

**Specialized Training: PREA Medical and Mental Care Standards
Notification of Curriculum Utilization
December 2013**

The enclosed *Specialized Training: PREA Medical and Mental Care Standards* curriculum was developed by the National Commission on Correctional Health Care (NCCHC) as part of contract deliverables for the National PREA Resource Center (PRC), a cooperative agreement between the National Council on Crime and Delinquency (NCCD) and the Bureau of Justice Assistance (BJA). The PREA standards served as the basis for the curriculum's content and development with the goal of the *Specialized Training: PREA Medical and Mental Care Standards* curriculum to satisfy specific PREA standard requirements.

It is recommended that the *Specialized Training: PREA Medical and Mental Care Standards* curriculum be reviewed in its entirety before choosing which modules to use. Any alterations to the original materials must be acknowledged during their presentation or requires removal of the PRC and NCCHC logos.

BJA is currently undergoing a comprehensive review of the enclosed curriculum for official approval at which point the BJA logo may be added.

Note: Utilization of the enclosed curriculum, either in part or whole, does not guarantee that an auditor will find a facility "meets standard". Rather, an auditor will take into consideration the curriculum used as part of their overall determination of compliance.

Specialized Training

PREA Medical and Mental Care Standards

Instructor's Curriculum Guide and Lesson Plans

September 2013



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SPECIALIZED TRAINING PREA MEDICAL AND MENTAL CARE STANDARDS

Overview of Training

- This is a 3.5 hour training that includes a panel presentation with interactive discussions and activities.
- The training includes accompanying PowerPoint® slides.
- The recommended training size is no larger than 40 people to allow for a more intimate setting dealing with a sensitive subject and so that all questions can be answered.
- The target trainees include individuals who work in a health care capacity (doctors, nurses, medical assistants and mental health staff) in prisons, jails, community confinement, police lockups and juvenile detention facilities.

Goal of the Training

The goal of this training is to develop an informed correctional health care staff, able to respond to sexual abuse in correctional settings.

Training Objectives

The training objectives are designed to accomplish the above goal. Health care professionals in correctional settings will learn to:

1. Identify the signs of sexual abuse and sexual harassment
2. Know how to respond in a trauma-informed way to survivors of sexual abuse
3. Recognize how to preserve and collect forensic evidence
4. Know how to report and to whom to report

How to Use the Instructor Curriculum Guide and Lesson Plans

Curriculum Layout

This "Instructor's Curriculum Guide" contains useful information for the trainers of this curriculum. The lesson plans are written in an easy, step-by-step table format. The *far left column* provides the trainer with the approximate time it will take to teach that segment. The *far right column* provides "teaching tips" such as small group activities, DVDs to play and questions to ask. Icons indicate the handouts referred to for that section and if audio-visuals are used. The *middle column* provides the actual speaking points for the trainer. Each topic heading is written in bold with the speaking points indented below it. Each dot indicates a new point to teach or a separate activity.

If audio-visual aids are used such as videos/DVDs and PowerPoint® slides, the icons below will appear in the right column. Pictures of the actual slides are not put into the instructor's guide so that they can be updated and customized for the group and jurisdiction if needed.



for video or DVD



for PowerPoint®



A hand indicates that the instructor needs to refer trainees to a handout.

The word "*Discuss*" in the right column instructs the facilitator to talk about that particular subject in the large group. It is an opportunity for full participant interaction, not small group work. The word "*Activity*" appears whenever there is an individual or small group exercise. General discussion questions posed to the full group by the instructor are not listed as an "activity."

If you use the accompanying PowerPoint® slides, *do not read* or talk "to" the slides. Use a remote control to forward the slides so you are not forced to remain by the equipment the whole time you are teaching. Practice using the equipment before the training.

It is suggested that you allow a sufficient time (as much as several hours) to review the lesson plan materials before you instruct the program. You should be able to present the materials comfortably with the lesson plan, your notes and the PowerPoint® simply as a guide.

Adult Learning Theory and ITIP

People have preferences as to how they want to learn – some are visual learners, some need to experiment and be more “hands on”, while others prefer a lecture format. Mix up your teaching style to reach the maximum number of people. Explain things in different ways and monitor your audience for comprehension through verbal interaction, watching their non-verbal behavior, and feedback.

The Instructional Theory into Practice (ITIP) lesson plan format draws upon prior knowledge of the audience and uses both covert (think, imagine, picture this) and overt (demonstration) approaches. This interactive, adult learning approach subscribes to the notion that there are many different types of learners that absorb information in different ways and ensures that examples and lessons are relevant to the adults’ lives and realities. ITIP builds a trusting environment where learners feel safe to express themselves and try new skills. The “*Lesson Objectives*” are first presented at the beginning of the curriculum. These are the module objectives not behavioral objectives. The “*Anticipatory Set*” is incorporated throughout this curriculum via interactive questions and builds on participant’s prior learning. ITIP’s “*Instructional Input*” are the lecture notes and the “*Guided Practice*” are the activities such as small group exercises and role playing. “*Input*” allows for trainees to be engaged in the process. Another ITIP step is “*Check for Understanding*.” This step includes asking for reflective comments from trainees, giving quizzes or facilitating group responses. Lastly, trainees are encouraged to do “*Independent Practice*” to begin to try the new skills and knowledge on their own.

For more information on the Instructional Theory into Practice (ITIP) approach read “Planning for Effective Instruction: Lesson Design” in Enhancing Teaching (1994) by Madeline Hunter or go to www.nicic.org for a document on ITIP teaching approaches.

Adult learning theory suggests that for maximum attention and retention, “non-lecture” activities be interjected approximately every seven to ten minutes. Group activities and participant involvement are a significant part of this training. Therefore, the curriculum is designed to be interactive, with instructor-generated questions for trainees, some small group discussion, etc. Group interactions with the trainer involving mutual inquiry, shared experiences and personal observations help keep the training interesting and relevant.

Selecting Trainers

The trainers of these materials should be experienced in the field and knowledgeable about the content in order to maintain the integrity of the curriculum. Because of the detailed discussions on medical and mental health, it is suggested that for those sections, faculty should be trained professionals such as doctors, nurses, psychologists, psychological associates, or psychiatric nurses.

Those in charge of selecting speakers for the training might want to use the following trainer selection criteria to ensure a consistently representative faculty:

1. Commitment to and interest in the topic of sexual abuse recognition and response and improving criminal justice environments.
2. Content expertise
3. Effectiveness as a speaker
4. Diversity (race, gender, age, ideas)
5. Credibility
6. Availability
7. Reliability
8. Technologically competent with presentation technology (e.g., PowerPoint®, webinar, e-learning, other current technologies)

Have speakers provide current “bios” for their introductions and for inclusion in the participant materials, if applicable. Each biography should be one to two paragraphs in length and highlight the speaker’s relevant experiences and qualifications. It should also include contact information for the speaker such as address, phone number, fax number and email address. The training coordinator should have personal contact ahead of time with the trainers to articulate expectations and needs, to answer any questions they may have, and to describe the audience so that their information is targeted appropriately.

TEACHING TIPS

Prior to the Training

Trainers need to be sure all classroom space, equipment and audiovisual materials (e.g., DVD) have been ordered or reserved in advance.

Trainers should confirm with the organizer that the “logistics” have been arranged (e.g., hot and cold beverages, food for lunches and breaks, special needs, room set-up, parking, printing of materials, nametags, contracts). Test all audio-visual materials (PowerPoint®, DVD) and equipment (projector, lap top, microphones) and be sure supplies are in the room (easel pad paper and pens, pen and paper for trainees) in the room to be sure they work. The resources needed for the module are listed at the beginning of that module.

Setting up the In-class Training Room

The training room should accommodate classroom-style (round or rectangular tables known as “pods”) tables and movable chairs with the teams together at the same table. This works well for moving into small group discussions and the tables for trainees who wish to take notes. The least effective seating layout in terms of learning and attention is “auditorium” with everyone in rows looking towards the front of the room. You may also want to try a “chevron” layout with tables in a “v” from the middle of the room.

Each trainee should have an unobstructed view of the front of the room and the panel, audio-visual screen and other training aids. It may be necessary to put the panel table on a riser so that they are high enough for everyone to see. Generally when a panel member speaks, he or she should stand up to be seen and heard. During the question and answer period at the end of the module, panel members may remain seated if so desired.

Good ventilation and room temperature are important for an effective and comfortable training environment.

Make sure restrooms are located nearby, unlocked and easily accessible.

Have water available for speakers and microphones, if needed. Good acoustics are also important to facilitate good communication. If the room is too large or not sound proof to outside noises, it may not be an effective training location. A lapel microphone may be an option for some speakers so they can be heard whether they stand or sit.

The lighting in the room should be able to dim slightly for showing PowerPoint® slides and/or DVDs.

Be sure the trainee refreshments are set up (e.g., water, coffee, tea, soda, non-caffeine alternatives, juice) for the morning and afternoon each day.

Be sure the training site meets the Americans with Disabilities Act (ADA) requirements for any special needs of trainees and speakers. Registration applications should ask trainees if they have any special needs or accommodations.

Panel Discussions: A “Team” Approach

This module is structured to be taught with other speakers. Therefore, prior to the presentation, meet or talk (e.g., conference calls) to the other speaker(s) about who is the lead speaker or moderator, who will be teaching what segments, teaching methods and styles of delivery and other details. You might also wish to discuss:

1. Background information about trainees, key issues and concerns, etc.
2. Whether it is useful to designate a “moderator” who introduces the next speaker, providing a common thread throughout the training, facilitates trainee questions, etc.
3. Goals and procedures for group activities, if applicable
4. Who will lead discussions following group activities
5. Whether everyone feels comfortable if another speaker interjects examples or ideas during another speaker’s presentation
6. Back-up plans in case a speaker is unable to train at the last minute

A meeting of the other speakers the day or evening before the training is suggested to finalize the training details and logistics.

Teaching to Maximize Effectiveness

Arrive at the training room at least 30 minutes before the in-class session begins. This allows time for you to get organized, be sure all the audio-visual equipment is there and functioning and that the appropriate room arrangements have been made.

Know the audience in your training. It is important that you have a good sense of what they want to learn and achieve, their level of experience, any particular group dynamics among the trainees, and political issues of significance.

Tailor your presentation to your particular audience's job role and setting. For instance, a jail facility may have limited medical and mental health staffing compared to a large prison. Correctional facilities for males may be structured differently than for females.

On the wall, tape two or three large blank pages (from the easel pad) for "Parking Lot" questions and issues. There may be issues that come up that will be better addressed in other modules later in the training. This is a good way to capture them and not lose the trainee's concerns.

Ask trainees to turn off the ringers on their cellular phones (encourage the use of less disruptive notification systems such as vibration or digital display).

Please review your own commitment to and passion for eliminating sexual abuse in corrections, for making things safer for inmates, and for responding to their health care needs. If you have doubts or hesitation about your ability to provide this training, please notify the training coordinator or other appropriate person so that he or she can address your concerns.

Be sure that your language throughout the training is gender appropriate. Avoid terms that are not gender inclusive (e.g., avoid phrases like "a two-man post" and use terms such as "two staff" or "two person post").

Keep language simple and avoid jargon; be clear. If acronyms or abbreviations are used, explain what they mean (NCCHC, APPA, BJA, NIC, etc.).

Even though this is a panel or group of speakers, avoid sitting when you present. Move around the room as you talk. Convey your energy about the work to your audience. Do you believe what you are saying?

Be supportive, non-judgmental, and give compliments to trainees: "That's a good question. I am glad you raised that..."

Encourage trainees to share their own experiences at the appropriate places but keep the pace moving along. Help trainees use this opportunity to reflect on desired outcomes and how best to reach them.

After you answer a question from a participant, ask them, "Does that answer your question?" "Do you agree?" or "Has that been your experience as well?"

Challenge trainees to speak up and be engaged in order to reduce passivity.

Always try to get clear answers from trainees and make sure that you fully understand the comments made. Ask for clarification if necessary. Encourage trainees to be succinct in voicing their comments and concerns. Help trainees who have difficulty presenting information by asking, "Is this an accurate summary of what you are saying...?"

Continually remind trainees that the information presented during this training is a combination of specific strategies and concrete examples as well as a philosophical change in the "way of doing business." The facilities are not "cookie-cutter." Each agency is unique, with particular issues, demographics, crime characteristics, personalities and existing structures.

Some activities may involve writing ideas on an easel pad. Be sure you can do this easily and still instruct. Also, be sure to write large and legibly. You may also want to ask a participant to write the responses for you.

Be flexible... issues arise, coffee is late, cell phones go off, audio-visual equipment stops working, people cough, egos emerge, other panel members get stuck in traffic, someone forgets the name tags and trainees have their own agendas. When you anticipate these things before they occur, some can be avoided but some simply cannot. Just keep going, recognizing that the best-laid plans sometimes have to be adjusted. Always have a back-up plan. A prepared trainer can go with the flow and still successfully present the materials.

Handling Challenging People

Do not take things personally or become defensive. Know your "hot buttons." It is important to encourage trainees to think critically and to challenge the effectiveness of correctional programs and policies to help facilities be PREA compliant. The training should be a safe place for trainees to challenge and ask questions about what is contained in the curriculum.

Be sure your values and emotions are in check prior to facilitating. Anticipate emotionally-charged challenging questions such as, "Why do we have to do this PREA stuff? Most facilities are safe. We never have sex abuse cases!" Develop a response that is compelling, clear, non-defensive and reasonable. Choose words that are not "hot buttons" for people, but rather help further communication and understanding.

During the training, manage the discussion and do not let one or two people dominate. Start a module by saying, "I would like to start this discussion by inviting people who have not spoken much to give us their thoughts." It is important that different viewpoints get expressed. Possible responses to difficult, controlling or domineering people include:

1. Politely interrupting them with a statement such as, "May we put that on the back burner for the moment and return to it later?" or "If it is all right, I would like to ask if we can discuss that on the break. There's another important point we still need to discuss and we are running a little short of time."
2. You can also jump in at a pause with, "That's a good point, let's hear from some of the others" or redirect the conversation. "We have had several comments in support of this idea, are there different viewpoints in the room?" This gives the control of the training back to the instructor.

A good facilitator allows everyone a chance to speak and facilitates opportunities for less vocal people in all parts of the room to be heard. If people do not participate in discussions or appear to have their minds elsewhere, call on them by name to give an answer, opinion, or recount an experience. However, do it in a way that does not put the person on the spot. Then praise the person for responding.

If a trainee is belligerent or rude, walk closer to the person, even standing next to them.

If a discussion escalates and becomes highly emotional, divert the conversation away from the people participating before it gets out of hand. "I think we all know how John and Bob feel about this. Now, does anyone else have a comment?" or validate their feelings or emotional reactions by saying something such as, "clearly this is a very emotional and difficult issue with differing viewpoints." Intense emotions can also be a good indicator of major issues in their system or agency (which is made up of people and values). You may want to give extra time for discussion to see if some clarity or understanding can come out of it.

Another option with heated discussions is to take a break, talk to the person in private, and be clear but polite with expectations

As you go along, register steps of agreement and disagreement with trainees. "Am I correct in assuming we all agree (or disagree) on this point?" or "you may simply agree to disagree on certain issues since each jurisdiction is unique."

If you need to control the person who "knows it all," acknowledge the person's contribution and then ask others in the group for their opinion of the person's statement.

If you have a person who “knows their job and doesn’t want to be told how to do it,” explain that s/he is just the individual you are looking for, that the training is a place to exchange ideas and points of view that will benefit everyone and that their experience will be valuable to all. Make this person a resource and give them “responsibility” for others’ learning while keeping it under control and accurate.

When a discussion gets off track, say, “Your point is an interesting one, but it is a little different from the main issues here. Perhaps we can address your issues during the break or after the session,” or, “We will be talking about that later in Module X. Your points are very interesting. Could you hold those thoughts until we get to that module?”

If a person speaks in broad generalizations ask, “Can you give us a specific example on that point?” or, “Your general idea is a good one, but I wonder if we can make it even more concrete. Does anyone know of a case where...?”

If a person in the group states something that is incorrect (yet no one addresses the misinformation due to the person’s status), avoid direct or public criticism. You can graciously correct the information or use indirect methods to set the record straight such as analyzing a similar case or situation in another jurisdiction where the correct information is given. You should talk to the person at the break and share the correct information.

You may choose to allow fellow trainees to respond to difficult people in the class.

Generally, try not to interrupt trainees. Be respectful and listen. Be open, yet firm, and manage the discussion keeping in mind what is best for the whole group.

Responding to Questions

Anticipate the types of questions trainees might ask and how to handle them. Before you begin the training, prepare a list of questions you are most likely to get and prepare your answers. You can use three by five (3X5) cards. You can also use these questions to stimulate group discussions throughout your presentation. Make sure your questions are designed to get thoughtful reactions to specific points. Do not ask questions that can be answered by a “yes” or “no” response. Open-ended questions generate better audience participation.

Questions from trainees are a good indication of the level of their awareness, attention and interest in your subject. Questions have value in helping you to clarify, modify or fortify points or to test an idea for its potential. Remember that answering a question is impromptu. Pause if you need to, relax, maintain your poise, and keep your answers short and to the point. Give the short answer first (e.g., yes/no) then explain why.

Some correctional issues or questions involving correctional safety and sexual abuse may border on giving legal advice. Be clear about when it is appropriate to refer a question to a lawyer in the group if he or she is willing to respond or suggest the questioner check with his or her own agency’s attorney.

If you do not know the answer to a question, acknowledge that fact and offer to find the information or check with the audience to see if anyone knows the answer. Not all questions have to be answered. Sometimes the most effective response is one that allows the audience to keep thinking about the issue or concern. Keep a running list of questions or issues on a displayed easel pad ("Parking Lot" issues) and come back to the questions throughout the training.

When a person asks a question, restate the question for the entire group and direct your answer to the audience, not the individual questioner. Make sure everyone has heard the question. Rephrase questions that are unclear or rambling. Diffuse emotional questions by politely asking for clarification.

Avoid a one-to-one conversation/argument with a trainee.

Adjusting the Curriculum to the Audience

Remember that you will likely be presenting this training in one of many environments (i.e. you may be in a jail, prison, lockup, juvenile or community confinement setting) and therefore will need to be careful not to present information that is not applicable to your setting.

LESSON PLANS




Total Time: 3.5 hours



Materials Needed: PowerPoint® slides and equipment; microphones; handout of PowerPoints® three-to-a-page for trainee note-taking




Introduction






10 minutes

Time	Speaking Notes	Teaching Tips
0.5 min	<p>Welcome</p> <p>Thank you for your time, expertise, professionalism and willingness to work in the correctional health care field. Our training today will help you do your job even better. We will be focusing on the Prison Rape Elimination Act, or PREA, and the standards with which we must now all comply.</p>	 <p>This three and a half hour session has four modules (and one break) and is packed with information. Keep it lively, engaging and moving along.</p>
3.5 min	<p>Introductions</p> <p>Our presenters today are...</p>	 <p>Introduce yourself and the other presenters. If time and if trainees do not know each other, have them introduce themselves by indicating their name, department/agency job title and expectations. List expectations on easel and review at the end of the day.</p>  Acknowledgements



<p>1.5 min</p>	<p>Logistics</p> <p>Agenda</p> <p>Module 1: Detecting and Assessing Signs of Sexual Abuse and Sexual Harassment</p> <p>Module 2: Reporting</p> <p>Module 3: Effective and Professional Responses</p> <p>Module 4: The Medical Forensic Examination and Evidence Preservation</p> <p>Participation</p> <p>We encourage participation and questions from the audience.</p> <p>“Parking Lot”</p> <p>We have taped blank sheets of easel pad paper on the wall. This paper is referred to as a “parking lot” where ideas, issues and questions “park” until they can be addressed. As issues and questions arise that are not appropriate to address during this module or further information needs to be gathered, they will be written on this paper. We want to ensure that all your questions will be addressed by the end of the session.</p> <p>I want to acknowledge that there may be stories from real victims and other topics that may be difficult to hear and discuss. If anyone needs to stand up or take a break, please feel free to do so.</p>	 <p>Review the agenda for the training, highlighting topics to be covered and explain there will be a 15 minute break.</p> <p>Indicate where bathrooms are located, importance of turning off cell phones, etc.</p> <p>Specify what you and the other trainers prefer if trainees have questions (e.g., raise hand, speak out without being called upon, wait until the end of the presentation). Adult learning best practices suggest allowing questions throughout.</p>
<p>0.5 min</p>	<p>History of PREA</p> <p>How many of you are aware of the Prison Rape Elimination Act or PREA? Were any of you involved in the process of getting it passed or giving input into the standards?</p> <p>Let’s go over some of the background of the legislation.</p>	 <p>Anticipatory Set</p>

	<ul style="list-style-type: none"> • The Prison Rape Elimination Act or “PREA” was passed by Congress in 2003. It was passed unanimously in both houses. • Final standards were released by US Department of Justice (DOJ) on May 17, 2012. • DOJ certified PREA auditors began auditing facilities in August 2013. • DOJ has published audit instruments for you to review. 	
0.5 min	<p>Why are you here? Why do you think you are here talking about PREA?</p> <ul style="list-style-type: none"> • Compliance with PREA Standards is mandatory for all correctional facilities. That includes prisons, jails, police lockups, community confinement facilities, and juvenile facilities. • That said, it is also the right thing to do and sets a baseline for best practices within the field. Full compliance will lead to safer facilities. 	 Anticipatory Set
0.25 min	<p>Overview of the PREA Standards There are four sets of standards:</p> <ol style="list-style-type: none"> 1. Adult prisons and jails 2. Lockups (police stations, courts, etc.) 3. Community confinement facilities (treatment centers, half-way houses, rehab centers, etc.) 4. Juvenile facilities 	
0.25 min	<p>Overview of PREA Standards One of the main reasons we are conducting this training is that it meets PREA Standard 115.35 which ensures that all full- and part-time medical and mental health care practitioners who work regularly in facilities are training in detecting and assessing signs of sexual abuse and sexual harassment; how to preserve physical evidence of sexual abuse; how to respond effectively and professionally to victims of sexual abuse and sexual harassment; and how and to whom to report allegation or suspicions of sexual abuse and sexual harassment.</p> <p>In these four modules, we are going to be covering standards that impact the correctional health care arena:</p> <p>Screening</p> <ul style="list-style-type: none"> • 115.41 (Screening for risk of victimization 	

	<p>and abusiveness)</p> <ul style="list-style-type: none"> • 115.42 (Use of screening information) <p>Protective Custody</p> <ul style="list-style-type: none"> • 115.43 (Protective custody) <p>Reporting</p> <ul style="list-style-type: none"> • 115.51 (Inmate reporting) • 115.53 (Inmate access to outside confidential support services) • 115.54 (Third-party reporting) <p>Official Responses Following Inmate Report</p> <ul style="list-style-type: none"> • 115.61 (Staff and agency reporting duties) • 115.62 (Agency protection duties) • 115.63 (Reporting to other confinement facilities) • 115.64 (Staff first responder duties) • 115.65 (Coordinated response) • 115.66 (Preservation of ability to protect inmates from contact with abusers) • 115.67 (Agency protection against retaliation) • 115.68 (Post-allegation protective custody) <p>Medical and Mental Health Care</p> <ul style="list-style-type: none"> • 115.81 (Medical and mental health screenings; history of sexual abuse) • 115.82 (Access to emergency medical and mental health services) • 115.83 (Ongoing medical and mental health care for sexual abuse victims and abusers) <p>Additional standards that are relevant but not covered in this training include:</p> <p>Zero Tolerance</p> <ul style="list-style-type: none"> • 115.11 (Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator) <p>Incident Reviews</p> <ul style="list-style-type: none"> • 115.86 (Sexual abuse incident reviews) 	
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<p>0.5 min</p>	<p>Overview of the PREA Standards</p> <p>First, let's be sure we have common definitions of terms that are used in the PREA standards.</p> <div style="border: 1px solid black; background-color: #f0f0f0; padding: 5px; margin: 10px 0;"> <p>(Standard §115.5) General Definitions¹</p> <p>"Confined individuals" are considered:</p> <ol style="list-style-type: none"> a. Inmates (adult prisons and jails) b. Detainees (lockups) c. Residents (juvenile or community confinement facilities) </div> <p>We may use the term "patient" from time-to-time but we are referring to these populations.</p>	 <p>When information from an actual PREA standard is presented in the lesson plans, it is in a shaded box.</p>
<p>0.5 min</p>	<p>Overview of the PREA Standards</p> <div style="border: 1px solid black; background-color: #f0f0f0; padding: 5px; margin: 10px 0;"> <p>(Standard §115.6) Definitions Related to Sexual Abuse</p> <p>"Prohibited Acts" include:</p> <ol style="list-style-type: none"> a. Sexual abuse b. Voyeurism c. Sexual harassment </div>	
<p>0.5 min</p>	<p>Overview of the PREA Standards</p> <div style="border: 1px solid black; background-color: #f0f0f0; padding: 5px; margin: 10px 0;"> <p>(Standard §115.5) General Definitions</p> <p>Staff include:</p> <ol style="list-style-type: none"> a. Employees b. Volunteers c. Contractors d. Health personnel <ul style="list-style-type: none"> • qualified medical practitioners • qualified mental health practitioners </div> <p>Any medical and mental health staff who regularly provide care in a facility are considered staff for the purposes of the standards.</p>	



¹ For consistency, the term "inmate" was used throughout this curriculum. Unless otherwise noted, the term "inmate" refers to all of these terms.


<p>0.5 min</p>	<p>Overview of the PREA Standards</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>(Standard §115.5) General Definitions</p> <p>The term “findings” means:</p> <ul style="list-style-type: none"> a. Substantiated allegation b. Unfounded allegation c. Unsubstantiated allegation </div>	
<p>1 min</p>	<p>Do you have any questions about PREA? PREA timelines? We will be discussing the actual standards in detail in a moment.</p>	 <p>Allow time to answer questions before proceeding.</p>





Module 1: Detecting and Assessing Signs of Sexual Abuse and Sexual Harassment









55 minutes



Time	Speaking Notes	Teaching Tips
<p>1 min</p>	<p>Detecting and Assessing Signs of Sexual Abuse and Sexual Harassment</p> <p>This module will cover detecting and assessing signs of sexual abuse and sexual harassment.</p> <p>Module Behavioral Objectives</p> <p>At the end of this module, trainees will be able to:</p> <ol style="list-style-type: none"> 1. Identify the dynamics of sexual abuse in correctional settings and how it is defined in the Prison Rape Elimination Act (PREA) 2. Detect signs and symptoms of both acute and prior sexual abuse 3. Summarize the short and long term effects of trauma on the brain 4. Describe considerations for the development of intake screening tool requirement in PREA 4. Recognize the health care provider’s role in the screening process 	
<p>10 min</p>	<p>Survivor Stories</p> <p>Let’s take a look at what survivors of sexual abuse while in confinement say about their experience and its impact on their lives.</p>	 <p>Show JDI video entitled, <i>“Three Survivor Stories”</i> Available through YouTube. Search for <i>“three survivor stories”</i></p> <p>Ask trainees for any comments or reactions. Point out a few ways that the survivors describe the impact of abuse and/or the ways having the standards in place would have helped them. If you do not have access to this video, consider a survivor panel presentation or develop your own video. Also, you can</p>




		<p>print off and read survivor stories from the Just Detention International website www.justdetention.org/en/survivor_testimony.aspx</p>
<p>2 min</p>	<p>Prevalence of Sexual Abuse in Correctional Settings</p> <p>The US Bureau of Justice Statistics (BJS) national surveys since 2005 have consistently documented that the two most common forms of sexual victimization are:</p> <ol style="list-style-type: none"> 1. staff sexual misconduct 2. inmate-on-inmate, non-consensual sexual acts (those acts considered to be rape in most jurisdictions) <p>One example of a recent survey by BJS (released in 2012) is the Sexual Victimization Reported by Former State Prisoners: 2008, a product of the National Former Prisoner Survey. In this report, the experience of over 18,000 former inmates was described. According to the study, 9.6% of former state prisoners reported at least one incident of sexual victimization during their most recent time of incarceration at any facility. Using this proportion and extrapolating the reports to the total population of state prisoners under active supervision at the midpoint of 2008, an estimated 49,000 former state prisoners were victims of sexual abuse.</p> <p><i>Source: Bureau of Justice Statistics, "Sexual Victimization Reported By Former State Prisoners, 2008" May 12, 2012.</i></p> <p>In 2013, the BJS released the data from the 2011-2012 National Inmate Survey, which showed that 4.0% of prison inmates and 3.2% of jail inmates reported experiencing one or more incidents of sexual victimization. As with the NFPS, weights were applied to produce national-level and facility-level estimates. Sexual violence in adult prisons and jails and juvenile facilities estimated numbers of inmates victimized in 2011-2012:</p>	


	<ul style="list-style-type: none"> • Adult Prisons 57,900 • Adult Jails 22,700 • Youth Facilities 1,720 • TOTAL 82,320 <p><i>Source: Bureau of Justice Statistics, "Sexual Victimization in Prisons and Jails Reported by Inmates, 2011-2012" May 2013.</i></p>	
0.25 min	<p>Prevalence of Sexual Abuse in Prisons</p> <p>This study also shows nearly equivalent rates of sexual abuse perpetrated by staff and other inmates.</p> <p><i>Source: Bureau of Justice Statistics, "Sexual Victimization Reported By Former State Prisoners, 2008" May 12, 2012.</i></p>	 <p>You should read these reports, understand the differences between them and be prepared to answer basic questions. For example do the reports indicate that the cases were substantiated? In addition, it is a good idea to see if there are more recent reports available.</p>
0.5 min	<p>Prevalence of Sexual Abuse in Prisons</p> <p>31% of inmates who reported sexual abuse were victimized three or more times.</p> <p><i>Source: Bureau of Justice Statistics, "Sexual Victimization Reported By Former State Prisoners, 2008" May 12, 2012.</i></p>	
0.25 min	<p>PREA Definitions of Sexual Abuse Incidents</p> <p>So what do we mean by sexual abuse incidents involving people in custody?</p>	 <p>Anticipatory set.</p>
0.25 min	<p>The Basics of Sexual Abuse</p> <p>Sexual abuse is any form of unwanted sexual behavior. This includes situations where the victim is unable to meaningfully consent to sexual contact.</p>	

0.5 min	<p>Definitions Related to Sexual Abuse</p> <p>(Standard §115.6)</p> <p>Sexual abuse of an inmate by another inmate includes any of the following acts, if the victim does not or cannot consent:</p> <ol style="list-style-type: none"> 1. Contact between the penis and vulva or penis and anus 2. Contact between mouth and penis, vulva, or anus 3. Penetration 4. Intentional touching 	
0.5 min	<p>Definitions Related to Sexual Abuse</p> <p>(Standard §115.6)</p> <p>Sexual abuse of an inmate by a staff member includes any of the following acts, with or without consent:</p> <ol style="list-style-type: none"> 1. Contact between the penis and the vulva or the penis and the anus 2. Contact between the mouth and any body part with the intent to abuse, arouse, or gratify sexual desire 3. Penetration 4. Contact intended to abuse, arouse, or gratify sexual desire 5. Display of genitals, buttocks, or breasts in presence of inmate 6. Voyeurism 	
1 min	<p>Definitions Related to Sexual Abuse</p> <p>(Standard §115.6)</p> <p>Sexual Harassment</p> <ol style="list-style-type: none"> 1. Repeated and unwelcome sexual advances, requests for sexual favors, or verbal comments, gestures, or actions of a 	

	<p>derogatory or offensive sexual nature by one inmate, detainee, or resident directed toward another.</p> <p>2. Repeated verbal comments or gestures of a sexual nature to an inmate, detainee, or resident by a staff member, contractor, or volunteer, including demeaning references to gender, sexually suggestive or derogatory comments about body or clothing, or obscene language or gestures.</p>	
0.25 min	<p>Detection of Victimization</p> <p>Who is typically targeted for sexual abuse in correctional settings?</p>	 <p>(title slide) Anticipatory set. Write responses on easel pad.</p>
1 min	<p>Who is at Risk for Victimization?</p> <ul style="list-style-type: none"> • People who identify as lesbian, gay, bisexual, transgender, questioning or intersex (LGBTQI) • People who are younger • People with disabilities (includes mental health, developmental/intellectual, physical) • People who are bi-racial or multi-racial • People who have been victims of previous sexual abuse 	 <p>Ask for information from the participants and list on an easel before each of the following questions are answered by the slide content; this creates interaction and knowledge bases are revealed.</p>
0.25 min	<p>Who is at Risk for Victimization?</p> <p>More than one in three gay and bi-sexual men in custody were sexually victimized during their stay.</p> <p><i>Source: Bureau of Justice Statistics, "Sexual Victimization Reported By Former State Prisoners, 2008" May 12, 2012.</i></p> <p>In California state men's prisons, 59% of transgender inmates reported sexual abuse, compared to 4% of other inmates.</p> <p><i>Source: Jenness, Valerie, Cheryl Maxson, Kristy Matsuda, and Jennifer Sumner. "Violence in California Correctional Facilities: An Empirical Examination of Sexual Assault," 2007.</i></p>	

<p>1 min</p>	<p>Barriers to Reporting</p> <p>What are some of the reasons that a sexual abuse victim in a prison, jail, or community confinement setting might not report the abuse?</p> <p>A. Feeling embarrassed or ashamed B. Lack of knowledge about how to report C. Afraid of being written up for misconduct D. Fear of retaliation by inmates and/or staff E. Fear of not being believed F. All of the above</p> <p>The answer is "all of the above" and there may be more reasons as well.</p>	 <p>Anticipatory set. Record the answers on the easel chart so that the trainees can compare their answers. As a follow-up question, ask participants to think about other barriers.</p>
<p>2 min</p>	<p>Barriers to Reporting</p> <p>What are some of the barriers or reasons inmates don't report a sexual abuse incident?</p> <p>Here is what the research shows as to why inmates do not report:</p> <ul style="list-style-type: none"> • 69% embarrassed • 70% didn't want anyone to know • 43% thought staff would not investigate • 52% afraid of perpetrator • 41% afraid of being punished by staff • 37% of victims of inmate-on-inmate sexual victimization said they reported at least one incident to facility staff. <p><i>Source: Sexual Victimization Reported by Former Prisoners, 2008</i></p> <p>Reporting to medical and mental health staff was less common, only about 14% of victims.</p> <p>5.8% of victims of staff sexual misconduct reported the abuse to staff.</p> <p><i>Source: Bureau of Justice Statistics, "Sexual Victimization Reported By Former State Prisoners, 2008" May 12, 2012.</i></p>	 <p>Anticipatory set. List on easel before showing the slide.</p>

<p>0.25 min</p>	<p>Physical Indicators and Responses to Sexual Abuse</p> <p>What are some of the possible <i>physical</i> indicators of victimization?</p>	 <p>(title slide) Anticipatory set. Write answers on easel pad.</p>
<p>0.5 min</p>	<p>Possible Physical Indicators of Victimization</p> <p>Although many victims of sexual abuse may have no physical indicators of the abuse (especially if the abuse occurred in the past), here are some possible physical indicators you might see as health care staff that could indicate sexual victimization:</p> <ul style="list-style-type: none"> • Sexually transmitted infections • Unexplained pregnancies (this is rare to become pregnant from a rape but is probable) • Stomach/abdominal pain • Anal/penile/vaginal discharge, bleeding, or pain • Difficulty walking/sitting • Unexplained injury • Possibility of no injury 	
<p>1 min</p>	<p>Potential Responses to Victimization – Acute</p> <p>What additional “<i>acute</i>” symptoms might you see in response to victimization?</p> <p>Here are some acute symptoms you may see:</p> <ul style="list-style-type: none"> • Acting out • Acting in/withdrawal • Anger • Anxiety • Depression • Difficulty with daily routines • Difficulty concentrating • Disbelief • Fear • Numbness • Suicidal thoughts • Difficulty concentrating during routine activities <p>It is important to think about how an acute crisis like a sexual abuse interrupts a victim’s ability to manage life in a correctional environment. A</p>	 <p>Anticipatory set. Write answers on easel pad. Ask trainees if they can think of any other symptoms to add to this list.</p>

	<p>victim, or sometimes referred to as a “survivor” in the advocacy profession, still has to follow the rules and get up, go to chow, line up for recreation, work and often times be near the perpetrator.</p> <p>Some victims react by turning inward while others act out. In a prison, jail, or juvenile facility, ‘acting out’ could look like risk-taking behavior that essentially puts the victim in a dangerous situation (like getting in an argument with staff or with a more powerful inmate or resident). The victim could also lose good time or privileges.</p> <p>In a community confinement facility, such ‘acting out’ could potentially lead to harsher consequences—like returning to prison or jail, or if they have a suspended sentence, being rearrested. For youth, such behavior is often seen as “attention-seeking.” If you see these behaviors, there could be a back story and more than meets the eye.</p>	
<p>1 min</p>	<p>Impact of Incarceration on Victims</p> <p>Being a sexual abuse victim/survivor is difficult for anyone but those who are sexually abused in confinement have unique concerns that impact their healing and recovery.</p> <p>What are some of the concerns in a confinement setting that a victim/survivor might have that would impact his or her recovery?</p> <p>Examples include:</p> <ul style="list-style-type: none"> • Little control over body/environment • Punishment/isolation • Limited access to services • Retaliation • Ongoing contact with abuser(s) • Increased likelihood of re-victimization • Environment/culture not conducive to expressing emotions • Family and support system not available 	 <p>Anticipatory set. Write responses on easel pad. Note for participants that use of “victim” or “survivor” are acceptable terms used by the victim services field.</p>

9 min

Potential Responses to Victimization – Long Term

What are some of the long-term effects of sexual victimization?

Here are some responses to victimization that are more long-term:

- Flashbacks/nightmares
- Mood swings
- Social withdrawal
- Sudden and unexplained changes in behavior/personality
- Changes in how the victim sees him/herself
- Increased feeling of fear/being in danger
- Post-Traumatic Stress Disorder (PTSD)

When someone is in a prison, jail, lockup, juvenile facility or community confinement, how is it different when these reactions emerge?

How do staff react to trauma responses?

What are the costs of expressing emotions in these settings? You can't even really withdraw—that also has consequences.

Where can you get help, or can you?

(Optional)

DSM Criteria for PTSD

In 2013, the American Psychiatric Association revised the PTSD diagnostic criteria in the fifth edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM-5)(1). In a moment, I will go through each of the diagnostic criteria (A-H).

Diagnostic criteria for PTSD include a history of exposure to a traumatic event that meets specific stipulations and symptoms from each of four symptom clusters: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity. The sixth criterion concerns duration of symptoms; the seventh assesses functioning; and, the eighth criterion



Anticipatory set. List responses on easel.

Optional:
Based on the needs of the audience and your experience with this topic, you may wish to just refer trainees to the link below for more detailed information on PTSD rather than present this nine minute section on DSM:

www.ptsd.va.gov/professional/pages/dsm5criteria.ptsd.asp

clarifies symptoms as not attributable to a substance or co-occurring medical condition.

Two specifications are noted including delayed expression and a dissociative subtype of PTSD, the latter of which is new to DSM-5. In both specifications, the full diagnostic criteria for PTSD must be met for application to be warranted.

Criterion A: Stressor

The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, in one of the following ways:

- Direct exposure.
- Witnessing, in person.
- Indirectly, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental.
- Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse). This does not include indirect non-professional exposure through electronic media, television, movies, or pictures.

Criterion B: Intrusion Symptoms

The traumatic event is persistently re-experienced in at least one of the following ways:

- Recurrent, involuntary, and intrusive memories. Note: Children older than 6 may express this symptom in repetitive play.
- Traumatic nightmares. Note: Children may have frightening dreams without content related to the trauma(s).
- Dissociative reactions (e.g., flashbacks) which may occur on a continuum from brief episodes to complete loss of consciousness. Note: Children may reenact the event in play.
- Intense or prolonged distress after exposure to traumatic reminders.

- Marked physiologic reactivity after exposure to trauma-related stimuli.

Criterion C: Avoidance

Persistent effortful avoidance of distressing trauma-related stimuli after the event, indicated by at least one of the following:

- Trauma-related thoughts or feelings.
- Trauma-related external reminders (e.g., people, places, conversations, activities, objects, or situations).


Criterion D: Negative alterations in cognitions and mood



Negative alterations in cognitions and mood that began or worsened after the traumatic event, indicated by least two of the following:



- Inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol or drugs).
- Persistent (and often distorted) negative beliefs and expectations about oneself or the world (e.g., "I am bad," "The world is completely dangerous.").
- Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences.
- Persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt or shame).
- Markedly diminished interest in (pre-traumatic) significant activities.
- Feeling alienated from others (e.g., detachment or estrangement).
- Constricted affect: persistent inability to experience positive emotions.


Criterion E: Alterations in arousal and reactivity

Trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event, indicated by at least two of the following:

	<ul style="list-style-type: none"> • Irritable or aggressive behavior. • Self-destructive or reckless behavior. • Hyper-vigilance. • Exaggerated startle response. • Problems in concentration. • Sleep disturbance. <p>Criterion F: Duration</p> <p>Persistence of symptoms (in Criteria B, C, D and E) for more than one month.</p> <p>Criterion G: Functional significance</p> <p>Significant symptom-related distress or functional impairment (e.g., social, occupational).</p> <p>Criterion H: Exclusion</p> <p>Disturbance is not due to medication, substance use, or other illness.</p> <p><i>Source: American Psychiatric Association. (2013) Diagnostic and statistical manual of mental disorders, (5th ed.). Washington, DC.</i></p> <p>Post-Traumatic Stress Disorder assessment measures, such as the Primary Care PTSD Screen (PC-PTSD), Clinician-Administered PTSD Scale (CAPS) and PTSD Check List (PCL), are being revised by the National Center for Post-Traumatic Stress Disorder to be made available upon the release of DSM-5.</p> <p><i>Source:</i> http://www.ptsd.va.gov/professional/pages/diagnostic_criteria_dsm-5.asp</p>	
<p>2 min</p>	<p>Potential Responses to Victimization – Long Term</p> <p>Victims of sexual abuse are:</p> <ul style="list-style-type: none"> • 3 times more likely to suffer from depression • 6 times more likely to suffer from post-traumatic stress disorder • 13 times more likely to abuse alcohol • 26 times more likely to abuse drugs 	


	<ul style="list-style-type: none"> • 4 times more likely to contemplate suicide <p>Think about the people you see in criminal justice settings, they have similar dynamics: higher rates of mental illness, depression, PTSD, higher rates of suicidal ideations (particularly those in isolative housing).</p> <p>Source: "The World Report on Violence and Health" is the first comprehensive review of the problem of violence on a global scale from the World Health Organization, October 2002</p> <p>Inmates generally have a higher incidence of past abuse than the general population. Many currently incarcerated victims of sexual abuse while incarcerated suffer on-going abuse, are unable to escape, and remain in the environment where the abuse occurred. This means that they experience a "complex PTSD" construction which is described in the work by Judith Herman. This form of PTSD is relevant to victims in detention.</p> <p><i>Source: Herman, Judith L. (1992) "Complex PTSD: A Syndrome of Survivors of Prolonged and Repeated Trauma" <u>Journal of Traumatic Stress</u>, Vol. 5, Issue 3, pp. 377-391</i></p>	<p>Although a 2002 report, this is the most comprehensive and still widely used.</p>
<p>0.25 min</p>	<p>Responses to Victimization</p> <p>How many of you have heard of the "fight or flight" response to a traumatic event?</p> <p>Have you ever had an inmate/resident/detainee report this kind of experience to you?</p> <p>What are some examples?</p>	 <p>(title slide) Anticipatory set.</p>
<p>1 min</p>	<p>Traumatic Events and the Brain</p> <p>You know firsthand then what trauma can do to the human body. Let's first focus on what trauma does to the brain.</p> <p>A traumatic event creates a human stress response. We have all probably heard of the "fight or flight" response that we mentioned above. That is, when confronted with a dangerous or</p>	

	<p>frightening situation, we try to either run away from it or stay and fight it off.</p> <p>Your body gives off increased:</p> <ul style="list-style-type: none"> • Adrenalin • Cortisol (steroid hormone) • Beta-endorphins (numbing agent) <p>The term “freeze” or “toxic immobility” means the victim is unable to move or speak in some traumatic situations. Often there is a complete lack of memory of what occurred. This too can be a response just like fight or flight.</p> <p><i>Source:</i> http://joyfulheartfoundation.org/wordpress/talking-about-toxic-immobility-on-tonights-svu/</p>	
<p>1 min</p>	<p>Traumatic Events and the Brain</p> <p>The cerebral cortex plays a key role in memory, attention, perceptual awareness, thought, language, and consciousness. Emotional stimuli goes through the cerebral cortex of the brain and results in an emotional response. However, trauma can make the brain skip the normal processing of stimuli.</p> <p>An inmate who has experienced a traumatic event must also deal with the stressors of living in a correctional environment. There are a lot of external stimuli in a correctional setting—the noise, clanging doors, yelling, other inmates, staff instructions over the loud speaker, lights, alarms. Potential contact with the abuser, abuser’s colleagues or associates, and pat/strip searches can be triggers for the trauma response.</p>	
<p>1 min</p>	<p>Traumatic Events and the Brain</p> <p>Chronic hyper-arousal</p> <ul style="list-style-type: none"> • Hyper-vigilance • Massive release of neuro-hormones • Action without thought • Unable to calm down • Intense/prolonged anxiety • Irritable/aggressive/impulsive 	

	<ul style="list-style-type: none"> • The “acting out” behavior we mentioned earlier <p>Long term effects—PTSD</p> <p>Another way to say it is that the chronic hyper-arousal essentially turns the amygdala² into a new “fear center.” Someone who has not lived through multiple traumatic events can react with surprise, shock, excitement, and nervousness to a range of events, while someone who has experienced trauma, particularly multiple times, has one reaction—fear.</p>	
<p>2 min</p>	<p>Traumatic Events and the Brain</p> <p>Here are two pictures of a brain. One is a normal brain. The other is one from someone who has PTSD. What do you notice is different? Do they look the same?</p> <p>J. Douglas Bremner, M.D. is Professor of Psychiatry and Radiology and Director of the Emory Clinical Neuroscience Research Unit (ECNRU) at Emory University School of Medicine in Atlanta, Georgia, and Director of Mental Health Research at the Atlanta VAMC in Decatur, Georgia. He kindly granted us permission to use his brain diagram for this training. Dr. Bremner conducted a study to see if PTSD symptoms matched up with a measurable loss of neurons in the hippocampus. This was first tested on Vietnam combat veterans with declaratory memory problems caused by PTSD. Using brain imaging, these combat veterans were found to have an 8% reduction in right hippocampal volume (i.e., the size of the hippocampus³), measured with magnetic resonance imaging (MRI), while no differences were found in other areas of the brain.</p> <p>The study showed that diminished right hippocampal volume in the PTSD patients was</p>	 <p><i>Ask question and wait for response.</i></p>

² The amygdala is a structure in the [limbic system](http://psychology.about.com/od/aindex/g/amygdala.htm) that is linked to emotions and aggression. The amygdala functions to control fear responses, the secretion of [hormones](http://psychology.about.com/od/aindex/g/amygdala.htm), arousal and the formation of emotional memories. (<http://psychology.about.com/od/aindex/g/amygdala.htm>)

³ The hippocampus is the part of the brain that is involved in memory forming, organizing, and storing. It is a limbic system structure that is particularly important in forming new memories and connecting emotions and senses, such as smell and sound, to memories. (<http://biology.about.com/od/anatomy/p/hippocampus.htm>)

	<p>associated with short-term memory loss. Similar results were found when we looked at PTSD sufferers who were victims of childhood physical or sexual abuse.</p> <p><i>Sources: Bremner JD, Scott TM, Delaney RC, Southwick SM, Mason JW, Johnson DR, Innis RB, McCarthy G, Charney DS (1993): Deficits in short-term memory in post-traumatic stress disorder. Am J Psychiatry 150: 1015-1019.</i></p> <p><i>Bremner JD, Randall PR, Scott TM, Bronen RA, Delaney RC, Seibyl JP, Southwick SM, McCarthy G, Charney DS, Innis RB (1995): MRI-based measurement of hippocampal volume in posttraumatic stress disorder. Am J Psychiatry 152: 973-981.</i></p> <p><i>Bremner JD, Randall PR, Capelli S, Scott T, McCarthy G, Charney DS (1995): Deficits in short-term memory in adult survivors of childhood assault. Psych Res 59: 97-107.</i></p> <p><i>Bremner JD, Randall P, Vermetten E, Staib L, Bronen RA, Mazure CM, Capelli S, McCarthy G, Innis RB, Charney DS (1997): MRI-based measurement of hippocampal volume in posttraumatic stress disorder related to childhood physical and sexual assault: A preliminary report. Biol Psychiatry 41: 23-32.</i></p>	
<p>0.25 min</p>	<p>Assessment and Screening Requirements</p> <p>Because you are all medical professionals, you are unlikely to be the people responsible for performing screenings for purposes of housing assignments; however, basic knowledge of this process is important for all correctional workers. How many of you currently screen for sexual victimization in your patient population? How do you screen? What do you ask and how do you ask it?</p> <p>Let's explore what the standards say about screening.</p>	<p> (title slide) Anticipatory set.</p>

1 min

Screening for Risk of Victimization and Abusiveness






(Standard §115.41)

Screening for risk of victimization and abusiveness

- (a) All inmates shall be assessed during an intake screening and upon transfer to another facility for their risk of being sexually abused by other inmates or sexually abusive toward other inmates.
- (b) Intake screening *shall ordinarily take place within 72 hours of arrival at the facility.* (Lockup standards – 115.141 – are a little different: require immediate assessment to be made regarding safety and for lockups that hold detainees overnight to do a less intensive screening than the one described here.)
- (c) Such assessments shall be conducted using an objective screening instrument.

The standards do not say who is supposed to conduct the screening so any correctional worker may be called upon to perform this task. Screening for risk of victimization is an area of active development and we cannot recommend specific objective screening tools at this time. However, the PREA Resource Center (PRC) does provide a screening guidelines document as well as an archived webinar. Please refer to the PRC website as well as the National Commission on Correctional Health Care (NCCHC) and other reliable sources in the field for the latest information. Again, those conducting screening should remember that screening for risk of victimization and abusiveness is for housing and classification purposes and documents produced will not be considered medical records protected by HIPAA and other protections afforded medical documentation. Medical and mental health staff can work with other staff doing intake to help train them on how to administer a screening

	instrument.	
1 min	<p>Screening for Risk of Victimization</p> <p>(d) The intake screening shall consider, at a minimum, the following criteria to assess inmates for risk of sexual victimization:</p> <div style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <p>(Standard §115.41)</p> <p>(1) Whether the inmate has a mental, physical, or developmental disability;</p> <p>(2) The age of the inmate;</p> <p>(3) The physical build of the inmate;</p> <p>(4) Whether the inmate has previously been incarcerated;</p> <p>(5) Whether the inmate’s criminal history is exclusively nonviolent;</p> <p>(6) Whether the inmate has prior convictions for sex offenses against an adult or child;</p> </div>	
3 min	<p>Screening for Risk of Victimization (Section 115.41)</p> <div style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <p>(Standard §115.41)</p> <p>(7) Whether the inmate is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming;</p> <p>(8) Whether the inmate has previously experienced sexual victimization;</p> <p>(9) The inmate’s own perception of vulnerability; and</p> <p>(10) Whether the inmate is detained solely for civil immigration purposes.</p> </div> <p>Let’s begin by looking at the definitions of these terms so we are clear on point #7 of the screening process and what needs to be identified and considered.</p> <p>You have all heard the letters “LGBTI” or some combination thereof. What do those letters refer to?</p>	 <p>Anticipatory set.</p> 

LGBTI: acronym for a group that includes lesbian, gay, bisexual, transgender and intersex individuals. We will now explore what each of these terms mean in addition to other terms included in the standards.

What is the definition of "gay?"

Gay: commonly refers to men who are emotionally, romantically, and sexually attracted to other men; can be an umbrella term to include lesbian women as well.

What is the definition of "lesbian?"

Lesbian: generally refers to females who are emotionally, romantically and sexually attracted to other females.

What is the definition of "bisexual?"

Bisexual: a person who is romantically or sexually attracted to more than one gender or sexual category.

What do we mean by "transgender?"

Transgender: a term including all people whose gender identity or gender expression do not correspond with their birth sex. Transgender refers to both those who self-identify as transgender, and those who are perceived to be transgender, for purposes of protection from discrimination and harassment. Transgender males are individuals who have female anatomy and self-identify as male. Transgender females are individuals who have male anatomy and self-identify as female. Of note, transgender individuals may be in varying stages of sex reassignment treatment and may not have complete male or female anatomy that corresponds with their self-identity.

What does the term "intersex" mean?

Intersex: a person whose sexual or reproductive anatomy or chromosomal pattern does not seem to fit typical definitions of male or female.

Intersex medical conditions are sometimes referred to as disorders of sexual development. A term no longer used for this condition is

"Aphrodite."

	<p>Before we discuss “gender non-conforming” let’s define a related term “gender identity”.</p> <p><u>Gender identity</u>: distinct from sexual orientation and refers to a person’s internal, deeply felt sense of being male or female.</p> <p>What do we mean by “gender nonconforming?”</p> <p><u>Gender non-conforming</u>: a person whose appearance or manner does not conform to traditional societal gender expectations. It has nothing to do with sexual orientation.</p> <p>Parts 8, 9, and 10 in the standard are straight forward. You need to screen for whether the inmate has previously experienced sexual victimization; the inmate’s own perception of vulnerability; and whether the inmate is detained solely for civil immigration purposes.</p> <p>The screening process for residents in a juvenile facility is slightly different than the adult, requiring that it take into account developmental stages of adolescents. It has different wording and different items. For example: (5) level of emotional and cognitive development; and (11) any other specific information about individual residents that may indicate heightened need for supervision. See 115.341.</p> <p>Community Confinement facility standards are also slightly different, with fewer items and a greater focus on conviction history. See 115.241. For further information, see <i>Recommendations for Administrators of Prisons, Jails, and Community Confinement Facilities for Adapting the U.S. Department of Justice’s A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents</i> by the U.S. Department of Justice.⁴</p> <p>Reference the new document by AU/NIC</p>	
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⁴ Office on Violence Against Women, *Recommendations for Administrators of Prisons, Jails, and Community Confinement Facilities for Adapting the U.S. Department of Justice’s A National Protocol for Sexual Assault Medical Forensic Examinations*, Washington, D.C.: U.S. Department of Justice (2013).

publication for Community Confinement guidance.

The Lockup standards are also slightly different, with more requirements for lockups that house detainees overnight. See 115.141.

Key Points

- Medical and mental health providers will not typically do the intake assessment but knowledge of the process is important.
- Consider the sensitive nature of the screening questions.
- Consider the set-up of your facility. For jails, they often don't have a private intake area.

The additional PREA screening standards for risk of victimization and abusiveness (not listed on the slide) are 115.41 (e) – (i):



(e) The initial screening shall consider prior acts of sexual abuse, prior convictions for violence offenses, and history of prior institutional violence or sexual abuse, as known to the agency, in assessing inmates for risk of being sexually abusive.


(f) Within a set time period, not to exceed 30 days from the inmate's arrival at the facility, the facility will reassess the inmates' risk of victimization or abusiveness based upon any additional, relevant information received by the facility since the intake screening.


(g) An inmate's risk level shall be reassessed when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the inmate's risk of sexual victimization or abusiveness.


(h) Inmates may not be disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to paragraphs (d)(1), (d)(7), (d)(8), or (d)(9) of this section.

(i) The agency shall implement appropriate controls on the dissemination within the facility of

	<p>responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the inmate's detriment by staff or other inmates.</p>	
<p>3 min</p>	<p>Use of Screening Information</p> <div style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <p>(Standard §115.42)</p> <p>The agency shall use information from the risk screening required by §115.41 to inform housing, bed, work, education, and program assignments with the goal of keeping separate those inmates at high risk of being sexually victimized from those at high risk of being sexually abusive.</p> </div> <p>How many of you work in facilities where medical and mental health staff are part of the classification committees?</p> <p>What are some of the ways this information is used?</p> <p>What about smaller jails where they might have two cells?</p> <p>What about community confinement facilities where programs all occur together?</p> <p>How can mental health staff use this information for treatment planning?</p> <p>What about when a risk of abusiveness is detected? How should that be handled differently?</p>	 <p>Anticipatory set.</p> <p>Pause and discuss these questions.</p>
<p>3 min</p>	<p>Use of Screening Information</p> <div style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <p>(Standard §115.42)</p> <p>(b) The agency shall make individualized determinations about how to ensure the safety of each inmate.</p> <p>(c) In deciding whether to assign a transgender or intersex inmate to a facility for male or</p> </div>	 <p>Discuss any segments that might need clarification or if trainees have questions. Trainers are advised to review the PREA Resource Centers "FAQ" section prior to the</p>

	<p>female inmates, and in making other housing and programming assignments, the agency shall consider on a case-by-case basis whether a placement would ensure the inmate's health and safety, and whether the placement would present management or security problems.</p> <p>(d) Placement and programming assignments for each transgender or intersex inmate shall be reassessed at least twice each year to review any threats to safety experienced by the inmate.</p> <p>(e) A transgender or intersex inmate's own views with respect to his or her own safety shall be given serious consideration.</p> <p>(f) Transgender and intersex inmates shall be given the opportunity to shower separately from other inmates.</p> <p>(g) The agency shall not place lesbian, gay, bisexual, transgender, or intersex inmates in dedicated facilities, units, or wings solely on the basis of such identification or status, unless such placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting such inmates.</p>	<p>training to ensure the information they present is up to date and to identify specific questions based on the most recent DOJ guidance on interpretation. www.prearesourcecenter.org</p> <p>For additional information, refer people to the National Institute of Corrections website for LGBTI training (including e-learning). www.nicic.org</p>
<p>2 min</p>	<p>Protective Custody</p> <p>(Standard §115.43)</p> <p>Inmates at high risk for sexual victimization shall not be placed in involuntary segregated housing unless an assessment of all available alternatives has been made, and a determination has been made that there is no available alternative means of separation from likely abusers. If a facility cannot conduct such an assessment immediately, the facility may hold the inmate in involuntary segregated housing for less than 24 hours while completing the assessment.</p>	 <p>Discuss any segments that might need clarification or if trainees have questions. Be prepared to discuss what to do in facilities that have limited space. This could include having a contractual agreement with a nearby facility or setting up some sort of secure room that would provide safety.</p>



	<p>What processes and policies does your jurisdiction have to address this standard? Why do you think this standard was written?</p> <p>Note that this standard only applies to prisons and jails.</p>	
<p>1 min</p>	<p>Medical and Mental Health Screenings</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>(Standard §115.81)</p> <p>If the screening pursuant to §115.41 indicates that a prison inmate has:</p> <p>Experienced prior sexual victimization and/or Previously perpetrated sexual abuse whether it occurred in an institutional setting or in the community, Staff shall ensure that the inmate is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening.</p> </div>	 <p>Discuss any segments that might need clarification or if trainees have questions.</p>



<p>1 min</p>	<p>Medical and Mental Health Screenings</p> <p>(Standard §115.81)</p> <p>(d) Any information related to sexual victimization or abusiveness that occurred in an institutional setting shall be strictly limited to medical and mental health practitioners and other staff, as necessary, to inform treatment plans and security and management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law.</p> <p>(e) Medical and mental health practitioners shall obtain informed consent from inmates before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the inmate is under the age of 18.</p>	 <p>Discuss any segments that might need clarification or if trainees have questions. This might include knowing who to notify if this information is presented to them.</p>
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Module 2: Reporting and the PREA Standards







50 minutes



Time	Speaking Notes	Teaching Tips
<p>1 min</p>	<p>Reporting and the PREA Standards</p> <p>Module Behavioral Objectives</p> <p>At the end of this module, trainees will be able to:</p> <ol style="list-style-type: none"> 1. Recognize health care staff’s role in meeting agency responsibilities for reporting; 2. Understand how to identify state-specific reporting requirements for vulnerable persons (e.g., elderly/disabled) and juveniles; 3. Help ensure access to outside confidential support services; 4. Encourage and support inmates, detainees, and residents to report sexual victimization and harassment when it occurs. 	
<p>2 min</p>	<p>Rodney Hulin, Jr. (Add as “Anticipatory Set”</p> <ul style="list-style-type: none"> • In 1995, 16-year-old Rodney Hulin pled guilty to arson with property damage less than \$500 and was sentenced to eight years in a Texas prison. • Within three days of his transfer to Clemens Unit, Rodney was raped and beaten. It went on for over two and a half months. • The Texas Department of Criminal Justice did not respond effectively. • The results were catastrophic. <p>On January 26, 1996, Hulin sent a suicide note to another prisoner and then hung himself. Hulin was taken to a Brazoria hospital where doctors restored his heartbeat. He was transferred to the prison unit of a Texas Department of Criminal Justice (TDCJ) Hospital Galveston Unit in Galveston. After Hulin turned 18 years of age, he was transferred to the Ellis Unit in unincorporated Walker County, Texas. Hulin's father, Rodney</p>	 <p>Anticipatory Set</p>

	<p>Hulin, Sr., applied for a medical parole on behalf of his son. The parole was granted and Hulin was scheduled to move into a nursing home in Abilene, Texas on May 11, 1996. Hulin died in the evening of May 9, 1996 before he could be transferred to the nursing home.</p> <p>You can find this on "YouTube" by entering Rodney Hulin's name or by this link on the slide: http://www.youtube.com/watch?v=R3j3Wk711zY&noredirect=1</p> <p>You may also review a more detailed review of the Suicide of Rodney Hulin, Jr. on Wikipedia at http://en.wikipedia.org/wiki/Suicide_of_Rodney_Hulin</p>	
<p>14 min</p>	<p>Rodney's Story</p>	<p></p> <p>Video is embedded into the PowerPoint® slide.</p> <p>Discuss at the end of the DVD.</p>
<p>2 min</p>	<p>Reporting</p> <p>In the general community, we know that rape and sexual abuse are the most underreported crimes in the United States. This is also true in correctional settings, in large part because the risks of disclosure for victims can be catastrophic.</p> <p>In 2008, there were only 7,444 formal allegations of sexual victimization in America's jails and prisons. Of those, 13% resulted in substantiated investigations.</p> <p>Guerino, P., Beck, A. "Sexual Victimization Reported by Adult Correctional Authorities 2007-2008" (January 2011) US DOJ, Bureau of Justice Statistics.</p> <p>For the remaining allegations, the most common result is unsubstantiated – that is, there was insufficient information or evidence to prove or not</p>	<p></p>



	<p>prove the allegations. This does not mean that inmates have been lying or making false reports.</p> <p>Let's take a look at reporting, the PREA standards, and what is being done nationally to address sexual abuse in confinement.</p>	
1 min	<p>NCCHC: Dedicated to Health Care Excellence</p> <p>The National Commission on Correctional Health Care (NCCHC) is the leader in preventing and responding to sexual abuse in confinement for health care practitioners. NCCHC believes that correctional health care staff are:</p> <ul style="list-style-type: none"> • Partners with administration in responding to sexual victimization • Have a unique perspective that enhances quality care for inmates who are victimized • Are committed to preserve community safety and improve public health 	
1 min	<p>Correctional Health Care Professionals Are Key Responders in Sexual Victimization</p> <p>The unique role of health care professionals requires the ability to respond affirmatively as we have been talking about in this training.</p> <p>If an inmate, detainee, juvenile or resident discloses sexual victimization, the health care professional must know, understand, and be able to implement the agency or institution policy and protocol. One way to ensure health care staff know how to report is through training.</p>	
1 min	<p>Specialized Training for Medical and Mental Health Care</p> <p>Medical and mental health staff need special training in:</p> <ol style="list-style-type: none"> 1. Sexual abuse detection/assessment 2. Physical evidence protection 3. Effective, professional response to victims 4. How and to whom to report <p>When health care professionals have these skills, they are able to respond effectively to reports of</p>	


	<p>sexual abuse, provide care to victims, and this in turn creates an environment where reporting sexual abuse is safer and accessible for victims.</p>	
<p>4 min</p>	<p>Recommendations</p> <ul style="list-style-type: none"> • Carefully review agency’s sexual abuse staff training and inmate education curricula. If this is not feasible or appropriate for your role, work with the designated training staff to add value to existing training. • Leadership should assess knowledge gaps among clinical staff – physician, nursing, mental health – and provide necessary training to eliminate those gaps. • Work with the PREA Coordinator or compliance manager to identify local resources (e.g., rape crisis programs, trauma specialists, forensic examiners and community SARTs, and LGBTI advocacy organizations) who can provide specialty training. • Plan and execute mock drills to test knowledge base of the staff. The drills should test the responses all the way through the process including reporting and medical care. • Work with the PREA coordinator to prepare pocket cards with key roles identified. The key roles include medical and mental health staff, as well as other facility staff. <p>What else can you do or have you done to look at your procedures? How to you structure in quality assurance?</p>	
<p>2 min</p>	<p>Pocket Cards for Staff Response</p> <p>Here are a couple examples of “pocket cards” some correctional departments have made so everyone is clear about their roles, protocol, and reporting procedures when a report of sexual abuse occurs.</p>	


<p>1 min</p>	<p>Pocket Cards for Staff Response</p> <p>Here is an example of a pocket card from the California Department of Corrections and Rehabilitation.</p>	
<p>1 min</p>	<p>Understanding and Complying with Agency and State Reporting Requirements</p> <div style="border: 1px solid black; padding: 10px; background-color: #f9f9f9;"> <p>(Standard §115.61)</p> <p>(a) The agency shall require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency; retaliation against inmates or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.</p> <p>(b) Apart from reporting to designated supervisors or officials, staff shall not reveal any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions.</p> <p>(c) Unless otherwise precluded by Federal, State, or local law, medical and mental health practitioners shall be required to report sexual abuse pursuant to paragraph (a) of this section and to inform inmates of the practitioner's duty to report, and the limitations of confidentiality, at the initiation of services.</p> <p>(d) If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable persons statute, the agency shall report the allegation to the designated State or local services agency under applicable mandatory reporting laws.</p> <p>(e) The facility shall report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators.</p> </div>	


	<p>(Standard §115.61) (Summary)</p> <p>Staff and Agency Reporting Duties</p> <p>Requires all staff immediately report according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse and harassment that occurred in a facility, whether or not it is part of the agency.</p>	
<p>3 min</p>	<p>Understanding and Complying with Agency and State Reporting Requirements</p> <p>As we have mentioned, health care staff are mandatory reporters by law; sexual abuse of inmates is a criminal act as discussed in standard 115.61 and when it occurs within a government facility, employees are required to report immediately. There are additional reporting requirements for staff of juvenile facilities since some acts may fall under the mandatory child abuse reporting law. What about something that happened prior to incarceration? Must you report? What if it was an incident at a previous facility?</p> <ul style="list-style-type: none"> • Reporting is not optional and is required at all times. • Staff must also report any incidents or suspicion of retaliation against any inmate, detainee, juvenile, resident or staff who has reported sexual abuse or harassment. • Staff also must report any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or harassment or retaliation for reporting. 	 <p>You may wish to expand this section to include a discussion of doctor-patient confidentiality.</p> <p>Give examples of policies here.</p>
<p>2 min</p>	<p>Meeting the Reporting Requirements</p> <p>Do you know the reporting chain of command in your facility?</p> <p>Unlike in the community where adults (with some exceptions) are free to choose whether or not a crime against them is reported, when medical or mental health staff learn of a sexual abuse, the correctional agency must be informed of the incident. It is also important to understand what will occur for a victim once he/she or you report</p>	 <p>Discuss and draw a chart of the chain of command for reporting. Acknowledge that it may vary in different facilities and encourage trainees to learn their own structure.</p>


	<p>an incident.</p> <p>You should understand your agency's reporting requirements, including who should be notified in accordance with your agency policies and procedures.</p> <p>What are the challenges and consequences of an inmate reporting or not reporting sexual victimization in a <i>jail</i> versus a <i>prison</i> setting? What are some differences in other settings and facilities like <i>community confinement</i>, <i>juvenile detention facilities</i> or <i>lockups</i>?</p> <p>There are differences between jails and prisons – jails generally hold inmates for short term stays, whereas prisons generally hold inmates for longer term stays. Community confinement facilities are pre release facilities where offenders transition from incarceration by participating in education, training and work programs. Lockups are temporary holding facilities, usually at police stations, where possible offenders are housed for interrogation, arrest processing, transfer to jail or for other administrative procedures. Juvenile detention facilities are a component of the separate juvenile justice system and are used to house minors.</p> <p>If an inmate reports while he/she is in jail, it is possible that he/she could be released to the community [requiring that community services are engaged], whereas in a prison, the victim is likely to continue to be incarcerated, and may be at on-going risk of victimization if he/she does NOT report.</p> <p>What are some of the implications of reporting or not reporting for the victim (e.g., there could be continued sexual abuse on victim or others)?</p> <p>It is important to clearly articulate verbally and in writing to the victim the <i>Limits of Confidentiality</i> and <i>Duty to Report Requirements</i> for patients/clients. Before you deliver services to an individual, discuss the limits of confidentiality and your duty to report with patients. Keep up to date on changes by regularly reviewing these.</p>	<p>Discuss.</p> <p>Discuss.</p>
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	<p>Information about a report of sexual abuse is only shared with other staff on a “need to know” basis. What do you think that means? Who needs to know?</p>	
<p>0.5 min</p>	<p>State-Specific Reporting Requirements</p> <p>Each state has specific requirements for reporting incidents of sexual abuse, including mandatory child abuse reporting statutes, and reporting abuse of certain identified vulnerable populations.</p> <ul style="list-style-type: none"> • Identify the laws regarding mandatory reporting in your jurisdiction <p>Here are some resources on this topic:</p> <p>National Institute of Corrections [NIC]/Washington College of Law [WCL] Project on Addressing Prison Rape <i>50 State Survey of Mandatory Reporting Requirements</i> which is available at www.wcl.american.edu/endsilence/documents/StateMandatoryReportingLaws.pdf</p> <p>National District Attorney's Association <i>Mandatory Reporting of Domestic Violence and Sexual Assault Statutes</i> available at: www.evawintl.org</p>	
<p>0.5 min</p>	<p>Finding Resources on Child Abuse Reporting</p> <p>The “Child Welfare Information Gateway” provides reporting and other information specific to your state. This is important to know if you work with youth.</p> <p>www.childwelfare.gov/systemwide/laws_policies/statutes/mandat.pdf</p> <p>Center for Adolescent Health Laws: Listing of Minor Consent Laws www.cahl.org/publications/consent-confidentiality-protection/</p> <p>Correctional Staff as Mandatory Reporters www.wcl.american.edu/endsilence/documents/CorrectionalStaffasMR.pdf</p>	


<p>0.5 min</p>	<p>Recommendations for Mandatory and Child Abuse Reporting</p> <ul style="list-style-type: none"> • First, to ensure coordination of efforts, medical and mental health staff should always consult with the facility or agency before engaging in outreach. • Review resources and consult with appropriate legal, child abuse, and administrative agencies in your jurisdiction. • Determine state-specific requirements for your agency and institution. • Prepare and post a listing of the agencies, with address, phone numbers and specific contact, where medical and mental health staff need to report. • Identify specific information that will be required, including forms that may need to be completed. 	
<p>0.5 min</p>	<p>Additional Components for Youth</p> <p>(Standard §115.353)</p> <p>(a) The facility shall provide residents with access to outside victim advocates for emotional support services related to sexual abuse, by providing, posting, or otherwise making accessible mailing addresses and telephone numbers, including toll free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations, and, for persons detained solely for civil immigration purposes, immigrant services agencies. The facility shall enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible.</p> <p>(b) The facility shall inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws.</p> <p>(c) The agency shall maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with</p>	

	<p>confidential emotional support services related to sexual abuse. The agency shall maintain copies of agreements or documentation showing attempts to enter into such agreements.</p> <p>(d) The facility shall also provide residents with reasonable and confidential access to their attorneys or other legal representation and reasonable access to parents or legal guardians.</p> <p>(Standard §115.353) (Summary)</p> <p>Resident and Resident's Families Access to Outside Support Services and Legal Representation:</p> <p>For juvenile facilities in particular, there are additional requirements in recognition of the fact that juveniles may be especially vulnerable and unaware of their rights in confinement.</p> <p>The standard mandates that juvenile facilities provide access that is reasonable (and, with respect to attorneys and other legal representation, confidential) rather than unimpeded.</p> <p>Summary:</p> <p>Juveniles and residents of juvenile facilities and their families must have reasonable and confidential access to:</p> <ul style="list-style-type: none"> • their attorneys • other legal representatives • parents and other legal guardians <p>Health care professionals can facilitate and support juveniles to get these additional services.</p>	
<p>1 min</p>	<p>Partnering with Community Resources</p> <p>A number of national resources exist to help guide you in identifying local, state community resources</p> <p>Office of Victims of Crime 810 Seventh Street NW., Eighth Floor, Washington, DC 20531</p>	 <p>This information may also be put into a handout.</p>

	<p>www.ojp.usdoj.gov/ovc/map.html</p> <p>RAINN - Rape, Assault, and Incest National Network On-Line Hotline 1-800-656-HOPE (24 hours/day – 7 days week) http://www.rainn.org/ http://centers.rainn.org/ Allows you to identify local crisis centers by city/state</p> <p>Just Detention International 3325 Wilshire Boulevard Suite 340 Los Angeles, CA 90010 Phone: 213-384-1400 Fax: 213-384-1411 E-mail: info@justdetention.org www.justdetention.org</p> <p>International Association of Forensic Nurses https://m360.iafn.org/frontend/search.aspx?cs=1932 http://forensicnurse.org 6755 Business Parkway, Suite 303 Elkridge, MD 21075 Helpline: 1-877-819-SART Email: info@safeta.org</p>	
<p>1 min</p>	<p>Making Reporting Possible</p> <div style="border: 1px solid black; padding: 5px; background-color: #f0f0f0;"> <p>(Standard §115.51)</p> <p>(a) The agency shall provide multiple internal ways for inmates to privately report sexual abuse, sexual harassment, retaliation by other inmates and staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents.</p> <p>(b) The agency shall also provide at least one way for inmates to report abuse or harassment to a public or private entity or office that is not part of the agency, and that is able to receive and immediately forward inmate reports of sexual abuse and sexual harassment to agency officials, allowing the inmate to remain anonymous upon request. Inmates detained solely for civil immigration</p> </div>	

	<p>purposes shall be provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland security.</p> <p>(c) Staff shall accept reports verbally, in writing, anonymously, and from third parties and shall promptly document any verbal reports.</p> <p>(d) The agency shall provide a method for staff to privately report sexual abuse and sexual harassment of inmates.</p> <p>Accordingly, agencies should make every effort to assist inmates to be safe, to be free of sexual abuse, and to report victimization by inmates or staff.</p> <p>What has been developed in your facility regarding this standard?</p>	<p>Discuss.</p>
<p>1 min</p>	<p>Making Reporting Possible</p> <p>In what ways could your facility make improvements in reporting procedures?</p> <p>Help make yours a facility where victims can report.</p> <ul style="list-style-type: none"> Remember that health care practitioners are often seen as reliable and able to assist in times of crisis. Work with your facilities to improve reporting procedures and make sure they are trauma-informed. Create and encourage a reporting culture, by being responsive and facilitating safety and discretion. Make sure the message that reports are taken seriously is included in inmate and resident education. 	 <p>Anticipatory set.</p>

<p>1 min</p>	<p>Third-Party Reporting</p> <div data-bbox="285 264 1024 548" style="border: 1px solid black; padding: 5px;"> <p>(Standard §115.54)</p> <p>The agency shall establish a method to receive third-party reports of sexual abuse and sexual harassment and shall distribute publicly information on how to report sexual abuse and sexual harassment on behalf of an inmate.</p> </div> <div data-bbox="285 548 1024 726" style="border: 1px solid black; padding: 5px;"> <p>(Standard §115.54)</p> <p>Stipulates that the agency provides the means for third parties to report</p> </div> <ul style="list-style-type: none"> • You may receive telephone calls or communication from an inmate’s family or friends about sexual abuse. • Other patients may express concerns about a particular inmate and sexual abuse. • Correctional staff or volunteers may express concerns about inmates and sexual abuse. • Be prepared to take action as necessary. 	
<p>2 min</p>	<p>Reporting to Other Confinement Facilities</p> <div data-bbox="285 1155 1024 1793" style="border: 1px solid black; padding: 5px;"> <p>(Standard §115.63)</p> <p>(a) Upon receiving an allegation that an inmate was sexually abused while confined at another facility, the head of the facility that received the allegation shall notify the head of the facility or appropriate office of the agency where the alleged abuse occurred.</p> <p>(b) Such notification shall be provided as soon as possible, but no later than 72 hours after receiving the allegation.</p> <p>(c) The agency shall document that it has provided such notification.</p> <p>(d) The facility head or agency office that receives such notification shall ensure that the allegation is investigated in accordance with these standards.</p> </div> <div data-bbox="285 1793 1024 1896" style="border: 1px solid black; padding: 5px;"> <p>(Standard §115.63) (Summary)</p> <p>Requires that correctional facility administrators</p> </div>	



	<p>make a report to another facility if an allegation of sexual abuse has occurred there.</p> <ul style="list-style-type: none"> • During intake screenings, assessments or in the course of history taking, health care staff may be informed by a patient that sexual abuse has occurred when he or she was at another correctional facility. • If this occurs, you must notify the appropriate institutional authority so that proper notification can be completed. • Reporting to another confinement facility is the role of the medical or mental health staff. The standard specifically states that this is what the agency head does. A report of something from another facility needs to be reported to the facility head or whatever facility policy states. • You must forward the report within 72 hours for lockups. 	
<p>1 min</p>	<p>Sexual Abuse Incident Reviews</p> <p>Sexual Abuse Incident Reviews (SAIR) are an important component of the response to a sexual abuse investigation and are the final event in the overall reporting and responding sequence. Health personnel should be a part of the SAIR as they are an important component of a coordinated response.</p> <p>(Standard §115.86)</p> <p>(a) The facility shall conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded.</p> <p>(b) Such review shall ordinarily occur within 30 days of the conclusion of the investigation.</p> <p>(c) The review team shall include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners.</p>	


- (d) The review team shall:
- (1) Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse;
 - (2) Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility;
 - (3) Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse;
 - (4) Assess the adequacy of staffing levels in that area during different shifts;
 - (5) Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; and
 - (6) Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to paragraphs (d)(1)-(d)(5) of this section, and any recommendations for improvement and submit such report to the facility head and PREA compliance manager.
- (e) The facility shall implement the recommendations for improvement, or shall document its reasons for not doing so.

(Standard §115.86) (Summary)

Requires that the agency conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation

- The review teams include upper-level management officials with input from line supervisors, investigators, and medical or mental health practitioners.

	<ul style="list-style-type: none"> • What are your current practices? Are they integrated in your policies? 	
2 min	<p>Sexual Abuse Incident Reviews</p> <p>This quality control procedure examines if there is a need to change policy or practice to better prevent, detect and respond to sexual abuse and:</p> <ul style="list-style-type: none"> • Considers multiple contributing factors such as race, gangs, gender identity, sexual orientation and ethnicity. • Examines institutional barriers, staffing patterns and technology. • Is a key opportunity to improve care. 	
4 min	<p>Summary</p> <p>Reporting requirements are key to quality service:</p> <ul style="list-style-type: none"> • They protect the agency and practitioners in reducing risk and liability. • They require specific actions by practitioners in their respective roles. • They help agencies to promote quality, effective care. • They assist agencies to improve safety. • A Sexual Abuse Incident Review is a requirement of every sexual abuse investigation. <p>Do you have any questions about your reporting responsibilities and the PREA standards?</p>	







BREAK: 15 Minutes

MODULE 3: Effective and Professional Responses



30 minutes



Time	Speaking Notes	Teaching Tips
0.5 min	<p>Effective and Professional Responses</p> <p>Module Behavioral Objectives</p> <p>At the end of this module, trainees will be able to:</p> <ol style="list-style-type: none"> 1. State the importance of a coordinated response to sexual abuse. 2. Identify the first responder duties and responsibilities. 	
0.5 min	<p>Responding to Victims of Sexual Abuse in Detention</p> <p>Based on PREA Standards we have covered, we have discussed:</p> <ul style="list-style-type: none"> • How to detect and assess signs of sexual abuse • Who is likely to be targeted • Physical and psychological signs and symptoms <p>Now let's move on to how to respond to an incident.</p>	
2 min	<p>Establishing A Coordinated Response</p> <div style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <p>(Standard §115.65)</p> <p>The facility shall develop a written instructional plan to coordinate actions taken in response to an incident of sexual abuse, among staff first responders, medical and mental health practitioners, investigators and facility leadership.</p> </div> <ul style="list-style-type: none"> • A coordinated response requires a written institutional plan to coordinate actions taken in response to an incident of sexual abuse. 	



	<ul style="list-style-type: none"> • US DOJ, Office of Violence Against Women (OVW) just released a guide that was developed for correctional settings on adapting the OVW national protocol. You may find that useful. Here is the link. http://www.prearesourcecenter.org/sites/default/files/library/preapdf.pdf • The plan should articulate actions of staff first responders in conjunction with medical and mental health practitioners, investigators, and facility leadership, recognizing that medical and mental health staff may also be first responders. • The standard requires a written plan to coordinate actions taken among staff first responders, medical and mental health practitioners, investigators, classification and facilities leaders. A coordinated approach is the best way to provide comprehensive care to the victim and minimizes trauma to the victim. An appropriate coordinated approach clearly defines each person's role. <p>Best practice in responding to victims is a three-tiered system:</p> <ul style="list-style-type: none"> • First responder/trained facility staff to inform victim of facility process and procedures • Forensic examiners provide information to victim on medical/forensic issues • Trained victim advocates to explain subsequent symptoms/reactions and recovery options 	<p>An archived webinar introducing this guide can be found on the PRC's website: www.prearesourcecenter.org</p>
<p>1 min</p>	<p>Recommendations to Ensure a Coordinated Response</p> <p>What recommendations do you have to ensure coordinated responses in your systems?</p> <p>Some examples include:</p> <ul style="list-style-type: none"> • Periodically review written response plan • Ensure specific roles are clear and appropriate • Identify lines of communication and 	 <p>Anticipatory set. Write ideas on easel pad.</p>



(Standard §115.64) Staff First Responder Duties


- (a) Upon learning of an allegation that an inmate was sexually abused, the first security staff member to respond to the report shall be required to:
1. Separate the alleged victim and abuser;
 2. Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence;
 3. If the abuse occurred within a time period that still allows for the collection of physical evidence, request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking or eating; and
 4. If the abuse occurred within a time period that still allows for the collection of physical evidence, ensure that the alleged abuser does not take any actions that could destroy physical evidence including as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking or eating.
- (b) If the first staff responder is not a security staff member, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff.


We will be addressing each one of these later. It is your responsibility to know your jurisdiction's time frames for evidence collection. Remember, if there are still questions about the appropriate time frame, contact a Sexual Assault Nurse Examiner (SANE) or the hospital for guidance. If you have questions about what constitutes a crime scene or separating the parties involved, talk to your supervisor or another member of your PREA team. We do not want you to respond beyond your scope as a first responder.


	<ul style="list-style-type: none"> • Alert appropriate custody staff immediately. This should be someone identified for this role such as the PREA coordinator, PREA compliance manager, PREA trained supervisor, etc. • Work cooperatively in a coordinated team response. • Separate the alleged victim and abuser (or ensure someone has arranged for that). <p>All of these things may not happen in this exact order, depending upon the situation. However, they all should be addressed early in the disclosure phase.</p>	
2 min	<p>First Responder Duties</p> <ul style="list-style-type: none"> • Assure protection, support and safety for the patient/victim • Be discreet and ensure that other inmates are not within sight or sound of the alleged abuser. • Ensure confidential space and setting. • Inform the inmate of your responsibility to report any knowledge, suspicion, or information of a sexual abuse to the agency. • Stay calm and support the inmate if needed. • Remain with him or her to preserve the crime scene or evidence until custody arrives. Request that the victim not take actions that can potentially destroy physical evidence such as eating, drinking, smoking, changing clothes, showering, washing, urinating or defecating or disturbing the crime scene(s) in any way. We will talk more about this in Module 4 when we talk about medical forensic evidence collection. 	
2 min	<p>First Responder Duties – Step 2 (Assess)</p> <ul style="list-style-type: none"> • Encourage dialog. • Conduct an immediate assessment to determine acute medical and mental health needs. • Be aware if the reported time period and circumstances allow for collection of evidence and for further referral. (More on that in Module 4) 	

	<ul style="list-style-type: none"> • Know the contact process for the Sexual Assault Nurse Examiners (SANE) and the Sexual Assault Forensic examiners (SAFE) referrals and for the local hospital and rape crisis center. Best practice is that inmates have access to trained forensic examiners (and the PREA standards require that access). We will talk more about the SANE and SAFE roles a little later. These connections should be clearly stated in policy about what should happen and where inmates should be sent for exams. • All facility health care staff should have documented training in these preliminary protocols. • Avoid the 'second injury' or re-victimization of the individual (Symonds, 1980) • Consider being present for interactions with security and investigative staff. 	 <p>Pause to discuss with trainees the benefits of this approach.</p>
<p>2 min</p>	<p>First Responder Duties – Step 3 (Medical Care)</p> <p>In Module 4, we will be talking about the actual forensic medical exam and evidence collection. However, there are several things health care staff can do for the patient/victim's care and treatment prior to that step.</p> <ul style="list-style-type: none"> • Discuss your role with the victim and prepare him/her for the process to follow. • If the victim seems fearful, confirm that he/she is not alone, will be safely placed and that an investigation will be conducted so that it will not happen again. Reinforce that reporting gives the best possible information so that others can keep safe and it holds the aggressor accountable. However, be careful about making promises about the outcome of investigations to victims. You don't know what the outcome will be. • Keeping victims/patients informed of what is going on and allowing them to be part of the decision-making can restore a sense of control. Staff need to take into account the patient's perceptions about where he/she would be safest. For instance, work with the victim to determine a safe housing 	

	<p>arrangement. Some systems actually have the offender sign a statement of placement. The final assessment is, of course, with the staff and classification. This will likely be a decision by security staff, not medical/mental health staff, although you may be able to provide recommendations. Remember, isolation of the inmate victim is not permitted unless no other option is available.</p>	
<p>2 min</p>	<p>First Responder Duties</p> <p>During this acute phase:</p> <ul style="list-style-type: none"> • Ensure access to and coordinate any necessary care such as emergency contraception, HIV testing and counseling, and medications that might be given at the exam site or once more information is gathered based on initial screening results. §115.82 	
<p>2 min</p>	<p>First Responder Duties</p> <p>During this acute phase:</p> <ul style="list-style-type: none"> • Coordinate tests for STIs and ensure prophylactic treatment • Inform that there will be no co-pay or costs incurred for treatment. One key goal of the standards is that the care be consistent with what is available in the community. For sexual abuse, one of these provisions is that services be provided at no cost, regardless of whether or not the victim names the abuser or participates in an investigation. • Document all encounters in the health record; fill out an incident report, consent, and release of information. <p>In the patient/victim's health record documentation include:</p> <ul style="list-style-type: none"> • Patient's ID, complaint, a brief description of the abuse (for determination of whether or not transfer for exam is necessary), demeanor, presence of visible cuts, bruises, scratches, trauma, complaints of pain or discomfort and any treatment rendered. Often the demeanor of the patient is something that can be significant for the first responder and should be noted in the medical record. 	 <p>Discuss the challenge of managing the requirement to provide care with the mandated reporter role.</p>

	<ul style="list-style-type: none"> • Mental health assessments, counseling or crisis intervention provided, mental status exam. • Do not indicate any results or conclusion regarding criminal activity or indicate personal opinions about the incident. <p>What type of tracking system do you have now in your facility to assure that there is the required follow-up?</p> <ul style="list-style-type: none"> • Make relevant information available to the inmate/patient. • Consider creating a standardized and approved packet of information and allow patients to take this with them. • One example of materials can be found at: http://www.cdc.gov/std/healthcomm/fact_sheets.htm 	
<p>2 min</p>	<p>Responding to the Victim's Physical and Emotional State (Access to Medical Care)</p> <p>We have just discussed the duties of health care professionals in the initial response. The PREA standards provide additional, specific guidance for medical and mental health care to be provided to the victim. The overarching intent of all of these steps is to ensure that victims receive emotional support and crisis intervention.</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>(Standard §115.82)</p> <p>(a) Inmate victims of sexual abuse shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment.</p> <p>(b) If no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, security staff first responders shall take preliminary steps to protect the victim pursuant to 115.62 and shall immediately notify the appropriate medical and mental health practitioners.</p> </div>	

	<p>(c) Inmate victims of sexual abuse while incarcerated shall be offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate.</p> <p>(d) Treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.</p> <p>It is also important to assess for suicide and other self-harm risk.</p> <p>How do you currently assess for suicide? Is it a formalized process? If an inmate is suicidal, what are the next steps?</p>	
<p>1 min</p>	<p>Responding to the Victim’s Physical and Emotional State (Access to Advocacy Services)</p> <p>The medical and mental health staff can be an important part of setting up a relationship between the facility and the local rape crisis center. In many states, the right to a victim advocate is the legal right of all crime victims. Rape crisis counselors often have a protected role that includes being present during investigative interviews and medical examinations. In this role, the rape crisis counselor is not part of the investigatory team and is not subject to being called to testify or having counseling notes entered into the investigation report.</p> <p>The agency shall attempt to make available to the victim a victim advocate from a rape crisis center. A rape crisis center is a community-based entity that provides intervention, emotional support, and related assistance to victims of sexual abuse of all ages. Providing their services to inmates and people in confinement is a relatively new undertaking for some advocates.</p>	

	<p>Here is a link to the Office of Violence Against Women’s website for all the state coalitions. This is a valuable resource for you as you set up your advocacy program: www.ovw.usdoj.gov/statedomestic.htm</p> <p>If a rape crisis center is not available, another qualified staff member from a community agency may be able to provide services or enlist the help of the hospital, social services, national agencies or hotlines. If neither of those options are available, a qualified staff member (e.g. one who has been trained appropriately to serve in the capacity of victim advocate) should be made available. All advocates need to be trained on their role and the unique considerations and dynamics of correctional facilities. Note that some contact may occur via telephone if it is a remote facility.</p> <p>Although this is all captured in standard 115.21, agencies shall document efforts to secure services from rape crisis centers. The rape crisis center may be part of another governmental unit if the center is not part of the criminal justice system. It must offer comparable confidentiality as a non-governmental entity that provides similar victim services.</p> <p>It is important to note that community-based rape crisis centers are generally the only victim advocacy entities that provide services regardless of the presence of a report.⁵</p> <p>For more internal staff training references and guidance, visit http://www.justdetention.org/.</p>	
<p>1 min</p>	<p>Responding to the Victim’s Physical and Emotional State (Access to Advocacy Services)</p> <p>The first part of this standard addresses the exam</p>	

⁵ Office on Violence Against Women, Recommendations for Administrators of Prisons, Jails, and Community Confinement Facilities for Adapting the U.S. Department of Justice’s A National Protocol for Sexual Assault Medical Forensic Examinations, Washington, D.C.: U.S. Department of Justice (2013).

itself and the second part, the advocates.

(Standard §115.21)

(a) To the extent the agency is responsible for investigating allegations of sexual abuse, the agency shall follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions.

(b) The protocol shall be developmentally appropriate for youth where applicable, and, as appropriate, shall be adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011.

(c) The agency shall offer all victims of sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate. Such examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. If SAFEs or SANEs cannot be made available, the examinations can be performed by other qualified medical practitioners. The agency shall document its efforts to provide SAFEs or SANEs.

(d) The agency shall attempt to make available to the victim a victim advocate from a rape crisis center. If a rape crisis center is not available to provide victim advocate services, the agency shall make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member. Agencies shall document efforts to secure services from rape crisis centers. For the purpose of this standard, a rape crisis center refers to an entity that provides intervention and related assistance, such as the services specified in 42 U.S.C. 14043g(b)2(C), to victims of sexual assault of all ages. The agency may utilize a rape crisis center that is part of a governmental unit as

long as the center is not part of the criminal justice system (such as a law enforcement agency) and offers a comparable level of confidentiality as a nongovernmental entity that provides similar victim services.

(e) As requested by the victim, the victim advocate, qualified agency staff member, or qualified community-based organization staff member shall accompany and support the victim through the forensic medical examination process and investigatory interviews and shall provide emotional support, crisis intervention, information, and referrals.

(f) To the extent the agency itself is not responsible for investigating allegations of sexual abuse, the agency shall request that the investigating agency follow the requirements of paragraphs (a) through (e) of this section.

(g) The requirements of paragraphs (a) through (f) of this section shall also apply to:

(1) Any State entity outside of the agency that is responsible for investigating allegations of sexual abuse in prisons or jails; and


(2) Any Department of Justice component that is responsible for investigating allegations of sexual abuse in prisons or jails.


(h) For the purposes of this section, a qualified agency staff member or a qualified community-based staff member shall be an individual who has been screened for appropriateness to serve in this role and has received education concerning sexual assault and forensic examination issues in general.


In review, the first several sections of the standards assure a protocol, forensic exam access, evidence preservation, and that there is an advocate made available to the victim - whether that be from an outside community agency or whether it is from internal facility staff. The victim should also have access to advocacy support through the exam and investigative processes and interviews.

One key thing that sets the rape crisis advocate apart from in-house services is the ability to have confidential communication with the victim.

If possible have a representative from the local

	<p>Another is that the rape crisis counselor provides services regardless of the status of an investigation. This is all standard practice for rape crisis advocates.</p> <p>It is also important to make clear that, because of possible conflicts of interest, a qualified internal staff member faces some real challenges in being an advocate when the perpetrator is a staff member.</p> <p>Below is a list of webinars that provide information on advocacy services:</p> <p>http://www.prearesourcecenter.org/training-and-technical-assistance/webinars/1315/first-step-prea-and-victim-services-in-jails-part-i</p> <p>http://www.prearesourcecenter.org/training-and-technical-assistance/webinars/1453/making-your-plan-prea-and-victim-services-in-jails-p</p> <p>http://www.prearesourcecenter.org/training-and-technical-assistance/webinars/1075/jdi-webinar-it-starts-with-you-victim-advocates-and-</p>	<p>rape crisis center present for this portion of the training.</p> <p>Discuss with trainees the role of a rape crisis advocate. It is critical that they understand the importance of that role and to consult with facility policy to ensure the scope of services the advocates can provide or have agreed to provide.</p>
<p>1 min</p>	<p>Responding to the Victim’s Physical and Emotional State (Access to Advocacy Services)</p> <p>Let’s focus for a moment on “d” of this standard.</p> <div style="border: 1px solid black; padding: 5px;"> <p>(Standard §115.21) (d) The agency shall attempt to make available to the victim a victim advocate from a rape crisis center. If a rape crisis center is not available to provide victim advocate services, the agency shall make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member. Agencies shall document efforts to secure services from rape crisis centers. For the purpose of this standard, a rape crisis center refers to an entity that provides intervention and related assistance, such as the services specified in 42 U.S.C. 14043g(b)(2)(C), to victims of sexual abuse of all ages. The agency</p> </div>	

	<p>may utilize a rape crisis center that is part of a governmental unit as long as the center is not part of the criminal justice system (such as a law enforcement agency) and offers a comparable level of confidentiality as a nongovernmental entity that provides similar victim services.</p> <p>The immediate assistance and support of a rape crisis advocate can be critical. This PREA standard recognizes that this is an important service and part of the health protocol for the victim. Experience suggests intervention with victims is more effective sooner rather than later.</p> <p>To emphasize the varying models of advocacy services, like community forensic exam capabilities, there may or may not be an advocacy agency located in your community. Recognizing that, the standard does allow for utilizing a government based advocacy service (e.g., systems-based advocates who--instead of being housed in a traditional rape crisis center--may work out of the prosecutors or law enforcement agency office). There may be different levels of confidentiality with the system-based advocates (having limited confidentiality because they are law enforcement based) to full confidentiality for rape crisis counselors (this varies by jurisdiction).</p> <p>What type of advocacy challenges are you having in this area?</p>	<p>Discuss and allow some time for brainstorming and problem solving.</p>
<p>0.5 min</p>	<p>Responding to the Victim’s Physical and Emotional State (Access to Outside Confidential Support Services)</p> <p>(Standard §115.53) (a) The facility shall provide inmates with access to outside victim advocates for emotional support services related to sexual abuse by giving inmates mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations, and, for persons detained solely</p>	

	<p>for civil immigration purposes, immigrant services agencies. The facility shall enable reasonable communication between inmates and these organizations and agencies, in as confidential a manner as possible.</p> <p>(b) The facility shall inform inmates, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws.</p> <p>(c) The agency shall maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide inmates with confidential emotional support services related to sexual abuse. The agency shall maintain copies of agreements or documentation showing attempts to enter into such agreements.</p> <p>(Standard §115.53) (Summary)</p> <p>Facilities shall provide inmates, detainees, and residents access to outside victim advocates for emotional support services</p> <p>Identify local, state, and national victim advocacy or rape crisis organizations with mailing address and telephone numbers Post contact information so that patients/clients can see and consider contacting these agencies Provide a safe environment to facilitate patient contact with these agencies, when appropriate Consider these agencies as treatment support resources</p>	
<p>1 min</p>	<p>Responding to the Victim's Physical and Emotional State (Special Circumstances)</p> <p>Victims may come from a variety of backgrounds, cultures, religions, or orientations, and furthermore may have physical or intellectual disabilities. The institution must be prepared to respond to allegations of sexual abuse from any victim. Furthermore, staff members must understand that the zero-tolerance approach to</p>	

sexual abuse applies to all inmates and the agency must ensure an appropriate level of cultural competency in all staff members. The following sections of the PREA standard provide detailed requirements for the agency in these areas.

(Standard §115.16)

(a) The agency shall take appropriate steps to ensure that inmates with disabilities (including, for example, inmates who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities), have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Such steps shall include, when necessary to ensure effective communication with inmates who are deaf or hard of hearing, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. In addition, the agency shall ensure that written materials are provided in formats or through methods that ensure effective communication with inmates with disabilities, including inmates who have intellectual disabilities, limited reading skills, or who are blind or have low vision. An agency is not required to take actions that it can demonstrate would result in a fundamental alteration in the nature of a service, program, or activity, or in undue financial and administrative burdens, as those terms are used in regulations promulgated under title II of the Americans With Disabilities Act, 28 CFR 35.164.

(b) The agency shall take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to inmates who are limited English proficient, including steps to provide interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary.

(c) The agency shall not rely on inmate interpreters, inmate readers, or other types of

	<p>inmate assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the inmate's safety, the performance of first-response duties under § 115.64, or the investigation of the inmate's allegations.</p> <hr/> <p>(Standard §115.16) (Summary)</p> <p>Engage principles of cultural competency to support:</p> <p>Victims from other countries, youth, people with disabilities, and limited English proficiency</p> <hr/> <p>(Standard §115.31)</p> <p>(a) The agency shall train all employees who may have contact with inmates on:</p> <ul style="list-style-type: none"> (1) Its zero-tolerance policy for sexual abuse and sexual harassment; (2) How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures; (3) Inmates' right to be free from sexual abuse and sexual harassment; (4) The right of inmates and employees to be free from retaliation for reporting sexual abuse and sexual harassment; (5) The dynamics of sexual abuse and sexual harassment in confinement; (6) The common reactions of sexual abuse and sexual harassment victims; (7) How to detect and respond to signs of threatened and actual sexual abuse; (8) How to avoid inappropriate relationships with inmates; (9) How to communicate effectively and professionally with inmates, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming inmates; and (10) How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities. <p>(b) Such training shall be tailored to the gender of the inmates at the employee's facility. The employee shall receive additional training if</p>	
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the employee is reassigned from a facility that houses only male inmates to a facility that houses only female inmates, or vice versa.

(c) All current employees who have not received such training shall be trained within one year of the effective date of the PREA standards, and the agency shall provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures. In years in which an employee does not receive refresher training, the agency shall provide refresher information on current sexual abuse and sexual harassment policies.



(d) The agency shall document, through employee signature or electronic verification, that employees understand the training they have received.


The most important principle is to respond to each patient without assumptions and by listening without judgment. Staff does not have to be the same sex, race or religious background unless it appears to be an issue and interferes with communication. If there is a health care provider with whom the patient feels more comfortable or shares a common language, consider asking that person to step in.

Culture may impact or influence health care beliefs for many people, but be particularly aware of this concern for federal ICE (immigration) detainees, immigrants, some religious groups, and Native Americans, to name a few.

Report any negative or unhealthy attitudes of staff towards the victim.

What preparation has your facility developed to address these issues?


<p>0.5 min</p>	<p>Responding to the Victim’s Physical and Emotional State (Inmate Education) §115.33</p> <p>Now that we have discussed the requirements and components of responding to victims’ physical and emotional response, we will now discuss some specific steps that staff members and agencies can use to help them be successful responders.</p> <ul style="list-style-type: none"> • Account for particular vulnerabilities to ensure effective communication and understanding of sensitive issues. For instance, an immigrant woman who may have experienced generations of rape in her family may be particularly vulnerable and prefer a female provider. Someone with a disability may require an interpreter, etc. • Use plain, simple language. Do not use euphemisms or slang. Produce written materials in common languages and large print. • Take reasonable steps to interpret, listen, and remain objective and non-judgmental. • Enlist interpretation services. The facility is required per the standards and 115.16 to provide interpretive services. Be cognizant of cultural or gender stigmas that could affect sound and accurate interpretations. Sometimes culturally-specific assistance may be needed. 	
<p>0.5 min</p>	<p>Continuing Steps</p> <ul style="list-style-type: none"> • Once emergency treatment is assessed and the inmate victim is referred to local services for a forensic medical exam (SAFE, SANE, or local hospital), remain with the victim until he or she is escorted outside of the facility. • Know how to initiate the procedures for transporting victims outside or bringing qualified medical examiners into the facility for forensic medical exams. • If a victim is being transferred to another facility, the institution may wish to have a 	



	<p>prepared set of basic supplies (a change of clothes, linens, toiletries, etc.) that will accompany the victim.</p> <ul style="list-style-type: none"> • A facility or agency will likely have a policy on this and the training for all staff should be tailored to match the policy. 	
<p>2 min</p>	<p>Implementation of an Effective and Professional Response</p> <p>How do you envision first responders working in your facility and what are some of the obstacles or challenges they might face? What about the training needs for first responders?</p> <p>Who needs the training? According to standard 115.64 all staff are considered first responders – should refer to this standard.</p> <p>What do you do if custody and health care have different ideas regarding steps and expectations in these cases?</p> <p>How do you develop trust between health care and custody so that they share information?</p> <p>Do you have any questions?</p>	 <p>Engage audience in discussion regarding challenges and successes.</p> <p>If time allows, break into small groups and develop an action plan and discuss what will be needed for implementation in their agency.</p>



Module 4: The Medical Forensic Examination and Evidence Preservation



60 minutes

Time	Speaking Notes	Teaching Tips
<p>4 min</p>	<p>The Medical Forensic Examination and Forensic Evidence Preservation</p> <p>What do we know about the use of victim advocacy groups and trained examiners for collecting forensic evidence?</p> <p>I will be covering three standards during this module. As we have already mentioned, standards 115.21 (evidence protocol and forensic medical examinations) and 115.83 (ongoing medical and mental health care for sexual abuse victims and abusers) talk about examination access or assuring that the victim of abuse has access to sexual abuse care and advocacy. There is current research that supports that access to trained examiners and advocacy both improve outcomes for patients in their long term physical and psychological health, and facilitates their participation in criminal justice proceedings.</p> <p>Solola, Scott, Sever, Howell (1982); Malloy (1991); Ericksen, et. Al (2002)</p> <p>The third standard, 115.64 – staff first responder duties, covers ways to assure that physical evidence is not destroyed prior to the medical forensic examination.</p> <p>What specific care is offered varies a great deal. Many state prison systems will offer Hepatitis B care and will provide the series of vaccinations, but such care isn't consistent. In lockup and jails where an inmate may only be there a short amount of time, they generally don't get this kind of care. In community confinement, they may use community services or they may use their related prison services. Practices in juvenile detention facilities vary from jurisdiction to jurisdiction.</p>	 <p>It is suggested in the instructor materials at the beginning of the curriculum that this section be taught by a skilled medical professional with experience in doing forensic exams.</p>

	<p>Most large prison systems will have the ability to do follow-up care. The PREA standards should help with consistency of general care but some health care such as offering vaccinations may still vary from place-to-place. HIV testing and prophylaxis may also be offered. The standards require that victims receive the same level of care as the community. That should be inclusive of pregnancy-related services for female victims.</p> <p>Today we are going to discuss ways that you, as a health care provider, can facilitate and improve your facility's response to sexual abuse and thereby meet the PREA standards in the area of forensics.</p> <p>Module Behavioral Objectives</p> <p>At the end of this module, trainees will be able to:</p> <ol style="list-style-type: none"> 1. Conceptualize ways to assure that the PREA standard for access to the medical forensic exam is met. 2. Give examples of ways to meet the PREA standard for access to trained victim advocates. 3. Verbalize some ways to meet the PREA standard for assuring that physical evidence is not destroyed. 4. Recognize standard health care follow-up for the inmate who has experienced sexual abuse. 	
<p>1 min</p>	<p>Protocol</p> <div style="border: 1px solid black; padding: 5px; background-color: #f0f0f0;"> <p>(Standard §115.21)</p> <p>a. To the extent the agency is responsible for investigating allegations of sexual abuse, the agency shall follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions.</p> </div>	

	<p>Part “a” of this standard indicates that an agency must have a uniform set of procedures in place to respond to sexual abuse victims and collection of evidence. Having these steps clearly written down in policy and procedural manuals is an important first step.</p>	
<p>1 min</p>	<p>Protocol</p> <div style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <p>(Standard §115.21)</p> <p>b. The protocol shall be developmentally appropriate for youth where applicable, and, as appropriate, shall be adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, “A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents,” or similarly comprehensive and authoritative protocols developed after 2011.</p> </div> <p>You can go on line at this link: https://www.ncjrs.gov/pdffiles1/ovw/241903.pdf The latest edition of the National SAFE Protocol is from April of 2013. Read through it and compare it with your agency's protocol.⁶</p>	
<p>6 min</p>	<p>Exam Access</p> <div style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <p>(Standard §115.21)</p> <p>c. The agency shall offer all victims of sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiary or medically appropriate. Such examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified medical</p> </div>	

⁶ Office on Violence Against Women, Recommendations for Administrators of Prisons, Jails, and Community Confinement Facilities for Adapting the U.S. Department of Justice’s A National Protocol for Sexual Assault Medical Forensic Examinations, Washington, D.C.: U.S. Department of Justice (2013).

practitioners. The agency shall document its efforts to provide SAFEs or SANEs.

How many of you do your exams in-house?

How many of you currently use SANE or SAFEs for your exams?

What may happen is that custody staff want health care staff to give them preliminary findings and may have difficulty understanding why using an experienced SANE from the community will provide more complete information.

This standard assures access to exams for all (including juveniles). It can be done in facility or outside but should be conducted by qualified SANE/SAFEs where possible.

Exams should take place as soon as possible to minimize loss of evidence and identify medical concerns.

Determine appropriate transfer facility, which may differ according to patient's age.

Talk with the patient about expectations and concerns: health care, advocacy and financial concerns. There should be no financial concerns since the treatment and follow-up is provided at no cost to the inmate.


Develop a process for contacting the exam site. Allow sufficient time as the examiner may not be readily available.


Have a plan for notifying the community advocate so that accompaniment can be available for the patient at the exam site.


The where of this process is where are the exams performed?


Each facility will have to determine where the exams will be done - some options are:


(a) Transfer the inmate to a local exam site


	<p>(b) Bring examiners in to the facility to do the exams on site</p> <p>Remember, the patient may prefer not to have an exam and that must be honored.</p> <p>This may be a facility where you do not normally send inmates for routine emergency care, so establishing a protocol and MOUs or process for receiving victims from your facility at the identified hospital or medical setting is essential.</p> <p>There may be different facilities that do exams for adults and juveniles and is an important distinction for protocol development.</p> <p>The examiner may not be on site, and the response time may not be immediate, so a notification process should be set up. You don't want the victim and custody staff sitting around waiting for the exam.</p> <p>There may also be sites that do forensic exams, but where rape crisis centers don't respond. They should take this into account as well.</p>	
<p>4 min</p>	<p>Who does the Exam?</p> <p>Let's talk about who does the medical forensic exam. It is usually:</p> <p>Sexual Assault Nurse Examiner (SANE) Sexual Assault Forensic Examiners (SAFE) Sexual Assault Examiner (SAE) Emergency Room Staff</p> <p>The PREA standard says that such examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. Trained examiners are those who have taken specialized training, usually 40 hours of classroom training, followed by a clinical experience. These health care professionals have generally done many exams and are experienced in evidence collection, care, and testifying.</p> <p>Not all hospitals or facilities have these trained</p>	



	<p>examiners. In those cases, the emergency room general staff may be doing the exam. It is clear in the standard that you should be looking for facilities to send people to that <i>do</i> have trained examiners. In setting up your protocol, one thing the agency needs to look for is where these trained examiners are located and where the exams are conducted. If you are not sure where the exams are done, there are resources available to help you find appropriate sites.</p> <p>https://m360.iafn.org/frontend/search.aspx?cs=1932</p> <p>It is important to note that exam sites may differ for juveniles. It is also important to note that correctional health care staff may serve as an important liaison with outside medical facilities as preparations are made for safety and security needs.</p>	
<p>1 min</p>	<p>The Medical Forensic Exam</p> <p>Let's take some time to talk about the actual examination itself. Why is it important for the victim to have access to an exam and what does it do? Why do we care if inmates have access to the exam?</p> <p>The primary purpose of the exam is for:</p> <ol style="list-style-type: none"> 1. Health care 2. Treatment of the patient <p>This kind of care is specialized and the treatment specifically targeted for sexual abuse patients. As it says on this slide, there is an additional purpose for the exam:</p> <ol style="list-style-type: none"> 3. Collection of forensic evidence in the form of samples, photography and documentation that can be used in criminal justice proceedings. <p>Should all inmates who report a sexual abuse get an exam?</p> <p>Sometimes correctional staff, being concerned with meeting their obligations and liability, take</p>	 <p>Anticipatory set.</p>


	<p><i>everyone</i> for an exam without strategically thinking about what has happened during the abuse.</p> <p>One facility took a woman whose cellmate had licked her breast four days earlier to the hospital. This sort of forensic sample would fall <i>outside</i> of the standard time frame for retrieval of DNA evidence. In a case like this, best practice would be to discuss the case with the forensic examiner to determine if transfer is needed.</p> <p>One of the concerns here really is “balance.” We want to provide good care, and not have the pendulum swing to a place where everyone is being sent out no matter the particular circumstances.</p> <p>Talk to the inmate about the purpose of the exam, including collecting evidence even when he/she declines to participate.</p> <p>What do you do in your agency in these “gray” situations?</p> <p>What is best practice for these types of situations?</p>	<p>Checking for Understanding Discuss. Give examples of best practices such as</p> <ul style="list-style-type: none"> • Performing a forensic exam as a systematic process each time. • Treating the inmate with dignity and respect. • Maintaining forensic ethical standards and maintaining chain of custody at all times. • Allowing for open communication with the inmate throughout the exam process.
<p>2 min</p>	<p>Steps in the Exam Process</p> <p>The slide shows a visual of the many facets of the medical forensic exam. The parts of the exam include physical assessment and treatment of injury, health care treatments such as - STI prevention and treatment, HIV prophylaxis when appropriate, emergency contraception and psychological treatment such as immediate crisis intervention, suicide risk assessment, lethality assessment. All of these things are done by the examiner at the time of the exam.</p> <p>The exam is just a piece of the investigative puzzle. It is one component that can be used in the criminal justice proceedings but the main focus is the care and well-being of the individual who has experienced sexual abuse. There are often misperceptions about what can and cannot happen during the exam, and that is one thing I</p>	

	would like to discuss next.	
3 min	<p>Common Misperceptions about the Exam</p> <p>How many of you have an idea of what exactly happens during the medical forensic sexual abuse exam? What can an exam tell you?</p> <p>How does an exam work? What happens during an exam? What can we learn?</p> <p><i>Can the exam tell you if the person has had sex?</i></p> <p>The answer is yes and no. The purpose of the forensic medical examination is to examine the patient for injuries and collect evidence. The question whether or not the patient had sex isn't relevant in this situation. The questions based on the forensic interview conducted before the exam will determine what evidence is collected at that time. The patient might have had consensual unprotected sex before the attack, so yes the exam can tell if there are bodily fluids present, however the forensic exam cannot determine which fluids were from the consensual act and which were from the alleged attack. A forensic medical exam cannot be performed to determine a yes or no answer of sexual acts.</p> <p><i>Can the exam tell you if the person is a virgin?</i></p> <p>The answer is no. This is not the purpose of the forensic medical examination. "Virginity checks" are no longer performed in the medical and/or scientific community.</p> <p><i>Will there be observable evidence that sex or a rape has occurred?</i></p> <p>The answer is yes and no. The purpose of the forensic medical examination is to examine the patient for injuries and collect evidence based on the questions answered in the forensic interview. The forensic examiner can note observations that sexual contact occurred (bodily fluids present, genital injuries consistent with sexual assault, etc.), but cannot base that on a confirmation that</p>	 <p>Anticipatory set.</p> <p>Ask these questions and get audience responses.</p>

	sex actually did or did not occur. With regard to rape, that is a crime and its occurrence is determined by the legal system.	
3 min	<p>Preparing the Victim</p> <p>What are the two primary levels of health to consider during an exam?</p> <ol style="list-style-type: none"> 1. Psychological Health <ul style="list-style-type: none"> • Advocacy • Options • Exam prep 2. Physical Health <ul style="list-style-type: none"> • Minimize evidence loss • Notification of custodial staff • Notification of exam site <p>The victim may not want the medical forensic exam.</p> <p>What would you do in this case?</p> <p>A victim is never forced to have an exam so they should be willing to cooperate with the examiner before being transferred. If the victim is not transferred then STI prevention, HIV prevention, emergency contraception and any treatment necessary care should be offered by health care staff at the facility.</p> <p>Exam prep: prepare the patient/victim for what to expect when they get to exam site or if an examiner is coming into the facility, ready them for what will happen. You may say: "There will be a nurse or physician or physician's assistant who will come in to do the exam. You will be offered an advocate to stay with you during the exam if you wish. The examiner will get permission from you to do the exam. There may be photographs taken during the exam. The nurse will ask you about what has happened in extensive detail."</p> <p>There will be a record made of the exam. The examiner may collect items that will go into an evidence kit for lab processing. The patient/victim will be offered medicines to prevent any exposure</p>	 Anticipatory set. Discuss.

	<p>to infectious diseases and treated for any injuries.</p> <p>Some of the physical preparation you may have to do may be to:</p> <ul style="list-style-type: none"> • Protect evidence loss (more on that later) • Notification of the custodial staff for transfer • Notification of exam site <p>The examiner will obtain “informed consent” for the exam at the medical site.</p>	
<p>3 min</p>	<p>Examination Site Options</p> <p>In-Facility Exam</p> <p>There are generally three options for conducting the exam on-site at the facility:</p> <ol style="list-style-type: none"> 1. Forensic examiners who are on-site at the facility; 2. Trained SANE/SAFE who respond to facility 3. The patient elects to not be transferred for exam, so health care concerns and treatment are offered at facility. <p>It is important to check with your legal department regarding “conflict of interest.” This might occur when a trained SAFE is also a member of the health care staff. In this case, the on-site staff should not do an exam because they may not be considered a neutral objective party since the abuser could be a co-worker/colleague.</p> <p>From the perspective of the victim, there may be more trust and comfort with someone from the outside. If there is fear that there will be a cover up or evidence tampered with, that fear will most likely be alleviated by working with an outside examiner.</p> <p>I would be really interested to hear your feedback about how to handle when someone makes a report and does not want to go for the exam. What will you do if there is pressure from custody to insist? What about confidentiality of records of subsequent treatment?</p>	

<p>2 min</p>	<p>Forensic Evidence</p> <p>There are three parts to forensic evidence:</p> <ol style="list-style-type: none"> 1. Principles 2. Identification 3. Preservation <p>Forensic evidence is the ‘physical things’ that help prove or support that a sexual abuse occurred and is used to establish the elements of a crime. It can help identify a person or an action. It provides guidance for law enforcement investigations and ultimately, helps convict the guilty and exonerate the innocent. It is <i>more than</i> DNA. It is also data presented to the court or jury in proof of the facts of a particular case or cause.</p> <p>It can be:</p> <ul style="list-style-type: none"> • Testimony of witnesses • Records and documents (including photos, medical record and mental health notes) • Objects • Biological substances <p>Understanding this can impact the way you look at the patient who comes to you after a sexual abuse and the things you do to them in the exam.</p>	
<p>1 min</p>	<p>Locard’s Principle</p> <p>Does anyone know what is meant by the Locard Principle?</p> <p><i>Kirk, P. (1953) “Crime investigation: physical evidence and the police laboratory.” Interscience Publishers, Inc., New York.</i></p> <p>Let’s start with “principles.” When a person or object comes into contact with another person or object, there exists a possibility that an exchange of material – physical evidence - will take place.</p> <p>When we talk about principles of science, don't we always start with a picture of some old guy with white hair? Locard's principle is one of the fundamental reasons we look for evidence in the</p>	 <p>Anticipatory set.</p>

	<p>places we do. No matter how much someone tries to clean up a crime scene, something is generally left behind. It may not always be detected, or even be visible to the human eye, but it's almost impossible to take any kind of violent action without shedding something. This principle, called <i>Locard's Exchange Principle</i>, has become one of the motivating factors in the development of forensic science.</p> <p>Edmond Locard was the director of the very first crime laboratory in existence, located in Lyon, France. Locard's techniques proved useful to the French Secret Service during World War I (1914–1918), when he was able to determine where soldiers and prisoners had died by examining the stains on their uniforms.</p> <p>The Locard's Exchange Principle, also known as Locard's Theory, simply says that every contact leaves a trace. In his own words: "Physical evidence cannot be wrong, it cannot perjure itself, it cannot be wholly absent. Only human failure to find it, study and understand it, can diminish its value."</p>	
<p>2 min</p>	<p>Evidence Types</p> <p>What are some types of physical evidence that connect the offender to the victim?</p> <p>Here are some various types of physical evidence that connect the offender to the victim:</p> <ul style="list-style-type: none"> • Physical/bodily injury (black eye, cuts, bruises) • Unique types- products of conception, tampons, condoms, latex gloves, plastic wrap • Biological evidence which contains DNA such as: <ul style="list-style-type: none"> » Trace » Hair » Semen » Saliva » Serological <p>Evidence is any object that can connect an offender or victim to a crime scene (in the case of</p>	 <p>List on easel.</p>

sexual abuse, the victim is also considered “a crime scene”). The physical evidence includes things like “trace evidence” which can include things like leaves, debris, toxicological specimens as well as “biological evidence” such as hair, blood, semen/sperm, saliva, etc. On the next slide, we go into more specifics about biological evidence.

In general, you can see trace evidence but are generally not able to see biological evidence.

1 min

Chain of Custody



Chain of Custody Form

Patient Name: Patient ID#:

Evidence Includes:


- Sexual Assault Evidence Kit
- Clothing (Number of Bags)
- OES Report
- Forensic Records (pages)
- Photographic Evidence
 - Digital Photos (Number of Photos) #of discs
- Other:

Date	Time	From (Print name & sign)	To (Print name & sign)	Date	Time
Sign:			Sign:		
Date	Time	From (Print name & sign)	To (Print name & sign)	Date	Time
Sign:			Sign:		

Here is a picture of a “chain of custody” form. For any legal case, it is critical that there is documentation of the movement and location of physical evidence from the time it is obtained until the time it is presented in court. You have to send something like this chain of custody form that indicates when you or custodial staff have obtained the specimen so that the legal system is able to trace the physical and biological evidence from the time the sample or object has been obtained until it was handed off.

Best practice is that the evidentiary items from a suspected sexual abuse are given directly from the victim to custodial staff for safekeeping in transfer to the medical facility or given directly to the investigating agency at the scene.

Ask question of audience and solicit responses.

	<p>Can you think of any examples where a victim may have items that are obtained in the health clinic at the correctional facility that should be sent with the victim to the exam off-site?</p> <p>Examples-</p> <ul style="list-style-type: none"> • Urine specimens • Clothing, if needing to change for transfer • If any gloves or items are used to search an inmate prior to transfer, they should be sent as possible evidence with the patient/inmate 	
<p>5 min</p>	<p>Minimizing Evidence Loss</p> <div style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <p>(Standard §115.64)</p> <p>(3) If the abuse occurred within a time period that still allows for the collection of physical evidence, request that the alleged <i>victim</i> not take any actions that could destroy physical evidence, include as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking or eating and</p> <p>(4) If the abuse occurred within a time period that still allows for the collection of physical evidence, ensure that the alleged <i>abuser</i> does not take any actions that could destroy physical evidence, include as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking or eating</p> </div> <p>PREA Standard 115.64 focuses on assuring that physical evidence is not destroyed by the victim and/or the abuser. To do that, we first need to identify what can destroy evidence.</p> <p>Can you name some potential evidence destroying behaviors?</p> <p>Victim:</p> <ul style="list-style-type: none"> • Request they refrain from: • Washing (any part of the body) • Showering • Changing Clothes 	 <p>Discuss and write responses on easel pad.</p>

- Combing hair
- Urinating
- Defecating
- Drinking/Eating
- Smoking

Abuser:

Ensure that the abuser refrains from:

- Washing
- Showering
- Changing Clothes
- Urinating
- Defecating
- Drinking/Eating/Smoking


If the abuse occurred within a time period that still allows for the collection of physical evidence, request that the alleged victim not take any actions that could destroy physical evidence as listed here. This also includes the abuser.


Injuries may contain potential evidence. Therefore, they *may* need to be identified, documented and the evidence collected at an exam site, prior to transfer. If you have to apply things like dressings to wounds to make the patient safe for transport then you would need to swab scratches and abrasions for materials that may have been exchanged during the abuse and provide these to law enforcement. Consult your local protocols and procedures for additional guidance.


Both the victim and perpetrator may have physical injuries that need treatment. Articles that are commonly used in treating, cleaning or dressing wounds may 'wash away' potential evidence. So before you clean, remember you may be interfering with the potential recovery of materials which are evidentiary in nature. It may be best to just cover injuries with a dressing and send them on to the exam site, but remember to make a notation of any treatment done by your facility health care staff prior to transfer.

Many inmate victims also save some kind of forensic evidence (e.g., a washcloth with semen, a baggie that was used as a condom, a cup they




	<p>spit semen into). Health care staff can ask questions to determine if this type of evidence exists. Promptly pass along any information on this type of evidentiary material to the investigator or appropriate correctional staff.</p>	
<p>2 min</p>	<p>Minimizing Evidence Loss</p> <p>Clothing:</p> <p>If the victim's clothes need to be cut away, do not cut through any wound areas. DNA may be present on clothing for long periods of time. Therefore, original clothing worn at the time of the abuse or directly after the incident may be helpful evidence.</p> <p>Articles of clothes should never touch each other. Each item should be taken off one item at a time and placed separately in paper bags (not plastic), labeled and sealed with your initials, time and date on the outside.</p> <p>Depending on the security level of the facility, a victim may be required to have a strip search. In many places, this is standard procedure before taking someone outside and returning them to a correctional facility. However, as in the case of a medical emergency, there are facilities that have modified this procedure in the case where there is a sexual abuse incident.</p> <p>If the sexual abuse victim must undress, have him or her undress over a clean sheet or butcher paper. This will catch any loose hairs, lint, threads or other pieces of evidence for the case. Do not put their clothes in a pile. To develop a trauma-informed approach, it may be necessary to think about past policies and procedures that could be perfectly fine in most circumstances, but re-victimizing for a sexual abuse victim and potentially damaging to an investigation in this situation.</p> <p>Tampons, sanitary napkins and condoms should be placed separately in a sterile container labeled, and transported with corrections staff (preferably by the transport staff and not the</p>	

	<p>investigator). Each item should be in its own container.</p> <p>As with all procedures, and in particular with someone who has been victimized and feels a loss of control, explain each step of the procedure to the victim. Use your judgment as to how much detail is necessary to calm the victim without overwhelming them.</p>	
<p>9 min</p>	<p>Minimizing Evidence Loss</p> <p>Let's discuss some scenarios and have you tell me how you would respond. Keep in mind what we talked about regarding using trauma-informed approach while doing medical care and evidence collection.</p> <p>How would you respond when ...</p> <ul style="list-style-type: none"> • An inmate is required to change clothes before transfer to exam site <p><i>Answer:</i> The clothing he or she is wearing at the time of the abuse may contain potential evidence. Each article of clothing should be placed into a separate paper bag, sealed, labeled with date time and patient name and sent with the patient to the exam site.</p> <ul style="list-style-type: none"> • A suspected abuser has injuries <p><i>Answer:</i> Injuries may contain potential evidence linking the victim and perpetrator. To prevent potential destruction of evidence, the injury should be left alone. If injury needs to be dressed before sending for exam, it should be noted and dressing applied so that potential evidence can be recovered at the exam site.</p> <ul style="list-style-type: none"> • An inmate comes to clinic nude after the abuse <p><i>Answer:</i> Although there may be evidence on the skin surfaces that might be helpful, it is important to recognize that clothing should be placed on the patient for transfer to an exam</p>	 <p>Checking for Understanding: Read scenarios. Take about 2-4 minutes for each scenario. Provide feedback on their answers.</p>

	<p>site. A change of clothing should accompany the patient, as the articles they are given for transport will be collected at the exam site for evidentiary purposes.</p> <ul style="list-style-type: none"> • An inmate has extensive physical trauma <p><i>Answer:</i> Always treat trauma as you would for any traumatic injury using trauma treatment protocols. Assure that appropriate documentation of any procedures done will assist with potential evidence recovery later. Evidence collection is always secondary to preserving the life and health of the patient/victim.</p>	
<p>2 min</p>	<p>Time Frames for Evidence Collection</p> <p>Let's talk about the time frames with which you need to be aware. The PREA standards keep mentioning "If the abuse occurred within a time period that still allows for the collection of physical evidence." What does that really mean?</p> <p>Facilities should have their own policies and procedures on how long after a sexual abuse evidence is gathered. Working with local law enforcement and crime labs should aid in time frames. More and more policies are moving away from the "typical" 72 hour rule and looking at each abuse on a case-by-case basis.</p> <p>There is no one rule for evidence collection. Some evidence can be collected beyond the cutoff point as warranted in certain cases.</p> <p>The U.S. Department of Justice's "National Protocol for Sexual Assault Forensic Examinations of Adults and Adolescents" recognizes that jurisdictions vary in their recommendations for when to collect forensic evidence using an evidence kit.</p> <ul style="list-style-type: none"> • The protocol states that evidence collection beyond currently recognized time limitations are not only conceivable, but that as technology advances, it is critical for us to realize that the need to extend time frames 	 <p>For additional information, direct trainees to "<i>Timing Considerations for Collecting Evidence</i>" and "<i>A National Protocol for Sexual Assault Medical Forensic /Examinations, Adults/Adolescents</i>", Dept. of Justice, April 2013.</p>

	<p>for evidence collection will change.</p> <ul style="list-style-type: none">• Evidence that was considered previously unusable when it was collected years ago is now being tested and DNA found.• In every case where patients/victims are willing, examiners need to obtain the medical forensic history, examine patients and document findings. Not only can the information gained from the history and exam help health care providers address patients' health care needs, but it can guide examiners in determining whether there is evidence to collect and what to collect.• It is also critical that we remain open-minded and aware of advances in forensic science and laboratory techniques and adjust time limitations, when necessary.• Many states are currently using anywhere from 72 hours to 120 hours as guidelines for the collection of forensic evidence after an abuse.• However, there are newer studies that show sperm can be recovered from the cervix as long as 14 days after an abuse. Know your policy and be sure it is up-to-date on best practices. <p>In summary:</p> <ul style="list-style-type: none">• Recognize the importance of gathering information for the medical forensic history, examining patients, and documenting exam findings, separate from collecting evidence.• Examine patients promptly to minimize loss of evidence and identify medical needs and concerns.• Make decisions about whether to collect evidence and what to collect on a case-by-case basis, guided by knowledge that outside time limits for obtaining evidence vary due to factors such as the location of the evidence or type of sample collected.• Examiners and law enforcement representatives should seek education and resources to aid them in making well-informed decisions about evidence collection.• There is a new reference guide about forensic collections from www.nlectc.org and as well as plans for a corresponding webinar.	
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<p>3 min</p>	<p>What to Include in the Discharge Summary</p> <p>What should be included in a discharge summary for a sexual abuse victim?</p> <p>The discharge summary should include:</p> <ul style="list-style-type: none"> • Any testing that was done • Any medications given usually for GC/Chlamydia and Trichomoniasis • Any treatment rendered for injuries • Medical or mental health findings and recommendations • Treating practitioner • Advocacy contact information • Follow-up care timing and testing needed <p>Information should be sent from the exam site on the treatment that was rendered to the patient. This treatment usually includes:</p> <p>STI treatment medications (most of them are one time doses unless there is a cephalosporin allergy).</p> <p>Emergency contraception, which also usually as a one-time dose.</p> <p>Any HIV prophylaxis that is given follows the CDC guidelines which requires a full 28 days of medication. Many prisons, jails and lockups now have the HIV medications on-hand. You may want to add this to your sexual abuse response protocol if your pharmacy already has the medications approved.</p> <p>If there were physical injuries, there may have been a tetanus shot or other medication administered.</p> <p>Usually the name of the treating professional (may be a nurse, MD or PA if they are trained examiners).</p>	 <p>Anticipatory set. Write responses on easel pad and compare with your list.</p>
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2 min

Appropriate Follow-up Steps and Available Resources

How will you document the follow-up care and track this for auditor's review?



Anticipatory set.

(Standard §115.83)

- (a) The facility shall offer medical and mental health evaluation and, as appropriate, treatment to all inmates who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility.
- (b) The evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody.
- (c) The facility shall provide such victims with medical and mental health services consistent with the community level of care.
- (d) Inmate victims of sexually abusive vaginal penetration while incarcerated shall be offered pregnancy tests.

(Standard §115.83) (Summary)


Medical and mental health should offer on-going services and monitor patient's adjustment

Timing for any follow-up care that needs to be done by the clinic.

Scheduling follow-up clinic visits and coordination with any outside consults and referrals may be the responsibility of correctional health staff.

Repeat testing for syphilis at 3 months, STI and other communicable diseases after 3 weeks; repeat HIV testing again at 3, 6, 9 months and one year. Repeat pregnancy testing at 6 weeks.

Follow-up care usually includes testing for STI and HIV, and may include follow-up photographs

	for injury. If this is needed, there may be an appointment made for it.	
3 min	<p>For More Information/Questions</p> <p>Let's take a short quiz on the topics we covered in the four modules on the medical and mental health PREA standards.</p> <p>Do you have any questions about the materials we covered here?</p> <p>For more information about PREA, contact the <i>National PREA Resource Center</i>, www.prearesourcecenter.org</p> <p>For more information about the medical forensic exam, contact the <i>International Association of Forensic Nurses, Sexual Assault Forensic Examiner Technical Assistance (SAFEta)</i>, www.safeta.org or 1-877-819-SART (7278).</p> <p>For questions about advocacy, developing trauma-informed response protocols, and common reactions of victims contact <i>Just Detention International</i>, www.justdetention.org, 213-384-1400.</p>	 <p>Checking for Understanding: Allow 3-5 minutes for the quiz to measure knowledge and to check for understanding.</p> <p>When everyone has completed the quiz, read the correct answers aloud for trainees to do a self-correction or collect the quizzes and "grade/review" later.</p> <p>Respond to any questions trainees may have or issues that may be on the "parking lot" list.</p>