The following is the opinion and writing of Harold C. Hirshman and Josh L. Parness, and does not reflect the opinion of Dentons US LLP. The repository of supporting documents from public records can be found at https://www.equipforequality.org/.

Dr. Stewart's 2023 deposition showcases his experience as the monitor to the Illinois Department of Corrections throughout the Rasho litigation, highlighting how the Department has largely failed to rectify the problems he has seen throughout the Department's mental health care system over the duration of his monitorship. The issues he identified in that deposition are expanded upon below, in their respective 'Rasho Issues' summary article. From his deposition, we identified fifteen systemic deficiencies that continually plague the Illinois Department of Corrections' mental health care apparatus and subject its mentally ill population to undue and excessive harms. Those problem areas are:

1. Confidentiality of Care
2. Crisis Watch
3. Discipline
4. Inpatient Care
5. Backlogs of Mental Health Treatment Appointments
6. Intake, Referrals, and Mental Health Evaluations
7. Medication and Psychiatric Care
8. Treatment Plans
9. Psychotherapeutic Care
10. Restraints
11. Restricted Housing
12. RTU-Level Care
13. Staff Shortages
14. Uncoordinated Care
15. Use of Force

Please see below for an in-depth description of each of these issues.

Confidentiality of Care:

In his 3/1/23 deposition, the court-appointed monitor Dr. Stewart discussed confidentiality as "one of the major… hallmarks of good [mental health] care", yet was categorically not present throughout IDOC. He refers to "bogus interventions to somehow ensure confidentiality", such as telling guards to stand slightly farther away from mental health professionals during their contacts with patients despite speaking at cell front through a steel door where all nearby guards and inmates on the tier can hear. He further remarked that the absence of confidentiality "puts at jeopardy" the validity of all clinical contacts, producing invalid data that prompts invalid treatments that amount to "non-psychiatric care." Moreover, Dr. Stewart noted how the IDOC's attempts to resolve these issues of confidentiality have been lackluster at best and have not meaningfully addressed the problem.

Non-confidential mental health care has been and consistently persists as a critical barrier to effective mental health care throughout the IDOC. In Dr. Stewart's first annual report from 2017, he describes confidentiality as an "evolving concept for IDOC" which was historically "almost nonexistent". He observed that intake screenings were done confidentially, however many mental health treatment provisions including Residential Treatment Unit (RTU) psychiatry visits, group therapy, and all treatment modalities in segregation were done cell-side or in otherwise non-confidential settings. Although he discusses in his second, third, fourth and fifth annual reports various initiatives by the Department to improve confidentiality of care – including introducing new paperwork, utilizing different rooms for groups, and changing prisoner movement schedules – those gradual improvements have largely been mitigated by "a significant and material decline in practice" in other areas such as cell-front contacts between patients and clinicians. By his 2022 annual report, Dr. Stewart recorded extensive deficiencies in the Department's confidentiality practices, including insufficient confidential settings at Dixon's X-House, non-confidential crisis contacts, cell-front clinical contacts and the occasional filming of those contacts. He also highlighted Pontiac's particularly appalling practices in confidentiality, noting that "clinicians almost uniformly recorded that contacts occurred at cell front" and only 3 of 35 contact records reviewed indicated confidentiality.

Confidentiality issues are largely prompted by inadequate staffing and inadequate physical space, yet largely reflect a non-willingness to conduct confidential treatment. Logan psychologist Norine Ashley in 2015, Dixon psychologist Jamie Chess and Pontiac mental health professional (MHP) Matthew Goodwin in 2022, and Chief of Mental Health Melvin Hinton in 2023 all testified that insufficient security staff has prevented the Department from moving patients to confidential settings for clinical contacts. Additionally, Melvin Hinton testified in 2018 to Pontiac's efforts to allocate more space for confidential contacts, including the construction of a "confidential booth." Nonetheless, Dr. Stewart testified in 2022 to the heightened use of cell-front mental health contacts throughout IDOC at facilities that allege to have made more staff and confidential space available for those interactions, and class member Anthony Gay in 2018 testified that mental health personnel, upon filling out a progress note after their visits, would post them on a clipboard where anyone nearby – officers and inmates – could

see them. Accordingly, IDOC has consistently failed to provide confidential mental health treatment for reasons of both logistics and non-logistical malpractice, which ultimately compromises the efficacy and validity of what minimal treatment is afforded to the Department's mentally ill population.

Crisis Watch:

The court-appointed monitor Dr. Pablo Stewart attests in his 3/1/23 deposition that the IDOC's use of crisis watch is inconsistent with the purpose of stabilization for crisis treatment: patients are isolated in restrictive conditions for protracted amounts of time without appropriate treatment planning or delivery, and with the primary contact available being predominantly "brief", non-confidential, cell-front daily mental health professional (MHP) visits that often consisted of "hey, how are you doing, do you feel like hurting yourself, do you feel like hurting other people, and that was it." He explains that despite that this form of isolation has a "deleterious effect" on patients, this crisis system "really didn't change much" following the Rasho case.

Former-monitor Dr. Patterson in 2014 reported on the anti-therapeutic conditions of crisis cells largely due to the "oxymoronic placement of crisis cells" in segregation environments within facilities, within which patients are contained for 23 to 24 hours per day. Likewise, in 2015, Logan psychologist Norine Ashley in 2015 and others, patients in crisis routinely have stripped rights and property, including hygiene products, clothing, mattresses, etc. Although crisis cells were largely moved out of segregation units after the Rasho settlement, years later, in his annual monitoring reports, Dr. Stewart found the crisis cells at Pontiac to be "the most chaotic and anti-therapeutic prison unit the monitor has ever toured in 30 years of working in correctional psychiatry". This is exacerbated by the incredibly extensive amount of time patients are held in those cells, which he notes have lasted as long as "three and a half years." This was despite the Department committing with the Rasho case to evaluate patients for a higher level of care after 10-days, if not sooner, as well as the 2018 and 2019 court orders on the harm being done to class members on crisis watch. Consequently, Dr. Stewart observed that many patients simply do not report their crises, preferring instead to deal with their issues on their own.

As for the treatment on crisis watch, Dr. Stewart testified in 2018 that patients get less treatment when they are on crisis watch than they did prior to going to crisis. Despite contradicting assertions from the 2018 testimonies of former-IDOC Director John Baldwin and Stateville psychologist administrator Inna Mirsky, Dr. Stewart further reported that treatment plans are not consistently updated upon entry and discharge from crisis, and when they are, they often do not address the causes of the crisis or make substantive changes to rectify them. Further, as of his final 2022 report only 60% of crisis patients saw a psychiatrist while in crisis and the majority were not seen timely. In 2023, Chief of Mental Health Melvin Hinton asserted that crisis patients had access to groups and out-of-cell time, Dr. Stewart found no evidence of any additional therapies or the "enhanced care" described in IDOC policies. The principal "treatment" continued to consist of daily "check-ins", intended to be 15-20 minutes -- in 2018, Wexford's regional mental health director, William Elliott, described them as the "absolute minimum" determined by IDOC. Nonetheless, patient records and trial testimonies from 2018 indicate that those meetings were typically only 5 minutes long and conducted at the cell-front. Additionally, in testimony IDOC's mental health leadership --- Dr. Hinton, Chief of Psychiatry Dr. Puga, Quality Improvement Manager Dr. Jeff Sim, and Wexford mental health Quality Assurance coordinator Amy Mercer—all claimed that all patients in crisis 10 days or more are

considered for a higher level of care. However, Dr. Stewart found no evidence that this was happening for all patients. Instead, his review found that less than half were actually referred – 36% of outpatients referred to Residential Treatment Units (RTUs), and 5% of RTU patients were referred to inpatient .

Additionally, the lack of access to mental health staff to stabilize individuals when experiencing crisis is a major problem. Dr. Stewart consistently reported in all of his annual reports that the Crisis Intervention Teams, as well as security staff, acted as "gate keepers" to crisis care. They often did not respond to crisis complaints, did not believe patients were in crisis, and sometimes threatened disciplinary action for patients who requested crisis care. This compels patients to threaten or enact self-harm to have their needs taken seriously.

Discipline:

The Rasho settlement agreement required that, prior to disciplining any individual with serious mental illness, IDOC utilize procedures to consider whether the person's mental illness contributed to the incident at issue and how any use of disciplinary restrictions might negative impact that person's mental health.

In his 3/1/23 deposition, the court-appointed monitor Dr. Stewart emphasized the critical lack of meaningful mental health considerations in the IDOC's discipline process. He testified that patients were not being appropriately assessed for mental health considerations in the incident including the failure to conduct face-to-face interviews about the event or to assess their mental status. He similarly testified that the Department did not properly consider the mental health consequences of disciplinary outcomes including segregation. In fact, the monitor reviews found that only 3 of 182 disciplinary cases involving individuals with serious mental illness (SMI) contained written rationales for those decisions, calling into question the legitimacy of those determinations and whether mental illness was actually considered as a mitigating factor in those infraction events. This is especially concerning as Dr. Stewart notes that Pontiac did not report any instances where mental health impacted any instance of behavior warranting discipline, which he describes as "very, very unlikely" and is indicative of mental health professionals not "doing their job". Consequently, individuals with serious mental illness have consistently been subjected to harsh disciplinary processes with little if any meaningful considerations of the impact of or on their mental health.

This is consistent with the historical practices of the IDOC which has systematically punished individuals with mental illness for their mental illness through disciplinary procedures. Former-monitor Dr. Patterson reported in 2014 that there were no policies in place to consider mental illness in disciplinary decisions, and only that Indeterminant Segregation Placement must be reviewed every 180 days. Dr. Stewart similarly reported in 2017 that "MHPs [mental health professionals] are not sufficiently advocating for the mentally ill offenders" and that staff demonstrated "episodic willingness to consider the mitigating aspects of mental illness, but this was not a consistent finding", especially at facilities like Pontiac where those decisions were largely unexplained and made without mental health input including for offenders in crisis, and the few documented rationales tended to be "generic and very brief." Chief of Psychiatry William Puga testified in 2018 to one individual's disciplinary punishment which entailed restrictions that directly contradicted his treatment plan. In later reports, Dr. Stewart highlighted further issues, including that:

- staff had been "pressured to remove an offender's SMI designation prior to disciplinary proceedings";
- segregation sentences "appear[ed] to be chosen at random… with no clear rationale";
- the Adjustment Committee in charge of sentencing for disciplinary infractions at times sentenced individuals to significantly harsher punishments than their mental health team recommended or, in some cases, that mental health staff actually proposed exceedingly harsh recommendations;

- and there were inconsistencies among disciplinary sentencing at different facilities.

These and other problems reflected "an institutional culture in which mental health's input is not valued." Although he did note several policy improvements over his time as monitor, Dr. Stewart reported many of the same issues by his final 2022 report, namely the lack of face-to-face assessments of offenders in the disciplinary process, poor documentation of disciplinary rationales, and the denial of mental health as a mitigating factor in infractions especially at Dixon and Pontiac. He describes these issues in 2018 as part of a "constant loop", where mentally ill individuals act out due to their illness and then get placed in segregation as punishment through processes that do not adequately address their illness, worsening their condition are causing them to act out again.

Accordingly, individuals with mentally illness have been subjected to intensive discipline for infractions likely caused by mental illness, both punishing them for and intensifying their mental illness. In 2015, Chief of Mental Health Melvin Hinton testified about one individual who was given 55 months of segregation time for incidents occurring in just three days, and was later scheduled for an additional 15-20 years after having already spent three years and nine months in segregation. Another class member was placed in segregation in 1990 for an infraction and accumulated additional tickets resulting in segregation sentences until 2029. Similarly, in 2018, class member Anthony Gay testified about disciplinary charges he received amounting to 100 years of segregation time for incidents that most occurred while he was in crisis and even discipline for acts of self-harm, although this extensive segregation sentence would have been reduced by our 2014 Agreement with the State.

Inpatient Care:

The court-appointed monitor Dr. Stewart testified in his 3/1/23 deposition that inpatient mental health care in the Department was critically deficient and below the community standards of care. In particular, he noted that both Elgin during its lifespan and now the recently-constructed Joliet Inpatient Treatment Center (JITC) hospital have run consistently under occupancy and the Department has made no meaningful efforts to effectively utilize those facilities.

Throughout the majority of the *Rasho* litigation, until Elgin opened in 2018, IDOC had no system to provide inpatient psychiatric hospitalization. Former-monitor Dr. Patterson reported in 2014 that IDOC, despite years claiming to engage in discussions with outside entities to acquire inpatient beds, never actually secured them. Instead, Chief of Mental Health Melvin Hinton testified in 2015 that inpatient-level patients were given an "enhancement to their treatment plan", however others including Logan psychologist Norine Ashley that same year stated that "these inmates need more care than is presently being provided." In his 2017 monitor report, Dr. Stewart affirmed that several class members were "extremely ill and require[d] immediate placement in a psychiatric hospital." Their continued deterioration during "enhanced treatment" is a "direct reflection of the poor psychiatric care they are receiving."

By opening its own psychiatric hospital, first at Elgin and later JITC , IDOC aimed to resolve these issues under the Rasho Agreement. But the facilities since their inception have remained chronically under-occupied . With only 22 male and 22 female beds at Elgin, Dr. Stewart repeatedly observed in his annual reports that "the majority of mentally ill offenders who carry the 'inpatient' level of care designation [were] not housed at Elgin", and the facility ran at approximately 1/3 of its stated capacity throughout the majority of his time monitoring – despite claims by IDOC that "they [didn't] have any open beds" as reflected in Dixon's Dr. Chess's 2022 testimony. Moreover, referrals to Elgin took as long as 15 months to be processed ; Dr. Stewart remarked about patients clearly experiencing worsening symptoms including the countless patients repeatedly in crisis or for longer than 10 days who were never referred for elevation to a higher level of care. Although Dr. Stewart noted that the few cases where inpatient care that *is* provided it does comply with the Rasho agreement in terms of the frequency of clinical contact and treatment planning, he maintains that IDOC "cannot be said to be making the required beds available."

JITC, though significantly larger, has conversely seen even less occupancy than Elgin did. Dr. Hinton testified in 2023 that JITC has a 150-bed patient capacity, yet as of 1/1/24 has seemingly never exceeded 16 patients. Dr. Stewart in his 2023 deposition expressed significant frustration with IDOC's failure to utilize JITC. He highlighted that it continually takes "an inordinate amount of time" to get patients into the hospital and that IDOC consistently fails to move people into the hospital setting because they have neither the clinical or security staff available there to care for inpatient-level patients. Consequently, and despite appearing to have made enormous progress towards providing inpatient care – starting without any inpatient setting and now having a 150-patient capacity inpatient hospital – Dr. Stewart stated that those needing

inpatient care were nevertheless "basically left to languish in their cells" because "the system wasn't able to treat them."

Backlogs of Mental Health Treatment Appointments

Throughout the life of the *Rasho* litigation, mental health treatment backlogs have been a severe barrier to effective treatment for patients within the IDOC.

The Department's backlogs, categorized as either mental health – which includes evaluations, follow-up, and treatment planning – and psychiatric appointment backlogs, subsequently cause patients to experience undue harms via a lack of treatment. Only one year into the settlement, Dr. Stewart declared the system to be in "emergency" in large part due to backlog of thousands of psychiatric appointments, leaving class members without needed medications or management. As testified by Dr. Stewart in 2018, those patients experiencing backlogs are "of the most serious type of mental illness."

While the psychiatric backlogs were reduced with he initiation of Rasho enforcement litigation, backlogs of other mental health sessions grew. For example, in 2017, Dr. Stewart reported a backlog of mental health evaluations at some facilities exceeding the 14-day requirement, the following year he reported that backlog to have risen to 495 evaluations backlogged between 1-60 days, and in 2019 reaching 2,305 evaluations backlogged over an eight-week period. In 2020, he reported that 40% of those evaluations were not completed until up to two months later than the deadline following the referral, or were missed altogether. In his final 2022 report, Dr. Stewart wrote that only 23% of evaluations were timely at the Department's reception facilities, and only 43% were timely system-wide. In his 2022 report, Dr. Stewart attested to patients' complaints, affirmed by treatment logs, of having to wait "lengthy periods" to be seen and are often "compelled to submit multiple requests before they are seen." IDOC's Chief of Psychiatry, Dr. William Puga, testified in 2018 that he routinely "bumps" patients who are having some type of "difficult situation", such as a crisis or increased security needs that might delay their appointment, to a later date so as to reduce the backlog of appointments. This means that high-need patients including those in crisis may conversely have their treatment singled out to be delayed. Further, Wexford mental health Quality Assurance coordinator Amy Cantorna testified in 2018 that in one case, a patient's treatment plan – which she refers to as the "beginning of the [treatment] process" – was backlogged for more than 8 months. At that time, February 23, 2018, 1,380 psychiatry appointments were backlogged and 3,116 mental health appointments backlogged.

IDOC's efforts to resolve the backlogs have often been insufficient band aid measures or, worse yet, deeply problematic – trying to eliminate the backlogs without providing the corresponding care. For example, in 2015, regional psychologist administrator Shane Reister testified that Pinckneyville slashed the number of groups offered in order to reduce backlog number, and "there was a period of time where there were no groups while focusing on getting evaluations completed". In 2018, Wexford Human Resources representative Elaine Gedman spoke to their use of PRN (as needed) staff and transporting psychiatrists across facilities to relieve the backlog, and Wexford Vice President of Special Projects Cheri Laurent testified that year as well to the use of mandated overtime. Nonetheless, Pontiac psychologist administrator Kelly Ann Renzi testified that year that, even with an increased use of overtime and additional services via telepsychiatry, Pontiac maintained a psychiatric backlog of almost 100 and a mental

health backlog of more than 400, and further that the psychiatric backlog fluctuated significantly over the surrounding time period seemingly unincumbered by those efforts. In 2018, the District Court found these measures to reduce the backlog were not long-term solutions and actually contributed to the problem by increasing staff burnout. These initiatives may also contribute to a lack of continuity of care, as patients will likely be seen by different providers.

At its core, these backlogs are a function of understaffing. In 2023, Mental Health Quality Improvement Manager Jeff Sim attested to witnessing a decrease in backlogs at Logan from 700 to 50 over a two year span, almost entirely attributable to heightened staffing at the facility, and Cheri Laurent claimed in 2018 that the psychiatric backlog was cut from 3,385 in 2017 to 1,149 in 2018 alongside the addition of 20.93 full-time-equivalent psychiatric providers. However, per Dr. Stewart's 2018 testimony and as IDOC continually fails to address its staffing deficiencies, patients are "suffering needlessly" due to the Department's expansive array of backlogged treatment responsibilities.

Intake, Referrals, & Mental Health Evaluations:

In his 3/1/23 deposition, court-appointed monitor Dr. Stewart remarked how "intake was working well as far as screening goes... But then the problem was their following up with an evaluation... [and] having their treatment that they received in jail continued", causing significant gaps in medication or dangerously long medication orders for as long as nine months. He discussed this issue further about Stateville's Northern Reception Center (NRC), noting that the Department tried to circumvent these delays by transferring individuals in need of mental health care out of the facility within 14 days; however, that neither resolved the problem nor relieved the harm done to those in need of care, who simply were made to wait longer to begin their mental health treatment at the new facility. Dr. Stewart testified, this occurred "pretty much the entire time" that he was the monitor between 2016 and 2022.

In 2014, former-monitor Dr. Patterson reported that the mental health screening process was significantly flawed and therefore not identifying people in need of mental health treatment during their incarceration. Dr. Patterson found many individuals "who are not on the [mental health] caseload but are clearly seriously mentally ill". In his first annual report from 2017, Dr. Stewart articulated that intake screenings and mental health and suicide risk evaluations, though generally timely, were highly deficient at all of the IDOC's reception (R&C) facilities where individuals enter the prison system; at multiple facilities, screenings lasted as little as 5 minutes, answers to evaluation questions "entailed just a single word or brief phrase" and often showed indications of "questionable psychiatric practice", an absence of prior mental health records, and failures securing continuations of previously prescribed medications, which led to "missing mental health issues including suicidality, past treatment including medications and other vital psychosocial information." Furthermore, individuals were held at those R&C for as long as 60 days, without significant out-of-cell time and with limited access to mental health services.

As time went on, these issues intensified: even though the initial screenings improved at identifying individuals in need of care, they were not being seen for the treatment evaluations needed in order to start providing that care. The mental health evaluations, required to be conducted after the screening referrals, became increasingly backlogged. Dr. Stewart reported in 2020 that approximately half of those mental health evaluations were more than 14 days late, with only 43% being done timely, and with 649 total evaluations backlogged excluding data from the Northern Reception Center, the largest R&C facility which earlier that year had 285 evaluations backlogged. By 2022, only 23% of those evaluations at R&C facilities were completed timely, and with 38% taking more than a month and as long as six months, which itself is likely an underestimate due to the Department's practice of transferring patients out of R&C facilities having never received those evaluations, and because, per mental health Quality Improvement manager Dr. Jeff Sim in 2023, IDOC's auditing process only checks for completed evaluations *after* being backlogged, not those missed altogether.

Beyond these failures in the process, referrals that originated from them faced similar problems that further detracted from patients' access to care. Per Dr. Stewart in 2018, only 47% of psychiatric referrals were followed up with timely, with the remainder taking between three weeks to two months, if they were responded to at all. While this has since improved through our

litigation efforts, follow-ups after the intake process remain an issue in IDOC. Further, Wexford mental health Quality Assurance coordinator Amy Cantorna testified in 2018 – and it still remains the case – that individuals are referred to mental health services as needed based on their screenings, however existing appointment dates are not maintained through facility transfers, meaning patients lose their pre-existing appointments through facility intake processes are placed on the waitlist to start anew if at all. Accordingly, IDOC's post-intake treatment outcomes were and continue to be widely inadequate to service the needs of the Department's mentally ill population.

Medication & Psychiatric Care:

In his 3/1/23 deposition, the court-appointed monitor Dr. Stewart highlighted two primary issues with the IDOC's administration of psychotropic medications for its patient population: timeliness and delivery. He testified that the IDOC's timing of medication was inconsistent and often produced medication non-compliance, for instance conducting evening medication passes as late as 1-2:00am and morning passes as early as 4-5:00am, and sometimes cancelling medication deliveries altogether due to their timing failures. In addition to these times where medications were altogether not being delivered, he further attested that there was no functioning "system" for nurses to ensure that patients were properly taking medications, to assess symptoms or side effects of medications, or to administer involuntary medication for many individuals who "were extremely psychotic" and "clearly met criteria" to do so. Moreover, he found that IDOC never made medication delivery a "priority", and that "there was never… any sort of major changes that would ensure that what the standard of care called for was being met" throughout his time as monitor.

In his annual reports, Dr. Stewart further highlights the Department's "extremely poor and often times dangerous" provision of psychiatric services, emphasizing deficiencies in the continuation of medication upon transfer into IDOC custody, the lack of timely follow-up appointments for individuals taking psychotropic medications, "dangerous practices" regarding prescriptions and enforced medications, and other complications that detract from the administration and effectiveness of medications. For instance, he reported in his 2022 annual report that only 20% of outpatient taking psychotropic medication were seen by a psychiatric provider every 30 days as required, with 40% experiencing multiple delayed appointments and with an increasing amount of delays as long as 10 weeks rising at ten facilities, and two patients in particular being "dropped for four to six months." Even at the Residential Treatment Unit (RTU) level of care, this benchmark only rose to 36%. Further, Dr. Stewart observed that 9% of patients reviewed missed medication altogether for an "extended period" lasting between 3 days and 5 weeks, with multi-week gaps present at each IDOC institution, and more than half of patients experiencing shorter-term gaps in their medications. Due to the obscene delivery times of medications, Dr. Stewart interviewed patients at Menard who "routinely" skip their medication and another who is compelled to "stay up all night" to make sure he gets his medications. Other patients at Pontiac reported days where medications were not administered at all. Elsewhere, he observed that nurses conducting medication passes have "uneven" practices ensuring that medications are in fact taken, noting several times where patients clearly hoarded medications and the nurse neither noted nor documented any issues; over an eight-month period, disciplinary procedures at eight institutions collectively identified more than 1,150 hoarded pills being stashed and traded among incarcerated individuals.

Particularly amid backlogs in psychiatric care and shortages of psychiatric providers, IDOC has increasingly relied on largely-untested-in-corrections telepsychiatry, which Dr. Stewart testified in 2018 likely produces inferior treatment for patients, especially at the RTU and inpatient levels of care. However, per the 2018 testimonies of former-IDOC Director John Baldwin and telepsychiatrist Jack Yen, IDOC is treating telepsychiatry as a "long term solution"

to their issues in psychiatric care, with many facilities only using telepsychiatry including in sensitive contexts like for patients in crisis, and contradictory to Dr. Stewart's guidelines for best practices to minimize harm. Nonetheless, and despite the negative treatment outcomes caused by the heightened use of telepsychiatry, Pontiac psychologist administrator Kelly Ann Renzi testified in 2018 that telepsychiatry at Pontiac had continually failed to eliminate the facility's psychiatric backlog.

Treatment Plans:

Between backlogs, insufficient content, and inadequate processes, treatment plans in the IDOC – the primary modality to outline a patient's individual mental health treatment – have been and continue to be a major impediment to the delivery of mental health care throughout the Department. In the court-appointed monitor Dr. Stewart's first annual report from 2017, he noted how treatment plans were generally not individualized and used "boiler plate" language, commonly omitted "key information" including the recommended frequency of clinical contacts or goals as well as medication and other past and present treatment, and were "clearly" made without team input. Many individuals simply did not receive treatment plans or have their existing plans reviewed at necessary intervals, including upon entry into Residential Treatment Units (RTUs) and crisis levels of care, and they were largely completed on a "when they could" basis as infrequently as once per year rather than monthly as required. By his final report in 2022, little had changed aside from nominal yet ineffectual alterations, mostly to relevant IDOC paperwork. He reported that there remained a "chronic backlog of uncompleted treatment plans" throughout the Department, hovering between 253 and 642 backlogged plans each month over the previous year, and a significant majority of which were backlogged for protracted periods greater than 14 days (this includes initial treatment plans, of which, per Wexford mental health Quality Assurance coordinator Amy Cantorna's 2018 testimony, one individual's plan was backlogged for eight months). Of the plans that *were* completed, only 28% showed team input, and plans were "generic in nature and not particularly specified to the individual patients' mental health and psychiatric needs". Although the Department increased the number of treatment plans reviewed upon entry into crisis to 83% and those upon entry into segregation to 50%, the monitoring team "did not find any evidence" that those reviews were accomplishing fundamental treatment planning objectives and thus did not meet the standard of care required – the remaining individuals often never received any treatment plan. Again, nominal yet ineffectual progress.

Exacerbating this issue, IDOC continuously fails to act on its alleged reforms to the treatment planning process and increasingly denies that this remains a concern at all. Whereas the testimony of regional psychologist administrator Shane Reister in 2015 and Chief of Mental Health Melvin Hinton in 2018 allege substantial effort to overhaul the treatment planning process, the later testimonies of mental health professional Michele Ruelas at Dixon and Matthew Goodwin at Pontiac in 2022 showcase the limited scope that treatment planning actually has, and Dr. Stewart further testified in 2018 that the existence and completion of those treatment plans does not guarantee "that the treatment they're getting is appropriate", especially in crisis settings, or that patients can access essential treatment resources such as contact with a psychiatrist; he indicates times when he "couldn't find evidence" of treatments documented in treatment plans actually occurring, and in one case attributes a patient's suicide to these deficiencies in treatment planning, whose mental health needs were not addressed by his treatment plan. Instead of acknowledging these issues in treatment planning, IDOC personnel largely maintain that treatment planning as required in accordance with the community standard of care is excessive. Chief of Psychiatry William Puga testified in 2018 that treatment plans had "never been a working document", blatantly contradicting other IDOC staff and the Department's treatment planning responsibilities; moments later, he stated that one individual

had disciplinary restrictions contraindicated by their treatment plan, leading the patient to act out and accrue even more disciplinary infractions. Further, Wexford regional mental health director William Elliott testified in 2018 that the mandated treatment planning requirements initiated through the *Rasho* litigation were "desirable" but not essential, citing an Indiana corrections policy for which the state was deemed to be violating the Constitution. As such, IDOC's continued failure to address treatment planning and its deficiencies causes significant harm to mentally ill patients in the IDOC.

Psychotherapeutic Care:

In his 3/1/23 deposition, the court-appointed monitor Dr. Stewart commented on the inadequate provision of psychotherapeutic care – activities including individually therapy, group programming, and structured out-of-cell time – to mentally ill individuals. Specifically, he highlighted how patients in segregation would have only "a 15-minute to 30-minute check-in once a month" as therapy, whereas the standard for care would be "weekly for at least an hour." Alongside the Department's lackluster provision of structured out-of-cell time, the failure to provide sufficient psychotherapeutic care to mentally ill individuals has been a consistent theme throughout the time of the *Rasho* litigation.

Beginning in his first annual report and repeated all later reports, Dr. Stewart states that "it remains difficult to actually be seen by an MHP [mental health professional]", regardless of having a referral, and "there was significant variability in the frequency of recorded contacts." Moreover, what few individual therapeutic contacts patients do have are largely reduced. Regional psychologist administrator Shane Reister attested in 2015 that individual sessions are regularly backlogged as MHPs prioritize other evaluations, and Dixon psychologist administrator Jamie Chess in 2022 attested that those sessions at Dixon are "usually a brief encounter and not documented". Further, per telepsychiatrist Jack Yen's testimony in 2018, many individuals receive psychotherapy from psychiatrists rather than MHPs, which lasts 10-12 minutes and are largely done via telepsychiatry. Group therapies are similarly inaccessible. Per regional psychologist administrator Patrick Horn's 2022 testimony, the majority of residents in Dixon's restrictive X-House residential treatment unit do not get any therapeutic groups in their monthly schedules, and Dixon MHP Michele Ruelas attested the following day that those groups routinely did not last the required 1-hour time slot due to "security concerns", moving patients to and from their cells, or a lack of available security staff. At Pontiac, MHP Matthew Goodwin testified in 2022 that group therapy "hasn't been happening", and individual sessions hadn't been being done in confidential settings since December 2021.

Beyond direct therapy, IDOC heavily relies on structured out-of-cell groups for psychotherapeutic care, however those groups consistently fail to provide adequate psychotherapy. As repeatedly testified by multiple individuals including Dr. Stewart and Matthew Goodwin in 2022, groups are repeatedly cancelled due to a lack of staff or lockdowns. Many of the groups that are offered, including community groups, are not effectively therapeutic for incarcerated individuals; Dr. Stewart testified in 2022 that for patients in Dixon's less-restrictive 'STC' residential treatment unit, "people are not getting any benefit out of the community meetings and they just stopped going." Similarly, other groups intended to be therapeutic are categorically non-therapeutic. Dixon's acting warden Justin Wilks, Patrick Horn, and Jamie Chess all testified in 2022 to using "basketball groups" as a form of therapy, despite no clinical research nor indications that playing basketball is remotely therapeutic. Even worse, IDOC largely relies on movie groups. Per class member Joe Champ in 2018, movie groups were his "main treatment", in which patients are cuffed to benches or the floor in "very uncomfortable" positions to watch a movie, at times with their hands behind their backs and feet shackled to the floor. These are intended to be followed by a "discussion" relating the themes of

the film to the individuals, but in reality amounts to a correctional officer asking, "How did y'all like the movie?" and little more.

Regardless, any positive impacts of psychotherapeutic care are significantly overshadowed by the anti-therapeutic nature of IDOC inhabitancy. Class member Anthony Gay testified in 2018 about his therapy at Pontiac and Menard, saying, "I would walk away feeling good... But then I'd go back to the psychological dungeon, and it was as if the therapy was useless." As such, what limited, lackluster psychotherapeutic care is offered to mentally ill individuals is negated by the wretched conditions of imprisonment in the IDOC as a mentally ill person, further subjecting mentally ill patients to increased and undue harm.

Restraints:

The court-appointed monitor Dr. Stewart articulated in his 3/1/23 deposition how the IDOC's use of restraints – straps, chains, and other means of tying down incarcerated individuals – contradicts the community standards of care both in the frequency and duration of its use. Specifically, he states that the Department's practice of administering restraints for 12-hour blocks, which are by IDOC policy prescribed by staff clinically unqualified to do so, does not comport with the standard of care, especially because using restraints was consistently "done before other interventions could be tried". Despite some efforts to resolve these issues – for instance he references Chief of Psychiatry Dr. Puga's efforts to use face-to-face contacts as a therapeutic alternative to restraint use – IDOC has made little if any progress towards more appropriately using restraints.

In his six annual reports, Dr. Stewart acknowledges that IDOC "is generally following its own procedures regarding the use of restraints", however those procedures have led to horrendous outcomes for patients. He refers, for example, to one patient held in a crisis cell for 10 months and was "in restraints for most of that time", with almost 25% of restraint orders being extended to times between 1 and 9 days, particularly at Elgin, Joliet and Pontiac, and also one patient at Stateville who was "restrained continuously for at least nine months" for mental health and medical purposes. Additionally, he writes that 65% of restraint uses were for extended periods of time beyond the initial order, with each additional extension "routinely" lasting up to 16 hours, and records "almost never reflected the less restrictive measures attempted or considered". In one particularly disturbing instance, as testified by class member Anthony Gay in 2018, he was placed in restraints for 15 hours after self-harming by inserting a fan motor into his leg, the entire time with the fan motor still in his leg. Furthermore, Dr. Stewart reported that as of 2022, only 24% of documentations for restraints uses indicated that patients were offered limb releases – brief breaks from restraints – at the required intervals, and only 14% documented the monitoring of patients' vital signs during the time of their restraint use. At the same time, he reports that the number of uses of restraints had doubled between 2018 and 2021, indicating that IDOC increasingly relied on these problematic practices at the expense of less intrusive, more effective solutions.

Concerningly, the Department did little to meaningfully rectify any of these issues with their use of therapeutic restraints. In 2023, chief of mental health Melvin Hinton asserted that Quality Improvement personnel and Oversight Committee are regularly assessing the Department's uses of restraints, and that the relevant Mental Health Authority and/or regional administrator for a given facility are expected to review all cases of restraints use to ensure that they comport with IDOC policy and are appropriately reasoned applications. However, Quality Improvement manager Jeff Sim testified that same year that he, as the statewide oversight manager, never did anything to assess the high use of restraints especially at the Joliet Treatment Center, and he didn't recall the Oversight Committee enacting any policy changes to address the issue either. Moreover, what few tangible policy changes made regarding the use of restraints have not materialized into any differential practices. In 2018, Melvin Hinton assured in his trial testimony that individuals are no longer restrained with their arms above their heads, both due to

direct orders from the Director of the Department and redesigns of the beds used for restraints that wouldn't allow for that to occur. Nevertheless, Chief of Operations Sandra Funk testified that same year that offenders were continually being restrained with their arms above their heads, not because policy dictated so but because that's how staff were administering them. She continued to concede that the main difference after those policy changes is that this type of restraint application is not being appropriately documented and is only recorded on the surveillance video footage produced by the team who places individuals into their restraints. Accordingly, IDOC continues to apply restraints in ways that contradict all standards of care, subjecting class members to unnecessary harm, and without any meaningful attempts to change these practices.

Restricted Housing:

In his 3/1/23 deposition, the court-appointed monitor Dr. Stewart highlighted the deleterious consequences of restricted housing on mentally ill individuals, citing a plethora of scientific literature showing consensus that "[individuals'] underlying mental illness worsens, and they develop other types of symptoms". Relating that to IDOC, he testified that IDOC consistently makes the "choice" to put mentally ill individuals in segregation, despite that the disciplinary offense prompting segregation is "usually due to the fact of being improperly treated for their underlying mental illness." Moreover, he spoke to the Department's "feeble" and insufficient attempts to provide the legally mandated hours of out-of-cell time for those individuals, with Logan being the only facility doing so by the end of his monitoring, but emphasized that "the time out of cell, be it three hours a day, be it one hour a day, be it five hours a day, is mitigated to the deleterious effects of placing them in segregation." Accordingly, the Department's practices about restricted housing routinely contradict the needs of their mentally ill population and intensify those individuals' suffering, consistent with their practices throughout the lifetime of the *Rasho* litigation.

In 2014, the former-monitor Dr. Patterson reported that IDOC had not been providing mental health check-ins for segregated individuals, that custody staff were not reporting decompensated individuals in segregation to mental health staff, that the Department had been "unreasonably slow" to review individuals' segregation statuses especially for those segregated longer than 60 days, and he expressed concern that IDOC was increasingly using segregation placement "in lieu of adequate treatment of mental illness." Identical issues appeared in Dr. Stewart's annual reports, where he repeatedly noted that individual treatment plans were not being followed in segregation – in 2018, only 15% of patients in segregation had their treatment plans updated within a week of entry into segregation as is required, and by 2022 that had only increased to 50%, of which the majority were inadequate and many "grossly insufficient" – and that there was "no formal mechanism" to identify individuals who had decompensated in segregation. He described the cells in 2022 as severely deficient, especially at Pontiac, and stated that there is a critical lack of the "enhanced therapy" to prevent decompensation that IDOC promises to its mentally ill segregated population, which is "exacerbated by the lack of structured and unstructured out-of-cell time class members assigned to segregation receive." Dr. Stewart reports that pharmacological treatment was largely insufficient in segregation, including non-delivery and deliberate withholding of medications, and medication administration at "inappropriately early hours" as early as 2-3am, causing many to miss their medications. Subsequently, the primary form of mental health treatment in segregation was individual counseling by a mental health professional occurring once every 30-60 days for only 15-30 minutes, and weekly segregation rounds done at cell front. This is especially problematic because, as Quality Improvement manager Jeff Sim testified in 2023, a disproportionately high 23% of individuals in extended restrictive housing – lasting 28 days or longer – are designated as seriously mentally ill.

Further, the dramatically antitherapeutic environment of IDOC segregation causes extreme suffering for mentally ill individuals. Class member Ralph Kings testified in 2018,

having been in segregation for almost nine years and being scheduled to remain in segregation until 2030, that he spends at most 3 hours out-of-cell per week and often has no time out-of-cell on any given day, and he has no access to using the phone, audiovisual privileges, commissary shopping, or any contact visits, which has evaporated his relationship with his family and the outside world. Class member Anthony Gay also in 2018 testified to his time in segregation at Pontiac, describing it as a "psychological zoo" with no out-of-cell time whatsoever, compelling him to engage in "self-mutilation at high value" almost daily due to his intensified mental illness while in segregation. However, he received no additional therapy or groups as a result; he instead accumulated 20 disciplinary charges and was stripped naked and strapped to a bed, his charges amounting to an additional 101 years of prison time.

RTU-Level Care:

In his 3/1/23 deposition, the court-appointed monitor Dr. Stewart described IDOC's Residential Treatment Unit (RTU) care as a mixed bag that was widely variable by facility, yet "deteriorated" during his tenure as the monitor. He testified that the Department had enough physical RTU bedspace "but they weren't utilized" due to patients not being transferred in, despite that oftentimes "you could just walk them down the hall", and also that some RTUs like Dixon's less restrictive STC provided "reasonable care" via out-of-cell activities whereas others like Dixon's more restrictive X-House had significantly fewer treatment opportunities.

As seen in Dr. Stewart's annual reports, the quality of residential treatment varied drastically based on the facility one was located in. He repeatedly wrote that treatment plans and reviews were being completed with the relative best quality and in a multidisciplinary manner at STC, Logan, and Joliet, whereas at X-House and Pontiac they often did not occur at all or were boilerplate or incomplete; he further wrote that there was "no evidence of functioning mental health treatment teams" in Pontiac's RTU setting. Whereas the STC, Logan, and Joliet all had some availability to run groups and therapeutic activities, Dixon psychologist administrator Jamie Chess and regional psychologist administrator Patrick Horn in 2022 both testified that X-House residents had no groups other than community meetings and no individual or group therapy. Dr. Stewart testified in 2022 that individuals in the Pontiac RTU received neither any groups nor individual or group therapy either. Additionally, whereas facilities like the STC had more freedoms for its inhabitants, for instance with some individuals having keys to their own cells and some ability to move around, per Patrick Horn's 2023 testimony and class member Anthony Gay and staff psychologist Al Doyle in 2018, people in X-House were stuck in their cells for as many as 23-24 hours per day, often only being seen by mental health staff for 15 minutes rather than the required 45 minutes, which was particularly detrimental to patients as X-House was a "big echo chamber" of people yelling and banging on their cell doors.

While there was variation at each facility, per Dr. Stewart's 6th annual report and affirmed by various testimonies including Jamie Chess, Acing Warden of Dixon Justin Wilks and Warden of Pontiac John Burle in 2022, as well as Chief Operating Officer Justin Hammers in 2023, every facility "fell short" of the mandated 10-and-10 hours of structured and unstructured out-of-cell time for RTU patients, the main reasons being staffing and physical space. Dr. Stewart's annual reports show consistent RTU staffing deficiencies for the same positions year after year of his time as monitor, and Jamie Chess in 2022 attested that Dixon for example did not have enough Qualified Mental Health Professionals to run groups. On the other hand, the Pontiac RTU and X-House both had severely limited capacity to run any out-of-cell activities; Patrick Horn testified in 2023 that Pontiac RTU patients were only receiving between 2-4.5 hours out-of-cell per week, leading them to implement a therapeutically untested strategy of using claustrophobic "therapeutic pods" that necessitate placing individuals in restraints in order to have any functional space to run groups.

The largest inhibitor to quality RTU care, however, is access. Whereas Dr. Stewart repeatedly wrote in his annual reports that the STC at Dixon ran at approximately 75% capacity and all other RTUs ran at either around or below 50%, patients at times waited up to 17 months

before either being transferred into an RTU, having their RTU referrals withdrawn, or being released from prison having never received any RTU care. Moreover, per former IDOC Director John Baldwin's 2018 testimony, the Joliet Treatment Center was designed to house 422 RTU treatment beds, yet only maintains approximately 175 beds. Moreover, although Pontiac psychologist administrator Kelly Ann Renzi claimed in 2018 that the RTU referral process takes only two weeks, chief of mental health Melvin Hinton attested that same year that there is no time limit for how long RTUs can take to process referrals and there is no oversight over how long they take to do so. As a result, Dr. Stewart repeatedly reports that patients are left to languish in crisis cells for protracted periods of time, worsening individuals' mental illnesses.

Staff Shortages:

In his 3/1/23 deposition, the court-appointed monitor Dr. Stewart comments on the "ridiculous" and inexcusable staffing shortages persistent throughout IDOC, which severely limit the Department's ability to perform essential mental health services including medication administration, intake and mental health evaluation processes, basic treatment for individuals in or entering crisis and restrictive housing, discipline, use of restraints, and any psychotherapeutic care activities. Notably, he refers to various discussions with IDOC staff who contend that these issues would be resolved with more staff availability, consistent with an extensive history of similarly identified staffing problems and proposed solutions never undertaken since the start of the *Rasho* litigation.

As far back as the 8/21/2014 report by then-court monitor Dr. Patterson, IDOC's "inadequate" mental health treatment was "in part because of the lack of staffing", referencing the Department's and its medical contractor Wexford's failures to satisfy Court orders for staffing requirements despite repeated false claims to have done so. Dr. Stewart's annual reports between 2017 and 2022 show "Chronic understaffing of both clinical and custody staff", highlighting vacancies in the same clinical and supervisory positions at the same departments within the same facilities year after year, leading to problems in the forms of patient neglect, unserved treatment responsibilities, and treatment backlogs, ultimately amounting to excessive and unnecessary suffering.

Various IDOC professionals have nominally sought to rectify this issue, however little if any meaningful progress has been accomplished as a result. Chief of mental health Melvin Hinton in 2015 referred to hiring plan initiatives "not put in writing" and claimed to work with 3rd party hiring agencies, however there is no evidence of either of these being acted on. Wexford human resource es representative Elaine Gedman and Hill psychologist administrator Melissa Stromberger among others testified in 2018 to the excessive use of overtime pay and telehealth treatment methods, despite that these efforts have made inconsistent impacts on treatment servicing and certainly come at the expense of quality of care. Meanwhile, the Department continued to pursue ineffective and insufficient staffing regimes, such as paying one psychiatrist a salary high enough to hire six mid-level practitioners in their place, as noted by Dr. Stewart in 2018. Vice President of Special Projects Cheri Laurent at Wexford similarly discussed mandating overtime and transferring psychiatrists throughout various facilities to reduce backlog, which others testify has led to "burnout" and has counterproductively reduced staffing, as well as compromising the continuity and consistency of care for the individuals being treated. Ultimately, IDOC's staffing strategy was almost wholly embodied by former-IDOC Director John Baldwin's 2018 testimony: "We continue to ask Wexford for additional staff", despite that said staff scarcely arrives.

Rather than addressing the issues created by staffing shortages, IDOC has gradually shifted strategy as to deny the existence of those problems. Whereas countless staff attested to the insufficiencies of mental health care in IDOC due to understaffing, including Logan psychologist administrator Norine Ashley in 2015, Dixon staff psychologist Al Doyle in 2018, and Pontiac psychologist Michelle Howell in 2022 for their respective facilities of occupancy

among others at different facilities, Department representatives, including Elaine Gedman, Melvin Hinton and Wexford regional mental health director William Elliott in 2018, increasingly maintained against factual accounting that vacant positions *were* being filled and that IDOC's staffing levels met the required numbers, and that the staffing targets ordered by the court should instead be "fluid".

Uncoordinated Care:

In his 3/1/23 deposition, the court-appointed monitor Dr. Stewart remarks on the uncoordinated nature of mental health care under IDOC supervision; he testified that care was "a series of disjointed, uncoordinated efforts" that resulted in patients "not getting better or continuing to suffer needlessly." This non-coordination observed in 2023 draws lineage from repeated coordination failures spanning across all realms of mental health treatment in IDOC. In his annual reports between 2017 and 2022, Dr. Stewart noted various manifestations of nonfunctioning treatment modalities due to incoordination. As he writes, there were no "functioning multidisciplinary team[s]" observed in any segregation units, treatment records and related documents did not accompany patients through transfers, custody staff consistently and unnecessarily impeded mental health care, treatment plans were not prepared collectively as required, and patients often had treatment functions and disciplinary defenses being performed by staff unfamiliar with the patient.

Other sources of poor coordination stem from inefficient and impractical treatment and administrative practices. Per chief of mental health Melvin Hinton's 5/22/15 deposition, that the only way to assess care in the IDOC is through individual searches into each patient's medical records, which other IDOC staff attest are kept exclusively in disorganized, non-chronological paper copies maintained in inconsistent conditions. Other staff, such as Chief of Psychiatry Dr. Puga and Dixon staff psychiatrist Al Doyle in 2018 and Pontiac Warden John Burle in 2022, consistently testify that essential treatment decisions are made "informally" and without documentation, which are often not acted on as a result. Further, despite being implemented as a tool designed to identify and resolve these issues, statements from Quality Improvement manager Jeff Sim between 2018 and 2023 indicate that the Department's auditing and quality improvement processes rely on small sample sizes that are frequently non-representative of patient experiences. Moreover, "there is no written protocol" and it is "in the facility's discretion entirely" for facilities to implement changes based on the limited findings of those reports, which are accordingly predominantly not acted upon.

Oftentimes, incoordination came in the form of not following IDOC procedures, which have been hailed to address mental health treatment shortcomings yet are only nominally impactful. Former-IDOC Director John Baldwin's and Melvin Hinton's and IDOC Assistant Director Gladyse Taylor's 2018 trial testimonies, and various others all attest to specific policies and structural initiatives to improve training, increase treatment policy efficacy, and better structure treatment modalities. However, these initiatives scarcely materialized; testimonies like that of Chief Operating Officer Justin Hammers in 2023 indicate that command structures stated in policy are "not currently happening".

Lastly, one of the major root causes of poor coordination of care is IDOC's convoluted relationship with its medical contractor Wexford. As exemplified by the testimony of Logan psychologist administrator Norine Ashley in 2015 and Melvin Hinton and regional mental health director at Wexford William Elliott in 2018, Wexford has its own internal chain of command that does not necessarily align with the IDOC's chain of command. As such, IDOC and Wexford staff both consistently attest that they often do not respond to directives from the other

Department, meaning that fundamental mental health treatment and related functions can take significant effort to happen if they happen at all. This especially impacts staff availability, where Wexford has consistently contested and has not satisfied Court-ordered staffing determinations, leading to substandard care.

Use of Force:

The court-appointed monitor Dr. Stewart testified in his 3/1/23 deposition about the horrific displays of force initiated against mentally ill individuals in the IDOC. Most pressingly, he discusses the "habitual" use of OC spray – mace – employed in contexts that ordinarily would not warrant its use and certainly not against a mentally ill person, stating that "it was like their first response", and that procedures intended to allow mental health staff to de-escalate conflict scenarios often did not occur. Disturbingly, he discussed one particular incident where OC spray was used against a patient in immobilizing four-point restraints, exemplifying the excessive use of the spray against mentally ill persons and in inappropriate contexts. He further describes seeing "excessive" force being used, and never received satisfactory explanations for those incidents.

Dr. Stewart's annual reports echo the same problematic practices consistently applied over time; all reports detail excessive physical assaults and verbal abuse by corrections staff against mentally ill individuals, and indicate that use of force is concentrated in the facilities with the most mentally ill individuals. By his final 2022 report, 20% of use of force incidents reviewed showed that force was used prematurely and/or unnecessarily, an additional 20% showed that the force applied was excessive and sometimes resulted in hospital visits, and several more showed indicia of corporal punishment. That includes using OC spray in response to non-violent behavior, initiating a takedown in response to "minor resistance by an already handcuffed patient under multiple-officer escort," and a habitual use of OC spray in situations of self-harm, "even when the issue is only a threat, serious injury is not imminent, or the risk has been abated" meanwhile there is no "effort being put to finding and removing the method of harm or connecting the patient with treatment related to the self-harm." Although Dr. Stewart does mention some positive indicators for improvements, such as a more common utilization of de-escalation teams compared to previous years, those are coupled with other severe incidents including the use of a pepperball launcher – basically a pepper spray grenade – at close range shot at a patient's naked body while locked in a cell, seemingly falsified narratives as to the events of a use of force incident, and violence inflicted against patients enacted in surveillance blind spots that are not documented. Other observed incidents included a one-on-one fight between two individuals in custody, during which 16 correctional officers stood in attendance and made no movement towards intervening.

These use of force abuses lead to anti-therapeutic and sometimes tragic outcomes for mentally ill individuals. In 2023, Chief Operating Officer Justin Hammers testified about one use of force event where an individual was beaten to death by correctional officers. He admits that the Department had recently disciplined an increasing amount of officers for abuses of force, which, in March 2023, a majority of use of force events were initiated against mentally ill individuals, and approximately half were against SMI patients. Further, he discusses repeated incidents of racial epithets being used against mentally ill individuals, and acknowledges that the racially hostile behavior of many correctional officers severely detracts from the treatment objectives they are intended to facilitate, whether or not the events themselves occur in therapy settings. Additionally, Dr. Stewart testified in 2018 to "intimidation" tactics employed by

custody staff against mental health staff at Logan and Pontiac, which also disrupts the delivery of mental health care; people cannot receive meaningful mental health care in unsafe environments. Accordingly, abuses of force enacted by correctional officers dramatically hinders the delivery of mental health care within the IDOC and particularly punishes mentally ill persons for their mental illness.