data). The doctors and medical providers in this case, on both sides, have meticulously detailed the difficulties in treating the prison population with the current staff. The use of overtime is pervasive, and to put it in terms of the witnesses, "unsustainable." (*See infra*, pp. 23-24). It is impossible to believe there is adequate staff, even with overtime and other efforts, given the significant number of inmates who are not being timely treated based on the Defendants' own backlog assessment. Andrilla's assessment is simply contrary to the testimony and established facts in this case.

To fully appreciate the impact of the staffing deficiencies, one need not look much further than the IDOC's backlog. The term "backlog report" was used throughout the preliminary and permanent injunction hearings. The backlog report contains data supplied by the correctional center. Mercer, Illinois Regional Mental Health Quality Assurance Coordinator for Wexford Health Sources, explained her role as quality assurance coordinator is to monitor, report, and translate data related to the IDOC's compliance with the Settlement Agreement. (ECF No. 2373 at 6). Mercer noted that, in the past, each facility would use a different mechanism to capture the mental health treatment data. (ECF No. 2373 at 14). Mercer implemented the use of a database template at every facility so that each facility's database would look the same and the facilities would collect the same data. (ECF No. 2373 at 15). Additionally, she focused on getting the facilities to collect and record the appropriate data in the database. (ECF No. 2372 at 6). Mercer explained that some of the data is automatically updated based on data that is manually inputted. (ECF No. 2373 at 10, "[W]hen certain information is entered into the database, for example, the date that an individual is identified as needing mental health services, the date that a person was last seen, what - -the number of days that the provider has indicated that they want to see that

person again, the database automatically generates due dates and follow-ups due dates and, *et cetera*."). Mercer noted, however, that the failure to manually input certain information can cause inflated numbers in the database. (ECF No. 2373 at 8). Ultimately, the backlog report (psychiatry) represents the backlog in "New/Face to Face," "Follow Up/Face to Face," "New Telepsych," and "Follow up/Telepsych." (*See* Df. Ex. 1F). The backlog is measured in increments of "1-14 day backlogged," 15-30 day backlogged," "31-45 day backlogged," "46-60 day backlogged," and "Greater than 60 day backlogged." *Id*.

The numbers on the August 17, 2018, backlog report show an improvement from the numbers presented during the preliminary injunction hearing. (Df. Ex. 1F). Defendants provide that the psychiatric backlog has been reduced to a total of 908. (Df. Ex. 1D and 35B). Defendants further provide that the backlog for new psychiatric appointments has been reduced to nearly zero. (Df. Ex. 1F). Nonetheless, while the backlog number may have been reduced, it is still significant in terms of the timing of the reductions, the current level of backlog, quality, and the methods undertaken to reduce the backlog. The evidence presented at the preliminary injunction hearing showed, as of October 2017, there were a total of 4,010 backlogged contacts. (ECF No. 1757 at 213). And as the Court noted in its previous Order, a significant reduction in the backlog only came about at the same time or after the filing of the Plaintiffs' initial Motion. (*See id*., *see also* ECF No. 1559, filed on 10/10/2017). Additionally, Baldwin acknowledged that the backlog had been reduced, at least in part, by overtime, a method he and others acknowledge is not a long-term solution. (ECF No. 2370 at 129, "Not a log-term permanent [solution]. I see it as a short-term [solution].").

Confirming the inability to continue the current efforts and the inadequacies of staffing, Renzi, Psychologist Administrator at Pontiac Correctional Center, testified as follows:

Q. I notice in the charts and in your testimony that in terms of trying to deal with the backlogs and provide adequate care, you're trying to have people come from other institutions and work there and also offer additional overtime, correct?

A. Yes.

Q. That doesn't sound like a very good plan. I mean, is that sustainable in the long term?

A. In the long term, it would be difficult to sustain that.

Q. Yes.

A. However, the mentality – the idea that providing them some service is better than providing them no service.

Q. Yes. So – but would it be fair to say that you acknowledge that you do need more staff at Pontiac.

A. I would acknowledge that, yes.

(ECF No. 2376 at 356). Dr. Stromberger, Psychologist Administrator at Hill Correctional Center, also affirmed this with her testimony as follows:

Q. Well, how does it all get done if you only have half the staff you're supposed to have?

A. We work very hard.

Q. You work overtime, right?

A. At times.

Q. And is there burnout because of the excess amount of work?

A. Yeah.

Q. And do you lose good people because they're working too hard?

A. Yeah.

Q. And isn't that a problem?

A. I would say.

--

> Q. Well, do you have an understanding of whether there were deficiencies – continued deficiencies in staffing of mental health people?
>
> A. Continued deficiencies in terms of staffing. Yes, there's been deficiencies for quite some time for staffing.

(ECF No. 2376 at 1433-34). In the Court's view there is presently no "Plan B."

At Dixon Correctional center, part of the plan to reduce the backlog was to have psychologists work on the weekends, non-traditional hours, and second shift. (ECF No. 2372 at 43). The Court agrees with Baldwin that the use of overtime is not sustainable. As Dr. Stewart testified, the overtime was putting a strain on employees. (ECF No. 2374 at 264, "Centralia has a minimal backlog, but the staff out there is at wit's end. They don't have enough people."). Dr. Stromberger testified that working excessive overtime causes problems with retention because of burnout. (ECF No. 2376 at 68). The Court has also considered the fact that in many cases the task associated with the backlog had been outstanding in the "1-14 day backlogged" benchmark. (Df. Ex. 1F). Nonetheless, even with the overtime, the backlog is still significant in certain facilities, including Pontiac, Dixon, and Menard. (Df. Ex. 1F). It should be noted that the deficiencies in staffing are not only related to psychiatrists. The deficiencies lie in all areas of mental health staff. (Pl. Ex. 48A; Df. Ex. 55B). This is a real problem, and one that must be addressed now.

Both Parties utilize the processes implemented by Dr. Sim in support of their positions. Defendants note that his work has resulted in a useful tool to allow the Defendants to focus on problem areas. Plaintiffs assert the reports show serious deficiencies in the actual delivery of services – and further demonstrate the difficulty with staffing. This Court finds both are correct.

Dr. Sim has been tasked with developing and implementing a mental health quality assurance process. Dr. Sim's process includes an audit tool and a mechanism to allow the

correctional centers to make corrective action. Dr. Sim described two different audit processes: (1) internal audits, conducted by the psychologist administrator or a social worker at the facility; and (2) external audits, conducted quarterly by regional administrators. Dr. Sim explained that his audit identifies 315 "problem statements." Problem statements are "verbiage" that came from the settlement agreement, standard operating procedures, or the administrative directives. (ECF No. 2375 at 125). These problem statements are then placed into four broad categories. (ECF No. 2375 at 126-128). The review uses these statements when conducting their audit as follows:

> [ ] when the mental health authorities, the psych administrator or social worker for when they conduct their audit, when they open up the documentation, the medical charts, if they see that certain things are not being [done] – that is on this list, that means it's considered non-compliant.

(ECF No. 2375 at 126).

The internal audit in turn uses these compliance categories and the problem statements to assess the Department's compliance in the following ten areas: (1) Intake; (2) Crisis Writ and Transfer; (3) Mental Health Follow-Up; (4) Mental Health Treatment Plan; (5) Crisis Management, Intervention and Documentation; (6) Psychiatric Services; (7) Mental Health Disciplinary Review/Restricted Housing; (8) Use of Restraints; (9) Mental Health Evaluations; and (10) Supervision for Non-Clinical Licensed Mental Health Staff. (ECF No. 2375 at 130; Df. Ex. 3D). The audits used to be conducted every month. (ECF No. 2375 at 132). Starting in July 2018, the audits were conducted every other month. *Id*. Dr. Sim explained this change was to allow mental health staff more time to provide services to inmates. In addition, Sim explained this would allow the auditors the ability to review the data and develop effective corrective action plans. (ECF No. 2375 at 133). The correctional centers can use the results as a tool to take corrective action. Undoubtedly, this is a good thing.

However, in July 2018, several of the institutions were performing below the 85% threshold set by the IDOC. (ECF No. 2375 at 180). In some cases, significantly lower. That, in and of itself, does not raise undue concern. But, an examination of the results further reveals the difficulty the IDOC is having with staffing. The following discussion highlights this Court's concerns:

> Q. For the corrective action plans for Pontiac marked July 18th, these would be the corrective action plans to follow the audit that we just looked at, correct?
>
> A. Yes.
>
> Q. Okay. And we see the 20 -- for the first sheet is about mental health treatment plans, and it has that compliance score of 20 percent at the top, correct?
>
> A. Yes.
>
> Q. Okay. And the first deficiency is, Mental health treatment plan was not filed in the medical record, correct?
>
> A. Correct.
>
> Q. And that's a clerical? It's listed as a clerical error on Missing Information?
>
> A. Yes.
>
> Q. That's the category?
>
> A. Yes.
>
> Q. But we don't know from this whether the treatment plan just wasn't done or it wasn't filed?
>
> A. I don't know.
>
> Q. Okay. But regardless, the action plan is for staff to use overtime to do treatment plans, right?
>
> A. Yes.
>
> Q. Okay. And the deficiency number two also relating to treatment plans is that there wasn't -- there was no monthly treatment plan updated for mental health patient in restrictive housing for more than one month. Do you see that?

A. Deficiency number two.

Q. Deficiency number two, correct?

A. Yes.

Q. So, that would have been one of the top three most common deficiencies for Pontiac in this audit?

A. Yes.

Q. And the corrective action plan here is for MHPs to use monthly one-to-one sessions for treatment planning for seg offenders. Do you see that?

A. Yes.

Q. So, that means that they're going to take time from the prisoner's individual counseling session to meet the treatment planning requirement, correct?

A. That's what it shows.

(ECF No. 2375 at 162-64). This colloquy between Plaintiffs' counsel and Dr. Sim demonstrates the ongoing shift by the Defendants of their limited staff resources from one area of concern to another and the need to cover essential items by use of overtime. This is simply unsustainable.

The Court further finds the Defendants have been aware of these deficiencies for an unreasonable period of time, and their failure to address these deficiencies amounts to deliberate indifference. *Wellman v. Faulkner*, 715 F.2d 269, 272 (7th Cir. 1983) (*citing Todaro v. Ward*, 565 F.2d 48, 52 (2d Cir. 1977)) ("When systematic deficiencies in staffing, facilities or procedures make unnecessary suffering inevitable, a court will not hesitate to use its injunctive powers."). There have undoubtedly been efforts on the part of the Defendants to address the staffing needs regarding mental health; however, these efforts have been generally ineffective – and have gone on far too long without any significant attempt to adapt or modify based on the knowledge gained from their recruitment efforts. While some efforts have been successful, including the recent

expansion of the use of tele-psychiatry, the Defendants have failed to achieve a minimum level of medical service to avoid the label of cruel and unusual punishment. *Id*.

Medication Management

Dr. Stewart explained that psychiatric conditions are brain illnesses. (ECF No. 1757 at 241). Dr. Stewart testified that psychotropic medications can have harsh side effects and require constant monitoring. (ECF No. 1757 at 242, Dr. Stewart specifically explained "[s]ome of [the medication] have some pretty harsh side effect profiles that require constant monitoring [and some that] you need to follow-up with laboratory work; you need to follow-up with [ ]blood pressure monitoring in certain cases [and] follow-up on the abnormal involuntary movement scale."). Additionally, the failure to properly monitor an inmate's medication may result in poor medication compliance, including the possibility that the inmate will cease taking medication. (ECF No. 1758 at 40, Dr. Stewart testified "where you have poor medication compliance because people are experiencing side effects, and they don't get those addressed, so the medications are just stopped."). Dr. Stewart ultimately concluded at the preliminary injunction hearing that "[i]t's rare when someone is being seen every 30 days [and he has] [f]ound examples of people being seen -- of medications being routinely written for anywhere from two to six months." (ECF No. 1757 at 243). The reason Dr. Stewart was given by prescribers, the nursing staff, and the clinical administrators for medication being prescribed for longer periods of time was because "[the IDOC doesn't] have enough people to see people every 30 days so [they] write the meds longer so the meds won't expire, and hopefully [they'll] see them within a couple months or three months." (ECF No. 1757 at 243-44). Dr. Stewart also testified that class members were exhibiting severe side-effects that were not charted in their records. (ECF No. 1757 at 251).

These conclusions went generally uncontested at the preliminary and permanent injunction hearings. In fact, Dr. Hinton acknowledged at the preliminary injunction hearing that

understaffing is a significant problem regarding medication management, noting that thousands of inmates who receive medication in the general population are placed in a dangerous situation by not being seen by psychiatrists. (ECF No. at 319-20).

The danger was recognized by the Parties and several provisions were inserted into the Settlement Agreement to insure proper medication management.

Sections XII(b) of the Settlement Agreement provides:

> Within ninety (90) days after the approval of this Settlement Agreement, IDOC shall also comply with the provisions of IDOC Administrative Directive 04.04.101, § II(F)(5), except that under no circumstances shall a SMI offender who has a new prescription for psychotropic medication be evaluated as provided therein fewer than two (2) times within the first sixty (60) days after the offender has started on the new medication(s).

(ECF No. 711-1 at 15). The referenced Administrative Directive provides:

> Offenders who are prescribed psychotropic medication shall be evaluated by a psychiatrist at least every 30 days, with extensions on follow-up care for those who psychiatrist have found and documented that the offender has reached stability (outpatient level of care: Not to exceed 90 days; RTU level of care: not to exceed 60 days).

Additionally, the Settlement Agreement requires:

> The regular charting of medication efficacy and side effects, including both subjective side effects reported by the patient, such as agitation, sleeplessness, and suicidal ideation, and objective side effects, such as tardive, dyskinesia, high blood pressure, and liver function decline [and]
>
> Adherence to standard protocols for ascertaining side effects including client interviews, blood tests, blood pressure monitoring, and neurological evaluations [ ].
>
> (ECF No. 711-1 at 15).

In addition to the staffing issues discussed above, the evidence at the permanent injunction hearing revealed the continuation of significant issues with the IDOC's medication management. First, the mental health staff at the correctional centers recognize there is an issue with follow-up

because the nursing staff who administer the medications do not notify them when inmates are non-compliant. Dr. Renzi testified that a lot of the inmates will accept the medication from the nurse, and then put the medication in their mouth as to appear as though they are taking it. (ECF No. 2376 at 278). However, the inmates may "cheek" the medication or swallow it, and later regurgitate it. *Id*. Dr. Renzi acknowledged that Pontiac continues to have difficulty in assuring that offenders are actually taking their medication, but there have been educational efforts to train staff. (ECF No. 2376 at 277-79). Dr. Stromberger testified that nursing staff are not fully aware of referral protocol when class members refuse medications. (ECF No. 2376 at 48). Dr. Stromberger, however, did note that there had been some educational follow-up on that issue.

This testimony is consistent with Dr. Stewart's testimony during the preliminary injunction hearing. Dr. Stewart testified that one major problem is that inmates are given their medications but not monitored closely to ensure they have ingested the pills, especially in segregation. (ECF No. 1757 at 123). Dr. Stewart testified one of the inmates he visited had numerous pills on his person that he had not taken. (ECF No. 1757 at 254). It should be noted that Dr. Puga is certainly aware of these issues and has been working on measures to assist in medication compliance. (ECF No. 2372 at 136-37). Nonetheless, these issues again highlight the general staffing issues and the need for additional measures to be considered.

Mental Health Treatment in Segregation

Segregation refers to an inmate's confinement in his or her cell for a period of 22 to 23 hours a day. (ECF No. 1757 at 103). In the IDOC, over 80% of the inmates in the IDOC who are in segregation are mentally ill. (Pl. Ex. 22, 897 out of 1105 inmates in segregation are mentally ill). Dr. Hinton opined that the "percentage of [inmates] who are mentally ill tend to have more behavioral issues, in part because of their mental illness." (ECF No. 1758 at 81). Dr. Hinton further opined that "there's nothing that is a good thing about being in segregation." *Id*.

Supporting such an opinion, Dr. Stewart testified "[a] person with a pre-existing mental illness placed in segregation will have an exacerbation of their pre-existing mental illness." (ECF No. 1757 at 109). Segregation can also cause a degradation of coping mechanisms and lead to increases in self-harm and other acting-out behaviors. (ECF No. 1757 at 109-111). Dr. Renzi also agreed that segregation can have a negative effect on mental illness. (ECF No. at 2376 at 295). Inmates Champs, King, Span, and Singleton all testified about their negative experience in segregation. (ECF No. 2376 at 91-112, 113-148; ECF No. 1758 at 271-287, 394-412). Given this, it is clear mental health issues must be addressed for mentally ill inmates in segregation.

Under Sections XV(a)(iii), the Parties agreed that:

> Mentally ill offenders in segregation shall continue to receive, at a minimum, the treatment specified in their Individual Treatment Plan (ITP). Treating MHPs and the Warden shall coordinate to ensure that mentally ill offenders receive the services required by their ITP.

(ECF No. 711-1 at 17). The Settlement Agreement places certain timeframes on MHP's review of, and updates to, the treatment plans for mentally ill offenders placed in segregation. *Id*. Dr. Stewart explained the purpose of this requirement is simple – when you place an inmate "into a segregation system, you need to review and update the treatment plan given the vastly different environment the person is in."[2] (ECF No. 1905 at 82).

[2] It should be noted that Dr. Stewart also explained that inmates in segregation are:

> [ ] some of the sickest individuals psychiatrically that I've seen in my career, and I've only worked with seriously mentally ill. And these people are just suffering immensely.
>
> And so -- you know, and they get nothing. Couple little things thrown at them. But they really don't get any sort of regular treatment.
>
> And so this is a real serious issue, you know. I don't want to put a number on it. It's, it's -- it's as serious as I've seen.

(ECF No. 1905 at 182-83).

During the preliminary injunction hearing, Dr. Stewart testified that the IDOC's medication management for those in segregation is worse than for Class Members elsewhere in the system. (ECF No. 1757 at 123). Dr. Stewart specifically noted that there is a significant problem in the failure to ensure that those in segregation who are prescribed psychotropic medication actually take the medication. (ECF No. 1757 at 123). Additionally, there was testimony and evidence during the preliminary injunction hearing regarding Defendants' non-compliance with the out-of-cell time required for mentally ill inmates placed in segregation. (ECF No. 1757 at 136; s*ee also* ECF No. 711-1 at 20, Section XV(c) of the Settlement requires "mentally ill offenders in a Control Unit setting for longer than sixty (60) days shall be afforded out-of-cell time.")

Dr. Stewart explained at the preliminary injunction hearing that the consequences of this failure are:

> [ ] psychiatric decompensation. And then we run into that whole line, you know, acting out, writing up, more segregation time and/or going to crisis, coming out. It's -- the fact that (vi)(A), which is continuation of the initial treatment plan with enhanced therapy, if necessary, to protect from decompensation that may be associated with segregation, that's not being done. People are getting worse in segregation.

(ECF No. 1905 at 174).

In addition to the above, during the permanent injunction hearing, there was additional evidence presented regarding inmates' out-of-cell time. In the record it is generally accepted that out-of-cell time for mentally ill inmates in segregation is necessary to avoid a rapid decline in mental health. Plaintiffs argue that the lack of adequate structured out-of-cell time is a continuation of the Defendants' failure to meet their obligation under Section XV(c) of the Settlement Agreement. Plaintiffs also argue that Defendants are not adequately addressing an inmate's refusal to participate in out-of-cell time.

As it relates to Menard, Pontiac, and Dixon, the "received" and "received minus refusal" structured out-of-cell time by inmates during June 24, 2018, through June 30, 2018, was summarized in Plaintiffs' Exhibits 45B, 45C, and 45D. Plaintiffs presented information regarding these institutions because they have large segregation populations. (*See* ECF No. 2374 at 124, Dr. Stewart testified that "I know Pontiac has a very large segregation population, but Menard also has a large segregation population."). The evidence showed inmates were receiving an average of 6.05 hours at Menard, 6.97 hours at Pontiac, and 9.3 hours at Dixon. (Pl. Ex. 45B, 45C, and 45D). However, it was noted that "received" hours included those that were taken and offered but refused. *Id*. The actual average out-of-cell time was 4.24 hours at Menard, 2.996 hours at Pontiac, and 3.13 hours at Dixon. *Id*. Parenthetically, it should be noted that the majority of structured out-of-cell time was by way of movies. (Pl. Ex. 45A; *see also* ECF No. 2374 at 126[3]).

The most significant issue raised by these numbers is the importance of staffing. Dr. Doyle and Dr. Mirsky both testified that refusing group or other mental health services can be a potential indicator of decompensation. (ECF No. 2377 at 48; ECF No. 2370 at 276). Nonetheless, the record indicates a lack of concern or follow-up for those individuals refusing to participate in these activities.

[3] Dr. Stewart testified about the use of movies as a structured treatment activity:

> It certainly would -- it could contribute to lessening the decompensation, but I don't -- it's not a -- necessarily a therapeutic activity, so I would question its validity for that purpose.
>
> I think it's a good thing to get people out of their cells and doing anything. I want to be real clear about that.

(ECF No. 2374 at 126).

Mental Health Treatment on Crisis Watch

Like segregation, inmates who are on crisis watch are in isolation and additional care is necessary to avoid exacerbating their mental health issues. Crisis refers to an acute exacerbation of mental illness, such as worsening psychosis or mania, or acting out behaviorally, or when someone is acutely suicidal or potentially violent. (ECF No. 1757 at 51-53). The purpose of crisis cells or watches in correctional mental health systems is to, first, protect the individual from self-harm or harming others, and second, to provide appropriate mental health assessment and intervention, such as re-evaluating medication, re-evaluating the psychosocial treatment, and addressing whatever issues precipitated the crisis (ECF No. 1757 at 219; *see also* at 38, Dr. Stewart explained that the crisis level of care is needed to assist "people that are presenting with acute problems that need aggressive intervention to deal with a particular acute issue."). During the preliminary injunction hearing, Dr. Stewart testified that it is "imperative that their treatment is reviewed, not just by one individual but for the entire treatment team that's involved with the case [ ] [a]nd that's not happening." (ECF No. 1757 at 52).

The Settlement Agreement provides certain requirements as it relates to crisis treatment. First, the Settlement Agreement provides:

> Beds that are available within the prison for short-term (generally no longer than ten (10) days unless clinically indicated and approved by either a Mental Health Professional or the Regional mental Health Administrator) aggressive mental health intervention designed to reduce the acute, presenting symptoms and stabilized the offender prior to transfer to a more or less intensive care setting, as required by IDOC Administrative Directive 04.04.102, § II(F)(2).

(ECF No. 711-1 at 3).

Dr. Stewart testified at the preliminary injunction hearing that, based on his review, the only treatment that regularly occurs on crisis watches is the daily contact by the MHP, which are

confidential sessions at some facilities but take place most often at the cell front. (ECF No. 1905 at 131). Dr. Stewart explained that:

> But again, as I said, the only thing that occurs is being placed in the cell, having certain property removed, and then getting these daily visits. And so there's no specialized treatment that occurs for people in crisis.

(ECF No. 1903 at 198-99) (emphasis added).

The Settlement Agreement also provides:

> For offenders transitioning from Crisis placement, there will be a five (5) working day follow-up period during which the treating MHP will assess the offender's stability on a daily basis since coming off Crisis watch. This assessment may be performed at cell front, using a form which will be specifically designed for this purpose by IDOC and approved by the Monitor. This five-day assessment process will be in addition to IDOC's current procedure for Crisis transition, which IDOC will continue to follow. This procedure requires an MHP to conduct an Evaluation of Suicide Potential (IDOC Form 0379) on the offender within seven (7) calendar days of discontinuation from Crisis Watch, and thereafter on a monthly basis for at least six (6) months. Findings shall be documented in the offender's medical record.

(ECF No. 711-1 at 10).

Dr. Stewart concluded that, at the time of the preliminary injunction hearing, Defendants are only conducting the first suicide evaluation, but are not continuing to assess monthly for six months. (ECF No. 1757 at 232). Dr. Stewart also opined that the Defendants' failure to conduct necessary evaluations and assessments of those who are discharged from crisis watches results in unnecessary harm and suffering, especially as those failures combine with inadequate treatment planning and psychopharmacology. (ECF No. 1757 at 231). There was no evidence to the contrary presented by the Defendants about the conditions at the time of the preliminary injunction hearing. Additionally, evidence regarding crisis watch was presented during the permanent injunction hearing. Most notably, Plaintiffs presented evidence of inmates who were kept on crisis watch longer than 10 days. In June 2018, there were 620 inmates placed on crisis watch, in July 2018, there were 486. (Pl. Ex. 53; Pl. Ex. 43). Of those inmates, 85 were kept on crisis watch longer

than 10 days in June, and 121 inmates met that criteria in July. (ECF No. 2374 at 111-12; Pl. Ex. 43; ECF No. 2376 at 314, Dr. Renzi's Testimony). The IDOC's Mental Health Procedures Manual provides that "patients who remain on crisis treatment level of care after ten consecutive days will be considered for a higher level of care." (Df. Ex. 49, p. 31). The record reveals little compliance with this requirement.

Moreover, Dr. Mirsky confirmed Dr. Stewart's finding that inmates on crisis watch are getting between 15-20 minutes of time with qualified mental health profesisonals and little other time. Notably, Dr. Doyle explained:

> "[If the IDOC had additional staff] it would mean that we could spend more time. Some people, it takes them a few minutes just to get comfortable sitting with you as a psychiatrist. So we could establish better rapport.
>
> Looking at the reverse as to what the damage is, I'm hoping that we're not doing any damage, but I couldn't say for sure if there isn't some."

(ECF No. 2377 at 81).

Mental Health Evaluations

As previously noted, there is no dispute the Defendants have failed to comply with Section V(f) of the Settlement Agreement. Section V(f) provides:

> Evaluations resulting from a referral for routine mental health services shall be completed within fourteen (14) days from the date of the referral (*see* IDOC Administrative Directives 04.04.100 § II(G)(2)(b) and 04.04.101 §II(F)(2)(c)).

(ECF No. 711-1 at 8).

There was much evidence regarding the significant backlog in psychiatric contacts with inmates. Contacts are activities that psychiatrists and mental health professionals are supposed to accomplish, including evaluations, treatment plans, and follow-up. (ECF No. 1757 at 212-13).

The Defendants argue that the backlog has substantially declined, noting that there is now a backlog of 313 initial evaluations. (ECF No. 1894, Df. Ex. 1a; *but see also* ECF No. 1757 at

213, where it was noted there was a backlog of 445 evaluations, 780 treatment planning contacts, and 2,785 follow-up visits; *compare with* Df. Ex. 1). The Defendants further note that a significant amount of these are only delayed 1-14 days. Finally, the Defendants suggest that the record does not identify the number of mentally ill prisoners at the various facilities, and thus, the Court is unable determine how the number of late evaluations at those four facilities compares to the number of mentally ill prisoners at those facilities. (ECF No. 1965 at 14). The Defendants' argument that the Court is unable to determine the extent of the problem based solely on the size of the backlog without additional information regarding the population is unpersuasive. Dr. Hinton testified as to the unacceptable nature of the backlog existing at the time of the preliminary injunction hearing. (ECF No. 1758 at 52, *et seq.*).

As discussed before, while the backlog number may have been reduced, it is still significant in terms of timing of the reductions, the current level of backlog, quality, and the methods undertaken to reduce the backlog. *Supra*, p. 22-24. The current system's reliance on overtime is not viable. *Id*.

Mental Health Treatment Plans

The treatment plan document plays a very important role in the delivery of mental health care – it guides the treatment of an inmate. (ECF No. 1906 at 106, 113, Dr. Hinton's Testimony; *see also* 280, Dr. Mirsky acknowledging treatment plans are the most fundamental document in the whole mental health system). The plan is created for each inmate who is diagnosed with a mental illness or receiving mental health care services. (ECF No. 1906 at 112). The treatment plan should capture how treatment is ultimately delivered and the goals of treatment. (ECF No. 1906 at 38). The IDOC utilizes the treatment plan to make sure that the inmate consents to the treatment. *Id*.

The Settlement Agreement provides:

> As required by IDOC Administrative Directive 04.04.101, § II(F)(2)(c)(4), any offender requiring on-going outpatient, inpatient or residential mental health services shall have a mental health treatment plan. Such plans will be prepared collectively by the offender's treating mental health team.

(ECF No. 711-1 at 9).

Plaintiffs have generally argued that the treatment plans are being done in a perfunctory manner that do not facilitate the delivery of mental health services. (ECF No. 1559 at 14; *see also* ECF No. 2406 at 78, "The treatment plans in IDOC are not helpful and do not facilitate the provision of mental health care; the forms are completed more as an administrative requirement and not true treatment planning.").

This Court's May 25, 2018, Order required that "[a]ll class members shall have a treatment plan that is individualized and particularized based on the patient's specific need, including long and short term objectives, updated and reviewed with the collaboration of the patient to the fullest extent possible." (ECF No. 2070 at 41).

The evidence at the preliminary injunction hearing makes it clear that the lack of adequate staffing significantly impacts treatment planning. Defendants argue the full record shows the IDOC has made substantial improvements with respect to treatment planning. This includes the use of a revised treatment plan document reviewed and approved by Dr. Stewart. (Df. Ex. 13). The problem arises, however, in the actual completion of the treatment plans. The mental health providers are so overworked that the treatment plans often become perfunctory.

Plaintiffs presented the Court with treatment plans from inmates at Pontiac Correctional Center. (ECF No. 2374 at 180). These treatment plans contained identical, or nearly identical, language describing the therapeutic focus, problems, and activity. (*See* Pl. Ex. 55C, 55G, 55I, and 55M). Dr. Stewart opined:

> What I – what I glean from this, in all seriousness, is this is a reflection of how overworked the mental health professionals are, where they are basically cutting and pasting these things because it's just one more requirement they have because they're stretched way too thin. That's how I read this.
>
> These treatment plans are identical. They're basically all worthless. They may apply to one of these people, and there may be some overlap, but come on, the same wording on four different patients?
>
> So, that's why I see this as the mental health professionals – and this confirms, you know, my walking around Pontiac. These people are just really – they're hurting out there, the mental health professionals, because they have so much work, and there's not enough.

(2374 at 188).

Deliberate Indifference

The above demonstrates the Defendants have breached the Settlement Agreement in the five areas advanced by the Plaintiffs. In order to warrant action by this Court, the Court must also find there is a violation of federal law.

To establish an Eighth Amendment violation, Plaintiffs must prove that Defendants have been deliberately indifferent to their serious medical needs, and in this case, their mental health needs. "[D]eliberate indifference to serious medical needs of prisoners constitutes the 'unnecessary and wanton infliction of pain' proscribed by the Eighth Amendment." *Estelle*, 429 U.S. at 104 (citations omitted).

An inadequate medical care claim requires a plaintiff to fulfill two elements: (1) the plaintiff "suffered an objectively serious harm that presented a substantial risk to his safety," and (2) "the defendants were deliberately indifferent to that risk." *Minix v. Canarecci*, 597 F.3d 824, 831 (7th Cir. 2010). The objective element requires that the plaintiff's medical need to be "sufficiently serious." *Gutierrez v. Peters*, 111 F.3d 1364, 1369 (7th Cir. 1997). The subjective element requires that the "official must both be aware of facts from which the inference could be

drawn that a substantial risk of serious harm exists, and he must also draw the inference." *Farmer v. Brennan,* 511 U.S. 825, 837 (1994).

To meet the objective prong, the medical need must be one that has been diagnosed by a physician as mandating treatment or one that is so obvious that even a lay person would easily recognize the necessity for a doctor's attention. *Gutierrez*, 111 F.3d at 1373. A medical condition "need not be life-threatening to be serious; rather, it could be a condition that would result in further significant injury or unnecessary and wanton infliction of pain if not treated." *Gayton v. McCoy*, 593 F.3d 610, 620 (7th Cir. 2010). The Seventh Circuit has agreed with other courts in concluding that the "[t]reatment of the mental disorders of mentally disturbed inmates is a "serious medical need." *Wellman*, 715 F.2d at 272 (*citing Ramos v. Lamm,* 639 F.2d 559, 574 (10th Cir. 1980)); *Inmates v. Pierce,* 612 F.2d 754, 763 (3d Cir. 1979); *Bowring v. Godwin,* 551 F.2d 44, 47 (4th Cir. 1977).

The subjective component requires a plaintiff to "provide evidence that an official actually knew of and disregarded a substantial risk of harm." *Petties v. Carter*, 836 F.3d 722, 728 (7th Cir. 2016); *Farmer*, 511 U.S. at 837. In order to establish deliberate indifference, "a plaintiff does not need to show that the official intended harm or believed that harm would occur." *Id.,* (*citing Farmer*, 511 U.S. at 842). However, medical malpractice, negligence, or even gross negligence do not equate to deliberate indifference. *Johnson v. Doughty*, 433 F.3d 1001, 1013 (7th Cir. 2006). *See also Estelle*, 429 U.S. at 106; *McGee v. Adams*, 721 F.3d 474, 481 (7th Cir. 2013).

The Seventh Circuit has recognized claims of systemic deficiencies in a prison's health care facility as a second category of deliberate indifference claims. *Cleveland-Perdue v. Brutsche,* 881 F.2d 427, 430–31 (7th Cir. 1989). In case of alleged systemic deficiencies, deliberate indifference can be demonstrated by "proving there are such systemic and gross deficiencies in

staffing, facilities, equipment, or procedures that the inmate population is effectively denied access to adequate medical care." *Wellman*, 715 F.2d. at 272 *citing Ramos*, 639 F.2d at 575; *Phillips v. Sheriff of Cook Cty.*, 828 F.3d 541, 554 (7th Cir. 2016), *reh'g and suggestion for reh'g en banc denied* (Aug. 3, 2016) (Claims of "systemic deficiencies at the prison's health care facility rendered the medical treatment constitutionally inadequate for all inmates, [ ]" plaintiffs must demonstrate that "there are such systemic and gross deficiencies in staffing, facilities, equipment, or procedures that the inmate population is effectively denied access to adequate medical care.")). The Seventh Circuit has concluded "that a clear consensus had been reached indicating that a prison official's failure to remedy systemic deficiencies in medical services akin to those alleged in the present case constituted deliberate indifference to an inmate's medical needs." *Cleveland-Perdue*, 881 F.2d at 431. *See Newman v. Alabama*, 503 F.2d 1320 (5th Cir. 1974), (affirming a district court decision finding that systemic deficiencies in the Alabama prisons including inadequate staffing, treatment by unqualified personnel, incomplete medical records, and lack of written procedures establishing the duties and responsibilities of the medical personnel.).

There is no dispute that the Plaintiffs suffer from a serious medical condition. (*See supra*, p. 2, definition of class). The Court has also found above that the Defendants have failed to provide medical treatment as required by the Settlement Agreement in the five areas advanced by the Plaintiffs. The Court also finds that the failure to provide treatment in the above areas puts the Plaintiffs at a significant risk for further injury and severe unnecessary pain and suffering. At the time of the preliminary injunction hearing, this fact was firmly established. Dr. Hinton, Dr. Dempsey, and Dr. Stewart all testified that the conditions in the IDOC, particularly the deficiencies in staffing, created a substantial risk of harm for mentally ill inmates. *Supra,* p. 13-17. These doctors used terms such as "dangerous," "emergent," and "emergency," to describe the situation.

Given this evidence, and considering the standard outlined in *Wellman*, this Court finds the Defendants' inadequate staffing levels creates a systemic problem that has effectively denied the mentally ill inmates access to adequate and constitutionally required care.

It should be noted that Defendants maintain the position that the law requires this Court to limit its decision to the care currently being provided by the Defendants. (ECF No. 2368 at 1). The Defendants further maintain any issues concerning the care the Department provided in the past are moot and irrelevant to a claim seeking forward-looking injunctive relief. *Id*. In support of their positions, Defendants note that the Supreme Court has explained that "deliberate indifference, should be determined in light of the prison authorities' current attitudes and conduct [ ]." (ECF No. 2368 at 3); *Helling v. McKinney*, 509 U.S. 25, 36 (1993). Defendants further note that a plaintiff pursuing a permanent injunction must demonstrate a continuing need for the injunction "during the remainder of the litigation and into the future," and even if prison officials "had a subjectively culpable state of mind when the lawsuit was filed," they "could prevent issuance of an injunction by proving, during the litigation, that they were no longer unreasonably disregarding an objectively intolerable risk of harm and that they would not revert to their obduracy upon cessation of the litigation." *Id*.; *Farmer*, 511 U.S. 825, 846 and n. 9 (1970).

In *Helling*, the Plaintiff complained that he was exposed to unreasonably high levels of environmental tobacco smoke due to his cellmate's smoking habits. *Id.* The Supreme Court found Plaintiff stated a claim, but cautioned that he may have difficulty in proving the objective and subjective factors of a deliberate indifference claim because he had since been moved to a new prison, no longer had a cellmate who smoked, and the state had enacted new policies in effect regarding smoking. *Id*. Here, much of this case surrounds the Defendants' most recent actions – or actions since the preliminary injunction was issued – to correct significant deficiencies in the

delivery of mental health treatment. The Supreme Court and Seventh Circuit precedent require this Court to consider the totality of the circumstances, including the condition as described at the preliminary injunction hearing, the chances of these conditions reoccurring, as well as the current attitude of the Defendants, in considering whether or not a permanent injunction should issue. Additionally, the Court has relied on the fact that the Defendants' actions frequently occur in response to the Court's intervention. *See Coleman v. Wilson*, 912 F. Supp. 1282, 1311 (E.D. Cal. 1995) (The Court in granting a permanent injunction cited the defendants' history of refusing "to address the serious issues underlying the preliminary injunction until forced to do so under pressure of this litigation.").

Defendants also argue that the problem is no longer systemic but only one that affects a few of the institutions. The Defendants specifically note the weekly backlog report shows that as of August 17, 2018, twelve facilities had no backlog with respect to treatment plans, six facilities had only ten or fewer total backlogs in treatment plans, while another seven institutions had fewer than 40 backlogged treatment plans. (Df. Ex. 1D and DX 1I). There is no doubt the Defendants have been able to reduce the backlogs generally and even substantially at certain institutions. However, the backlog remains a real issue within the IDOC given the significant problems with documentation as well as the widespread use of overtime to handle most of the staffing needs to address the backlog. Moreover, the ability to minimize the backlog at certain locations comes at the cost of providing care in other areas. The Defendants have failed to put forth any long-term sustainable solution to address their staffing needs.

The record also establishes the Defendants knew of, and disregarded, a substantial risk of harm to the Plaintiffs. While the record shows the Defendants have recently made efforts to address many of the problems associated with the delivery of adequate mental health care,

particularly recently, the Court remains concerned with the overall lack of a sense of urgency. As previously noted in this Court's Preliminary Injunction Order, the issues associated with the staffing deficiencies began as far back as 2014 when the Defendants created their own 2014 remedial plan, and at this time, the Defendants have yet to fulfill any of their own staffing requirements. A significant problem with the Defendants' approach is the reliance on Wexford to provide the necessary staffing to fulfill their constitutional obligation. This record demonstrates Wexford has been unable to handle this job, a job the Defendants are unable to delegate to evade their constitutional duties. (*See* Pl. Ex. 7, p. 2, Wexford long recognized the need to amplify its recruitment efforts). High level officials in the Governor's office have written Wexford "encouraging" them to fill the required positions, yet the staff necessary to provide constitutional care has yet to be hired; nor have the Defendants generally sought to take a different approach. (ECF No. 2354 at 72; Pl. Ex. 59, p. 3; *see also* ECF No. 2354 at 76, Baldwin testified that they depend on their partners for filling the vacancies.). The Court recognizes that the changes needed in the IDOC have been monumental. The Parties also recognized this and entered into a comprehensive Settlement Agreement providing deadlines and budget contingencies. However, the Defendants have failed to meet many of the terms. It is clear mentally ill inmates continue to suffer as they wait for the IDOC to do what it said it was going to do. (*See supra*, fn. 2). The Court cannot allow this to continue. The Court further finds that there is no adequate remedy at law. The Defendants must provide adequate and constitutionally required care for mentally ill inmates.

Defendants argue the balancing of harms weighs in their favor as Plaintiffs have not met their burden of proof to show the class members are currently facing a sufficiently identified harm in the absence of granting additional prospective relief. The Court disagrees with Defendants'

assessment for the reasons stated herein. The Defendants also argue that compliance with a Court imposed order taxes an already over-worked mental health staff. This argument further demonstrates the need for additional staff.

Given this all of this, the Court finds that a permanent injunction must issue in order to ensure the constitutionally required care will be given to the mentally ill inmates in the custody of the Defendants.

Americans with Disabilities Act

Plaintiffs also argue that class members in segregation have established a violation of the Americans with Disabilities Act ("ADA"). Under Title II of the ADA, "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132.10. In order to succeed on a claim under the ADA, a Plaintiff must establish "that he is a qualified individual with a disability, that he was denied the benefits of the services, programs, or activities of a public entity or otherwise subjected to discrimination by such an entity, and that the denial or discrimination was by reason of his disability." *See Wagoner v. Lemmon*, 778 F.3d 586, 592 (7th Cir. 2015). Plaintiffs argue they have established their claims in two ways.

First, Plaintiffs argue the Defendants have failed to provide a reasonable accommodation to class members in segregation. Plaintiffs provide the law requires the correctional centers, as a public entity, to make reasonable accommodations in order to avoid discrimination on the basis of disability. *Pennsylvania Dep't of Corr. v. Yeskey*, 524 U.S. 206, 210 (1998) (*citing* 42 U.S.C. §12131 ("State prisons fall squarely within the statutory definition of 'public entity,' which includes 'any department, agency, special purpose district, or other instrumentality of a State or

States or local government.'")). Plaintiffs further provide that the regulations implementing Title II of the ADA requires that a public entity:

> Make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.

28 C.F.R. § 35.130(b)(7).

Plaintiffs argue they have requested the accommodations that class members in segregation be given out-of-cell time and the minimal standards of treatment. (ECF No. 2407 at 21). Plaintiffs further argue that without these accommodations, they have, and will continue to suffer. *Id*.

Second, Plaintiffs argue they have established a disparate impact claim under the ADA. In order to establish a disparate impact claim, a plaintiff must prove the defendant "adopt[ed] a policy or practice that is 'facially neutral in [its] treatment of different groups but that in fact fall[s] more harshly on one group than another and cannot be justified by [a nondiscriminatory] necessity.'" *Swan v. Bd. of Educ., No. 13 C 3623*, 2013 WL 3872799, at *5 (N.D. Ill. July 25, 2013) (*citing Raytheon Co. v. Hernandez*, 540 U.S. 44, 52 (2003)). Plaintiffs conclude that the evidence presented at trial demonstrates the facially neutral treatment of prisoners in segregation actually causes greater harm to people with mental illness.

It would not be unfair to characterize Plaintiffs' evidence and argument at the preliminary and permanent injunction hearings as focused on their deliberate indifference claim. (ECF No. 2431, closing arguments, *ad passim*). In their present Motion, Plaintiffs specifically note that "[t]his hearing will test whether Defendants have instituted the reforms necessary for long-term solutions to the Eighth Amendment violations at issue in this Court's preliminary injunction order." (ECF No. 2112 at 2). The framework used by the Plaintiffs at the preliminary and permanent injunction hearings infrequently, at best, used the term ADA or Americans with

Disability Act. Moreover, it is abundantly clear that in their initial Motion to Enforce the Settlement Agreement, Plaintiffs did not raise a disparate impact claim under the ADA. (ECF No. 1559 at 31-32). The Court recognizes the Parties' joint pre-trial brief notes the Plaintiffs sought to include the contested issue of law of whether Defendants have discriminated against Plaintiffs in violation of the Americans with Disabilities Act by excluding Class Members from participation in or denying the benefits of services, programs, or activities of the IDOC on the basis of disability. (ECF No. 2286 at 3). Nonetheless, Defendants steadfastly maintained the ADA is not at issue in the permanent injunction hearing. *Id*.

Having fully considered the Parties' positions, the Court agrees that the ADA claim is not part of this proceeding. That does not mean there has not been a violation of the ADA, but rather, given the Parties' own agreed limitations contained in the Settlement Agreement, it would be unfair to allow the Plaintiffs to expand this proceeding to include such a claim. Plaintiffs did not adequately present their claim, in terms of their motion, or evidence, or arguments during the trial proceeding in a way that would have given the Defendants a reason or full opportunity to address this claim in their defense during the trial proceedings. As such, the Court makes no finding with respect to Plaintiffs' ADA claim.

Motion for Order on Payment of Deferred Attorneys' Fees

Plaintiffs have moved for an order requiring the IDOC pay the "deferred, agreed-to fees" in light of the Court's order dated May 25, 2018. (ECF No. 2233). The fees identified by the Plaintiffs are part of the Parties' Settlement Agreement. Section XXXIII of the Settlement Agreement provides:

> The parties agree that an award of fees is appropriate in this matter. The Court shall determine the amount of the fees and costs due to Plaintiffs' counsel. Fees are to be determined as if the Plaintiffs are the prevailing party. One half of this sum shall be payable one hundred twenty (120) days after the Court determines that amount.

> The remaining half of the fees will become immediately due if the Court enters an order pursuant to Section XXIX(g). In no event will the award be more than six million dollars.

(ECF No. 711-1 at 32).

Notably, the Parties agreed that the fees referenced in this provision be set at $3,800,000.00, and requested that the Court enter an order finding this amount was reasonable and appropriate. (ECF No. 1091). The Parties agreement on the attorneys' fees specifically provides:

> In consideration for the full and complete settlement of the claim for attorney fees and costs, the parties agree that the sum of $3,800,000.00 (Three million, eight hundred thousand, and 00/100 dollars) shall be considered to be a reasonable amount due pursuant to the plaintiffs' attorneys and the parties will so represent that to the Court pursuant to this Agreement. The Parties further agree that the sum of $1,900,000.00 (One million, nine hundred thousand, and 00/100 dollars) shall be paid to Equip for Equality [ ] to be distributed to Plaintiffs' counsel under Section XXXIII of Document 711-1. In the event the Court enters an order under Section XXIX(g) of the Document, another payment of $1,900,000.00 (One million, nine hundred thousand, and 00/100 dollars) shall become due and owing under the terms of Section XXXIII of Document 711-1. The parties understand that the entire amount payable under this Agreement is subject to state law governing the State Comptroller's obligation to withhold funds that Plaintiffs' counsel may owe to other person or to state agencies. The validity of these claims may be contested through applicable state procedure.

(ECF No. 1091 at 2-3).

After providing notice to the class members, the Court accepted the Parties' agreement on fees and entered an Order finding that, pursuant to the Settlement Agreement, one-half of the fees ($1,900,000.00) would be due within 120 days as required under the agreement, and the remaining one-half would be due if the Court entered an Order pursuant to Section XXIX(g). (ECF No. 1211).

Defendants make two arguments opposing the entry of the requested order. (ECF No. 2276). First, Defendants argue that this Court's Order dated May 25, 2018, was not the requisite order under XXIX(g) that would trigger the fee requirement.

Section XXIX(g) provides:

> To permit enforcement of the terms of this Settlement Agreement in federal court, the parties agree that, should it become necessary to seek the Court's assistance as to violations of this agreement, any order granting such relief must include a finding that the relief is narrowly drawn, extends no further than is necessary to correct the violation of federal right, and is the least intrusive means for doing so.

(ECF No. 711-1 at 30). The Defendants correctly note that this Court's Order was issued under the preliminary injunction standard, a likelihood of success. This obviously raises the issue of whether the Court's Order dated May 25, 2018, was a final order under the Section XXIX of the Settlement Agreement. Having fully considered the matter, the Court finds that it is not. This becomes clear when considering the Court explicitly noted in its previous Order that the "Plaintiffs w[ould] have to seek permanent relief at some point in this proceeding[,]" should they want to prove an actual violation of federal law. (ECF No. 2070 at 13). This Order is issued pursuant to Section XXIX(g) of the Settlement Agreement, and therefore the deferred fees are now due. Defendants are directed to immediately inform the Plaintiffs whether the payment will be made as required. Should the Defendants elect not to do so, Plaintiffs may file a Motion seeking relief from the Court. However, at this time, the Motion is DENIED without prejudice.

CONCLUSION

For the reasons stated herein, Plaintiffs' Motion for Permanent Injunction (ECF No. 2112) is GRANTED. The Court finds that Defendants have been deliberately indifferent to the medical needs of the Plaintiffs in medication management, mental health treatment in segregation, mental health treatment on crisis watch, mental health evaluations, and mental health treatment plans within the meaning of the Eighth Amendment.

The Court further finds the Plaintiffs have established by a preponderance of the evidence that a permanent injunction is appropriate and necessary. The Court specifically finds that the

Plaintiffs have suffered or will suffer irreparable injury if a permanent injunction is not issued. There are significant deficiencies in the delivery of mental health services within the IDOC. The evidence establishes that there are systemic and gross deficiencies in staffing that effectively denied the Plaintiffs access to adequate medical care. The Plaintiffs are at a significant risk of harm. The Court further finds that there are no adequate remedies available at law to compensate for these injuries. Plaintiffs are mentally ill inmates incarcerated within the IDOC, and Defendants are required to provide adequate care. The balance of hardships weighs heavily in favor of the Plaintiffs. While appropriately staffing the IDOC with mental health providers is a significant task, it is one that can, and must, be done. The public interest also weighs heavily in favor of the Plaintiffs. Defendants are hereby given 14 days to submit their proposed action to address the constitutional deficiencies outlined herein. (Minute Entry dated 9/28/2018). Plaintiffs have seven days thereafter to file their response to the Defendants' proposal. *Id*.

Motion for Order on Payment of Deferred Attorneys' Fees (ECF No. 2233) is DENIED without prejudice.

So ordered, this 30th day of October 2018.

/s/ Michael M. Mihm
Michael M. Mihm
U.S. District Court Judge