

My name is Christine Kregg and I am a program director at Just Detention International. Any of you ever heard of us before, JDI? No. Okay, great, well that's why you're here. Good.

JDI- we're a non-profit health and human rights organization and our mission is to end sexual abuse in custody. So we were founded in 1980 by a survivor of prisoner rape, someone similar to Joe, who was committed to addressing this issue in a multitude of ways. So we work through policy, we do a lot of work directly with corrections departments, so juvenile justice agencies, jails, prisons, immigration detention... and help to really address comprehensively the issue of sexual abuse in custody. We don't litigate, we're not coming in to catch you doing something wrong, we're really here as helpful partners to assist you in again eliminating and addressing, minimizing as much as possible sexual violence in detention.

So I also want to just briefly introduce Joe. We'll do more of a... a more in depth introduction when he's about to speak but Joe Booth is a member of our survivor counseling. He came all the way from Los Angeles to be with you today, to share his story, so we're really glad he's here.

A teeny bit more about me since you notice I don't have any letters after my name- all my bona fides come from my work in the field. I've been with JDI for 6 years and my background is as a rape crisis counselor, rape crisis therapist. I'm in California so that's a 60 hour certification for domestic violence and sexual assault and I've worked with literally thousands of prison rape survivors, again, like Joe, who contact JDI daily.

So we get about 3,000 letters a year from people, over 3,000 now, actually, of people who've been abused in custody. And so for a number of years, my job was to provide crisis intervention, support, information, and referrals to those folks. Then I got a very wonderful promotion and I'm traveling around the country doing trainings and TA, and also pairing directly, again, with corrections departments to help them to implement the PREA standards and again to address sexual violence. So my expertise again is in policy analysis, lots of staff training, inmate education, especially peer education where inmates train one another about this issue. I've helped to establish confidential inmate housing programs in facilities and also coordinated response teams or sexual assault response teams, also known as SARTS, within custody settings. *To someone on the panel* Think that covers it, right? Cool. *Joking* They'll listen to me now, right? Okay, great.

So, again, really, really glad you're here. We see this as much more of a conversation. There is quite a bit we'd like to cover with you in the next 90 or so minutes, but again your questions, your feedback, your input... I know you all are in a variety of places, I'm sure, with PREA implementation. Just to get a sense, how many of you attended Sundays specialized training for medical mental health? Ok, so a good half of you. My apologies in advance, then, for any redundancies- JDI worked very closely... is working very closely with NCCHC to develop that curriculum so you'll see some cross-pollination. What I'm hoping to do today, though, is to get a little bit

more in detail and in particular to bring survivor perspectives into some of these issues, so apologies if any of this feels like review.

For the rest of you who didn't attend that session, just so you know, NCCHC is developing the actual curriculum, the content, for the specialized medical and mental health training that's required through the standard so that's an awesome shortcut that all of your departments and agencies will have and it's something we're really excited to be a part of.

Quick question again for all of you... and then I promise we'll jump into the content... as far as thinking about PREA implementation, either in your facility or in your agency, we'll exempt our Canadian colleague, you're free for not answering this... I want to get a sense of how far you all feel like you are as far as implementing. You can think maybe specifically the medical mental health standards if you're not aware sort of agency-wide, but just to get a sense of how many of you would say you're about halfway or less to where you want to be- so maybe 50% or less of implementation at this point? *She waits for the audience to raise their hands*

Ok. Thanks for your honesty. Cool. You've got 'til August, so that's not bad. And the rest of you- who would say you'd be like 50-75, you're doing pretty good but there's some areas... *Waits again for audience*

Ok. And who feels like they're pretty darn there, ready for an auditor to come in tomorrow? *Waits for response*

Great. *Joking* So I'll be handing the mic over to you then throughout today's... no? Ok.

Well, please though, I really want all of you, again, to share your perspective, share what you're doing, and we'll dive in.

The last thing I'll say is that this is the first part of sort of a two part session today, the next session when I'm sure most of you will be scattering to the airport, but for those of you who are here, our last hour of the day will be spent looking at more pragmatically, how do you actually take all this really, hopefully, useful information and translate it into actual practices, trauma-informed approaches with your patients, with your clients. So just know, again, this will be a bit more of a broad overview, the start of the conversation, our next hour will be really 'so what do you do with all the info?' Right? Ok. So any questions off of the top of the hour, of things you know you'd like to have covered or are dying to ask about PREA, just so I know to cover it? *No one responds* Ok, you're giving me free reign, don't forget that. Okay, let's jump in.

Okay, have to get this out of the way- we have no financial relationships, we're a non-profit, that'll never change, so no commercial interests... aside [from] the fact that I love Starbucks . Oops, I was not supposed to say that. No, just kidding.

Okay, let's talk about what we're going to do here in the next 90 minutes. So the first thing is I want you to get a better sense of how do you actually identify some of

those dynamics of sexual abuse in custody and, in particular, what might those differences be depending on the populations you're serving or treating?

Let's... we're gonna have a... hopefully a nice overview of the immediate, short-term, and long-term impact of sexual abuse in custody. That's also where Joe's testimony will be able to give you that first-hand account that no matter how much research I give you, he's going to be able to show you better than I can ever tell you. And then finally I want you to understand, if you don't already, the basic requirements of the PREA standards for medical mental health practitioners. And we'll also, hopefully, give you a chance to ask some questions regarding the standards if any of it is unclear. So that's what we're up to today.

Again, I'm going to be asking a lot of questions, keep you moving as you're digesting your lunch. How many of you have had direct contact with someone who's been sexually abused while in custody? So again, not someone who's previously been sexually assaulted but someone who's been abused in some form of confinement? Show of hands. Ok. It's a trick question- what do you think the answer is? All of you. The fact is that all of you, whether you know it or not, whether you're aware of it or not, have had contact with someone who's been sexually victimized during their detention. And the reason I say that is because we'll get into some of the more prevalence in the reporting rates but just know this is one of the most, if not the most, under-reported violent crime including in custody settings. And so whether or not inmates are disclosing, there is just no way in your work, in facilities, that you haven't had contact with someone like Joe. So I just want you to keep that in mind, thinking about your patients, any one of them could've been victimized at some point during their detention and you might never know so we're going to hope to change that, increase those disclosures, and increase services for folks.

Ok and I just want to emphasize here- JDI's approach, our belief, our philosophy is that no can end prisoner rape and sexual abuse in custody on their own. What I mean is it's not just the job of nurses, of wardens, of doctors to put an end to this violence. This is such a pervasive, such a complex issue that is multi-layered. If we're serious about ending abuse in custody and I know you are, that's why you're here, we have to really take a multidisciplinary approach. So we have to have medical mental health at the table but we also have to have survivors and inmates and their loved ones, their voices and perspectives are really critical. Obviously, corrections officials, the custody side of things, law enforcement, prosecutors, of course, are really critical as well as advocates, sexual assault advocates.

The other thing I want to mention about survivors is JDI has a survivor counsel... I forgot to explain what that means, Joe... so that means Joe serves in an advisory capacity with about 10 other survivors, does that sound right, from around the country...

Joe speaks 11.

11, ok, he's got the stats- who've been abused at some point in their confinement. They provide us with policy recommendations, feedback, they obviously come speak with us as often as possible and again we also have survivors who serve on our Board of Directors which means they're my boss, which is great.

Okay so let's again... let's do kind of an overview of sexual abuse in custody and to start us out Joe is going to be sharing with you his story, his first-hand experiences. Joe was sexually assaulted by his cellmate in the California State Prison in 2008. He first contact JDI in 2009 and has been in touch with us ever since, which is our great privilege and great honor, that we've gotten to work with you. Joe's been featured extensively in our communications and in national media outlets so he has bravely spoken out and shared his story over and over again. Again he came all the way from LA and last time Joe and I... and the first time Joe and I spoke together was for the Virginia Department of Corrections. It was the first time Joe had been on a plane since Carter was in office, so this is how much this issue means to him, and he left his three beloved puppies which is a big deal. So it means a lot to him to be here and to share with you all today.

I also want to share with all of you some really exciting news that Joe just found out last week he's off parole for the first time in, what, decades? So this is really exciting news- he is free, thrilled to be here, no piece of paper, a permission slip coming with him. And again if you all would just help me and join me in welcoming Joe to share with you today.

Joe

Thank you for inviting me. I need to start this off by saying that I'm going to cry. Some of the stuff that I'm going to give you is pretty factual and pretty nondescript but some of it is very personal and it is very painful. So this is how I heal myself is by sharing my story and hoping that maybe some of you take a piece of it with you. It's an honor to be here.

I'm one of over 200,000 people who are sexually abused every year in the Department of Corrections. In the fall of 2008, I went to prison for attempted robbery. That was in the state of California. I'd been in prison a couple of time, had served quite a few years, I thought I knew how to handle myself. I thought I knew what to avoid. I was wrong. I didn't expect to be housed with a convicted rapist who would torture me for days. I was sentenced to 3 ½ years for the crime that I did. I will live a life sentence as a survivor. The rapes I suffered, like most cases behind bars- most, I'm gonna say all- was preventable. I don't know about all prisons but California prisons are required to separate perpetrators, predators, from likely victims, from those that would be easier to prey on.

Sam, that was my cellmate, was a known sex offender, convicted rapist, lifer. Not only was he a convicted rapist, not only was he a lifer, but he had multiple cases of assaulting his gay cellmates while incarcerated.

I'm gay, openly gay- have been since I can't even tell you when. I was considerably smaller then; I was a lot more frail. Should've never been put there. Should've never been put in that cell. I was scared from the first day I was put in that cell. Before I went to bed that first night, he caught and tortured a mouse and bragged about how he had the power of God. I told my psychologist the very next day. She told me, "we'll speak to staff and see if we can get you moved." I stayed in that cell. That move never happened.

The second night, he raped me for the first time. Pulled me off my bed, held me down, and threatened me with a knife if I resisted, told me that he would kill me, made it... no uncertain circumstances that he was a lifer and had nothing to lose. The following days were pretty close to hell for me. Each night he found new ways to hurt not just my body but me. Each one was... you know, how's it... each one was worse than one before but how do you determine what's worse?

During the day... night was hell... during the day, he would brag about to his buddies, homeboys, about what he was doing. I can't even tell you what kind of degradation it feels like to stand at a door and have people talk about you and what it's gonna cost to sell you to another man... like a was a CD player or a cup of coffee.

So I tried multiple times to talk to the staff for help. "Ah, it's a lover's spat." Really. They acted like I was the problem, like I was the one that caused this. Really. Standing crying at the door- I'm the one that caused this?

After several days of this, the rapist was taken to the medical for chest pains or whatever, I don't know. I begged, pleaded, crying to the first officer I saw- "Help." Shrugged me off. "I don't have time for your gay shit." Really.

Luckily, the second officer was an officer that I happened to know and took me pretty seriously and got me out of that cell. I thought I was safe. They took me out into the day room butt naked and sat me on a 4x4, the metal... the little cotton collection swabs. In the middle of the day room they sat me on a 4x4.

Then the ISU came. Cool, I like that. Yeah. The ISU came.

Christine speaks Investigative Services Unit. Investigators.

Joe resumes speaking We called 'em the squad. Came in with a video camera, went straight to the sergeant, talked to the sergeant and left. No interview, no questions. I knew right then that that investigation was only happening because that officer said that he thought that this was necessary but the investigation was not going to be taken seriously. How can you take it seriously if you don't ask me what happened?

I sat in the day room for about an hour with no clothes on, hands cuffed behind me, all the peoples in the cells yelling and screaming at me. Then they dressed me and sent me to the infirmary. The nurse asked me some questions completely unrelated to what I was going through. There was a correctional officer between us. I was handcuffed, the attitude towards me like I was the perpetrator, like I was the one

that did something wrong again. After the nurse asked me these few unrelated questions, I interrupted and said, "Hey look, I was raped for four days by my cellmate." They decided to send me to an outside hospital and give me a rape kit. Put me in a suicide cell and you know, of course at the time you don't think that's necessary but now I understand the situation but boy, I didn't at the time. The processes really started then. You know did the whole full medical exam, the whole 9 yards. Had a rape advocate. I can't even tell you how much of an angel that lady was. She was the first person in that whole situation that asked me what my first name was, that treated me like a person. Not just G-2-7-whatever-whatever whatever. I'm a human being. And then after the exam they returned me back to the prison and put me in the cell right next to him. So I complained. They put me in another cell with no running water for a week... in July in a cement cell. Those of you that work in institutions, you know how bad that can get.

Once I was out of immediate danger, I began to sense the... the devastation of what he took from me. I've been beat up, stabbed, all that, that hurts... but nobody ever took what he took from me. I had a complete medical... a complete breakdown. I was destroyed. I was already living with HIV. My doctors and I was pretty sure that I was going to be one of those people that you hear about, you know that live 10, 15 years with HIV without ever having to take a pill. I was completely undetectable, those of... you're all... most of you are medical professionals, the numbers are pretty much irrelevant but I was undetectable.

Immediately after the assault, my diagnosis changed from HIV to AIDS. I now will take medication for the rest of my life. That really kind of hurt. You know it's one of those things that, once you start medication, you gotta take 'em for the rest of your life. Sam robbed me of that. Sam robbed me of not having to get up every morning and take a pill. That doesn't sound like much but it means a little bit to me.

As I slowly started to accept the reality of the fact that I was a rape survivor, I made contact with JDI, by the way the only organization dedicated to this cause- and believe me I searched and looked, this is the only organization dedicated to that. At the time I didn't know there was anything like that- I know, I looked. They put me in contact with rape crisis service centers, some other organizations and... you know, that helped me with some legal issues to seek justice. They held my hand through the mail- between them and my mama, I don't know how... if I'd a made it through.

You know but once I was transferred out of that prison and put into a lesser security... oh by the way, this all happened in ad seg. I began to pursue legal actions. They found DNA evidence (*points to himself*) willing victim. Nothing was happening with the investigation. I was determined to try and change that. I contacted the sheriffs department, Department of Justice... if there's a department, I contacted them. I didn't receive... not a single response with the exception of the Sheriff's office and what they told me was that, "Because I'm an inmate, I cannot file a sexual assault case against another inmate in the state of California." Really.

So I'm educated, good vocabulary. I got in the library and started educating myself. With absolutely no assistance, no paralegals, nothing, me reading books, I was able to get my case in front of the California Supreme Court. And that's when I ... after I got in front of the California Supreme Court, that's when I was finally able to get an attorney to help. There had never been a prisoner charged by another prisoner for rape in the prison that I was in. I was the first one to do that.

The case went to preliminary hearing- dismissed for lack of evidence. Anybody on the street can say, "He did this to me" and they're going to take it to court. There wasn't enough evidence, huh? The charges were reduced to a lesser crime; lesser crime- consensual sex inside a prison. I did not consent.

Oh boy. I've been through a lot but I can stand here and talk to you folks because of JDI, my mom- their support is just unmatched. I no longer consider them a source. They're my friends, they're my cohorts. My mom, RIP, is my guiding angel. I am also much healthier now. I still take medications. I am 60 pounds heavier, 65 pounds heavier than I was then, much better shape. Not everyone is so lucky.

You know, of the hundreds of people who are sexually abused each year in the detention center, most do not even get the delayed reaction that I got. All you gotta do is look at the prisoner victim suicide rate. Those of you in the... you know what that's like. They don't have friends or family or JDI.

Knowing first-hand the devastation of prison rape, I want to make sure that this kind of thing doesn't happen to anyone, ever. The prison where I was incarcerated should've never let me get raped; should've never put me in that prison. And once I was raped and disclosed, they should've reacted professionally. They should've listened to me. But I'm just an inmate.

It's still not easy to share my story but if people like you who are inspired just a little bit to look at everyone that's in your care, everybody that's in your care- I don't care how big or strong they look or how weak or small they look- don't look at their chart, look at their face. You're going to make a change; you're going to help somebody. You know if it's only one person, isn't that worth it? Thank you.

Christine Kregg

I think I can speak on behalf of all of you in thanking Joe, very sincerely that satnding ovation for you, for your courage.

Joe knows that the deal is when he comes to do this, he gets to do whatever he needs and wants to do to take care of himself. So we'll actually be exploring some of the trauma reactions that Joe is sitting here going through right now and so if he steps out or isn't available for your questions, you can contact me. Via me, we can get in touch with Joe. He's committed to being here but again he may step out for a moment, he may rejoin us, whatever Joe's gotta do, he's gonna do today to take care of himself but I thank you all very much for listening so respectfully. Joe's testimony

is also available on our website at justdetention.org if you'd like to read it. Joe, thank you again.

So before we get into the numbers, right, nobody came to sit in here for the numbers... I want you to be thinking during the rest of the presentation about Joe, about inmates like Joe, about survivors like Joe... as we talk about some of these immediate short-term and long-term responses, I'm actually going to refer to some of Joe's experiences since there isn't a day... there isn't a day that goes by that he's not still dealing with this. He never gets to not be a prisoner rape survivor so my hope is that there never is a day that's going to go by when you're not going to be an advocate or supporter of prisoner rape survivors. That's the difference we can make together.

Excuse me, I'm just going to do a quick time check though- ok got a couple minutes to make up here. Just want to see where we're at.

Ok folks, so for those of you who were here on Sunday, this is a familiar graphic and, again, just want to underscore that our most recent research, the best stuff we've got, which comes through the Bureau of Justice Statistics through the Department of Justice, shows that nearly 1 in 10 former prisoners report some form of sexual victimization during their most recent incarceration. I'm going to give you a couple of caveats here to put this in a little context. The first is that these are anonymous self-reports. Inmates sat at sort of self-enclosed cubicles, there was a video and sort of a computer component to this, so these are not official reports, I'll give you those in a second. And again keep in mind this is only during their most recent incarceration. Joe was incarcerated I want to say 3 or 4 times in his life so this is only during a single period of confinement so we know that the actual numbers of people are actually higher. Also, this isn't incidents, this is individuals. So if we saw one number and you're picturing Joe's face, he was raped how many times? In how many different ways, right? So again, we're not talking about incidents of victimization, we're talking about people. Nationally, as Joe mentioned, that rate is about 209,600 people who were abused in the U.S. in confinement- so jails, prisons, youth detention in a single year alone. It's not ever, ok, single year- so that's what we're looking at.

The other thing I want to point out is that when we're talking about official reports in '08, there are about 7,5000 official allegations, right? Ok so Joe reported, that would be considered an official report. When prisoners were surveyed anonymously, it was 91,400 who disclosed sexual victimization during that same time period. So for our math geeks, what kind of a reporting rate is that? 'Bout 8%. That's what that comes out to- about 8%. So again, in that time period, facilities were aware of... or not aware of 92% of the sexual victimization occurring and survivors like Joe are in the minority who have the courage to come forward and report so just keep that in mind. Many, many more are suffering alone, suffering in silence with this... with this abuse. And again I welcome your questions at any point- I'm just gonna keep us rollin'.

What we also know from the research... I think this is for me this is one of the most devastating stats is that half of all known perpetrators are staff members- that's custody and civilian. Other half are inmate perpetrators. That is true of men and women... well, so this is our overall number, I should specify. With female detainees or inmates, they're actually more likely to be abused by another inmate- which is surprising to a lot of people. So again, if you're a woman in a women's institution, you're more likely to be abused by another inmate. If you're a male detainee or male prisoner, you're more likely to be abused by staff. Among juvenile detainees, juvenile survivors, those prevalence rates are even higher, 1 in 8 are abused in custody. Of those, 80% of perpetrators are staff. So again, if you're a juvenile, if you're in juvenile custody, you're far more likely to be abused by a staff member- just want to point that out.

The other thing we know is that survivors are abused repeatedly. So in about a third of overall cases, survivors are victimized 3 or more times, so those are the Joes we're talking about. But when we're looking at staff sexual abuse, 2/3 of those survivors are abused repeatedly. Again, you don't have to scribble down the stats, I'm happy to e-mail them to you or point you to the research but just know we're looking at truly an epidemic. This isn't something that's incidental, it's not something that's every once in a while, it's happening every day around the country in facilities like yours. So again, that's why I'm really glad that you're here. Just keep in mind that repeated victimization by staff, a lot of that has to do with access and not getting talk- and we'll talk a little bit more about that.

All right, before I flip the slide, I'm going to ask you all who do you think those inmates or detainees or residents are who are most likely to be targeted? So thinking about Joe, thinking about his characteristics and others, thinking like a perpetrator... ew gross... but seriously- who would you go after? Who do you think is most vulnerable to sexual victimization? And you can just call it out, you don't need to use the mic.

An audience member responds

The weak? I always hear that. What does that mean, weak?

The audience member answers

Frail, ok. So you're talking about physically, kind of physically smaller in stature. Yes, absolutely. Who else?

Someone else responds

Timid, ok- so maybe newer to the facility, less aware, maybe less experienced, absolutely, sure, yep, perpetrators can sniff that out in a second.

Another audience member shouts out

Introverted, okay, so again looking at some of those social characteristics, yep

Another response

Mentally ill. Absolutely, right. And again, let's think like a perpetrator. Perpetrators are looking for three things, this is their... this is the rapist success plan, ok? The first is go after someone who is least likely to tell, right? So somebody who, for whatever reason, prior victimization, perhaps they're not even coherent are unlikely to tell. The second thing is if they do tell, they're least likely to be believed. Ok, so they're the people who, for whatever reason, and I missed the first one is those who are least likely to fight back. Right? Who are physically less likely to defend themselves. So least likely to fight back, least likely to tell, least likely to be believed if they do tell. So what we know, [of] course, chronically mentally ill or seriously mentally ill inmates many times are seen as malingerers or that they're exaggerating and again, look, we get reports from some survivors who report being raped by satellites in their sleep. Ok, obviously we know 99% of the time they're not being raped by a satellite, but what would that indicate to you all? Something's going on. Mental illness but also that perhaps something is going on, there's some abuse that's occurring that they're not able to articulate, right? Or that there's some kind of act of auditory or visual hallucination doesn't mean there shouldn't be a full investigation, yeah, but we even... we of course hear from folks who are very seriously mentally ill.

Ok, I'm going to fill in the rest of it. Again, this is from national research as well as from incidentally what JDI hears from survivors. The first group is bi-racial or multi-racial inmates. Why do ya'll think that is? Why would those folks be more likely to be targeted sort of in a national sample? It's because, I'll give you the punchline just 'cause we're short on time, it's because they don't have a natural affiliation group, right? Think about your facilities, think about the racial segregation that we know still occurs- if not formally, then informally. If you are not, right, black, white, latino... if you don't have a natural affiliation group or a gang that you can affiliate with, you're on your own, right? You're much more vulnerable and so we see repeatedly in studies much higher rates of victimization in those folks. Also, any minorities, racial minorities, in a facility or in a unit, are more likely to be targeted. So what I mean is you might be in an area where people of color are in the minority perhaps in your community but if in a facility they're in the majority, they're more likely to be the perpetrators and whoever is sort of the racial minorities in the facilities are more likely to be targeted. So just keep that in mind. We hear a lot of myths about prisoner rape of, for example, black, predatory inmates, it's just simply not true. Those racial stereotypes don't play out in custody- has to do with the composition usually of your inmate population.

Ok, folks with disability or mental illness, we talked about that- seen as less credible, certainly, oftentimes many more barriers to reporting for those folks. Survivors of previous sexual abuse, yep, what we know from research is they're about six times more likely to be targeted than those inmates that don't report a history of trauma. Younger inmates, absolutely, especially juveniles in juvenile facilities.

And then finally, lesbian, gay, bisexual, transgender, and intersex inmates. For those of you who've read the standard, that's an acronym we see in there a lot, right? Talks

about LGBTI inmates as well as gender non-conforming inmates. For those of you who aren't familiar, transgender refers to someone who's... it's sexual identity, not sexual orientation but sexual identity, doesn't conform with the sex they were born to. So if I was born with male sex characteristics but I've always identified as female or as a girl or a woman, I might be considered a transgender woman. Okay intersex refers to people whose, um... it's more kind of a genetic designation of someone who's genitalia may be ambivalent... or not ambivalent, ambiguous. And then finally, gender non-conforming – folks whose gender presentation doesn't conform to social or societal norms. Those folks are at absolutely the highest risk of any group of inmates. So Joe, perfect example of that... but they are ten times more likely than heterosexual-identified inmates to be targeted- so this is a group we really have to keep our eyes on... and even those who are perceived to be, I can't tell you how many survivors we've heard from who are assumed to be gay who are targeted for that reason. We had one guy who... also in California... who the inmates found out he was a bouncer at a gay bar and so his cellmate a couple nights later tries to sexually assault him or, no, he didn't know he was a bouncer he just knew he used to go to gay bars or his best friend was gay, he didn't know he was a bouncer and so in the course of...

Joe reenters the room

hey, Joe...

In the course of the night, he went to go attack this guy and he was able to physically defend himself in this case, but all it took was him being perceived to be gay for him to be at increased risk. Questions about that?

40:30

I want to look more now at some of the actual dynamics, right, I know that some of this had come up in the presentation on Sunday. [I] want to get into a little bit more about this so that you all as practitioners again sort of know what to look for, know what some of those dynamics are, and also to see what dynamics are prevalent at your facilities that you're aware of.

First thing I want to put out there, I think we're all in agreement on this but if not I have to say it is that sexual assault is an act of violence. It has nothing to do with sexual desire, lust, or attraction. And the way I put that out there is for you all... if you have sexual desire or attraction to someone, my guess is that you don't want to actual humiliate, degrade, or physically overpower them, right? Intimacy, attraction is about connection, it's about intimacy, it's about respect. Rape is a violent crime where sex is the tool, is the weapon, if you will, that the perpetrator uses. It's about power and control; it's a way to maintain hierarchies, which as you all know, in custody settings- pretty hierarchical places, right, not only between staff and inmates but among inmates. So rape, sadly, is one of the most effective ways to keep people in their place. That's why we see it as such a prevalent war crime, because rape is a really great way to degrade, humiliate, and destroy people, unfortunately.

What we know about sexual assault is that it exists on a spectrum and it often, if it's not caught, if it's not reported, if it's not stopped, it's likely to increase in intensity and severity over time. Unfortunately, Joe's story is a perfect example of that. He talked about how over the period of the abuse it actually worsened if that's even possible to put it that way. But the perpetrator, once he knew he could get away with it, proceeded to sort of deepen the level of humiliation and abuse of what he was perpetrating. So we know that. So it's important to keep that in mind.

What I want to mention is that state and federal sexual assault laws, so criminal sexual assault laws, right, your penal codes- do you think they extend to prisons and jails or no? Show me by head, yes or no. What do you guys think? Yes, yes, yes.

Yes. 100% yes. The same sex crimes that are illegal in the community extend to every single confinement facility in this country. There are no exceptions to that. They carry the same penalties. If anything, they may now carry additional penalties so since Joe was victimized, many states have passed laws or increased penalties for sexual abuse that occurs in custody, particularly for staff members. So you'll now see some additional added penalties that prosecutors can use to go after staff perpetrators or inmate perpetrators. Sadly though, we hear and see all too often- cases like Joe's where those charges can be bumped down to sex with an inmate, consensual sex with an inmate, which of course is not a sex crime, it's not a felony. So we take that really seriously.

One thing I want you to keep in mind, ya'll, is as you're thinking about sexual violence in custody is we're not talking about someone, right, jumping out of the bushes or attacking someone in the shower with a lock and a sock. Certainly it happens, certainly we see overt physical force being used and we'll talk about that. But the vast majority of abuse in custody uses forms of coercion that are often not physical in nature, right? So threats, abuse of authority, promising additional privileges, right, taking advantage of someone's vulnerability... and the reason for that is: perpetrators are cowards. Perpetrators are going to use the least amount of force necessary to carry out sexual abuse, to be successful. Why do ya'll think that is?

If I could get away with threatening you, for example, with a knife instead of physically beating you, why might that be beneficial for me as a perpetrator?

The audience responds

Thank you. Yes. Less evidence. Exactly. If I can get away with threatening you and your family, leave no physical trace, right? "Semen- that just means we had consensual sex. What are you trying to prove?" Right? If I can get away with sexually abusing you or coercing you without use of physical force- less evidence. Does that mean these cases are going to be tougher to investigate? Yeah. Does that mean your role in collecting information and providing care is that much more important? Absolutely. But these aren't the easiest cases to understand or uncover, especially given the shame around it. So I just want to point that out.

It's important to keep in mind that prisoner's choices, like Joe's, are constrained in so many ways that often, instead of thinking about consent, it's more helpful, I think, when we talk about prisoner rape to think about coercion, to be looking for the absence of consent but more so-what coercive factors might be at play? What power differentials are going on? So again I encourage you to sort of think of it that way.

I want to really quickly go through some of these again and I'm just going to glance at our time here. Ok. So when we talk about sexual harassment, folks, the reason I want to emphasize this for a second is not only that it's included in the PREA standard so we've got to be thinking about sexual harassment- so unwanted, unwelcome sexual advances, it can be requests for sexual favors, it can be comments about someone's body that are degrading, right? The reason why sexual harassment is such a big deal, guys, is that it often lays the foundation for more serious forms of sexual abuse. We also know it's a frequent grooming behavior of perpetrators. What do I mean by that?

I work directly with the Miami Dade County Department of Corrections. There are 6 sites... no, used to be 6, now 5, they closed one down... site department, county department, they've got over 6,000 inmates; they're bigger than a lot of prisons I've worked in. And I was working with one of the security lieutenants who told me that there was an inmate in one of her facilities who was being leered at by another inmate in the shower. It was a guy who would watch him all the time when he showered. Do you think he reported it? No. "Come on, right. He's just... the guy is just messing around with me, he's just being a jerk, no big deal." A couple of weeks or a couple of days after that, the inmate who was leering in the shower left his pubic hair on this other inmate's bed. That was when the inmate who had been leered at realized, "look, this guy's sick, this is escalating" and he told staff. The great news is that MDCR, Miami Dade County, did a great job of responding to the incident, collecting information, they separated the two and they moved...

Something goes wrong with the presentation. It takes a minute or two to correct.

Ok. Pubic hair in the bed- that's where we left off, right? Okay. You wouldn't believe the vocabulary we get to use everyday. Just like ya'll, right? Medical staff or crisis counselors - we get the same thing; we use words most people never want to have to hear. Okay. Scrotum, right? Okay. Still hate that word.

All right so in this case, right, they intervene, inmates were separated, the victim was given some needed services, assessment, reclassified so was the perp, did an investigation... Do you think by those actions, MDCR prevented possibly more serious sexual violence? Absolutely, right.

An audience member says something regarding the presentation messing up again

Otherwise we'll hear screaming. Ok. Gotcha.

Kim moves to fix the presentation

Thank you, Kim, I appreciate that. Um, we'll all pretend like we can totally concentrate now, right. We'll just... we're in this together.

Okay, so again. Preventing more serious crimes. If sexual harassment is occurring, you don't want to wait and find out if the perpetrator intends on escalating, right, the violence... so good to be aware of.

Protective pairing, right? What do I mean by that? You all are the experts, you tell me-what am I talking about there?

An audience member responds

Okay, so you're talking about more sort of protective custody and classifications. Sorry, no, but good point- he absolutely should've been protected. What I mean...

Another audience member, George, responds

Yep. He or she doing that. Exactly. So I'm not sure everyone heard George so, yes, another prisoner, exchanging... essentially when someone exchanges protection by providing sexual or other favors, oftentimes they're doing a lot more than being raped... oftentimes they're also cleaning for someone, cooking for them, taking care of them. So it's often a very gender dynamic, right, someone is seen as the man, someone is seen as the woman. It's also a dynamic that can occur with staff members.

An audience member speaks

Say that again?

The audience member speaks again

Yes. Yep, you'll here "daddy," exactly. You'll hear those terms although, again, with the kind of... the coercive sexual nature, keeping in mind that if I'm exchanging sex for my survival, is that consent? Right, no. Consent we're talking about an act of free will, right, of someone understanding the ramifications. If I'm doing that in order to survive or I'd rather be raped by one person than gang-raped, that's not consent. The reason why that's so important for you all to understand that is in your education and work with your... with your patients, with your clients... that many of them will look at that dynamic and assume that that's consensual. Joe and I talked about that over coffee this morning for an hour. He's got a lot of really great ideas about outreach and how to educate inmates on this topic in particular so feel free to approach him on that. But it's something and it's really important... that is perceived, both by inmates and staff as consensual many, many times and it's just simply not. You don't see trauma reactions from that... from a non-consensual...

An audience member speaks

Uh huh. Good question. So the question was asking whether or not... your understanding from PREA is that there's no consent. So, actually you're right and

wrong so let me tell you about both. It's... both are true. So according to PREA, PREA has nothing to do with inmate on inmate consensual contact. The standards actually acknowledge, the Department of Justice acknowledges, that two adults can agree to have a sexual relationship in custody, however, it's against the rules in many states and against the law. So in many of the jurisdictions we work with it's a misdemeanor, it's considered a rule infraction. So the Department of Justice has no opinion whatsoever on your ability to regulate inmate sex, but the standards have nothing to do with sex. What is considered non-consensual per the PREA standards is any sexual contact between staff and inmates. So in all 50 states, that's considered sexual assault, right, it's part of the penal code, it's considered a sex crime, in some states... it carries various penalties. So you're correct. When it comes to staff having sexual contact with inmates it doesn't matter if it was willing or not, it's considered sexually abusive and it's covered under PREA. But if 2 inmates are caught engaging in what appears to be consensual sex, you're going to have to make that determination whether or not there was coercion. If there wasn't, then it doesn't fall under PREA. Good question. You can still have a rule violation but it's not PREA.

An audience member raises his hand

Yes sir.

He speaks

What do you... which PREA... sorry, PREA's not a person- are you talking about the commission? What are you referring to?

He speaks again

Uh huh. So maybe looking at the commissions report, yeah, over time that really changed and so I don't know if that was from input from survivors or from various advocates. I'm not sure when the shift happened to be honest. I do know though that in the final draft of the standards that it makes a distinction between what's considered consensual sex, again even if it's against the rules, even if your department says inmates can't have consensual sex, and coercive or non-consensual sex, because again there's really a need to handle those differently. I'll give you one reason why and then ma'am I'll come right to you. The reason is that if you have a case of two inmates who are having sex, consensually but against the rules, you have potentially, right, a rule violation. You've got two sort of suspects in that case, right, two people who've broken the rule but you don't technically have a perpetrator, right? There's not someone who is violating or sexually abusing someone else, which means you also don't have a victim. So in cases where there is non-consensual sexual activity happening between inmates, you're going to handle those two people or there could be multiple people, but your suspected perp, your suspected survivor very differently, right? One is going to need access to emergency medical mental health care, there might be a collection of forensic evidence, one's potentially facing felony charges, right? You're potentially looking at a federal crime, I'm sorry, a felony conviction. So those really are, excuse me, two very different scenarios. The

challenge for departments is in determining: how do you really parse out what's consensual and what's not? And it's not an easy thing to do, especially when you're criminalizing sex, makes it even trickier, inmates aren't going to want to talk about it and many times they'll just say, "No, no no. We agreed on it" because they don't want to escalate. Ma'am, you had a comment or question?

The audience member speaks

Yeah. That's correct. I'm talking about adults, thank you for clarifying. Yes. In juvenile custody, exactly, of course, the same laws regarding consent, age of consent applies. Yes. Thank you for clarifying; that's really important.

Ok. Let's zip through these 'cause I do want to keep us going and I don't want us to miss some more of what's kind of coming down the pike. Ok so we talked about exploitation, abuse.

I want to quickly mention abuse during searches, ya'll. We're hearing more and more from people who are being sexually abused during pat searches. Again, thinking like a perpetrator, if you're a staff member who wants to abusively grope someone, penetrate them, right? We've heard of survivors who have anal tearing as the result of abusive searches... just think that's a great opportunity to sexually assault somebody, right? Cuz then you can just say, "I was doing my job. It was a misunderstanding. I was simply being thorough." Right so if it's something where... if it's a he said, he said or a he said, she said, who do you think most people believe? Right. The staff member, so just being aware of that.

Really quickly just be aware- perpetrators, we talked about, will use a variety of methods again usually the least amount of force necessary to carry it out. The only one I want to comment on briefly is medication and drugs. I don't just mean perpetrators medicating somebody in order to carry out a sexual assault. That does absolutely happen; we hear that in custody. What I'm also talking about here are inmates who are overmedicated. I'm talking about your patients, your clients who may go back to the cell block take their evening meds and knock out, literally, right? Or during the day they take their daily dose and they're just kind of... kind of passed out, slumped on a table, sort of catatonic. Unfortunately we've heard more and more reports from inmates who will take their meds as prescribed, they're not abusing them, they're not cheating them, they're taking their meds, who wake up from sleep and are anally bleeding or who wake up and someone tells them, "Look, last night some guy came over in the dark, I don't know who but he was groping you on the butt. I don't know who it was, I couldn't see." Right? So we've actually heard repeated reports from inmates who are, again, overly medicated who are being targeted by perpetrators for that reason. So as medical mental health practitioners, yet another reason to be sure that we're really making sure that folks are on the proper dosages; we're really tracking their level of functioning. It can put them at much higher risk for abuse if they're checked out, if they're falling asleep and sort of in that very deep sleep from the meds. Perpetrators know it. Right?

Ok. I know that this was covered as well on Sunday, I just want to briefly remind you all, again, that what we know is that the majority of survivors don't report. That's especially true with staff sexual abuse. What percentage of cases of staff abuse do you all think are reported? Just throw out some numbers. Out of 100 inmates, how many are going to tell? 2? Less than 10? Ya'll are too smart. 6. You got it, yeah. So about 6% of abuse that's perpetrated by staff members is reported. Inmate on inmate it's closer to a third of the cases.

This also came up Sunday but just know that for medical mental health, we always assumed incidentally that medical mental health staff were much more likely to get disclosures because of the relationships you have with inmates and your contact. Unfortunately from the research we're seeing only about 15% of the time are medical mental health staff getting that initial disclosure. So part of our goal with training like this is to really help inmates perceive medical mental health staff as a real resource and as a real ally in addressing sexual assault. So your role could not be more important.

As you can see in the graphic, the reasons why most of these folks, again, like Joe, never come forward- embarrassment and shame is the largest reason; also fear of being punished by staff and of course fears about the perpetrator- and we'll talk more about that. These fears are well-founded, folks, right? People aren't making these up. So if you can see, for folks in the back, the victim, the perpet... or, sorry, not the perpetrator but the survivor was actually written up nearly half of the time when there's a staff perpetrator and nearly a third of the time when it's inmate-on-inmate. So again, someone like Joe coming forward and him actually getting a disciplinary case, right? Again, maybe perhaps for inmate sex, right, we hear that all the time. Moved to solitary confinement- for many survivors that can be experienced as a form of punishment, for others it can really be... feel like a relief, it can feel like a much safer place to be, it just really depends and that's why that case-by-case checking in with your patients, seeing where they'd feel safest is really critical. That's also why your role as medical mental health in responding to these incidents is so important because who's going to know better than you all where someone would be safest, right, where someone would physically, emotionally, and mentally be safest, right? Your recommendations are critical; it can't just be custody making those decisions. They've got to be consulting with you if they're not already.

And finally perhaps even worse case scenario, Joe, I don't know if you'd agree with me on this- no response, right, in cases of staff abuse or inmate abuse. We need to be aware of that as well. What a huge disincentive to come forward to report, to risk being labeled a snitch, if you know not a damn thing's going to happen, right? You're possibly risking your life for what? Some of these are very well founded fears. Again this is through the BJS, this isn't our research.

Ok. So let's get into a little more of the fun stuff, right? Let's talk a little bit more about sexual trauma and about what it's like to be in custody when someone's been immediately traumatized or over time. So this will get us a little bit more into trauma. How many of you all sort of feel comfortable or familiar with trauma? And I

don't mean sort of blunt trauma, physical trauma but more kind of... ok. So a couple of ya'll. Ok.

Essentially, trauma theory is still pretty new, right. It's a field sort of... we've got... Since the 1970's we really started looking at more theory around trauma where researchers and practitioners were seeing sort of similarities and reactions from Holocaust survivors, survivors of abuse, right, people coming back from conflict, from combat... and so what we know is that trauma, a traumatic event overwhelms a person's normal ability to cope. It's experienced as life-threatening- so either the threat of life or the actual sort of immediate possibility of someone losing their life. Traumas are experienced with a sense of fear, a sense of horror, often a sense of helplessness, right, where someone is powerless to change what's occurring to them. It's physically and emotionally overwhelming and painful and trauma really describes the physiological response of what's going on with someone when they're experiencing a traumatic event. Nationally about... for those of you who do trauma research, you know this stuff, but about 70% of folks in our country at least have experienced some form of trauma in their lifetimes. However, of those, about... up to 20% of them will develop PTSD and we'll talk about why that is, why that distinction.

Let me ask you though: what are some examples of trauma you can think of that sort of fit in that criteria? It's not having a fight with your spouse, right, it's what are those situations that can be perceived as life-threatening to someone?

An audience member responds

Car accident. Absolutely. Any kind of accident of that type, yep, any kind of major travel accident so airplane, train, absolutely. Other examples of trauma?

Another response

Absolutely, of course, hurricanes, tsunamis, you name it- natural disasters. Absolutely, of course depending on the severity. We get... what are those called? Why can't I think of the name? They're not hurricanes... what is it in L.A? *One of the other panelists tries to help her come up with the word*

No, not typhoons. When the earth shakes. *The panelist says "Earthquakes."*

Thank you! Is it Friday? No. Anywho, we get a lot of those all the time; those aren't quite traumatic though. Yes- other examples of trauma?

Another audience member responds

I was just going to say- witnessing... especially a sudden, unexpected violent death or mutilation, absolutely. Sexual assault, right? Any kind of physical assault can be experienced as traumatic if it's life-threatening. Also witnessing ongoing abuse or severe abuse to someone else can be a form of trauma. Great.

So let's talk about what's really going on for someone during a trauma. So let's talk about a little of the fun, neurobiology stuff for a second. So when someone is experiencing a trauma, most of the time, and for those of you who attended Sunday, you're picturing that diagram that Karla had, right, talking about the bypass of the brain. For those of you who didn't get to see it, I'm just going to kind of move around my hands to show you. But for our normal cognitive functioning, most of us are using our... the front of our brain, right? Cerebral cortex. We're kind of higher level cognitive functioning, we're thinking, we're reasoning, we're making decisions, right? That's sort of that adult, more advanced brain. When someone is exposed to trauma, that survival mechanism kicks in. It's no longer about thinking, about rationalizing, we're immediately moving into survival mode which means our amygdala's taking over. Our brains are literally hijacked during a trauma so that our fear center, right, you can call it our reptile brain, right, is in charge which means there's no time to think- we're reacting. And I'm sure many of you have heard of the 'fight or flight' response, right? Who's familiar with that? We've kind of heard about that. Ok.

Freeze is one that doesn't come up as much but in fact is far more common. Tonic immobility is a term some of you, right, are familiar with. A lot more research has been done with tonic immobility with mammals, non-human mammals, but there's been some great research out there looking at the effects of when someone is being traumatized looking at that short-term paralysis. Many times survivors will say "I couldn't scream. I opened my mouth and nothing would come out." That can be a sign of that tonic immobility- someone literally unable to process verbally or to speak verbally during... when that's going on. And Joe, you had talked about how as you were being abused there was much more of that fear response or that freeze response, right, and how uncomfortable that was to you as somebody who was used to physically defending yourself. Again, that is a normal neurobiological response and I think, again, as medical mental health practitioners to be able to even just explain that and I mean, Joe, you and I have talked about that and the biology of trauma it can just help to take away that shame and that stigma that somehow you did something wrong because you didn't physically fight back or defend yourself.

One of the other ways you can kind of make sense of it to a survivor is looking for examples in nature... so that survival response. If you see a bear that's being attacked or there's some threat to a bear, most bears are going to either flee, get the heck out of there, or try and fight- that's what those nice big claws are for. You don't often see them curling up in a ball and trying to play dead, right? That's just not what their instinctual response is. But if you're looking at gazelle or something, right? Are gazelles are going to fight back? Are they kind of putting up their dukes? No. Their instinctual response is to run, is to flee. If you're a prisoner rape survivor in a cell in ad seg in the middle of the night...

(Talking to Joe) Were there any officers posted outside your cell, no, that you could've screamed for? What option did Joe have except to shut down and bear it, to try and do everything he could to make the abuse be over as quickly as possible?

Because he knew not consciously but in his neurobiology, his survival mechanisms, that if he tried to fight back he could be killed. So that was an instinctual response and it is so common with the survivors we work with.

Again, another example of the freeze response- just think about what possums do when they're threatened. You ever seen 'em curl up in their little ball with their tail up and just kind of sit there like they're dead? Possums literally play dead when they're being targeted, when they're being threatened so those are some examples of things we see in nature. We're just mammals at the end of the day- we're no different, so it's a good example of that. Ok, good, covered that.

Let's talk about sexual trauma though since that's what we're really covering, that's what PREA is about. So what we know about sexual assault that's different from, say, a car crash, right, or a natural disaster is that it's one of the most personal forms of victimization and the most personal form of trauma. And there's a couple of reasons for that. The first is that during a sexual assault, someone is not only out of control what's happening with their body but it's literally like their entire choice, their entire personhood is being taken away from them and Joe sort of described that, right? All of their agency is being taken away from them by that perpetrator. It's also experienced by many survivors as something they did that caused the abuse to happen. When I'm involved in an earthquake, I don't think that I caused it because of my attitude that day or what I was wearing. "I didn't cause the earthquake- it just happened. I just happened to be involved in it." Same thing- car crashed. Sometimes there's some self-blame involved but you don't typically have support groups for people who are self-blaming because of maybe someone hitting them on the freeway, right? There's still a trauma response but the difference with sexual violence is that victims are primed to blame themselves and we have a victim-blaming society, especially for male survivors in custody- so just being aware of that.

The other thing is that in most sexual assault cases the perpetration is by someone they know. This wasn't a stranger who was abusing Joe, it was his cellmate, someone he was supposed to be safe with. In cases of staff perpetrators, 90 some percent of the time, they're going to know the person abusing them. So again, that increases and compounds the trauma and the victimization for the person. It's very personal and again leads them to believe it was something that they did.

We also know, of course, as Joe described, sexual assault affects survivors' core sense of self, it affects their health outcomes over time, it affects their self-esteem, sense of who they are. He described the affects on his HIV then moving into AIDS so just being aware of that. That's not always true of every kind of trauma.

The other thing we know is that that abuse, or, I'm sorry, the affects of that abuse can last a lifetime. There's a lot of great research on mitigating factors that can reduce the incidents of PTSD but what we're going to talk about is that, in custody, those resiliency factors are pretty darn hard to come by when someone's in a confinement setting just because the very nature of the environment is often re-traumatizing- so we'll talk about why that is.

Be sure I didn't miss anything critical here for ya'll. Ok.

So let's really look at what's going on then in the immediate aftermath of a sexual assault, right? So what we know is that when we're looking at trauma responses, when we're looking at hyper-vigilance, right, the release of those adrenaline... the hormones that are getting released and the hyper-arousal... we know that the immediate functioning of a survivor is impacted. So again, as practitioners, we're looking for... someone comes in the clinic and says, "My butt hurts," but you notice they're trembling, thoughts are racing, they're having a hard time concentrating on what you're saying, they mention that they haven't been able to sleep in three days, what are you... what should you be thinking? Probably there's some kind of sexual abuse that might have occurred, absolutely, and there's more to the story that you might not be hearing.

The other thing that you want to be aware of is that whenever a survivor is triggered, so not just in the immediate aftermath but if, say, months later and Joe, can I share the story about when you were pulled in the day room at that other prison? Yeah.

Joe was transferred to that other facility he told you about. Well one day there was a race riot, right, and they asked... the officers in the unit asked that all the inmates go into the... was it the kitchen, the cafeteria, and sit handcuffed in the middle of the room, right, and just sit there out in front of everybody. Well at the time Joe was an extremely compliant, would you say you were a good programmer? He never had any disciplinary issues. He flat out refused to do it. He's like, "There's no way you're getting me to go do that, sit down handcuffed in the middle of the room." He didn't even know at the time the reason he refused to do it was because that is what had happened to you, when he was sexually assaulted but that instinctual survival protective response kicked in to keep him safe. His brain, his body was saying, "If I go do that I'm going to be abused again. If I go do that, I might not survive." Joe didn't even know why then, right? It was only until later that you realized that was that kind of response.

Give you one other example. Last time Joe and I spoke together- can I share about when you went up to your room with the noise? *Joe responds* Ok. You're reminding me about all this stuff.

Last time when Joe spoke to an audience he did an amazing job, he was thanked by all of you, he went back up to his room for some rest. When Joe was in prison, or just... two of the main ways he relaxes is listening to music, right, having on some nice tunes and he could sleep, right again because you've been down a long time with all the lights on. Right, curl up for a nap with this lovely fluorescent lighting. Well, two things happened after he shared his testimony and went upstairs. He couldn't stand the sound, couldn't stand the music of the radio- he turned it off. And would you believe the lights bothered him like crazy? They felt really, right, intrusive, overwhelming. Again, thinking about the nervous system, about that hyper-arousal, he was in survival mode. When animals, when people are in survival

mode, we're alert, we're taking in stimuli, we're accessing for danger all around us. So again, I just want you to keep that in mind, he was in a state of hyper-arousal as a result of talking about the trauma. And so just imagine for a moment that he wasn't going back to a cozy hotel room but rather a drafty cell with no running water. How's he going to be functioning? How's he going to be doing? So just keeping that in mind.

We know the long-term impact is potentially the development of PTSD. Rape and sexual assault are two of the most predictive factors for PTSD- so just being aware of that. Women [are] twice as likely as men to develop it. We won't get into the diagnostic criteria today because we don't have the time but just know that- got to be more than a month and you're going to have those 3 key factors, right? Which is... we're looking for intensive re-experiencing, so flashbacks, right, and intrusive thoughts, avoidance or dissociation, right, so it can be perceived as numbness, abusive substances, numbing feelings or thoughts, and then arousal. Again, Joe gave us some great examples of that- jumpy, sleep disturbances, nervousness, irritability, right? All of those can be signs.

We also know and Joe talked about this- increased likelihood of suicide. You all know that the folks in your care are more likely to commit suicide anyway, right, as prisoners, as detainees. So are sexual assault survivors as a group so when you overlay those two groups we see a much greater likelihood of attempting suicide or even being successful- and for those of you who saw the Rodney Hulin story you got to see first-hand the disastrous consequences.

We also know, of course, that sexual assault, sexual trauma can actually worsen psychiatric disorders or the symptoms of that. So to give you an example, we work with some survivors who are bipolar, right. If you think about the mania or the hyper-mania or the depressive stages, imagine again the nervous system being shot into these hyper-aroused or sort of shut down places, dissociative places- it can really... sexual violence can really exacerbate those symptoms so that's why again your care and your services are so important.

I want to... I think this is probably one of the most important things we'll talk about. I just want you to think about what can be challenging for survivors in custody. I want to ask all of you that. So if you've got a survivor or someone who's victimized like Joe and they're locked up- thinking about your own facilities for a second, what do you think could be most challenging for someone to deal with if they're locked up after a sexual assault? Just environmental issues... what do you think might be challenging for them?

An audience member responds

Ok. Seeing the perpetrator, possibly repeatedly. Absolutely, absolutely. Right. We know that having ongoing contact with someone who has harmed you- and not just the perpetrator, right, but also their friends, right? Joe talked about how his perpetrator was talking, bragging with other inmates about the sexual assault.

There was no confidentiality for him. As well as if it's a staff perpetrator, their colleagues, sometimes in some states staff have entire families working in a facility so you're absolutely right. Yep. Other thoughts?

Another audience member responds

Yeah, chaotic. Right? Absolutely, the lack of control. Certainly, again, yep. Thinking... you're exactly right... thinking about sights and sounds and what might be difficult. Absolutely. And so...

Just overall, guys, lack of control in custody settings is really difficult and triggering for survivors and the reason for that is: one of the primary goals of healing... when I'm working with a client, when I'm working with a survivor, one of the primary goals is to help them reestablish power and control and safety. Right? Because that's what was taken away from them when they were abused. And so if you're in a custody setting where you're told what to do, when to get up, the lights being on or off, sounds around you, you have no control over your cellmate, you're supervised while toileting, showering, on the phone; if you're writing letters... so lack of privacy, right? Very little say over your medical providers for example, right? So in thinking about that, it can really be challenging for survivors to regain any sense of safety or well-being when they have such a lack of control. I think that may have been part of why Joe really threw himself so much into the... the case he was doing 'cause that was a good distraction, right Joe? That was something you could have some control over. He went to the library; he gave himself a sense of structure, that's great. I know you all think, probably, inmates are really litigious- part of that is that might be a way of coping with their traumas. "Let me go, let me read, let me write, let me think about anything other than the rape."

Limited access to services, that's certainly changing as a result of PREA. Just remember we're expecting these folks to access services in the same environment where they were abused, sometimes even very nearby the physical location. And again, from staff who, whether or not staff were the perpetrators, staff in some sense failed to protect that person, right? So there's often an antagonism that survivors naturally feel towards staff- even wonderful, well-intentioned ones like you all because, frankly, if you had really cared about them, you would've prevented the abuse in the first place- that's what we hear over and over again that survivors feel that way. So just know that's sort of a barrier we're up against

[I'm] really proud of this picture. The bald guy all the way on the right is Tom Cahill. He is also a member of our survivor counsel. He is a prisoner rape survivor. He was brutally gang-raped in a TX state prison after he got picked up for non-violent protest in the 1970's. He's our former president, actually, and that's, of course, him shaking the hands of President Bush at the signing ceremony. So whenever we can, prisoners are at the table and they're the ones... survivors are the ones taking the lead. Actually, Tom jokes that he had just said to the president, "Mr. President, what does it feel like to have a hippie in the oval office?" George Bush kind of cracked a

half smile and then they took the picture, so... Tom loves to tell that story. He was in fact probably the first hippie to make his way in there so he was quite proud of that.

Okay, ya'll know this, right? Four sets of standards apply to adult prisons and jails, lockups, community confinement, and of course juvenile detention. As we're going through here today I'm going to give you... we'll come back to that... I'm going to give you a little cheat sheet. Take a look up at the number of the standard at the top so we're going to talk about training 115.35. If you see a 1 in parentheses following that, then you know lockups- that's applicable to lockups. Ok? All of these are applicable to prisons and jails, that's kind of the standard if you will... for better or for worse that was sort of the DOJ's base line. If you see a 1 that means lockups are covered. [If] you see a 2 that means community confinement facilities, right, so if we've got anybody from halfway houses, community reentry centers... and if you see a 3, that's for juvenile detention. So just know a little bit of shorthand for whatever agencies you represent... as you're taking a look at these, just know that's kind of what we're looking for, ok?

Anyone fall into category I know we've got ICE here today. ICE has the lovely privilege, as a result of a Presidential memo that came out last year, of creating their own set of standards that are equal to the PREA standards those have currently been released for public comment. JDI sent 100 pages of feedback on them and they're currently being finalized through the DOJ as well or through ICE. But anyone here not fall into one of these categories? Ok, great. So this is relevant. Good stuff.

Staff are covered, right? That's what I want the take home message... full, part-time, anyone providing medical mental health care in any of these settings, you're going to be covered under these applicable medical mental health standards. Anyone here not consider themselves a staff member per the PREA standards or do you have a question about whether or not you qualify? Like administrators? No. Ok. So just let me know if you've got questions about that but the standards are pretty clear about who's considered a medical mental health staff member.

Ok, you all know this- that's why you're here- especially those of you who attended Saturday, or Sunday rather- there's the required specialized training for medical and mental health staff. It's got to be documented, all of your medical mental health practitioners have to get it again by... the audits start August 2013 so if you all are administrators or you know your colleagues haven't gotten this information, just know NCCHC is developing that specialized curriculum and also at JDI we're happy to assist if we can in helping you to get connected with where you can get some information, but NCCHC is a great resource for this.

Ok. Coordinated response. What I just want you all to know is the standards are really clear that there has to be a coordinated response to allegations of sexual abuse in custody among all those folks you see there and the reason for that is that there is so much going on in the immediate aftermath. I want you to just think for a second in Joe's case- how different would it have been when he told the first staff member he told first of all if they believed him, if they took him seriously and if they

had initiated a response and had coordination among medical staff, among mental health, among the sexual assault nurse examiner, the rape crisis advocate, the investigators, law enforcement, custody? Can you imagine if they were on the same page, they were all communicating with one another, and all of their first and top priority was his safety and well-being and also, obviously, addressing the incident? And instead, Joe got this really protracted, disorganized... some of the time frames were off, he went to different people at various points- it wasn't coordinated and so that's part of why the standard is so critical and why especially for you all, no one brings the expertise you bring. No one has the knowledge and the professional experience that you all bring to addressing these incidents so you are absolutely critical. If right now your facility gets an allegation and they start the investigation and no one is involved in medical or mental health, they're on the wrong track. So again your role is really critical to effective response.

Evidence protocols- I think this is gone over quite a bit. I'm not sure this is new to anybody, but just knowing that victim survivors have the right to access to medical forensic exams- that's really critical. They've got to be provided by qualified practitioners, someone with specialized training. I actually want to pause there.

Joe, I know you have to go and catch your shuttle. We can always come back to this but any questions specifically for Joe or any comments before he leaves us since he's got to run out to the airport? Just want to give you all a chance before we wrap up. Anything for Joe?

The audience says "thank you" and starts clapping. Several of them give him a standing ovation.

We love you, Joe. I'll call you tomorrow. Let me know when you get in. Ok, you better.

Joking Who wants to go back to the standard? No, just kidding. That's recorded! That can be cut out, right? JDI never said that about the PREA standards.

Ok. Where are we at? 20 minutes. Or I mean 10 minutes left. Ok so here's what you have to do. I really want to be like bbbbbbrrrrrr (*speeding through it*) 'cause I really want to have a little time for some discussion.

Outside confidential services, that's really critical. Just know rape crisis advocates- they are your friends. They're not there to duplicate the work you're doing, they're not there to provide medical mental health treatment, they're there to provide special, confidential rape crisis counseling services. I work in conjunction with all of you. When I'm assisting a survivor, I'm not there to take your place, we're there to work together because I get to have confidential access to them, you all don't, right, because you're medical mental health practitioners, you're mandated reporters. So just know the differences in those roles is really critical and to really work as a team. We have great working relationships with medical, which I'll talk about more in the next session but just so you know.

Access to emergency medical services, right, you all know that, I hope. In the PREA standards, folks have got to get the emergency medical treatment. It's got to be provided at no cost so if your agencies or facilities have a standard co-pay, those have got to be waived. You've got to find a way in your intake process to be sure folks are aware of and understand those services are free. And again it doesn't matter if the perpetrator is named and it doesn't matter if the survivor's participating in the investigation. You've got to offer it. They can refuse it but it has to be offered, as well as ongoing care and treatment, both medical and mental health. And it's got to be consistent with the community level of care.

Again, think about the impact for Joe if there had been effective, comprehensive medical services; if he didn't get an insensitive provider in his case. But also- what if he had gotten some follow-up services? Do you think the impact of the trauma would have been as acute, would have been as great if he had been able to get effective treatment, get roped into services? Course not, right? But he was left to fend for himself. He was transferred, got the hell out of there and no one wanted to hear about it anymore.

Ok. Other quick thing to know for our mental health staff, medical staff is that in your intake screening process, if someone discloses prior sexual victimization, you've got to offer a follow-up within 14 days. So just know that that's for juvenile, residents, and in prisons or jails. So if you're staff there, during your intake process someone discloses that, we've actually got to follow-up on that, ok, within... you've got 2 weeks to do that.

Again, so this is if someone discloses previous perpetration. Same thing- you've got to offer a follow-up. The person can decline it but it has to be offered. This is solely for prisons or in juvenile facilities. Someone discloses prior perpetration...

An audience member asks a question

Yes sir. You know the standards are... they don't specify it but essentially the thinking behind it if you look at their report is to offer, for example, to do any assessment to see if there's any treatment services that could be offered. Right? If there's any way to address whatever underlying issues there might be that either contributed to the perpetration in this case or if they were previously sexually abused, it's to offer any potential services. So counseling, right, so... yeah. It's not just sort of verify the veracity if you will but it's to follow up and offer services.

Ok. There's some good information in the standards about who should have access to the information and the importance of informed consent. Just want you to keep in mind and, again, we're just focusing on sort of the most relevant standards for you all as medical mental health, but what I'd say is that your expertise should inform every single one of the standards and what your agencies are doing to comply with PREA. Nobody knows what you know and what you bring to the table is invaluable. Any of the jurisdictions I work with we don't do coordinated response protocols without medical mental health. I don't want to go and have a SART meeting without

you guys there; I don't want to talk about analyzing policies if I don't have medical mental health there- I just won't do it because your expertise is so critical. Again, no one can replace your knowledge. You're just... you're that important... and you're that important to survivors.

So just keep in mind though some related standards where your roles are going to especially come into play- protection from retaliation, for example. In some jurisdictions, it's medical mental health staff that do the follow-up and the monitoring for retaliation 'cause that's required on an ongoing basis for 90 days.

Ok well thank you all so, so much for being here.

Audience claps

It was a pleasure, my privilege. I'll have my cards up here. Thank you.