Dr. Pablo Stewart is a correctional mental health care expert who was appointed by the Court in 2016 as a monitor to oversee the Illinois Department of Correction's implementation of the *Rasho* settlement agreement. Between 2016 and 2022, Dr. Stewart and his monitoring team produced six annual reports based on site visits, interviews, and document reviews that detailed the IDOC's compliance with the various provisions of the settlement agreement. In the following deposition, Dr. Stewart discusses his experience as the monitor in *Rasho*, highlighting the profound deficiencies in mental health care throughout the Department during his monitorship, and offering unique insight into the ongoing failures of mental health care in Illinois prisons.

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

ASHOOR RASHO, PATRICE DANIELS, GERRODO FORREST, LYNDA SMITH, LATERIAL STINSON, AND KEITH WALKER)
)
Plaintiffs,)
)
vs.)
)
ROB JEFFREYS, Director of the Illinois Department of Corrections, et al.,)
)
Defendants.)

No. 1:07-CV-1298

REMOTE VIDEOTAPED DEPOSITION
Via ZOOM of
PABLO STEWART
March 1, 2023
8:09 a.m. PST

STENOGRAPHICALLY REPORTED BY:
JO ANN LOSOYA, CSR, RPR, CRR
LICENSE #: 084-002437

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Videographer: Kevin Duncan

EXAMINATION

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THE VIDEOGRAPHER: Good morning. We are going on the video record at 8:09 a.m. on March 1st, 2023.

Please note this deposition is being conducted virtually. Quality of the recording depends on the quality of camera and internet connection of participants. What is heard from the witness and seen on screen is what will be recorded. Audio and video recording will continue to take place unless all parties agree to go off the record.

Here begins Media Unit 1 in the video-recorded deposition of Dr. Pablo Stewart, taken on behalf of the plaintiffs, in the case matter of Ashoor Rasho et al versus Rob Jeffreys, et al., filed in the U.S. District Court for the Central District of Illinois, Peoria Division bearing case number 1:07-CV-1299-MMM-JEH.

My name is Kevin Duncan. I'm a certified legal video specialist representing Veritext Legal Solutions. The court reporter today is Ms. JoAnn Losoya from Veritext Legal Solutions.

I'm not authorized to administer an oath, I'm not related to any party in this action, nor am I financially interested in the outcome.

Counsel, please identify yourselves

and affiliations starting with the noticing party.

MR. HIRSHMAN: My name is Harold Hirshman. I represent the plaintiffs.

MR. REES: My name is Doug Rees from the Office of the Attorney General for the defendants and I'm join by Laura Bautista from my office and Melissa Jennings from the Department of Corrections.

I would like to make a request that plaintiff, Harold, on your side, I think Nicky has her own on or her computer on, and so we're getting feedback from both of your devices. So if we could have the other one on mute so we only hear one.

MR. HIRSHMAN: Right now we're waiting on the host let us in, and now we have connecting. So this all may -- there it is. Okay. I'm going to turn off my phone.

THE VIDEOGRAPHER: Let's go off. We're are going off record at 8:12 p.m.

(Whereupon, a break in the proceedings was taken.)

THE VIDEOGRAPHER: We are back on record at 8:13 a.m.

Will counsel identify themselves for the record starting the representing party.

MR. HIRSHMAN: Harold Hirshman

representing the plaintiffs and Nicole and Maddie are here with me.

THE VIDEOGRAPHER: Mr. Rees.

MR. REES: Yes, Doug Rees, from the Office of the Attorney General for the defendants and I'm joined by Laura Bautista from my office and Melissa Jennings from the Department of Corrections.

THE VIDEOGRAPHER: Anyone else?

Okay. Will the court reporter please administer the oath.

(Witness sworn.)

WHEREUPON:

PABLO STEWART,

called as a witness herein, having been first duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. HIRSHMAN:

Q. Dr. Stewart, would you please identify yourself with respect to your relationship to the case where we're taking this deposition?

A. I was the federal court appointed monitor between May of -- May 22, 2016, until June -- excuse me -- June 2022. And in that capacity, I was overseeing monitoring the implementation of the settlement agreement that had gone through a variety

of modifications over the course of my monitorship.

Q. How did you go about monitoring the course of the settlement agreement?

A. A variety of ways. Relied upon reviewing records that were provided by the Department in a number of areas. Logs regarding out of cell times, length of times in crisis care, and -- and, you know, almost innumerable items that were provided by the Department to me. We also did site visits where we'd spend either a day or day and a half or two days even walking around the facility, inspecting the physical plant, speaking with staff, speaking with inmates.

We also did numerous chart reviews on a variety of the different topics, such as segregation, crisis care, evaluations, treatment planning, medications. Pretty much all the different aspects of the settlement agreement were confirmed also by chart reviews.

Q. You said "we," who constitutes "we," sir?

A. I'm sorry. It was myself as a monitor, and then I had an assist -- I had three assistants. One assistant was Dr. Reena Kapoor, she had a limited participation due to her professional schedule, but she looked -- but she looked at a

variety of issues including discipline. And then I had Ginny Morrison who looked at use of force, out of cell time, medication follow ups, crisis care, length of stays in crisis care, and probably more than just that, but those are the ones that come to mind. And there was also an assistant by the name Miranda Gibson who would help me with chart reviews.

Q. Is it a usual practice of a monitor like yourself to be assisted by the various individuals you just described?

A. Yes. And, in fact, consummate -- yes.

Q. Have you been a monitor before, before you were sent down to Rasho?

A. I have been a monitor on two previous occasions for the federal court, one in the -- both in the Northern District of California. One was looking at the Gates v. Gomez case and another one was the Madrid v. Dumagin case and I was the court appointed monitor on those.

Q. What was -- briefly what was the Gomez case about?

A. The Gomez case focused in on the facility called the California Medical Facility, which had an inpatient physical hospital, excuse me, as well as inpatient psychiatric hospital. And it was the

place prior to the population in the California Department of Corrections, you know, expanding from 50,000 to almost 200,000 is where all the psychiatric inmates and medically ill inmates were sent, and at the time, HIV was a huge problem and that was the HIV treatment center also.

Q. What were your monitoring duties in that case?

A. My monitoring duties in the Gates versus Gomez case were -- I believe the phrase was to ensure that appropriate psychiatric care was being provided to the inmates at the California medical facility.

Q. And in the second California case, what was that?

A. That was the Madrid v. Dumagin case that involved the supermax prison near the Oregon border called Pelican Bay. And there had been a variety of court orders that prevented the Department from placing certain categories of mentally ill individuals into solitary confinement and my duties were to ensure that that was being implemented properly.

Q. Can you attach a date to each of those cases when you acted as the federal monitor?

A. My monitoring duties in the first case at the California medical facility was basically the decade of the '90s. I started early, I believe '91, '92, and I lasted all the way until 2000 or '99. The Madrid case, in the mid '90s. I don't remember exactly which years.

Q. You have also been retained as an expert in assessing the delivery of mental health care in prison systems, have you not?

A. Yes.

Q. Can you tell me what prison systems you have looked at as a plaintiff's expert?

A. My work as a plaintiff's expert has taken me to the Arizona Department of Corrections, the Mississippi Department of Corrections, the Nebraska Department of Corrections, and currently I'm working on a case with the Connecticut Department of Corrections.

Q. That's all on the -- that's all to assist the plaintiffs in those cases, right?

A. In those cases, I was the plaintiff expert in litigation, yes.

Q. Have you ever been a defendant's expert in litigation?

A. Yes, I have. That's really testing my

memory about what year, but I was the defendant's expert in the case against the New Mexico Department of Corrections and it had to do with the establishment of mental health care for high security prisoners that were being held in solitary confinement.

Q. With respect to your work in Arizona, did you render any opinions with respect to the mental health care in Arizona?

A. Yes, I did.

Q. What was your conclusion with respect to the mental health care being delivered in Arizona?

A. Well, overall, I felt -- it was my opinion that the mental health care being delivered to the inmates in the Arizona Department of Corrections did not meet standard of practice and fell -- and placed them at a substantial risk of serious harm.

Q. You just mentioned the phrase "standard of practice" and you had earlier mentioned a phrase I believe "appropriate psychiatric care." How do you go about as an expert determining the standard of practice? Let's do that in the first instance.

A. Well, the standard of practice is what is currently acceptable in the field of psychiatry.

That includes proper diagnosis, treatment, follow up, the proper use of medication or other treatment modalities, the integration of psychotherapeutic interventions into your treatment plan. This is an evolving standard that exists in the community as well as in custody settings.

Q. You mentioned "community." Certain documentation talks about the community standard of care. Is that different in some way than the psychiatric standard of care you just mentioned?

A. No. There's one standard of care, and I don't know how the term originated, but it is often referred to as a community standard of care, and that's the standard of care that that dictates my professional work currently where I work as a treating psychiatrist.

Q. And today, in addition to being -- having been the monitor in Rasho and these other cases, are you a practicing psychiatrist in a correctional setting?

A. Yes. I currently work as a clinical professor in the Department of Psychiatry here at the just of Hawaii. Part of my duties there include supervising psychiatric residents in the provision of psychiatric care to the inmate population of our

local jail which is called the Oahu Community Center or OCCC for short.

Q. You mentioned several times the word "psychiatric care." How, based on your experience, is psychiatric care provided in the prison context?

A. Psychiatric care in the prison context is the same as psychiatric care in any context, except obviously it's different because people are in custody and they don't have the freedom to come and go, but it involves screening, evaluation, assessment including the diagnosis and the formulation of a treatment plan. That could include medications, psychotherapy.

Q. In terms of the delivery of mental health care, are only psychiatrists permitted to deliver mental health care either in the community or in prison?

A. No. And I might want just to just clarify. I used the word psychiatric care as opposed to mental health care because throughout the course of my career, due to the relatively big shortage of psychiatrists, psychiatrists have been relegated to performing what I will call medical psychiatry, which is diagnosis and treatment usually using medications. And mental health care such as

psychotherapeutic interventions are often provided by non-psychiatric mental health professionals.

Q. And what is the standard for measuring those non-psychiatric professions in terms of their role in delivering mental health care?

A. May I excuse myself before I answering that question. The sun is sort of coming in.

Q. I was just going to say something to you about that. Go right ahead.

A. Could you repeat the question, please.

MR. HIRSHMAN: JoAnn, could you read it back.

(Record read as requested.)

BY THE WITNESS:

A. I don't know if I actually understand that. Standards of how you measure their -- how they deliver care.

Q. Okay. What is the standard of care for those non-psychiatric persons who deliver mental health in prison?

A. Again, there's one standard of care. So if a person is providing psychotherapeutic care, for example, it would mean ensuring confidentiality, it would mean seeing the person on a set frequency based on your assessment, it would mean meeting with

the prescribing psychiatrist in the case of those inmates who were being treated with psychiatric meds as well as those who weren't being treated with psychiatric medications and working together to arrive at a treatment.

Q. So treatment in the prison context involves a team approach; is that correct?

A. Care can be provided in a team approach and that's how it usually is provided. I can think of examples where, say, a psychiatrist could -- would do the whole, the entire package of care, meaning medications, psychotherapeutic inventions, crisis intervention, et cetera, but again because psychiatrists tend to be more expensive and there's not that many of them, they tend to farm these other non-medical issues off to other mental health professionals.

Q. Focusing how on the Illinois system, which you were the federal monitor for five or so years, did that -- did the Illinois Department use a team approach as opposed to leaving -- focusing on treatment by an individual psychiatrist?

A. Well, there was -- there was a team approach on paper, where it said there was a team approach, and at times, I found that there were --

the care was provided in a team-like fashion, but throughout the course of my monitorship, I didn't find that as the rule.

Q. What did you find as a rule?

A. Well, it was kind of a series of disjointed, uncoordinated efforts where, you know, the -- now, when I refer to mental health staff, I mean the non-psychiatric staff.

The mental health staff would be going off in one direction with a mentally ill person. The psychiatrist may be going off in another direction. I found little evidence of true coordination. I certainly did find evidence of coordination, but that was -- again, that was not the usual way the care was provided.

Q. Would you say that because the care was disjointed in the way that you have just described, that was consistent with a community level of care or not?

MR. REES: Object to form.

BY THE WITNESS:

A. I felt that it did not comport with a community level of care.

Q. Does the failure to coordinate in the way you have described have any consequences to people

with mental illness?

A. Yes. It -- boy, the most important thing is that the lack of coordination often results in the person not getting better or continuing to suffer needlessly. Also at times, the lack of coordination could put the patient at risk of harm.

Q. In your opinion, over the course of the time that you were the monitor, do you believe to a reasonable degree of professional certainty that the Illinois Department as a whole was delivering a community level of care to the inmates in the system?

MR. REES: Object to the form.

BY THE WITNESS:

A. As a whole, I felt they were not. There were examples within the overall system where community level of care was occurring, but as a whole, they were not.

Q. You're aware that there are several levels of the delivery of care in the Illinois system, right?

A. Correct.

Q. And one level is inpatient care, right?

A. Yes.

Q. And one level is something called RTUs,

right?
A. Residential Treatment Unit, yes.
Q. And I want to focus for a minute on inpatient level of care. What is the purpose of having inpatient level of care?
A. Well, inpatient level of care is reserved for those patients that can't be stabilized at lesser levels of care. Examples would be, you know, intractable psychosis or severe depression that's not responding to interventions. A person remains chronically suicidal or a person who is self-harming. Those are just examples.
But it's no different than when you consider the physical medical aspect. You could have -- you could be ill but be adequately treated as an outpatient but if your illness progresses to the point where you can't be adequately treated as an outpatient, then you're moved into the hospital for more intensive care. The same thing for psychiatric patients.
Q. When you were the monitor, did the Illinois Department have any ability to move patients to an inpatient level of care that was outside of the IDOC system?
A. Not that I was aware of.

Q. And were you or weren't you aware of whether on the physical side, that is to say for a physical illness, serious physical illness, the IDOC had the ability to utilize non-IDOC facilities to address physical ailments?
MR. REES: Object to the form.
BY THE WITNESS:
A. I am aware that when it came to physical illness, I was aware that inmates were transferred to, quote, outside hospitals, you know, community hospitals, university hospitals.
Q. Now, based on your familiarity with Illinois, were you aware of whether there were any psychiatric facilities at private hospitals or elsewhere in Illinois that could have treated serial mentally ill prisoners?
A. I'm aware that there are community psychiatric facilities in the State of Illinois and they certainly could have accepted inmates from the Illinois Department of Corrections.
Q. Did you ever have any discussions with anyone in the Illinois -- no. Let me try it a different way.
In the years that you were the monitor, could you explain what the situation was

with respect to inpatient level of care in the system?
A. When I first started my monitorship in May of 2016, there was not an inpatient facility where psychiatrically impaired individuals could be transferred to.
During the course of my monitorship, I don't remember the exact year that the Department took over a facility from the state that provided for 22 beds for males and 22 beds for females at Elgin, and that was the state of affairs throughout the rest of my monitorship.
I certainly was aware that they were building a psychiatric hospital on the grounds of the Joliet treatment center but it wasn't functioning by the time I left my role.
Q. In your professional opinion, were there adequate inpatient beds available to treat seriously mentally ill persons -- prisoners while you were the monitor?
A. No, I didn't feel there were.
Q. What is the significance to the system of an inadequate number of inpatient beds?
A. Well, the lack of appropriate number of inpatient beds results that sick patients that

should in any other circumstance be treated in a hospital are forced to be treated at facilities they don't have the capacity to treat them.
Q. Could you explain what the failure of the capacity of treatment at the facilities consisted of?
A. I'm sorry. Could you repeat that or restate it?
Q. Sure. Sure. You just said that people remained at the facilities that didn't have the capacity to treat them. Could you please explain what you meant by the capacity to treat them under those circumstances?
A. A very common reason for admitting someone to a hospital psychiatrically is to do a very close monitoring of their medications where you could see them every day and really fine tune the medication that a person is being treated with. That was not -- that was not able to be done at the prisons. They don't have the capacity to monitor people that closely. There are other -- other situations where a person is chronically suicidal or self-harming, and the only thing the prison facilities had at their recourse was either put the person on a one-to-one suicide watch or have them

restrained and people then were restrained for long periods of time, where that wouldn't necessarily be the case moving them to the hospital where they could be closely monitored in the absence of being in restraints, for example, or in the absence of being held in a solitary cell by themselves wearing a suicide gown. Those are just some examples that just come to mind.

Q. In your professional opinion, were the people over time who were being held in these individual facilities either in a suicide gown or restraints being treated pursuant to the appropriate standard of care.

MR. REES: Object to the form.

BY THE WITNESS:

A. They were not being treated appropriately.

Q. You mentioned a suicide watch and a suicide gown. Is that a form of mental health treatment or not?

A. It's not treatment per se. It is -- if someone -- for example, in -- I was really impressed over the course of my monitorship the severity of the mental illness that I found in the Illinois Department of Corrections. These were really sick

individuals with major mental illnesses such as schizophrenia spectrum disorders, major mood disorders, trauma disorders, severe personality disorders, and some of them were really serious self-harmers. So they would get anything they possibly could to hurt themselves, cut themselves, swallow things.

So a protective approach would be just to strip away all their personal belongings, put them in a suicide gown that can't be ripped and can't be, you know, torn apart, and put them in a solitary cell. That's not treatment. That's just preventing -- a method you would use to prevent self-harm. That's okay in the acute phase. We found people staying in crisis care that were coming in and out of these conditions for weeks and months.

So in the community if someone needs that type of self-harm prevention, we do that, but then you quickly move them to an inpatient facility where that doesn't necessarily have to be the case.

Q. In your five or so years as the monitor, was the Department quickly moving people of the kind you described into the hospital-like setting?

A. No. This was the part that was really -- I didn't understand it, and it was very frustrating.

Because the hospital -- I mentioned it had 22 male and 22 female beds -- was often run under full census. So say the average census was somewhere like 13, 14, 15. So there -- based on my evaluation, there was always available inpatient beds.

And then when I would go to the facilities, out in the field, I would see people that clearly needed inpatient care, and they can't -- they couldn't move them or even when a person was recommended for inpatient care, it took an inordinate amount of time to get them to the hospital. That is not any sort of standard of care.

Q. Did you ever have any discussions with anyone about your concerns about the fact that people who needed inpatient level of care weren't getting it promptly?

A. I had numerous discussions with a variety of individuals about this exact issue.

Q. Would you name them or name some of them.

A. I know for a while, my assistant monitor Ginny Morrison and I were meeting with Dr. Puga and Dr. Hinton about the fact that the Elgin inpatient facility was not accepting certain patients because they had medical -- concurrent medical problems or

they had security concerns. So we met with them over a period of time to try to address that and nothing was done.

Met with the administration about this. I've reported it in -- when it became clear that there was this inordinate delay in moving people to hire levels of care, I started reporting it in my -- my semi annual reports. I had communications with the director, both Mr. Baldwin and Mr. Jeffreys about this issue and numerous administrators in the Department of Corrections.

Q. What was their explanation to you?

A. Boy, well, we can't do that or we have to clear people or a lot of -- I mean, I initially thought because -- the Department of Corrections is such an overly bureaucratic system. It's cumbersome. It can't respond quickly to any type of situation. I'm thinking that part of it was this really dense bureaucracy where they had to get cleared and they had to get cleared from the person or another person before anything could happen. But it seemed to be more than that. And that I couldn't explain.

It was -- I didn't understand why when you clearly identified a person who needed to

be in the hospital that it took months to move them. We're not talking about having to transport them across state lines or anything else. It was just driving them from Stateville to Elgin, for example, or from Pontiac to Elgin, and it was so frustrating about that it wasn't occurring.

Q. So during the five or so years that you identified this problem, did you ever receive an adequate explanation for why this practice persisted?

A. No. The only explanation -- the only real explanations I got was those meetings that Ms. Morrison and I had with Dr. Hinton and Dr. Puga regarding certain patients they wouldn't accept at Elgin due to medical and/or security needs.

I said -- they said we don't have a full-time physician or we don't have someone to care for their medical issues. And I said, well, you got to get one. I mean, come on. This is a hospital. You're basically telling me that a person is too sick to go to the hospital, which is ridiculous.

And then they said, well, we have these guys with really high security concerns. I said then you need to beef up your security. But those were the explanations I was given, but nothing

was done about it. That was the real frustrating thing.

Q. In terms of -- you testified that you saw a significant number of seriously mentally ill people who in your judgment should be in a hospital setting. Did all of them exhibit the characteristics of being dangerous or somehow physically ill or was that only a subset of the people that you saw?

MR. REES: Just a second. Object to the form.

BY THE WITNESS:

A. That was a subset of the overall group. There were certain people that were, you know, high -- I don't understand this -- high security and they couldn't take them to the hospital because the hospital didn't have that level of security. I said, well, fix it, get a higher level of security in the hospital.

But to answer your question, I'm sorry, the medically ill and the high security individuals were a subset of the overall group that weren't getting transferred in a timely manner.

Q. What is the significance in your opinion of the failure of the IDOC to have adequate

hospitalization when necessary with respect to the system as a whole?

A. I'm sorry.

Q. Sure. When you yourself analyzed the system, one of the first areas you look at is the people with the most profound mental health concerns, right?

A. Yes.

Q. Why do you do that?

A. It is -- it has been my practice and my experience that you can gauge the overall quality of the system by the way it manages its most severely ill patients. And so I wasn't cherry picking, but I was looking at these really severely mentally ill individuals that were just basically left to languish in their cells. I can't say it any more clearly than that and the system wasn't able to treat them.

Q. So a prisoner is in languishing in their cell, is that evidence that they don't need treatment?

A. No, not at all. You know, if anything, that would indicate that they need more treatment; that you would need to have more extraordinary interventions; that you would need to do more for

these people. You know, I -- I -- and there are numerous examples that I could give of that situation.

Q. Why don't you give us a few examples or point us to somewhere where we could find them?

A. Well, I remember -- I spent a lot of time looking at the RTU or the supposed RTU at Pontiac. And there were individuals that hadn't come out of their cells for extended periods of time and, you know, the response from the staff were that, well, what do you want us to do, a cell extraction to get him to group? I would say no, but you need to try to understand why they're not come out of their cells.

And so I would go to the cells and talk to these individuals and I found they were examples where they were extremely psychotic, they were refusing medications, they clearly met criteria for involuntarily medication, but it wasn't done because there wasn't enough staff or there wasn't enough will to do it.

That is my general memory of what I found there. It wasn't just at Pontiac.

Q. Where else did you see examples of this?

A. Menard. Stateville was a little better

but they still had serious issues in this regard. Illinois River. Boy, that one way out in the middle of nowhere, near the Iowa border. I'm blanking on its name.

Q. That's okay. What about Dixon? You haven't mentioned Dixon in your litany.

A. Well, Dixon was -- is an interesting --

MR. REES: Just a second. I'm sorry, Dr. Stewart. I object to the form of the question.

BY THE WITNESS:

A. Dixon was interesting in that they had an RTU, which was referred to as the STC. Now when I first began monitoring, the STC was actually providing reasonable care to individuals, getting them out of their cells, spending most of the days out of their cells either involved in some sort of structured activity or allowing them to have day room time or things of that nature.

But then at Dixon, there was an RTU called the X-house which was for the higher security patients, and there they spent most of the time in their cells, they had very limited out of cell activities. There were few activities that they could participate in.

So Dixon was sort of a mixed bag.

They were doing some good things, and then they were doing some poor things.

That was at the beginning, but then as time went along, Dixon's treatment of their RTU patients deteriorated.

Q. Now, as I understand the Illinois system, RTUs are designed to provide treatment to people who can't function appropriately in the general population. Is that your understanding as well?

A. Basically, yes.

Q. And are they supposed to do something with these people in order to help them adjust to the prison situation so they can be returned to general population?

A. That's the stated goal. But as these RTUs were being set up, you know, at Dixon and in Joliet, they found that there was a subset of individuals who could never be returned to outpatient because of the severity of their mental illness, and the only way they could function -- have any sort of degree of functionality would be to keep them at the residential level of care.

Q. Were there enough beds to provide residential level of treatment to the people who would never return as well as to the people who had

some hope of returning?

MR. REES: Object to the form.

BY THE WITNESS:

A. I missed the first part of your question.

Q. Sure.

Were there enough beds at the RTUs so that people who would never return could are remain in the RTU or people had some hope of returning could be serviced in an RTU?

A. There were -- the settlement agreement for example stated a number of beds that needed to be constructed. The Department met that number over the course of time. They were very late in achieving that but they did finally achieve that, but then, just like the inpatient unit, oftentimes they weren't at full capacity.

So the same issues that I talked about earlier about the difficulty in moving someone to the hospital was present also in trying to move people to the residential level of care, where there were vacant beds and because of bureaucracy or inertia or a lack of will or whatever, they weren't able to move these people, for example, that were having extended stays in crisis beds to move them to a residential treatment unit.

So there were physically enough beds, but they weren't utilized to the extent that they were -- that I felt they were meant to be. So I don't think they -- so de facto, they weren't using it the way they're supposed to.

Q. Well, in your judgment, your professional opinion, to a reasonable degree of professional certainty, was the system operating appropriately in failing to provide residential treatment level of care to those in need of it?

MR. REES: Object to form.

BY THE WITNESS:

A. It was not operating appropriately. It was this overly cumbersome dense bureaucratic system that couldn't get out of its own way. You know, the parts were all there. They had outpatient, they had crisis, they had residential, and they had inpatient, eventually during the course of my monitorship. They didn't have all that at the beginning. But then it almost didn't make any difference that they had it because they couldn't move people around fast enough or even in a reasonable manner. So it was -- it did not meet the standards of care.

Q. Did you ever raise this issue with anyone

and if so, who?
A. Boy, I -- you know, I felt like the boy crying wolf all this time. I was just telling you guys look, you got -- why does it take two months to move someone from a crisis bed to a residential unit? You could just walk them down the hall. And I never got any satisfactory answer.
And, you know, I know you asked who specifically I spoke with about all this. And it was, you know, again, the chief of psychiatry, the chief of mental health, the legal counsel, the executive individuals, the director, the local facility people I spoke to about this. Everyone that I could get an audience with I would speak about this.
Q. So you said you can just walk them down the hall. Would that be, for instance, if someone was in crisis at Pontiac, they could be moved from crisis to RTU?
A. That's --
Q. I'm sorry. Without having to go being put into some kind of vehicle?
A. That's an example of what I'm talking about. You know, the one place that was finally able to do that was Logan because Logan had an RTU.

And so Logan was able to move their people quickly from outpatient to crisis to RTU. But even Logan experienced delays in getting people from Logan itself to the inpatient hospital, not to the same extent that the men were waiting, but even that, they were the most nimble facility among all the facilities. But that's an example.
You know the same thing for like Dixon. You got someone in crisis there at Dixon in outpatient or general population, you could just move them to residential. What's the problem with that? Why does it have to take months? Why do you need to get multiple levels of approval?
Q. Well, this failure to move the people that you just described, does that cause anybody any harm?
A. Exactly. And it's no different than the physical medical example. Okay. If you are having chest pain and they have you in the emergency room, they could only do so much. They need to move you to cardiac care unit. And if you have to wait an inordinate amount of time in the emergency room, you're going to -- you have a risk of death, but you also have a risk of incurring serious injury that's not going to be recoverable. It is the same example

for psychiatric patients. It's no different.
Q. Now, I take it, is there in the community something that is the equivalent of a residential treatment unit that isn't a hospital?
A. Yes.
Q. And to your knowledge, did the IDOC make any use in the years that you were the monitor of moving people to facilities outside of the IDOC to provide residential treatment?
A. No.
Q. Now people who need residential treatment, they should be focused on by the system, right?
A. That's one group that should get focus. I mean, it's -- I understand your question. But every aspect, outpatient, crisis, intake, screening, evaluations, treatment, all of those areas require focus. There isn't, oh, we have really sick patients, so let's focus on them. The whole -- all the aspect of the system require attention.
Q. Okay. Let's start with intake. What is the significance of intake with respect to the system as a whole?
A. Well, that's -- the intake is probably the most important point of the system when a person

enters it. So if they're at intake, theoretically, the patient should be properly screened for both medical and psychiatric illness. If they are currently being treated at the local jails where they came from, that treatment needs to be continued. And then they also need to be sent for a timely evaluation. And then based on that evaluation, they could be referred for psychiatric follow up or to arrive at an initial treatment plan but that intake point in the system is probably, as far as systems go, the most important part of the system.
Q. And in your time as the monitor, was the intake portion of the system working appropriately or not?
A. The intake when it came to screening, yes. Initially, they had some difficulty, but over the course of time there, the intake was doing okay in that they would properly screen people. The problems then existed in getting persons of properly -- that the -- let me back up.
So the intake was working well as far as screening goes. So they were able to identify people who had either a history of mental illness or presented with mental illness. But then the problem

was then their following up with an evaluation and that continued to be a problem throughout my tenure as monitor.

Early on in my work as monitor, there was a problem of getting people -- having their treatment that they received in jail continued. So there would be great gaps in their medication or due to the lack of having enough psychiatrists, they were given a medication order for six to nine months, which is very dangerous.

Q. I take it, the purpose of the screening is to separate people with mental illness -- identifiable mental illness and those who don't have mental illness, right?

A. Say that again, please? Sure.

Q. The purpose of the screening is to divide between people with mental illness and people without mental illness?

A. Yes.

Q. And the people with mental illness are supposed to be then further looked at, right?

A. Yes.

Q. As I take your testimony, that wasn't being done appropriately in the years when you were the monitor?

A. Correct.

Q. And what was the problem?

A. You know, I spent a lot of time at Stateville, the intake unit at Stateville. And there are very well-meaning people but they just didn't have enough staff. Because if they had enough staff, you have your assembly line, you get them screened, you get them -- the screening if they have -- if they flag for mental illness, you get them evaluated right on the spot, and then if they're evaluated and found positive for psychiatric stuff, then they go right to see the psychiatrist. And they couldn't do that but they didn't have enough people. They didn't have enough QMHPs. So the Department was trying to jury-rig some BS system to try to justify what they are doing, or they came up with some other way that, oh, we won't keep these people here longer than 14 days so they can get an evaluation at their new facility. But it never was -- whatever they tried didn't work. The net result was people not being evaluated in a timely manner.

Q. Does that failure have any consequence to a person who isn't evaluated in a timely fashion?

A. Yeah. It's -- it's -- you know, again, I

use the emergency room examples.

When you come into the triage station and you tell them you have this issue, you're having leg pain, and then they say, okay, fine, we're going to get you to be evaluated for it, but then they wait, and don't get evaluated for it. Well, whatever is going on is still happening. It could be really serious that could cause irreversible damage.

And the same thing with psychiatry. You identify an issue. A person is psychotic or depressed or manic or you name it and as long as -- the longer it's not treated, the worse it's going to get, and it's going to put -- it's going to result in the person experiencing unneeded suffering at a minimum.

Q. So you did have discussions -- did you have discussions with anyone in the prison system about improving the intake such that people with mental illness were timely evaluated?

A. Yes. You know, this is such a big issue. It's so important that both myself and my assistant monitor Ginny Morrison and I really paid a lot of attention to this. I visited the Stateville, the NRC, many times, and sat down with the staff and

tried to figure out a way, how could we improve this, what are methods that we can come up with together here, brainstorming how to ensure these people are properly evaluated and treated. And it came down to lack of staff.

I would add to that. This wasn't like a one shot deal. This was, you know, pretty much the entire time that I was doing this work with Illinois that they weren't able to do these evaluations in a timely manner.

Q. And how do treatment plans relate to evaluation, if they did?

A. Well, you know, the sequence is you're screened, you're found positive for something, a mental illness, you're further evaluated for it, then based on that evaluation, you would come up with a treatment to address whatever was determined during the evaluation.

Q. So is the treatment plan in the blueprint for delivering care for a mentally ill person?

A. Yes.

Q. And how do you create a decent treatment plan?

A. Treatment plans necessarily are multidisciplinary activities. So, again, going

through the screening, evaluation, psychiatric evaluation, the individuals involved would sit down together, usually with the patient, and come up with a plan to address the patient's issues. They may or may not include psychiatric medication. They may or may not include different psychotherapeutic interventions or assessment about proper level of care. All of these things would be done during a treatment plan -- the development of a treatment plan during a multidisciplinary team meeting.

Q. Assuming the treatment plan is done right, does it have any goals?

A. Yes. You would state what you're trying to do. You say, okay, the first problem is psychosis, for example, and the goal would be to eliminate auditory -- bothersome auditory hallucinations, and the way you would get that would be through medication and psychotherapeutic interventions, and then you would come back at a predetermined frequency, and to see how well you were doing with that. If you were doing well, then you would say the treatment was working but if you weren't doing well, you would modify the treatment to try to address that problem.

Q. You mentioned -- well, I guess -- let me

try it a different way.

You have tools to address mental illness, right?

A. Yes.

Q. One of them is medicine, right?

A. That's one, yes.

Q. And two is some kind of psychotherapeutic activity, right?

A. Those are the two big general categories. There are others, but for our purposes, I think in talking about Illinois Department of Corrections, those are the two major interventions, yes.

Q. And psychotherapeutic could be divided itself into individual psychotherapy and groups, right?

A. Generally, that's a good way to think about it, yes.

Q. Well, did the Illinois Department in the time that you were there have enough clinically able employees to provide individual psychotherapeutic care?

MR. REES: Object to the form.

BY THE WITNESS:

A. To a very limited extent. In reviewing, you know, hundreds -- can I say hundreds? Yes,

hundreds of cases of people being in restrictive housing, for example, looking at their treatment plans, it was usual that they would be -- the patient would be seen by their mental health professionals every 30 to 60 days -- well, usually every 30 days, for anywhere from 15 to 30 minutes.

So we have these seriously mentally ill in restrictive housing and they're having a 15-minute to 30-minute check-in once a month. To me that clearly showed that there was an inadequate number of staff to do this because that is way below the standard of care.

Q. What in your judgment would be the standard of care with respect to a seriously mentally ill person in restrictive housing?

A. Well, as far as individual psychotherapy would go, it would necessarily be weekly for at least an hour.

Q. Now, does restrictive housing have any impact on the seriously mentally ill in your professional judgment?

A. It's well known both in my opinion and the scientific literature, it's very clear that individuals with serious mental illness do very poorly in segregated housing. Their underlying --

their underlying mental illness worsens, and they develop other types of symptoms secondary to just being in segregated -- in restrictive housing.

Q. During your tenure as monitor, did the Illinois Department of Corrections actually put any seriously mentally ill prisoners in segregation or isolation?

A. Oh, yes.

Q. Did you ever have any discussions about whether that was appropriate or not?

A. Again, that's one of the things that I talked a lot about, both at the facility level and at the -- it is called the executive level, in addition to talking to Dr. Puga and Dr. Hinton.

And it isn't as if there weren't agreement about this. People agreed that placing mentally ill people in segregated housing worsens their underlying mental illness, but yet, I think mainly -- again, it goes back to not having enough staff, and not just mental illness staff but custody staff, to get these guys out of their cells. That's how you treat that.

Q. Was there any discussion about simply not putting the seriously mentally ill people in restrictive housing?

A. You know, I don't remember that. I just don't remember. I think I -- I'm remembering one time on cross examination there in front of Judge Mim I believe Mr. Rees suggested, well, if you have a mentally ill person that committed a violation of the rules, of course you are going to put him in segregated housing. My response was no.

That's your choice. If a mentally ill individual breaks the rules, it's usually due to the fact to being improperly treated for their underlying mental illness, and then by putting them in segregated housing, it's only going to worsen that illness. If you choose to do that, then you're acknowledging that you need to really beef up the treatment for these individuals while they're in segregated housing.

Q. Did you see evidence of the Department beefing up the treatment in the way that you just described while seriously mentally ill people are put into restrictive housing?

A. You know, there were I will call feeble attempts. They were mindful of the requirement of the settlement agreement that talked about ten hours of structured, ten hours of unstructured time. But again, the only place that I saw -- the only

facility that I saw that met that, and it was near the end of my time as monitor, was Logan. In their segregated housing they were meeting that requirement. Other than that, the other facilities weren't.

Q. What was the purpose of unstructured out of cell time with respect to seriously mentally ill people in restrictive housing?

A. Just to get them out of their cell. I mean, there's nothing more. There's nothing fancy about it. The longer people stay in their cell, the longer they have lack of social interactions with individuals, the worse their mental health is going to be. So this is just a measure to sort of maintain them. It isn't -- that it improves their mental illness. It just sort of tries to slow down their decompensation.

Q. And is there any reason why you provide ten hours of mental health treatment while someone is in restrictive housing, and by someone, I mean a seriously mentally ill person?

A. It's the same thing. It's the acknowledgement that being mentally ill in segregated housing is very bad for your mental illness so you try to get them involved therapeutic

activities. Hopefully to -- I mean, just pragmatically you are doing that to hopefully just decrease the amount of decompensation, and then you would hope that also would result in their getting a lot of better. But basically it was just sort of putting your finger in the dike to keep them really getting worse.

Q. Does creating an environment where a seriously mentally ill person or prisoner can decompensate have a useful, in your judgment, penological purpose?

MR. REES: Object to the form.

Could you read that back? I need the court reporter to read that back.

MR. HIRSHMAN: I'll rephrase it. It's okay.

BY MR. HIRSHMAN:

Q. In your view does putting a seriously mentally ill person in restrictive housing make them better prisoners?

MR. REES: Object to the form.

THE WITNESS: Was there an objection there?

MR. REES: Yes.

BY THE WITNESS:

A. No. It doesn't. See, this is where it gets -- where Illinois Department of Corrections really needs to sort of come into the modern world. You know, there's still this prisoners punishment, you break a rule, you get punished, and then you break more rules, and you get more punishment, and in the case of the seriously mentally ill, the literature is really clear as well as my experience in general, and in particular with the Illinois Department of Corrections, that mentally ill people will act mentally ill and they won't follow rules necessarily or they will do things that are challenging to the staff, but it is due to their mental illness. And then you slap them in segregated housing, they only get worse. It serves no penological or -- however that word is. I don't want to say something obscene. So it doesn't help anybody. Let's put it that way.

Q. You mentioned crisis care. What is crisis care?

A. The term crisis in an individual as a particular issue or issues that puts them at risk of, you know, psychiatric decompensation or puts them at risk for serious self-harm or puts them at

risk of serious harm to others, and that you would want to pull those people out and put them in a situation that would provide for aggressive treatment to address whatever it is that's causing this crisis.

Q. And during the years that you were a monitor, were the prisoners in crisis given aggressive treatment or not?

A. No.

MR. REES: Object to the form.

BY MR. HIRSHMAN:

Q. Could you explain what you saw with respect to people -- prisoners in crisis and the kind of care they were receiving?

A. At the beginning of my monitorship, they weren't getting much more than a daily visit, a very brief visit by a mental health professional that usually occurred at cell side. That consisted of, hey, are you doing, do you feel like hurting yourself, do you feel like hurting other people, and that was it.

Over the course of the time I was monitor, it really didn't change much. The major clinical intervention was this daily check-in. I use that term particularly because it was, again, a

very brief visit that occurred on a daily basis, if it occurred at all.

In addition that there was the requirement that people would need to get their treatment plan reviewed upon entry into crisis. And so they'd have a treatment planning meeting, and then they would be seen by a psychiatrist but not on a consistent basis.

A certain number of the facilities were trying to do a little more, like, for example, I'm thinking of Stateville NRC, that if someone was in crisis greater than a week, they would bring them out for one extra individual session or a group meeting per week and a couple of the other facilities were doing similar small interventions like that. But all-in-all, that was the extent of their treatment, and it certainly, in my mind, didn't meet the term aggressive, you know, intervention.

Q. When you use the term aggressive intervention, is that something that is -- what is done in the community with respect to -- prescribed in the community by the -- as a hallmark of how to treat people in crisis?

A. Well, I use -- I got the term aggressive

from the settlement agreement because that's what is stated about the type of care that people in crisis were to get.

That term isn't necessarily used in the community, but the interventions are similar, and that if someone comes in in crisis, they get a medical evaluation, they have a psychiatric evaluation, they get tested for drugs and alcohol, they are often given medications acutely to address whatever the acute stressor is, and then a variety of psychosocial interventions, therapeutic interventions to stabilize them, and the hope is that we could get address the crisis and then get them out of the crisis situation and back to their normal routine.

In those cases they can not be stabilized quickly, then they're moved to an inpatient level of care. That's how the community works.

Q. Okay. Applying the community model to crisis in the IDOC, did the IDOC provide the kind of response to a crisis that is consistent with the community model or not?

A. No, they did not.

Q. The community model calls for medical

evaluation. Was there any effort to do a medical evaluation of people in crisis?

A. Not that I'm aware of.

Q. Why would you do a medical evaluation?

A. Well, there's many reasons that a person's symptoms could be due to some untoward medical situation going on. You know, just to name some of the real common ones, it's like diabetes. You have fluctuations in blood sugar, that could cause a variety of significant symptoms, even to and including psychosis.

So if you get someone in crisis, you do a fingerstick blood glucose. I mean it's not a big deal, but you want to make sure that that isn't an issue. Those are the types of things that are done in the community, and I wasn't aware that those were being done at all in the crisis situation.

Q. Now, you mentioned medication. With respect to people in crisis, was there a prompt review of their medication by a psychiatrist?

A. Not usually. I'm sorry.

Q. I'm sorry.

A. Please.

Q. When you say not usually, what did you mean by that?

A. That during the course of my monitoring, one of my assistants, we would get crisis admissions from a variety of facilities and we'd look to see how often a psychiatrist saw the person and the measure would be if the person is seen by a psychiatrist on the day of admission to crisis and we found that it was inconsistent. And I forget the exact percentage of it, but it wasn't usual.

And there was another aspect, too, that baffled me, but I got so much pushback from the Department on this, is that they said, well, the person wasn't prescribed medication in the first place before they went to crisis, why do they need to see a psychiatrist, which is ridiculous.

Of course you need to see a psychiatrist because it may be an issue that requires medication intervention, even though they hadn't been on meds before.

Q. Could it be possible that someone in crisis needed a different kind of medication than they had been on before, even if they had been on medication?

A. That's a common occurrence. It could mean that they needed a higher dose. It could be that there's some crisis -- there's some acute

stressor that's happening where a person just needs a brief augmentation of their medications to stabilize them and to keep them out of crisis. But that requires a psychiatrist being involved from the get-go, even prior to moving someone to crisis.

Q. In your professional judgment, were there sufficient psychiatrists in the system available to do a prompt medical evaluation -- medical -- I'm sorry -- medicine evaluation of people going into crisis?

A. No.

Q. Did you ever have any discussion with anyone about the need for that kind of evaluation?

A. Yes, sir. Again, this is when you asked the questions in the previous examples, I was telling anyone that would listen to me about the need to have the person being seen by a psychiatrist, and it was the same thing, Puga, Hinton, I talked to the director about it, talked to the facility people, the executive individuals. It was -- all these issues, I certainly didn't keep to myself.

Q. Well, did they have any explanation for why they weren't doing this?

A. Well, like I said, I used to get a lot of

pushback saying why do we need to do that, why do we need to have them see psychiatry, they're not seeing meds. It would be characterized as if it were my issue that I required that as opposed to me being a representative of knowing what the community standard is.

You know, that applies to most of the things that I was suggesting to do, it was characterized as sort of something that I was pushing forward, that I was going above and beyond what was necessary, and it really showed just a complete ignorance on the part of the IDOC to understand what the proper community standard is.

Q. As I understand an element of crisis care in the IDOC, it was to isolate an individual in a cell and remove all of their personal possessions is. That consistent with your understanding?

A. Yes.

Q. Now does that just by itself have any deleterious effect on mentally ill people?

A. Yeah, it certainly does.

MR. REES: Sorry. Could I just have that question read back, please.

(Record read as requested.)

THE WITNESS: And the answer is yes.

BY MR. HIRSHMAN:

Q. How come?

A. Well, I mean, you're having an issue. You're -- I mean, this is -- you're feeling, like, for example, you believe that ending your life is the best solution to what's going on with you at the time. Just put it in that context of suicidal individuals. Or that your psychosis is a lot worse and the voices are telling you to hurt yourself or hurt someone else.

And then you move them to a place where you strip them from their clothes and give them a suicide gown and feed them bag lunches with no property, with no access to their television or radio or books or anything. I don't see how that's supposed to help people.

I mean I understand that you do it acutely to prevent self-harm, but it's done acutely, and then you get people out of there because, in fact, throughout my tenure, and this isn't just with the Department of Corrections in Illinois, that other states use the same method. The common response from individuals is I will not let staff know that I'm suicidal out of fear of being put in these places because I'd rather just sort of tough

it out in my own cell than having my property taken away and my clothing and having to be naked in a little cell by myself.

Q. You used the word acute, I believe. Could you tell us what that means?

A. Well, something that is, you know, of new onset, of short duration new onset. That's what I'm talking about acute, as opposed to something that's been going on for a while.

THE VIDEOGRAPHER: This is Kevin, the videographer. Can we go off record in a moment to change media?

MR. HIRSHMAN: Sure. And maybe it's a good time to take like a 15-minute break.

THE VIDEOGRAPHER: Thank you. We are going off record at 9:40 a.m.

(Whereupon, a break in the proceedings was taken.)

THE VIDEOGRAPHER: We are back on record at 9:57 a.m. You may proceed.

Dr. Stewart, please unmute your microphone.

BY MR. HIRSHMAN:

Q. Dr. Stewart, returning for a moment to seriously mentally ill people in restrictive

housing. You mentioned something about the settlement agreement requiring 10 and 10, 10 hours of structured and 10 hours of unstructured time. Do you remember that?

A. Yes.

Q. I don't care what the settlement agreement said. What I want to understand is whether there's any purpose in your judgment about having seriously mentally ill people who are in restricted housing out of their cells some amount of time every day?

A. Yeah. The purpose is to prevent decompensation of their primary mental illness and their acquired mental illness while they're in segregation.

Q. And I did a little math. The 20 hours of the settlement agreement equate roughly to being out of their cell three hours a day. That means confined 21 hours a day.

In your judgment is there any psychiatric basis for about three hours out every day?

A. How do you mean psychiatric basis?

Q. Well, it's your testimony, at least as I understand it, that keeping seriously mentally ill

people in segregation is not good for them.

A. Yes.

Q. And it's also your testimony that being out of their cells a certain amount of time mitigates the damage from isolation, right?

A. Correct.

Q. And so I want to know whether there's any kind of time, day, hour per day, that in your judgment is a minimum of what they need out of cell or not?

A. You know, my opinion on that is -- first of all, this 10 hours and 10 hours situation was arrived at nationally as a legal standard. It really -- it really was never a psychiatric standard. And so my opinion is that seriously mentally ill individuals should not be placed in segregated housing at all, but as you said in your question, 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.

Q. So in your professional judgment, it is critical to mitigate the damage of segregation to seriously mentally ill people that they be out of their cells some amount of time every day?

A. Yes. And the point I've always tried to make with the defendants is that it helps them to have these people out of their cells, it prevents them throwing feces, it prevents them from decompensating, it prevents them from assaults and self-injurious behavior by getting them out of their cell.

Q. Do you know of any other systems where if they put seriously mentally ill people in isolation, they provide a certain amount of time every day that those people are out of their cells?

A. In addition to Illinois California Department of Corrections and Arizona Department of Corrections requires that they have a certain number of hours out of their cell every day.

Q. And with respect to restraints, could you explain what restraints are and what purpose they serve in a mental health environment?

A. Restraints are literally tying someone up to prevent them from harming themselves or harming others or to help them maintain some type of control over themselves because they're so out of control.

Q. Should restraints be used at all?

A. Yes. There are times when restraints are necessary to briefly help someone retain control of

themselves.
Q. You use the word briefly. What is the significance of the amount of time people are in restraints?
A. Well, you know, I'm certainly aware that at times someone needs -- they're so out of control that they need to be physically restrained. So that's what restraints are. You're basically tying someone up to a bed or to a chair to prevent them from harming themselves or harming others.
But it's always felt that that's the mechanism of last resort, and if they're used, they're used at the least period of time to help the person regain control, but they're not the only thing.
When someone needs to go into restraints, it should be accompanied by an evaluation of psychiatrically to see if they need emergency medications to help them regain control.
So restraints don't necessarily are used in isolation of other interventions.
Q. In your professional judgment, is a restraint a treatment mechanism for a psychiatric illness?
A. It's a intervention. I wouldn't call it

a treatment per se, but it's a type of intervention that you would use for the very severely mentally ill individuals.
Q. And is there some kind of community standard of care for how long restraints should be used?
A. Since restraints are such a restrictive intervention, that the community standard is that they can only be done under direct order of a psychiatrist. In the absence of the psychiatrist, a doctorate level psychologist can also write the order, but the order is time limited. The community standard is four hours maximum per order, and it needs to be renewed every four hours if the person continues the need to be in restraints.
Q. During the time that you were the monitor, did the Department use restraints?
A. Yes.
Q. And in the use of restraints, did the Department limit the order -- the initial order to a psychiatrist or a doctorate level of psychology?
A. Yes.
Q. Were the orders for only four hours?
A. The initial order was for four hours. But then the Illinois Department of Corrections had

this policy where I believe the second order could be for much longer than four hours. I want to say it's like 12 hours or something in that range. I forget the exact number of hours.
So the first order would be for four, then after that, if they kept them in restraints, it would be for much longer.
Q. In your judgment, is the Illinois practice or rule that the second order be for 12 hours consistent with the community standard or not?
A. It is not.
Q. How come or in what way?
A. Well, the community standard is that if the order -- if required to be continued is four. Let's say at noontime, a psychiatrist evaluates someone and feels that that person needs to be in restraints, writes the order at noon. That order expires at 4:00 p.m. At that time, the psychiatrist or a different psychiatrist would evaluate that person at 4:00 p.m. to see if the condition of the patient was such that they continued to need restraints, and if in his or her opinion, then they would write the order for an additional four hours, and every four hours, it needs to be reevaluated as

opposed to first four hours and then at 12 hours. I've never seen that anywhere except in Illinois.
Q. Well, did Illinois have enough psychiatrists or doctorate level of psychologists such that they could evaluate patients in restraints every four hours?
A. No, they didn't. And even built into their policies was that an RN could renew the order, or the RN could evaluate the person at the end of the time where the restraint order would expire.
Q. And that was not consistent with community practice, right?
A. Correct.
Q. I know you are not necessarily an expert with respect to the limitations on what an RN's license permits, but do you have a view or perhaps you have an opinion as to whether it is within the license competence of an RN to order restraints?
A. To answer that question, let me explain a situation where the RN may be the highest professionally prepared individual on-site and the RN can then have the person put in restraints and then they immediately need to contact the psychiatrist or doctorate level psychologist to get the order, and then the RN could get a verbal order

from that -- the M.D. or the PhD. And then that person that gave the verbal order would have to come and evaluate the person in face-to-face.

So, they could initiate it, but then it would have to be backed up.

Q. And was that the practice at the IDOC during the time that you were the monitor that if an RN was the initiator, a psychiatrist or a doctorate level psychologist then did a face-to-face evaluation?

A. You know, I don't remember offhand if that was the practice.

Q. In your professional judgment, was the use of restraints at the IDOC consistent with community standards or not?

A. No. I felt it was not consistent with community standards.

Q. And why not?

A. Because it was done too frequently and it was done before other interventions could be tried before a person is put in restraints. For a while, when Dr. Puga was a treating psychiatrist at Pontiac, the numbers at Pontiac where people were being put in restraints significantly dropped, and in my discussions with him, it was because prior to

putting them in restraints, he would be able to do a face-to-face evaluation and offer the person medication and maybe even order involuntary medication, and that intervention significantly decreased the number of people in restraints. But that was only for a brief period of time at Pontiac. For the rest of the system, I never saw anything like that being done.

Q. Did you ever have any discussions with anyone in the prison system with respect to your view that how they used restraints was not consistent with community level -- the community level standard?

A. Yes.

Q. Who did you talk to?

A. And, again, it was the same group of individuals, the people -- the staff at the facility, Dr. Puga, Dr. Hinton, and any of the executive level people and I would document it in my reports.

Q. Did they ever give you an explanation as to why they were acting consistent with the community level standard with respect to restraints?

A. Not that I'm aware of.

Q. With respect to psychotropic medication,

is there any significance in your professional opinion as to when the medication is delivered to the inmate prescribed psychotropic medication?

A. The timing of the medication delivery is an important aspect of the care because if it's given at inconsistent times, one, it decreases the therapeutic efficacy of the medication, and if it is given at times -- it needs to be -- let me restate that.

It needs to be given at times that's going to contribute to the patient being compliant with the medication. So if you are giving a sedating medication early in the afternoon, the patient may not want to take it. If you are trying to give a person their medications at 3:00 or 4:00 in the morning, that person is not going to be inclined to take it.

So yes, the timing of the medication is very important.

Q. Did you observe during the time that you were the monitor whether or not psychotropic medication was being delivered in a consistent time frame?

A. It was really -- initially it was really facility specific where if I -- the facilities

had -- like, how can you call it -- stated what time the medications would be delivered and in some facilities, they met that, you know, within a reasonable amount of time. Like I said medications would be delivered between 7 and 9:00 a.m. and generally, that was done during that time frame. I'm thinking of Dixon, for example.

But then in other facilities, the time for the morning medication would be 4 or 5:00 in the morning, and sometimes the evening medication because of staffing issues wouldn't be delivered until 1 or 2:00 in the morning the following day.

So there was really inconsistencies amongst facilities as far as when medications were administered.

Q. Did you have any discussions with anyone about the significance of these inconsistencies with respect to the delivery of psychotropic medication?

A. This was an issue that I was talking to anyone who would listen to me about, and it was interesting that in the IDOC's quarterly reports that characterized my desire to change the medication administration from 4:00 a.m. to a more reasonable time as "my issue" or "my concern" as

opposed to a standard of care. And I think characterizing it like that as if -- that this was, you know, just a bug that I had, that I said you can't do medicine so early, it was just my own idiosyncrasy, really revealed the ignorance on the part of the Department about the proper use of psychotropic medications.

Q. It's your understanding of the standard of care that the medication be delivered consistently at a time that the patient is likely to take the medication, right?

A. That is the standard, yes.

Q. Was the Department in general -- I'm sorry. Was the department's delivery of psychotropic medication in general consistent with that statement?

A. Not in general. There were certain facilities that were doing that and other facilities that weren't.

Q. Did anyone explain to you why -- we'll pick a facility. Did Pontiac deliver psychotropic medication in a -- at a time that was consistent with your view of the standard of care?

A. Not consistently.

Q. Did anyone ever explain why Pontiac

wasn't doing that?

A. Well, it was -- it was during one of my tours of Pontiac, I was there in the morning time and interviewing inmates who were on the mental health caseload who were being prescribed psychotropic medication, and I started get complaints that they weren't get their medications usually, regularly.

As it turned out, when I asked the medication nurse and the facility leadership, that sometimes they don't have a nurse to do it. So the evening meds wouldn't necessarily be done until late in the morning or -- well, early in the morning of the following day. So instead of giving medications at 7 to 9:00 p.m. they were giving it at 1 or 2:00 a.m. the following morning, and then several hours later they would be given the morning medications.

So there were several examples of where the -- because of lack of nursing staff to administer the meds, the evening medication distribution was cancelled so people weren't getting their evening meds because it would only be a couple of hours between the evening meds and the morning meds.

Q. You mentioned that they told you that they didn't have a nurse, I thought you said RN maybe, to deliver the meds. Is it even necessary that an RN deliver medication?

A. That's preferable to have a medically trained individual because medication distribution is one you need to have someone who is competent to ensure that the person is taking the medication, not just cheeking it and spitting it out as you move to the next cell, but also to observe the patient to see if there's any overt symptoms that aren't necessarily being treated properly, or the presence of side effects and that in the medication -- I'll call -- I'll refer to it as a medication nurse would then document his or her observations and refer that back to the treating provider. That's the proper way that this loop is supposed to go.

Q. Was there a system at the time in the IDOC where the delivering medical delivering nurse actually did the various functions you have described?

A. You know, that was always my -- what I was hoping to see. I observed one medication delivery that I felt that was okay but as a rule, they weren't.

Q. Did you have any discussions with anyone about the failure to do the appropriate delivery mechanism that you just described?

A. You know, and, again, I had multiple discussions with a variety of individuals, and especially ongoing discussions with Dr. Puga when he became Chief of Psychiatry about trying to strategize about how to increase compliance and to ensure that the person was being observed properly when they were actually given the medication.

Q. Did he come up with any suggestions that worked?

A. There was a variety of interventions they tried, but overall, you know, I will admit that it's a challenge to administer medications in a correctional setting, but it came down to it was one more task that an already overburdened staff person needed to do, and it was -- there was never in my opinion any sort of major changes that would ensure that what the standard of care called for was being met.

Q. It's my understanding from your testimony that simply adding a few more nurses to the delivery system would significantly alleviate the issues you have described, am I --

MR. REES: Object to the form.
BY THE WITNESS:
A. It certainly would help. I don't know if alleviate is possible, but it certainly would help. If anything else, it would just ensure that people were getting their meds at the time they were prescribed. So their evening medications were given at, you know, in the evening hours say 8 to 10:00 o'clock as opposed to the next morning.
Q. And -- and to your knowledge, did the IDOC make it a priority to increase the medical delivery -- medicine delivery while you were the monitor?
A. Not that I was aware of.
Q. Now, you mentioned something about cell front. You said something earlier about in crisis, at least originally, all that happened was some kind of visitation at cell front for people in crisis. Do you recall that?
A. Yes.
Q. What's wrong with the cell front as a methodology for delivering psychiatric care?
A. One, it doesn't meet the community standards when it comes to confidentiality. The standard is to have the person be evaluated in an

area where other people can't hear including other prisoners or other staff.
And cell front, you're speaking through the cracks of these big metal doors and you are asking someone are you suicidal, are you still hearing voices, and you have to raise your voice to the point that everyone in the tier can hear you. That's not the standard.
Q. And in the years that you were the monitor, was mental health care in crisis being delivered cell front?
A. The majority of it was. There were examples where people were coming out of their cells, but the majority of the care was delivered at cell front.
Q. In your view, is that consistent with the community standard or not?
A. It is not.
Q. Did you have any discussions with anyone about that?
A. Again, this was an ongoing discussion with the same people that I have had ongoing discussions about all the issues we have been talking about this morning.
Q. Were you given any explanation for why

care was being delivered at cell front when in your judgment that was inconsistent with the standard of care?
A. The main reason I was given, which was very inadequate in my estimation, was that the patient didn't want to come out of their cell. I found it very disingenuous in that when I would come and evaluate people, I would insist on having the staff remove the patient from their cell, and it was a rare, rare individual who wouldn't come out of their cell to meet with me.
And so I -- I -- I felt that they weren't -- it was too convenient just to walk down the tier going from cell to cell at cell front as opposed to having guards involved, cuffing the person up, moving them to a confidential office, a space where they can be interviewed. I think it was more out of convenience to the staff.
Q. That seems to balance convenience of the staff with delivery of care that meets the communal standard, that's not an appropriate balance in your judgment; is it?
MR. REES: Object to the form.
BY THE WITNESS:
A. You know, a lot of things in mental

health care are inconvenient. But that doesn't -- just because something is inconvenient doesn't mean that the standard of care is lowered. The standard of care is the standard of care.
And yes, it is more challenging to go to get guards involved, to safely move the prisoner from their cell to a place where they can be evaluated in a confidential manner than just going up to the cell door and shouting through the crack about if you are feeling suicidal.
Q. Don't all prisons in your experience just deliver mental health care at cell front?
A. A lot of them do, but it doesn't make it the standard.
Q. Do you know of any prisons that don't? And by don't, I mean don't deliver mental health care by shouting it through the cell front door.
A. I can just share my experience here. Here in Hawaii, it is obviously a very small system so the jails and prisons are all one system, and that when I go as my psychiatric residents to evaluate the prisoners, we insist that the guards move them out of their cells, even people on suicide watch, even people that are there for, you know, because they have been threatening, they do the

proper security measures, we get them in a confidential space and interview them, and it's inconvenient to be very clear.

Q. Well, is a confidential setting important in any way for the delivery of these groups that we have talked about as one of the psychotherapeutic measures?

A. Absolutely. There's no difference. Because, you know, how can you feel comfortable in talking about the issues that are really bothering you if you know that custody staff are overhearing it.

Q. How about for individual psychotherapy, assuming that it is being given, is confidentiality important for that?

A. It's -- it's one of the major, you know, hallmarks of good care, confidentiality. It's interesting in talking about this confidentiality, because in any other setting, it would be a ridiculous question to ask that, you know, isn't confidentiality important to psychotherapy? You know, the answer -- the people would look at you incredulously and say, what the heck, of course, it is.

This is where I beat my head against

the wall for six years with the Department in trying get them to understand the importance of confidentiality, and I left very frustrated because I don't know how much -- you know, how much they really understood it at the end of my time.

Q. Did anyone tell you, hey, Pablo, you're just crazy to think that confidentiality has any role to play in the delivery of mental health care?

A. No one ever said that to me because that's so far out of the standard. But they would say, well, we'll go there and we'll make sure that the guard stands far enough back, they don't hear, and we'll whisper through the door, and all these other sort of bogus interventions to somehow ensure confidentiality. But the fact remained you were going to a cell, having to talk through a steel door about exceedingly personal and confidential issues where the whole world -- well, the people on the tier and the guards could hear.

Q. And so that -- excuse me.

If -- if psychiatric care is delivered in a non-confidential setting, that simply negates whether it's really psychiatric care; is that right?

MR. REES: Excuse me. Object to the

form.

BY THE WITNESS:

A. I understand the question. I think I understand the question. But what it does is it puts at jeopardy everything you're hearing whether it's valid or not. Then if you are basing your assessments and treatments based on invalid data, then that isn't psychiatric care. I mean, it's not even poor psychiatric care. It's non-psychiatric care.

Q. Does it -- so in your judgment, during the years that you were the monitor, it was a consistent and persistent problem that the Department was attempting to deliver psychiatric care in non-confidential settings?

A. Yes.

MR. REES: Object to the form.

BY MR. HIRSHMAN:

Q. And you raised that with the various people that you have identified over time, right?

A. Yes. And now that I'm thinking about my tenure being the monitor, I started in May of '16, and the first report wasn't due until May of '17, but I felt it was necessary to update the court and so I made an appointment with the judge and

representatives from the plaintiffs and the attorney general were there meeting with the judge and it was done under oath with a court reporter, and this was November of '16, and I let the judge know then how serious the lack of confidentiality was.

So this is -- from the very beginning of this case to the end, this has been a very important issue.

Q. By chance, do you have your 6th annual report handy?

A. Yes.

Q. Could we mark the 6th annual report as Exhibit 1 of Dr. Stewart's deposition.

(Deposition Exhibit 1 was marked for identification.)

BY MR. HIRSHMAN:

Q. If you look, this is a report you delivered to the court pursuant to your obligations as the monitor?

A. Correct.

Q. If you look at page 73, you address the issue of confidentiality?

A. Yes.

Q. And what was -- what was the problem you identified with respect to confidentiality in your

report?
A. That the Department continues to provide psychiatric care as well as mental health care in non-confidential settings.
Q. And you reference in the box, your mid-year report of December 6?
A. Yes.
Q. Can you read into the record that sentence that begins in the midyear report?
A. In the midyear report of December 6, 2021, I requested the Department to create a Corrective Action Plan to address these problems, meaning the non-confidential setting problems, and they did not respond to my request. It says, this lack of confidentiality places class members of a substantial risk of serious harm.
Q. Have you ever received such a Corrective Action Plan from the Department?
A. Not based on my requests after the midyear report.
Q. Independent of your request, have you ever seen a plan for the Department to provide corrective action with respect to confidentiality?
A. I made a request for a Corrective Action Plan based on my report of November 2020, and I did

get a report back from them in March of 2021, but they did not respond to my one based on my report of December 2021.
Q. The Corrective Action Plan that you received that you just testified about, did that in your judgment meet the problem that you were identifying?
A. No.
Q. Is that why you requested another Corrective Action Plan?
A. This is sort of testing my memory. It was during the time of gathering the information for my midyear report of 2021, and that's usually due at the end of November/beginning of December of the year, there were continued lapses -- serious lapses in confidentiality. That's why I asked for an additional Corrective Action Plan.
Q. With respect to -- do me a favor before we leave confidentiality -- well, let me just go on.
With respect to use of force, did you note the use of OC spray as something that the Department was using with respect to seriously mentally ill people?
A. Yes.
MR. REES: Object to the form.

BY MR. HIRSHMAN:
Q. And what is your view about the use of OC spray with respect to the community standard for dealing with mentally ill?
A. OC spray is not used in the community in dealing with mentally ill.
Q. Is there some justifications for using OC spray on mentally ill people in the prison system in your judgment?
A. Well, I can think of some situations where there were life or death situations where OC spray could be used, but other than that, not routinely.
Q. And what was your experience with the IDOC while you were a monitor with respect to the use of OC spray on mentally ill prisoners?
A. It was -- it was like their first response was the OC spray, and their own policies called for in the case of an emergency, a case of potential use of force event, that mental health staff would be given the first chance to de-escalate the patient, but I found that that wasn't always the case, and OC spray was used first. If a person wasn't obeying an order, they would spray him for example.

Q. Would you look at page 85 of Exhibit 1, your 6th annual report. The second paragraph addresses a situation where OC spray was used on a patient in four-point restraints. Is that consistent with even IDOC practice?
MR. REES: Object to the form.
BY THE WITNESS:
A. First of all, could you point out where that statement is?
Q. It's in the second full paragraph on page 85, and it is the third sentence in that paragraph. Do you see it?
A. Yes, I see it. Thank you.
And the question again, please?
Q. Is spraying -- using OC spray on a person in four-point restraints consistent with proper IDOC practice?
A. I -- I -- no, it's not. I can't imagine a situation where you would use OC spray for someone in restraints.
Q. If you go on to the next paragraph, "One practice is evident as a pattern. In some institutions, it has become habitual to use OC in situations of self-harm, even when the issue is only a threat, serious injury is not eminent, or the risk

is abated."
Do you see that?
A. Yes.
Q. Is using OC spray in your professional judgment even in a prison context appropriate with respect to situations of self-harm?
A. Not generally. There's some sort of rare exceptions that I can think of. If a person is holding a razor blade to their neck and you come upon them and you want to disable them before they cut themselves, that would be a situation. But short of that, not if someone is just expressing verbally that they want to end their life or so. Again, there could be rare examples where it's appropriate, but generally, it's not.
Q. Then you talk habitual use of OC in situations of self-harm.
Do you see that?
A. Yes.
Q. Is that appropriate?
A. It is not.
Q. Have you come across any situations of excessive use of force?
MR. REES: Dr. Stewart, he asked you a question. You shouldn't be reading your report.

THE WITNESS: I'm not reading my report. I'm just trying to think about -- I have come across examples where I felt the use of force was excessive, yes.
BY MR. HIRSHMAN:
Q. And with respect to those examples, did you attempt to communicate with the Department about them?
A. Yes.
Q. And did you receive satisfactory explanations for situations where you believed there was excessive use of force?
A. No.
Q. Now, if you look at page 86 of your report, the paragraph that deals with excessive.
A. Yes.
Q. This paragraph is an accurate reflection of your conclusions with respect to excessive use of force over time, is it not?
A. Yes.
Q. With respect to discipline, were discipline of seriously mentally ill offenders in the first instance to be evaluated by a mental health professional before the discipline could be imposed?

A. Well, I found that that was occurring but it was occurring by chart review and it wasn't -- it wasn't based on someone who actually knew the prisoner involved, and it didn't involve a face-to-face evaluation or an interview of the prisoner in question. It was just a review of the record.
Q. In your professional judgment, is it consistent with the community levels of care to discipline someone without examining the actual patient and understanding the reason why an event occurred?
A. It is not the community standard.
Q. What, in your understanding, is the community standard?
A. It's that you need to thoroughly examine the patient's record, including an interview to determine whether or not the incident in question was a manifestation of their mental illness or if it was a completely volitional act occurring outside of their mental illness.
Q. It's true, isn't it, that a consequence of discipline at the IDOC for the seriously mentally ill was isolation, right?
A. Yes.

Q. And so is it more or less important when the consequence is isolation to have the kind of in-depth understanding of the cause of the disciplinary event in your judgment?
MR. REES: Object to the form.
BY THE WITNESS:
A. It absolutely is required in my opinion that the person be evaluated face-to-face, especially given the consequence of what -- of what would happen to the person if they were found culpable for their disciplinary infraction.
Q. Your report at page 88 talks about discipline of seriously mentally ill offenders.
Do you see that?
A. Yes.
Q. And you suggest that the Department meet with Dr. Kapoor to deal with her findings with respect to discipline, right?
A. Correct.
Q. Do you know whether such a meeting ever occurred?
A. I know that a meeting like that never did occur.
Q. Did you have any discussions with anyone at the IDOC over the time that you were the monitor

about the discipline of seriously mentally ill prisoners?

A. Over the course of my monitorship, I had numerous conversations with individuals in the Department of Corrections regarding their inappropriate use of the disciplinary when it came to seriously mentally ill individuals. I couldn't tell you the exact names of individuals, but they were both facility level and more executive level individuals.

Q. Did anyone offer you an explanation for why it was unnecessary to have the mental health professional who was reviewing the possibility of discipline actually discuss the matter with the prisoner?

A. I believe it was in the quarterly reports.

Let me start again. I never had a conversation with an individual, either a staff member or a member of the executive level, tell me that that was not a -- that that was not appropriate.

What I do remember is through the quarterly reports produced by the IDOC, they were saying that the settlement agreement did not require

that. So, therefore, they were not -- that was their interpretation of the settlement agreement. And that's why they didn't do it. Although I suggested to them that the standard was not that, that you did require a face-to-face.

Q. Did they argue with you that that -- that you were -- that the standard didn't require face-to-face?

A. I don't remember discussions about the standard. My memory is that the discussions were mainly about what they -- how they interpreted the settlement agreement.

But it comes down to, you know, what I encountered throughout my time as monitor is that the Department tried to fit what they are doing given their inadequate staffing. Because in order to do this correctly with a large number of disciplinary infractions that people would be written up for, that it would almost have to have a dedicated QMHP to do this work and to -- and to explain why they felt it was mitigating or not mitigating the inmate's mental illness. And so it was -- that was my understanding why they weren't doing it because it was more staff intensive.

Q. They just didn't have the staff or just

wouldn't hire the staff to do this aspect of work to meet the standard of care as you understood it?

MR. REES: Object to the form.

BY THE WITNESS:

A. I can answer that by saying I know they didn't have the staff. I don't know if they didn't want to have the staff, but they didn't have adequate staff to do this properly.

Q. No one ever told you that they were going to hire people to do this, right?

A. No, I was never told that.

Q. If we turn to page 93 of your report, in the paragraph that was under the italics, you write, "Furthermore, during the current assessment, I found that in just 3 of 182 cases of SMI discipline did IDOC's documentation contain any rationale for the MHP's opinion."

Do you see that?

A. Yes.

Q. Well, is it appropriate for a mental health professional who is making some kind of judgment about the serious consequence of discipline to a seriously mentally ill person not to explain their rationale?

A. No. I didn't understand why they didn't

even put a few sentences, you know, together saying that -- even something as simple as "reviewed the findings and circumstances and found that the mental illness did not contribute to the offense in question," something like that. I mean, there was not even that.

Q. Without some kind of -- there is a place in the form for them to explain their reasoning, isn't there?

A. Correct.

Q. And without some explanation, one can't judge the validity of the decision by the mental health professional, right?

A. You certainly can't judge the rationale behind the decision so I guess in the same way that would speak to the validity, yes.

Q. You thought that this constituted random recommendations, if you look at the last sentence of that paragraph?

A. If you look at the data, there's 182 cases of SMI disciplinary reports and only three contained any rationale, then I think it's very easy to say that this is sort of just a checkbox sort of thing and it's like random as opposed to more thoughtful and based on a proper evaluation of the

circumstances. That's the basis of that sentence.
Q. And based on your testimony, I take it it's a serious matter whether or not a seriously mental ill person is put in isolation?
A. Absolutely. We talk about deleterious effects -- the well known of deleterious effects of placing the mentally ill in segregation. And these effects were also well known to the Department.
Q. Let's turn to page 94, Dixon and Pontiac were -- had very significant mental health -- people suffering from serious mental illness, didn't they?
A. Yes.
Q. And if you look at the paragraph under the bar chart, the professionals at Dixon and Pontiac as noted in your November report opined that "mental illness never contributes to offensive behavior, and this was true of all cases at Dixon and Pontiac during the current review."
So over the course of a year, the mental health professionals at Dixon and Pontiac never saw any situation where the discipline related to mental illness; am I reading that correctly?
A. I believe so, but I would state it that they didn't feel that the mental illness -- the person's preexisting mental illness contributed to

the event that led to their being written up.
Q. So with respect to hundreds of tickets, not a one resulted from mental illness; is that possible?
A. You know, I find it very, very unlikely that that's actually the case. That's why that was reported like that.
Q. A mental health professional who is supposed to evaluate conduct to determine whether it was caused by mental illness who never sees that conclusion can't be doing their job in your judgment, can they?
A. I don't believe so.
Q. With respect to a mentally ill person who says through cell front door, one-on-one, "I don't want to talk to you. I want my treatment to end," is that a direction which must be followed instantly without analysis?
A. Certainly not instantly without analysis.
Q. Is the refusal of treatment itself potentially an indication of the need for treatment?
A. Yes. That certainly can be the case.
Q. And does such a judgment require an appropriate amount of time interviewing the patient in a confidential setting to determine as a matter

of professional judgment whether it's appropriate to cease treatment?
A. Well, let me just say that prisoners retain the right to refuse treatment. But clinicians also have the responsibility to determine what's behind their refusal. You certainly can't force people to have treatment unless it's in certain emergency situations. But short of those, it's the responsibility of the clinician to really try to get to the bottom of this. There may be legitimate situations where the person says, "I'm done, I don't want to do this any more, I don't want to take meds, I don't want to see you, just leave me alone," and that would be appropriate, but it would require more of a -- more of an evaluation to determine that.
Q. In your time as the monitor, did you come across situations where the patient's simple refusal to have treatment or to leave their cell or to take medications was simply accepted at face value?
A. Yes. I remember multiple examples of that, although I can't give you one particular example.
Q. Did you call the failure to adequately investigate the reasons why someone was refusing

treatment or refusing to leave their cell was something that had to be investigated and taken and understood?
A. Okay. I think I lost the question in that.
Q. Okay. In a situation where you identify an issue as to whether sufficient care had been taken to accept a refusal of treatment or a refusal to leave a cell for treatment, did you ever have any discussions of that with IDOC personnel?
A. Yes.
Q. And were they the same group that you have already testified about?
A. Generally, yes.
MR. REES: Sorry. I was on mute. Object to the form.
BY MR. HIRSHMAN:
Q. Did they have an explanation for why they weren't doing a careful investigation?
MR. REES: Object to the form.
BY THE WITNESS:
A. I never had a reasonable explanation, but I did receive a bunch of explanations like "what do you expect us to do, have a cell extraction because the guy won't come out?" "It is his right to refuse

medications." You know, "We can't force treatment on people."

It was those types of really cavalier responses that that in their mind seemed to justify not wanting to look at this further.

Q. In your professional opinion, is that kind of cavalier attitude consistent with the community level of care?

A. No.

Q. Why not?

A. Well, it's very common that people want to stop their medications, and what I found in IDOC is they would just discontinue the medication. If the person just refused it over a period of time, the medication would automatically be discontinued, and I saw if there was an absence of further exploration on the part of the psychiatric team to understand what that was about.

In the community, people refuse their medications and then you set up an appointment, you meet with them, you discuss it. Maybe it has to do with side effects, maybe it has to do with timing of the medications, maybe it has to do with the fact that their condition has resolved to the point where the patient wants to try to go on without

medication, but you just can't necessarily assume any of that unless you do your evaluation.

Q. Based on your observations at the time you issued Exhibit 1, the 6th annual report, was the Department providing mental illness care consistent with community standards?

A. No.

Q. Was the Department failing to provide that in many areas?

A. Correct.

Q. Have we identified those areas in your testimony today?

A. I believe so. That we have talked about certainly -- I don't want to say major areas. Because all the areas that we discussed today are major. Evaluations. Treatment planning. Medication. Psychotherapeutic intervention. Out of cell time. Crisis care. Referral to higher levels of care. All of those are major issues, and I believe that we touched on pretty much all of them. There may be some that we didn't, but just thinking about what we have talked about this morning, I think we hit most of the issues.

Q. And as I understand your testimony, essentially, the problems you identified at the

beginning were the serious problems that existed at the end of your tenure as the monitor; is that fair?

MR. REES: Object to the form.

BY THE WITNESS:

A. Some of the problems that existed at the beginning had some areas of slight improvement or had periods of time during the six years -- remember, we're talking about a six-year period -- that may have been addressed, but by the end of my time, as reflected in my last report, I found all of those areas to be non-compliant and not meeting the community standard.

Q. And no one offered you a plan for when they were going to be compliant; is that correct?

A. No. Never -- never got anything like that.

MR. HIRSHMAN: Why don't we take a break. I think I'm done, but I need to talk to my people.

THE VIDEOGRAPHER: We are going off record at 11:09 a.m.

(Whereupon, a break in the proceedings was taken.)

THE VIDEOGRAPHER: We are back on record at 11:12 a.m.

You may proceed.

BY MR. HIRSHMAN:

Q. In Arizona, you offered an opinion which was accepted by the court as to whether the mental health care and the conditions of the confinement met constitutional minima and you concluded they did not.

Based on your experience and understanding of the constitution, was the care and treatment of the mentally ill in the Illinois prison system, did the care meet constitutional minima in your judgment?

MR. REES: Object to the form.

BY THE WITNESS:

A. It was my opinion that it did not.

Q. And you have given the reasons in the course of this testimony?

A. I believe I have.

Q. And you were using the same method and mode of analysis that you used in reaching your collusions in Arizona?

A. Yes. But, in fact, with the Illinois Department of Corrections, I had much more data upon which to base my opinion.

MR. HIRSHMAN: I'm done.

THE VIDEOGRAPHER: Any cross anyone?

MR. REES: I'll have cross.
Dr. Stewart, I know we took a short break. Do you need a break or are you good to continue?
THE WITNESS: I think I'm okay if you are.
MR. REES: Why don't we go ahead and continue and then see if we need to take a break.

EXAMINATION

BY MR. REES:

Q. Did you do anything to prepare for today's testimony?
A. Yes.
Q. What did you do?
A. I reviewed my 6th annual report several times and I reviewed the court's finding in the Arizona case also.
Q. Did you review anything else?
A. There were several references from my last report that I had written two previous reports and I briefly looked at some of those.
Q. You looked at some of the previous reports?
A. Yes, my previous reports.
Q. Do you happen to know which ones?

A. I'm sorry. I lost you.
Q. Do you happen to know which ones you looked at?
A. No, not offhand. I think the December 2020 -- the December 2021, I might have glanced at a couple of things.
Q. Did you do anything else to prepare?
A. I had a conversation with plaintiffs several weeks back.
Q. When was that?
A. That was on the day that the original deposition was scheduled and then it was postponed until today, I had an hour long conversation with plaintiffs.
Q. Who participated in that conversation?
A. Mr. Hirshman. And I believe there were other people from the plaintiffs' team there and I know for sure I was speaking with Mr. Hirshman during that time.
Q. What did you discuss?
A. I just discussed what -- in general what was going to be the measure of his asking me questions so I could properly prepare for them.
Q. Did Mr. Hirshman tell you he was going to be asking you about the community standard of care?

A. I don't recall.
Q. Did you discuss the standard of care during that call?
A. I believe I might have. Yes.
Q. What did you discuss about that?
A. I'm trying to remember exactly. Words to the effect of that the community standard of care is the standard of care that applies wherever you're talking about psychiatric care.
Q. Did you -- did Mr. Hirshman or anyone else talk to you about the constitutional standard of care?
A. Not that I recall.
Q. Did you have any other discussions about a standard or a measure that you used to determine -- to measure the Department's compliance?
A. Well, I certainly talked about the settlement agreement and how my monitoring was based on the requirements of the settlement agreement.
Q. Did plaintiffs' counsel talk to you about something other than the settlement agreement about, you know, assessing your questions about whether aside from the settlement agreement, whether you thought the care did or did not comply with some other standard besides substantial compliance with

the terms of the settlement agreement?
A. I believe we had a brief discussion about the community standard, yes.
Q. What else did you discuss with them during that call?
A. That was about it.
Q. Did you do anything else to prepare for today's testimony?
A. No. Just reading my last report several times.
Q. Did you talk to your assistant monitors?
A. I did not.
Q. Did you talk to any other individuals?
A. I did not.
Q. You didn't review any other documents except for your reports?
A. And the one document I talked about from Arizona.
Q. You talked about your prior assignments and you mentioned that there was one time when you were an expert for the defendant, I think you said it related to the New Mexico Department of Corrections or correctional center regarding mental health care for prisoners in solitary confinement is what I wrote down in my notes.

A. That was -- my initial consultation was about that. Brief story -- back story on that was it was a group of plaintiffs that were suing the Department for the lack of mental health care for high security inmates they were keeping in solitary confinement who had been designated as having mental health needs, and they wanted me to help design a program that with meet the community and legal standards for providing care.

Q. And you said it was testing your memory, what year, could you give us at least a rough estimate of when that was?

A. Oh, man, let me think. Best I could do was in the '90s, and you may have an updated copy of my CV. I certainly listed it in there.

Q. And since your position as monitor was terminated in Rasho, you have not been a monitor for any other prison system; is that correct?

A. Not a court-appointed monitor, correct.

Q. And have you been retained by any party since then, since last June, other than the plaintiffs in Connecticut -- suing Connecticut?

A. You know, I have an ongoing relationship with plaintiffs in the Coleman Plata matter in California and so over -- since I terminated my

monitorship in Illinois, I have had several consultative questions. I believe they were around the use of telepsychiatry in the prison system.

Q. And are you getting paid for today's testimony?

A. That to be quite frank with you, I'm not.

Q. Have you talked to these plaintiffs, Mr. Hirshman and his team, about being retained as an expert for them in this case?

A. I have not had that discussion.

Q. Just to be clear, on the record, your role of monitor of the Rasho settlement agreement ended in July of 2022?

A. I believe it may have been at the end of July, yes, around that time.

Q. Do you recall what you were paid by the Department of Corrections in 2022?

A. The total amount?

Q. Yes.

A. I want to say in the range of maybe $150,000.

Q. Do you recall what the Department of Corrections paid you in 2021?

A. Probably around double that. Around $300,000, in that range.

Q. Maybe 321 or so?

A. I'm sorry.

Q. Maybe 321 or so?

A. That's very likely, yeah.

Q. And when was the last time you visited an Illinois prison facility?

A. In March of '22.

Q. That was your last visit at Logan Correctional Center, March 25, 2022?

A. That sounds about right.

Q. And those visits are reflected in your report, correct?

A. Yes.

Q. So I mean, we could look at the report, if you need to, but by my glancing of it, it looks like in 2022, you visited three facilities, you visited Joliet, Pontiac, and Logan?

A. Yes.

Q. All in March of 2022?

A. Correct.

Q. And in 2021, you visited Joliet in July of 2021 and Pontiac in August of 2021?

A. And Dixon in October.

Q. When was the last time you visited any other facility -- any other Illinois Department of

Correctional facility before those visits in 2021?

A. It would be in the fall of 2020. Well, see, it's -- I don't remember now because we're still talking about really big COVID times.

So during the COVID lockdowns, I was doing what I refer to as virtual tours. So I set up a meeting with all the pertinent staff at the facility and go through a series questions, and then back that up with chart reviews. So I don't know during 2020 how many site visits I actually did.

Q. I think you testified earlier today about discussions with Director Jeffreys. How many times did you meet with Director Jeffreys?

A. You know, I would say in the range of -- officially, I met with Director Jeffreys maybe three or four times, probably four times, but there were other times when he would call me up outside of there would be other counsel present and we would talk about things.

Q. Do you have records of those communications?

A. I do not.

Q. Was it, in fact, you only met with him twice?

A. I'm sorry. Is that a question?

Q. Yeah. Isn't it true you met with Director Jeffreys just twice?
A. In-person or on the phone?
Q. Yes.
A. I believe it was more than that. I know I met him once at Menard when he first started. I know there was another time in the fall where I went to Chicago and I went to the headquarters and I met with him there and there was a couple of what I'll call formal phone calls where I requested to speak with him and then he was on the line, but he had counsel present. I know I did that at least once.
Q. And the purpose of your monitoring for the Department was to assess substantial compliance with the settlement agreement, right?
A. That was my responsibility, yes.
Q. I think you have already confirmed that a rating of non-compliance could mask IDOC's true performance, correct?
A. I think I mentioned that that in the -- as you're aware, during the course of my monitorship, I attempted to use a rating of partial compliance but I was not able to do that because that's not part of the settlement agreement. So it was either yes or no, compliance or non-compliance.

Q. Right. And a non-compliance rating could mask IDOC's true performance in meeting the requirements of the settlement, correct?
A. No. I didn't mean that. I meant that a non-compliance rating would mask some facilities that were doing better than others. And so, remember, the non-compliance was based on serious or systematic were the two prongs that needed to be meet and they were "or." So like, for example, I found over the course of my monitorship that Logan was doing a lot better than the other facilities in certain areas.
Q. Let me just restate my question. I'm asking you if the rating of non-compliance may mask IDOC's true performance and you're saying that's not accurate?
MR. HIRSHMAN: Objection.
BY THE WITNESS:
A. Well, I'm trying to answer the question. So I don't know if you can restate that in a different way or something.
Q. Why don't you look at page 8 of your 6th annual report. On page 8 under the paragraph -- under the heading "compliance ratings" in bold.
Do you see that?

A. Yes.
Q. "The team," meaning the monitoring team, "applies 'circumstantial compliance' and 'non-compliance' ratings for each provision as specified in the settlement agreement. In actual fact, these may mask IDOC's true performance."
That's what you said in the report, correct?
A. Right. But then the next sentence is important too. I say "IDOC had made substantial progress in a number of requirements, which possibly could be more accurately described as partially compliant" but I was not able to use that term because it's not a part of the settlement agreement. So yes, I agree.
Q. Thank you.
Your report does not address a community standard of care, correct?
A. My report --
Q. None of your reports to the Department addressed a community standard of care?
A. My report addresses the settlement agreement.
Q. Your reports did not address a community standard of care, correct?

A. Correct.
Q. They also didn't address your view on what might be a constitutional standard of care?
A. I believe in some of my reports, I might have used that phrase that I felt that certain areas were falling below constitutional standards, but in general, no.
Q. I might have misheard you but when you described the community standard, did you say that that's an evolving standard?
A. Correct.
Q. Evolving based on what?
A. You know, the field of psychiatry is evolving. What might have made a standard before, like I say on a particular treatment, where a medication that we would use that would meet the standard of care back in the 1970s, such as we used to use Thorazine, which is an oral, outdated medication. That was the standard of care. But now it's not the standard of care because it's evolving because there has been progress in the field, there have been new meds. That's an example of what I mean by evolving.
Q. Are you aware, is the community standard of care written down in any way?

A. No.
Q. So if we wanted to look and see what the psychiatric community accepts as the community standard of care, do we have a source that we could look at to determine what that is?
A. I don't believe you could find one source that would particularly say this is the community standard.
Q. So what standard do you use to identify what is the community standard of care?
A. What is the current acceptable standard for psychiatric care right now.
Q. Acceptable according to whom?
A. According to the psychiatric community.
Q. How do you assess what the whole psychiatric community determines to be the acceptable standard of care?
A. By practicing within that community and understanding what things -- where things are as far as the standard of psychiatric care.
Q. If the things that you gave testimony about today, have you conferred with other colleagues about those opinions?
A. Okay. Now, help me understand that question.

Q. Have you conferred with other psychiatrists about the opinions that you express today?
A. I certainly had discussions. I don't know about conferring. Not that I would ask people, say, look, this is what I'm thinking what the standard of care is, but what you think. But in discussing -- that's the beauty of where I work now. I'm in an academic department so I talk to colleagues all the time about the evolving standard.
Q. Do you agree that the standards that are written by the NCCHC, do those reflect the community standard of care?
A. Not necessarily.
Q. Why not?
A. Because not just in my opinion, but opinions of the court has found that NCCHC doesn't necessarily reflect the standard of care. Those are -- those are particular -- that's the proprietary company that sets standards, and they charge people to go in there and assess their institutions for it.
Q. What court do you think has found that the NCCHC standards don't reflect a proper standard of care?

A. I couldn't tell you offhand, but I know that that has been found the case in court.
Q. Can you as you sit here today tell us in any particular way that you disagree with any of the standard that are written in the NCCHC standards of care?
A. I cannot.
Q. What does NCCHC standard for, just for the record?
A. National Commission on Correctional Health Care or something like that.
Q. And are you familiar with the group called the ACA, the American Correctional Association, also has written standards?
A. Yes.
Q. Do you think that those standards reflect an accepted standard of care?
A. No.
Q. Why not?
A. Let me restate that. They reflect a standard of care based on ACA, but it doesn't necessarily reflect the community standard.
Q. In what way do they not?
A. I couldn't give you examples right now.
Q. And do you have any way -- a particular

way that you disagree -- let me restate that.
Do you disagree with the ACA standards in any particular way?
A. I couldn't give you details on that right now.
Q. And as part of your work for Rasho or with respect to your testimony today, have you ever embarked on a study to compare the type of mental health care that individuals get in Illinois prisons compared to what mental health care is available for them in their local communities?
A. I have not.
Q. Have you done any study to compare the kind of mental health care that individuals get in Illinois prisons compared to what they received in the county jail before they transferred to the Illinois Department of Corrections?
A. I have not.
Q. And have you done any kind of a comparison of the care provided by the Illinois Department of Corrections compared to the care provided by other state or federal prisons?
A. A study? Not a study.
Q. Yes.
A. Not a study, but I'm certainly familiar

with other systems and how they compare to Illinois.
Q. Have you done any written analysis that we would be able to look at that would compare how Illinois compares to other systems?
A. I have not done a written analysis.
Q. And have you come to a conclusion based on your work, whether Illinois' system is better or worse than the systems that you have looked at?
A. Now, what was the first part of that question?
Q. Have you done any analysis or reached any conclusions as to whether the care provided by Illinois is better or worse than the care provided by other prison facilities that you have looked at?
A. I certainly have my opinions about that, yes.
Q. What's your opinion?
A. Well, it depends on what system we're comparing it against and what particular aspect of care we're looking at.
Q. Okay. That's fair. Are there systems overall that you think are doing a better job than Illinois that you're aware of?
A. And again, in what aspect are we talking about? Because there so many parts of care. Like,

for example, I can look at the care for people in segregated housing. Okay. Where Illinois is flatly falling on their face about that. They've never been able to do the proper amount of out of cell time, either unstructured or structured, and they don't do the proper assessments, treatment planning, or follow-ups.

Then I look at California Department of Corrections, which has a very similar -- it's called different names, but it's the same thing. We have the mentally ill people -- seriously mentally ill that are in segregated housing. During my time as plaintiff monitoring in the Coleman Plata case, California Department of Corrections was doing much better about getting their people to get 10 hours of structured and unstructured time during the week, and they would meet with their primary therapist weekly, and they would meet with their psychiatrist monthly. It would be in confidential settings. In that aspect of care, compared to California, Illinois is falling down.

Q. What areas in your view was Illinois doing better than other systems?
A. When I first started the monitorship in the first couple of years, I felt that Illinois was

doing a very good job at screening; that everyone that came in was screened in a timely fashion; and I know that was -- that -- when I compared that to other systems that I have been involved in like Arizona or Nebraska or California -- California was doing okay with that also. I can certainly compare it to Arizona, that Illinois was doing better as far as screening goes.
Q. Let me go back and ask a question about your latest annual report that I think Mr. Hirshman marked as Exhibit 1 in your deposition, your 6th annual report. I think for the record that is dated May 31, 2022; is that correct?
A. Yes.
Q. Now, the way that report works is that you don't address any of the provisions that you previously monitored where monitoring was terminated because of substantial compliance; is that correct?
A. Correct.
Q. And are you aware that you were historically I think monitoring 110 different provisions, and as of your May 2022 report, 66 of those had been terminated because of the Department's substantial compliance?
A. I don't remember the exact numbers, but

that sounds about right.
Q. At the time of your report in May of 2022 of the sections that remained subject to your monitoring, you found five of those in substantial compliance. I think they're reflected at the beginning of your report, but it was participation and programs, CQI systems, monitoring, and reporting and recordkeeping; is that right?
A. Yes.
Q. You found those to be in substantial compliance?
A. Yes.
Q. And then you had one rating related to segregation, Section 15(c)(1)1 where you gave no rating. Do you know why you gave no rating on that section?
A. Let me refer to my report for a second. 15(c)(1)?
Q. I if I wrote it down correctly.
MR. HIRSHMAN: It is 15 (c)(ii) -- I don't see anything with respect to segregation.
MR. REES: I may be wrong on what I wrote down.
BY MR. HIRSHMAN:
Q. I think that I wrote down that you had

given a rating -- a "no" rating on one section and I thought it was 15(c)(1).

A. You know, as far as the segregation section goes, there's multiple, numerous subsections. So it's possible that one of the subsections I gave a "no" rating on, but I don't recall it offhand.

Q. And were there certain sections of your report that were the primary responsibility of Ginny Morrison, Ms. Gibson, and Ms. Kapoor?

A. Yes.

Q. Do you recall which ones those were?

A. Well, first of all, I'm responsible for the report. So they reported their data to me, which I reviewed and approved of.

So all the opinions expressed in the report are mine. I know for Dr. Kapoor, she emphasized the disciplinary section. Ms. Morrison did a variety of things, including use of force, medication follow-up, length of time in crisis, referral to higher level of care. She did a lot of them that we worked -- she primarily did the data analysis and wrote it up and then we would discuss it when she would send me her draft findings.

Q. And during your testimony today, you

referred to, I wrote down "a big shortage of psychiatrists." Is there a nationwide shortage of psychiatrists?

A. Yes.

Q. And is there a nationwide shortage of psychologists, clinical psychologists?

A. I could only talk to you about psychiatrists. I know there's a manpower shortage about psychiatrists.

Q. Can you describe that manpower shortage?

A. Well, it is just -- right now, it's -- there's insufficient number of the psychiatrists that are available to fill all the clinical spots in the country, and so because of that, systems, like the system that I work within, we have a very active program of training psychiatric nurse practitioners to be able to fill in the gap under supervision of psychiatrist.

Q. Have you assessed I'll use the term the free world, outside of the custodial situation, how long people have to wait to see a psychiatrist, have you done any study of that question?

A. Well, I'm certainly aware that people can wait for several months for an appointment. I have not done a formal study, however.

Q. Do you know if it's worse for people who don't have insurance?

A. Not necessarily because there are -- there are -- you know, there's a private system and then there's a public system, and oftentimes, in certain areas, the public system is more robust than the private system. So people that have insurance go through the private insurance and they may have longer waits than people in the public system who can be seen more frequently.

Q. Have you done any study or analysis of the waits that people face in the public system?

A. Not any study. I'm certainly aware that there are waits.

Q. I'm not trying to argue with you. I think I just want to make sure I heard you correctly. You said you could comment on the shortage of psychiatrists, but you are not prepared to comment on the shortage of clinical psychologists and other mental health staff?

A. No. That's not anything that I follow.

Q. During your testimony, I think you talked about various potential consequences and risks associated with the care that was being delivered. Just let me clear. You are not aware of the care

that's being provided about the Illinois Department of Corrections now, correct?

A. No. Now, as of, what are we, March 1st, no, I'm not aware of what's going on today for sure.

Q. And are you aware of what the Department either has or has not done since you were terminated in July of 2022?

A. No, I do not know.

Q. With respect to your testimony about consequences or outcomes, you talked about a number of areas with Mr. Hirshman, one of which was purported delays in moving people to inpatient care.

A. Yes.

Q. Do you recall that testimony?

Have you done any assessment, a study to determine whether there were individuals that faced harm as a result of a delay in a move to inpatient care?

A. I did not conduct any studies per se or analyses of that cohort.

Q. How about with respect to delays in moving people to an RTU, did you do any study or assessment of whether any individuals actually suffered a consequence, a harm as a result of the delay in a move to an RTU?

A. I did not conduct any studies or analysis.
Q. How about with respect to delays and evaluations -- I mean, I can go through each of these. For all of the things that you testified about today, have you done any study or analysis to link any harm to the care that you talked about today?
A. Not any study or analysis, correct.
Well, let me rephrase that, please. I have never done any formal study. As you say study, that would be to look at it as a particular research issue. But certainly, I am aware of negative consequences for delaying people to be seen, to move up to a higher level of care, but I haven't done any particular study.
Q. Well, and that's kind of the challenge that we're facing is I'm trying to determine whether you have done anything to isolate, for example, harm that might occur because of one issue as opposed to harm that might occur because of another issue. Do you understand my question?
A. Yes. And, you know, quite frankly, sir, I -- there were so many things going on -- there's so many studies that are so ripe to be done in the

Illinois Department of Corrections. You know, not just to delays in referral to higher level of care, or the delays of completing the evaluation, but the consequence of using appropriate medication distribution times. There's so many issues, and no, we were not able to do any of those studies. The Department -- I will say the Department didn't embark on any of those studies either.
Q. How do we deal with the question of individual harm? I mean, do we -- do you agree that the care needs to be individualized?
A. Do I agree that care needs to be individualized?
Q. Yes.
A. Yes.
Q. And do you agree that harm is also -- the assessment of alarm is an individualized question?
A. I never thought about that. Yeah. Harm -- if we're looking at harm, you have to look at individuals, yes.
Q. I don't know if I can find it in my notes, but are you aware that Illinois did try and has tried to use a multidisciplinary approach?
A. I'm aware that they have tried, and in certain circumstances -- in certain facilities, it

is more commonly done, based on my most previous analysis, and in other facilities, they basically blow it off.
Q. Okay. And if I understood your testimony correctly, I wrote down that you said care could be provided, for example, by a psychiatrist but, you know, there are not enough psychiatrists, that's what I wrote down you said. Did I get that correct?
A. Say that again, please?
Q. That the care could be provided by a single psychiatrist if there were enough of them?
A. Well, I think the question was something about is multidisciplinary team the only way that psychiatric care can be provided, and the answer is no. It could theoretically be done by an individual psychiatrist who could be responsible for medications, medical evaluations, psychotherapeutic interventions, because psychiatrists are trained in all of those areas.
Q. Do you have an opinion of whether a psychologist could provide psychological therapy -- that that could be done by a single psychologist?
Do you hold yourself out as an expert as to care by clinical psychologists?
A. I hold myself out as an expert about the

care of psychiatric patients, and that I have often worked in multidisciplinary teams where not everyone has been a medical doctor, and that certain psychologists can provide excellent psychotherapeutic care. I'm certainly aware of that.
Q. When Mr. Hirshman was asking you about people transitioning to an inpatient level of care, I think you testified to the effect that there are Illinois psychiatric facilities that could have treated seriously mentally ill prisoners. Did I get that right?
A. Yes.
Q. Which facilities are those?
A. Again, I'm not familiar with the entire mental health system in Illinois, but I'm certainly aware at a minimum that university hospitals have inpatient psychiatric care.
Q. But are you aware of a single psychiatric hospital in Illinois that will take convicted Illinois prisoners?
A. See, that's a different question.
Q. That's the question I'm asking.
In Illinois prisons, these are convicted individuals. Are you aware of any

Illinois psychiatric hospitals that will take those people?
A. I never looked at that particular aspect.
Q. I guess it's the same thing, residential treatment in the private world, are you aware of any residential treatment centers that would take Illinois prisoners?
A. I never looked at that.
Q. And it sounds like when you had some discussion I think that you and Ginny Morrison met with Dr. Puga and Hinton about the fact -- about whether Elgin should be taking more individuals. That's the topic I want to ask you about.
A. Okay.
Q. That discussion.
And I have down that you said that they raised that there were some people that they thought in their assessment should not be moved to Elgin because of either security concerns or medical -- other medical issues. Is that what was your understanding?
A. Correct.
Q. And I mean, do you -- is this just a matter of what you disagree with their judgment on that question?

A. No, it wasn't matter of my disagreeing with their judgment, but if that's the case, then you need to do something to still treat those people. You can't deny inpatient psychiatric care just because someone has real severe diabetes.
Q. And did you examine what interventions were being done by and recommended by the multidisciplinary treatment team when an individual was needing to stay at a facility before being moved to an inpatient facility?
MR. HIRSHMAN: Object to form.
MR. REES: Let me rephrase it.
THE WITNESS: Please.
BY MR. HIRSHMAN:
Q. Do you know -- do you have any personal knowledge of whether the Department tried other interventions for individuals who, for whatever, reason were not being moved to an inpatient facility?
A. I was generally aware that -- I'm thinking of a couple of side visits that I did. I'm remembering Pinckneyville where I discussed with the mental health person in charge about why they were keeping people that clearly needed inpatient level of care, and they said there was an argument they

had among the staff about we can handle them here versus we need to transfer them. And so they tried to do some things there at the facility. I'm aware of that example.
Q. Are you aware of other examples where the Department tried to other interventions for individuals who could not be moved to an inpatient facility?
A. I'm not aware of any particular interventions, no.
Q. If they did, would that be a good thing?
A. It depends, you know. You could --
Q. What does it depends on?
A. Well, you know, again, thinking about psychiatric care is no different than medical care. You could treat a person's heart attack as an outpatient, but the outcomes are not going to be as good as unless you move to a hospital.
Same thing. You could treat severe schizophrenia or bipolar disorder or other mental health illnesses as an outpatient, but at a certain point, you need to say, no, this person needs to have better care that can only be provided in a hospital. So their outcomes aren't going to be as good. So even if they try to do different things in

the field, I mean, that's good if they're doing that but it doesn't -- doesn't any negate the fact that they need to be moved to a hospital.
Q. You talked a little bit about staffing and gave some views on staffing and I wrote down that you said that the Department was trying to jury-rig getting more coverage to help the QMHPs, words to that effect. Do you remember that?
A. No, it wasn't -- I remember that question from Mr. Hirshman.
Q. I think you were the one that said jury-rig. I was trying to find out what you meant by that?
A. I used the word -- you know, jury-rig is an old sailing term, that you kind of put things together by bailing wire and duct tape to sort of make something work. So you're using what you got.
For example, remember, we had discussions, you and I had discussions about the fact that they weren't -- that Stateville NRC wasn't able to meet its requirements to do psychiatric -- to do mental health evaluations, and you had asked me if we could just use psychiatrists because Stateville NRC was more richly staffed with psychiatrists than it was for QMHPs, and we had that

discussion. That's an example of trying to jury-rig what you got to make -- to meet the standards that you're supposed to meet.

Q. But you're aware that the Department did make efforts to try to obtain and find more people, more mental health staff? Are you aware of those efforts?

A. I'm not aware of those efforts because I didn't see any results. I didn't see anything change.

Q. I understand what you're saying about results. I'm asking if you saw the efforts. Do you have an opinion about their efforts?

A. My opinion is that their efforts weren't adequate. That's my opinion.

Q. Weren't adequate because they didn't get the result that you wanted to see?

A. Not that I wanted to see, but to meet the requirements, to meet the standard of care. Again, Mr. Rees, this is not -- these aren't my standards. I'm not the one who determines the standards. But --

Q. Okay. But what's the standard -- is the standard for mental health professionals, is it based on a particular ratio?

A. No. It is based on whether or not you could provide the care they are required to provide. Okay. So I'm not looking at hard numbers. There are studies out there that look at numbers. But I'm just talking about -- NRC is a perfect example because you've got this tremendous number of people coming in every month. You know, a bus shows up and there's a hundred new people on a Thursday afternoon, for example.

Well, you got to mobilize staff to do all the things that you need to do, and necessarily with the staff at NRC have to shortcut because they didn't have the people to do what was supposed to be done.

Q. Okay. But that's what I want to talk to you about a little bit because what is supposed to be done under the settlement agreement is one thing, do you agree with that?

A. That's one standard, yes.

Q. Right. But then there could be another standard, which is what needs to be done to protect a particular individual from suffering substantial harm. Do you agree with that?

A. Yes.

Q. And do you know if the Department of

Corrections has the mental health staff in place to protect individuals from substantial harm?

A. I believe they do not.

Q. Can you identify any individuals that suffered substantial harm as a result of what you considered to be an insufficient mental health staff?

A. I cannot identify any individual hurt people.

Q. You talked about treatment. I don't know if I understood it correctly. Mr. Hirshman was talking to you about treatment, and I think it was about therapeutic out of cell time, and I wrote down that you said that you thought the standard was that everyone should have one hour per week. Do you recall that testimony? I just want to make sure I got it right, and I understand what you were saying.

A. That one hour --

Q. I think it might have been SMI people and restrictive housing.

A. No. It was -- my one hour a week comment is about people who are seriously mentally ill in restrictive housing should be able to meet with their individual therapists or primary care or however you want to refer to it, their MHP, on a

weekly basis in a comfortable setting for one hour.

Q. Okay. And is there -- can I find that standard written down anywhere?

A. You could find it written down in the court orders from the California Department of Corrections, Coleman Plata case, because that's the standard they follow.

Q. That's your basis for it?

A. That's the -- that's not my basis. That was what was felt to meet the standard in California, in the prison system.

Q. I'm not trying to argue with you. I just want to make sure I understand the source where you're coming up with that.

A. It wasn't a standard that I created.

Q. And the question of who goes to segregated housing, restrictive housing, do you agree that's reserved to the judgment of correctional staff?

A. No.

Q. Why not?

A. Because then you will end up in a situation like I found for six years in the Illinois Department of Corrections where you had people that were seriously mentally ill that had no business

being in restrictive housing because they are put there by correctional staff without consultation with mental health staff.

Q. Are you aware of any written standard, accepted standard, that -- which mentally ill people should not go to segregated housing?

A. All of them. That's the standard that's been established in the field of psychiatry since the early '80s.

Q. Where can I find that standard?

A. You can review the literature starting back in the early --

Q. Why don't you tell me what literature says that no mentally ill individual should go to restrictive housing?

A. The literature talks about the negative consequences on a person's mental health status when they're put in segregated housing. One author I would suggest you look up is a person by the name Stuart Grassian. There is another one by the name of Dr. Craig Haney, he's written extensively about the deleterious effects of solitary confinement. Those are two people that I would suggest you look at.

Q. Let's assume that I can for the moment

agree with you that there could be deleterious effects of people being in segregated housing. I guess I go back to the same question I asked you at the beginning, though. You are not aware of any study that actually isolates instances of harm that individuals in Illinois have suffered as a result of their time in segregated housing?

A. Not any studies that isolated the incidents of harm to Illinois prisoners. There's plenty empirical studies done on the effect of segregated housing for prisoners, but nothing that I'm aware of that looked at Illinois prisoners.

Q. During your testimony you said that this idea of I think 10 hours of structured time and plus 10 hours of -- I don't know if I'm saying it correctly. Let me start over.

If I understood you correctly, you said that the concept of 10 hours of weekly structured time and 10 hours per week of unstructured time is a national legal standard, you said it was never a psychiatric standard.

A. Well, by that, I meant this was a standard that was decided in court to be the -- to be the standard. And this goes back to my work in the Madrid case in California where, in fact, in

that case, there was a list of diagnoses that precluded anyone being put in solitary confinement. So if you're a schizophrenic bipolar schizoaffective delusional disorder, you were not allowed to be placed in the segregated housing.

Q. I'm not that -- I'm really not trying to argue with you. I'm trying to understand where you have come up with the idea that there's a national legal standard for 10 hours plus 10 hours. It comes from your Madrid case?

A. That was -- that was the first time that I was aware of that -- that I was made aware that was the standard. I wasn't involved in the litigation on that case. I came in as a monitor. And so when I came in as a monitor, that was the standard. Same with the Coleman Plata case. I was part of the plaintiff class -- I mean plaintiff expert, but then the court decided that that was the standard.

So that's what I mean. Maybe I'm not stating it right because I'm certainly not a lawyer. But I think that's more of a -- there's no psychiatric literature that states that. It's the evolving standard for treating seriously mentally ill people in restrictive housing situations in

correctional custody.

Q. Fair enough. I understand. And Dr. Stewart, you understand that during your time as monitor, the Department overhauled its restrictive housing program?

A. Yes.

Q. And was consequence to significantly limit the time that people spent in restrictive counsel?

A. I'm aware that was the goal, yes.

Q. Including limiting the time that mentally ill or SMI people were in restrictive housing, right?

A. I believe so, yes.

Q. Do you agree that that's a good thing?

A. Yes.

Q. This idea of crisis care, not the idea, but the concept of a community standard for crisis care, I'm having a hard time understanding how to understand what the crisis -- what the community standard is for crisis care.

Can you explain that?

A. Well, the crisis care system within Illinois Department of Corrections is akin to the emergency room setting in the community where

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someone presents themselves in an acute crisis, either they're brought in by the police or they walk in on their own; and in that case -- in that case, they're evaluated medically, they're evaluated psychiatrically, and their treatment center is immediately provided to attempt to alleviate the crisis, such as self-harm, harm to others, or being disabled because of mental illness.

If they can't be stabilized in a timely manner in this emergency room setting, then they're transferred to a higher level of care. That means they're admitted to the hospital. If not, if they are able to be stabilized, then they're released back to their outpatient care.

Q. And your testimony about restraints, I don't know if you recall that the settlement agreement -- and I think your report with respect to the use of restraints referred to Administrative Directive, the number was 04.04.103 and form 0376. Let me just ask you, I don't know if you need to look at those, but do you agree that the standard that the AD -- the administrative directive and the form that they complied with your standard of care?

A. I'm not able to answer that, sir, because I haven't reviewed that -- those policies.

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Q. Well, as I understood it, the criticism in the report with respect to restraints was that the assistant monitor was concerned that some facilities were using restraints too frequently without using less restrictive means first.

A. Okay.

Q. Do you agree with that, that that's the criticisms?

A. That was one of the criticisms, yes.

Q. And where was that happening?

A. In the report, they mentioned that it was at the sort of what I refer to as the big ticket facilities: Pontiac, Stateville, Menard, Dixon.

Q. Is that your testimony that that's where it was happening?

A. That's my memory of where it was happening based on the report. There could be more.

Q. Are there facilities where that was not where they were doing the better job?

A. Well, the analysis of restraints was that, like, the overwhelming percentage of them were only occurring at some facilities. So there were some facilities that never used restraints. So it's hard to say whether they were following the procedure because they just never had any people in

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restraints. Okay. So looking at those facilities where the overwhelming majority of the restraints were occurring, that was Ms. Morrison's analysis.

Q. Do I understand that it's your -- your judgment or your medical opinion that you would rather use forceable medication to reduce the use of restraints?

A. You know, of course, every case is individual, but I think that it's not just forceful medications, but it could be voluntarily taken medications could reduce the use of restraints.

So if -- you know, someone just doesn't go to zero to 60 like that and they need to go into restraints. If they're being properly monitored, you could see their buildup. Maybe you could intervene early on with an offer of medication that isn't an emergency or involuntary medication, and that could truncate the whole -- the whole journey to restraints. But sometimes maybe you get there and it's too late and they're really out of control and maybe you do do an emergency administration of medication to prevent restraints.

Q. That's what I'm asking. In your view, if an individual is out of control, is it your preference that they be forcefully medicated instead

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of restrained?

A. If they meet the requirements for emergency medication, yes.

Q. That kind of brings me to another topic, which was do I understand you correctly that if there's a mental health professional talking to a patient at the cell front in the cell and the individual wants to stay in the cell, it's your opinion that it would be better to call the security guards and forcefully remove that person to take that person to a confidential setting?

A. That has never been my opinion. What I was saying that cell front do not meet the standard of care because of complete lack of confidentiality. In those cases where a person has consistently and persistently refused to come out of their cell, there may be an example where you get staff to help them come out of their cell. I'm not talking about violent cell extraction. But we do this a lot. In regular care, people barricade themselves in their rooms, and we go in there with security staff and we bring them out so we properly evaluate them.

Q. If an individual wants to -- if an individual chooses to stay in the cell and consult with his or her mental health professional at the

cell, is that a choice that the individual has?
A. If it is truly a choice, yes. But if the fact that they don't want to come out of the cell is a reflection of improperly or incompletely treated mental illness, then it's not an informed decision.
Q. Is that something that should be decided in the judgment of the mental health professional -- the treating mental health professional?
A. In conjunction with the psychiatrist, yes.
Q. On this topic of cell front visits, I think you referred to page 73 of your report where you noted that in your report dated I think December 6, 2021, you asked for a Corrective Action Plan, and it wasn't forthcoming.
Do you recall that testimony?
A. No, that's the one that I did get a letter from the Department in March of '22, and then based on that, I asked them for an additional Corrective Action Plan, which they didn't respond to.
Q. I just want to be clear on the record. When you say after that, you asked for an additional Corrective Action Plan, what are you talking about, when did you make that request?

A. Sometime during the course of the second half, you know, between, you know, the first half of 2022.
Q. And how or to whom did you make that request?
A. I don't remember offhand. Probably to, you know, all the -- through the channels I normally went through, Dr. Hinton or Dr. Puga. It went through Melissa Jennings I believe.
Q. When you talked to Mr. Hirshman about discipline and Dr. Kapoor's recommendations about discipline, I want to talk to you about that topic.
A. Yes.
Q. And do I understand that that assessment by Dr. Kapoor was based on chart reviews?
A. Hers was done on chart reviews, yes.
Q. She didn't interview any of the individuals that were affected?
A. No.
Q. Her criticism was that the Department needed to interview individuals?
A. That was one of her criticisms, yes.
Q. And do you recall that the monitoring team found that no evidence that the Department was using segregation as a punishment for SMI offenders

for 300 and 400 level infractions?
A. Yes.
I'm sorry?
Q. Is that a good thing?
A. Punitive placement in segregation is never a good thing. So, yes, the fact that they weren't doing that in our opinion is a good thing.
Q. And did you ever study or assess whether if there were two individuals in DOC that committed the same offense while they were in prison whether they were disciplined differently, was that ever part of your bailiwick?
A. No.
Q. You don't have any opinion on that issue?
A. Opinion on the issue of whether people were getting differential levels of punishment?
Q. Discipline, yes.
A. No. I never -- I never looked at that issue.
Q. My understanding from reading -- I think it was in your report, we can find it if I need to, in your Arizona report, that your methodology was there was that you asked plaintiff's counsel to identify the individuals who are most frequently on the logs of self-harm and suicide watch so you could

talk to those people?
A. Yes. I believe that was part of my methodology.
Q. Those are the folks you talked to -- is that what you based your opinion on in the Arizona report talking to those individuals?
A. Boy, certainly, in part. I don't know if that's all that I did, but certainly I looked at those individuals.
MR. REES: If you don't mind, let's take a -- I would like to take a -- exercise my prerogative like Mr. Hirshman did, and take a 15-minute break.
THE WITNESS: That's fine with me. But what time do you think we'll be done?
MR. REES: I think we'll be done fairly soon. Time for you to get out surfing.
THE WITNESS: Not surfing. Today I'm one of the ice cream severs at an ice cream party.
THE VIDEOGRAPHER: Please stand by. We're off the record at 12:19 p.m.
(Whereupon, a break in the proceedings was taken.)
THE VIDEOGRAPHER: We are back on the record at 12:32 p.m.

Earlier I misspoke with the wrong time: The current time is 12:00 o'clock hour.

Go right ahead. You may proceed. Thank you.

BY MR. HIRSHMAN:

Q. Dr. Stewart, thanks for your patience. I just a few more questions to wrap up. We'll see if Mr. Hirshman has a few more. Hopefully we'll get you on your way.

I have down that you mentioned during your examination earlier that today that you can gauge the overall quality of a prison mental health system by the most severe patients. Did I hear you correctly on that?

A. Yeah. It is my opinion that how a system treats the most severely ill, you can get an idea about their overall care that they provide.

Q. Is that concept, is that in the literature anywhere?

A. No, that's not. That's just something that I've arrived at over my years of experience doing this.

Q. And with respect to the department's policies, my understanding is that the Department had a practice, or I think it was consistent with a

settlement agreement provided the policies to you and then you had an opportunity to respond or comment on those policies to the Department; is that a correct understanding?

A. Well, my memory of that was slightly different in that if there were changes to the existing policies or the creation of new policies, they would -- they would send that to me. But I don't believe I had the ability or the responsibility to review their entire bank of preexisting policies.

Q. But if they had new policies or changes, they would provide those to you and you had an opportunity to comment?

A. Yes.

Q. And with respect to this issue of confidentiality, do you recall that before the pandemic in I think -- we can go back and look at your reports but I think in 2019, 2020, and even May of 2021, the Department was substantially compliant with the confidentiality terms, do you recall that pre-COVID and even the beginning of COVID?

A. I believe during the course of my tenure, there were reports where I found them, the Department to be in compliance with the

confidentiality, yes.

Q. Okay. On this issue of your reports, both sides are asking you a lot of questions about what's in your report. Is it fair for us to conclude that all of -- that your opinions that were provided to the Department are contained in your prior monitoring reports?

A. You know, generally, but a lot of the -- a lot of the work that I did, especially in the field, so going to a particular facility and a particular facility would ask me questions, for example, how do we meet this requirement or what can we do or I'd see things where I thought I had ideas on how to streamline their processes, so I would tell them, and we would discuss it in a collegial fashion and those opinions weren't necessarily included in the reports. So there were those examples.

I couldn't give you an example of one of -- well, I can give you one example. Where it came to medication, I was at Dixon, and they really were concerned because they didn't have enough staff to give the medications as they felt they should. So I suggested to them that they could move to one-a-day dosing, most psychiatric medications can

be done once a day, or to really move to using long-acting injectable antipsychotic medication, which would decrease staff time, et cetera, et cetera. It was that type of thing that was not included in my reports necessarily.

Q. Okay. And was that suggestion adopted as far as you know?

A. I don't know if it was adopted.

Q. But then I think what you were saying, if I understand it correctly, was that at the end of your visits, I think you talked about this before, you would visit, and then you would usually sit down and have a debrief with the facility staff at the end of one of your site visits where you would have this collegial discussion back and forth, is that right?

A. Initially, they were collegial, but near the end, they turned out to be pretty contentious. But yes, that was how we did it.

Q. Okay. And when you say contentious, is that because -- I think you mentioned before because counsel was present?

A. Yeah. That's exactly right. Ms. Jennings would be listening to the call, which is her right and responsibility to do that, but then

would, you know, argue about my findings saying, well, that's not right, and things like this. And I found it very -- I found it not helpful.

MR. REES: I will turn the time over to Mr. Hirshman at this point. I'll reserve the opportunity to follow up if necessary.

EXAMINATION

BY MR. HIRSHMAN:

Q. Dr. Stewart, were you provided with your expert declaration and direct written testimony of Pablo Stewart from the Arizona case?

A. Yes.

MR. HIRSHMAN: And I'd just like to mark that as Exhibit 2 because we referred to it. Any objection, Doug?

MR. REES: No.

(Deposition Exhibit 2 was marked for identification.)

MR. HIRSHMAN: I have no further questions.

MR. REES: Before I say no, Laura, Melissa, do we need to confer or are we good?

MS. BAUTISTA: I'm good.

MR. REES: Mr. Hirshman, Dr. Stewart, and the court reporter, and the videographer, everybody,

thank you for your time. I think we're done at least for today.

THE VIDEOGRAPHER: We are going off the video record at 12:38 p.m. and concludes today's testimony. Master media will be retained by Veritext Legal Solutions.

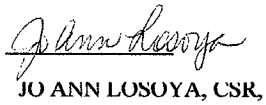
Thank you all.

(Off the record at 12:38 p.m. PST)

REPORTER CERTIFICATION

I, JO ANN LOSOYA, a Certified Shorthand Reporter of the State of Illinois, do hereby certify that I reported in shorthand the proceedings had at the deposition aforesaid, and that the foregoing is a true, complete and correct transcript of the proceedings of said deposition as appears from my stenographic notes so taken and transcribed under my personal direction.

IN WITNESS WHEREOF, I do hereunto set my hand at Chicago, Illinois, this March 14, 2023.



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