

**STANDARDS** FOR THE PREVENTION,  
DETECTION, RESPONSE, AND  
MONITORING OF SEXUAL ABUSE IN  
**JUVENILE FACILITIES**

**NATIONAL  
PRISON  
RAPE  
ELIMINATION  
COMMISSION**

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## PREFACE

Ours has been a daunting task, albeit a deeply motivating and compelling one—to provide the President, members of Congress, the Attorney General, and the Secretary of Health and Human Services with national standards by which to detect, prevent, reduce, and punish prison rape.

As we submit these standards to the Attorney General for review and approval, I and my colleagues on the Commission believe that they are as urgently needed now as they were in 2003 when Congress mandated this groundbreaking project as part of the Prison Rape Elimination Act. Sexual abuse of incarcerated individuals remains a persistent problem, with life-altering consequences for victims, for the integrity of correctional institutions, and for fundamental principles of justice. We discuss the problem in great detail in our report; this standards document and its companion volumes are our blueprint for lasting nationwide change.

The standard's development process benefited from, and indeed could not have happened without, the contributions of dozens of private and governmental organizations and more than 400 individuals—corrections professionals, academics, researchers, practitioners, and survivors of sexual abuse in confinement—who provided testimony at hearings, advice at expert committee and stakeholder meetings, and input during an extensive public comment period. In finalizing these standards and incorporating their expertise, our discussions have been long and lively and our debates rigorous. We are particularly grateful for the insights and lessons learned from early reformers—corrections professionals who have been working to prevent sexual abuse in their facilities since long before the passage of the Prison Rape Elimination Act and who continue to do so.

Each set of standards has been customized to ensure validity for particular conditions of confinement. The members of the National Prison Rape Elimination Commission are confident that the implementation of these national standards can have a substantial and salutary effect on the safety of prisons, jails, lockups, immigration detention centers, juvenile detention facilities, and community correctional facilities.

We are proud to entrust the enactment and implementation of these standards to the many capable policymakers and professionals who will now take up the torch. It has been an honor for us to play a part in the elimination of sexual abuse in confinement. A just and civil society should strive for nothing less.

A handwritten signature in black ink, appearing to read "Reggie B. Walton". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

The Honorable Reggie B. Walton, Chair



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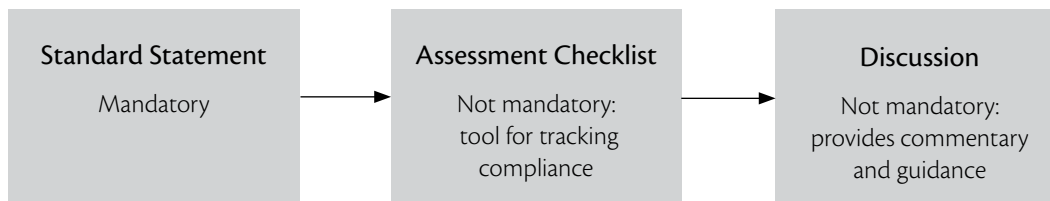
# INTRODUCTION

Sexual abuse of people in confinement violates their basic human rights, impedes the likelihood of their successful reentry into the community, and violates the Government’s obligation to provide safe and humane conditions of confinement. The government’s obligation is even stronger when it comes to ensuring the safety of young people in its custody, youth who by virtue of their age are even more vulnerable to abuse and less likely to be able to protect themselves.

The juvenile justice system was created in recognition of the developmental differences between adult and juvenile offenders and the need to provide a rehabilitative and therapeutic environment for young offenders to ensure they become healthy and productive members of society. Sexual abuse of juveniles in confinement is not only traumatic for young offenders, but also extremely disruptive to the rehabilitative process. No juvenile court sentence, regardless of the offense, should ever include rape. A core priority of any confinement facility must be safety, which means protecting the safety of all—the public, the staff, and the resident population. In recognition of this, Congress formed the National Prison Rape Elimination Commission (NPREC or Commission) to develop national standards that will help eliminate prison rape and other forms of sexual abuse in confinement.

The Prison Rape Elimination Act (PREA) of 2003 requires agencies to comply with the national standards proposed by the Commission and approved and promulgated by the Attorney General to eliminate sexual abuse in confinement. Fundamental to an agency’s success will be its commitment to zero tolerance of sexual abuse—a recognition that sexual abuse in confinement facilities is unacceptable under any circumstances and as dangerous a threat to institutional security as an escape or homicide. Agencies must demonstrate zero tolerance not merely by words and written policy, but through their actions, including what they do to prevent sexual abuse and their response when it occurs.

The standards developed by NPREC are organized as follows:



Each standard statement contains mandatory requirements. Under each standard statement is an assessment checklist. The assessment checklists are designed as a tool for agencies and facilities to self-assess and track their progress toward meeting the standards. They are also meant to be a starting point for the external audit of a facility’s compliance with the standards. The agency head, facility head, PREA coordinator, or a designee must complete the assessment checklists for every standard. Although answering “yes” to each checklist item is not mandatory, meeting the requirements in the standard is mandatory. Therefore, when completing a given checklist, if an official answers “no” to a checklist question but believes the facility/agency is meeting the requirements of the standard using a different process or procedure, he or she should explain how the alternative process or procedure meets the standard. The PREA coordinator or other official should attach documentation of compliance with the standard to the checklist unless compliance is self-evident.



After each assessment checklist is a discussion of the standard. Discussion sections provide explanation for the rationale of the standard and, in some cases, offer guidance for achieving compliance with it. Although the discussion sections sometimes offer further clarification on the meaning of terms or phrases used in the standard, the glossary should be used as the primary source for the meaning of terms or phrases. The discussion sections do not contain any additional mandatory requirements. When mandatory requirements are mentioned in a discussion section, they have been drawn directly from the standard statement.

In crafting these standards, NPREC has kept in mind the following overarching considerations: (1) agency and facility heads should retain the flexibility, responsibility, and authority to establish systems, practices, and protocols that will eliminate sexual abuse in their confinement facilities; (2) successful compliance with the standards and elimination of sexual abuse require ongoing systemic efforts to assess and adjust policies, practices, and the allocation of resources to address problems and improve safety; and (3) greater transparency of the agency's sexual abuse data and efforts to prevent, detect, and respond to sexual abuse will improve public trust and confidence in our Nation's juvenile facilities and aid in the elimination of sexual abuse in confinement.

The Commission recognizes the importance of the juvenile justice system's rehabilitative philosophy and approach to improving outcomes for youth and keeping youth safe while in confinement. As a result, although many of the PREA standards for juvenile facilities are similar to the standards for adult prisons and jails, the standards for juvenile facilities take into account the major differences between adult and juvenile confinement facilities in such areas as the availability of and access to programs, the psychological and physical development of the detained population, and staff training requirements and responsibilities. These standards also speak to many legal issues uniquely relevant to the care and supervision of youth in confinement settings, including State and local mandatory reporting requirements for all acts of abuse against children. Finally, the juvenile standards address the wide age and developmental range among youth confined in a single facility, with some jurisdictions housing individuals as young as 10 or as old as 24 together in the same facility.

These standards are the product of lengthy study, consultation and reflection. The Commission held eight public hearings, during which more than 100 witnesses testified, including corrections and juvenile justice leaders, formerly incarcerated survivors of sexual abuse in confinement, researchers, investigators, prosecutors, and advocates for victims and the incarcerated. In addition, the Commission convened expert committees comprised of similarly diverse stakeholders with broad juvenile justice expertise to help inform the content of the standards during the drafting process. Site visits to a cross-section of confinement facilities enabled the Commission to receive feedback on the draft standards from a variety of corrections and juvenile justice officials. NPREC also conducted a thorough review of the literature. Finally, during its 60-day public comment period, the Commission received and considered comments on the standards, many extensive in nature, from more than 225 individuals or entities representing a wide range of perspectives.

The Commission believes that full adoption of these standards by all of the Nation's juvenile facilities is necessary to achieve the elimination of sexual abuse in confinement facilities as Congress intended in passing PREA.

# GLOSSARY

The following are terms that are used throughout the standards, and agencies should note and understand the definitions of these terms as provided below to ensure proper compliance with the standards. The Commission wishes to draw special attention to the fact that the definitions of sexually abusive conduct that appear here differ from the definitions used by the Bureau of Justice Statistics (BJS). The Commission recognizes that the BJS definitions have been used by agencies for data collection purposes but has formulated somewhat different definitions to capture the full range of conduct the standards seek to address. Additionally, the Commission has deliberately excluded definitions for resident-on-resident indecent exposure and voyeurism. Legal definitions for indecent exposure and voyeurism rely on the concept of a sphere of privacy, and although residents have a legally cognizable privacy interest, that interest is extremely limited by security interests. Because the extent of residents' privacy rights necessarily varies according to legitimate security needs, so too would the circumstances in which it would be appropriate to penalize residents for indecent exposure and voyeurism, complicating the task of setting forth a clear policy and consistent practice of enforcement. The reality is that residents are in states of undress around other residents and staff on a regular basis, raising the possibility that residents might be penalized for conduct that is part of the ordinary course of life in confinement.

**Age appropriate:** A way of communicating, explaining, interviewing, or providing services to a resident that is suitable for the resident's age and level of emotional and cognitive development.

**Agency:** The unit of a governing authority with direct responsibility for the operation of any facility that confines residents, including the implementation of policy as set by the governing authority.

**Agency head:** The chief authority of a Federal, State, or local juvenile justice or law enforcement system.

**Allegation:** An oral, written, or electronic statement that sexual abuse has occurred or might occur that is provided to a staff member or outside agency.

**Audit:** A thorough investigatory review of information, including written records and interviews with staff and residents, to determine whether and the extent to which an agency's and/or facility's policies, practices, and protocols comply with the PREA standards.

**Auditor:** An individual or entity that the jurisdiction employs or retains by contract to perform audits. An auditor may also be authorized by law, regulation, or the judiciary to perform audits; however, an auditor cannot be an agency employee. An auditor is able and prequalified by the U.S. Department of Justice to perform audits competently and without bias. Prequalification does not require prior employment with any particular agency.

**Contractor:** A person who provides services other than direct services to residents on a recurring basis according to a contractual agreement with the agency (e.g., maintenance contractors).

**Credibility assessment:** An investigator's process of conducting interviews and weighing evidence to determine the truthfulness of victim, witness, and suspect statements.

**Critical incident:** An occurrence or event, natural or human-caused, which requires an immediate response to protect life, facility safety, or property.

**Cultural competence:** The ability to work and communicate effectively with people of diverse racial, ethnic, religious, and social groups based on an awareness and understanding of differences in thoughts, communications, actions, customs, beliefs, and values.

**Direct care staff:** Staff responsible for the direct supervision of residents in housing units, recreational areas, dining areas, and other program areas of the facility.

**Employee:** A person who works directly for the agency or facility or a person who provides direct services to residents in a facility on a recurring basis according to a contractual agreement with the agency (e.g., contracted medical and mental health providers or contracted food service providers).

**Facility:** A place, institution, building (or part thereof), set of buildings, or area (whether or not enclosing a building or set of buildings) that is used for the confinement of individuals. A facility may be owned by a public or private agency.

**Facility head:** The chief authority of an individual confinement facility operated by a Federal, State, or local juvenile justice or law enforcement agency or by a private entity (whether for-profit or nonprofit).

**Gender identity:** A person's internal, deeply felt sense of being male or female, regardless of the person's sex at birth.

**Gender nonconforming:** A person whose gender identity and/or expression do not conform to gender stereotypes generally associated with his or her birth sex.

**Intersex:** A condition usually present at birth that involves reproductive, genetic, or sexual anatomy that does not seem to fit the typical definitions of female or male.

**Jurisdiction:** A legal entity of government with geographic boundaries, such as the United States, a State, a county, or a municipal entity.

**Medical practitioner:** A health professional who, by virtue of education, credentials, and experience, is permitted by law to evaluate and care for patients within the scope of his or her professional practice. A "qualified medical practitioner" refers to such a professional who has also successfully completed specialized training for treating sexual abuse victims.

**Mental health practitioner:** A mental health professional who, by virtue of education, credentials, and experience, is permitted by law to evaluate and care for patients within the scope of his or her professional practice. A "qualified mental health practitioner" refers to such a professional who has also successfully completed specialized training for treating sexual abuse victims.

**Need to know:** A criterion for limiting access of certain sensitive information to individuals who require the information to make decisions or take action with regard to a resident's safety or treatment or to the investigative process.

**Pat-down search:** A superficial running of the hands over the body of a resident by a staff member to determine whether the resident possesses contraband.

**PREA coordinator:** A senior-level full-time position that reports directly to the agency head. The PREA coordinator's responsibilities include developing, implementing, and overseeing the agency's plan to comply with the PREA standards. He or she is also responsible for ensuring the completion of the assessment checklists in this body of standards.

**Preponderance of the evidence standard:** The standard of proof used in most civil cases that requires the party bearing the burden of proof to present evidence that is more credible and convincing than the evidence presented by the other party. This standard is satisfied if the evidence shows that it is more probable than not that an event occurred. Preponderance of the evidence is a lesser standard of proof than "beyond a reasonable doubt," which is required to convict in a criminal trial.

**Protocol:** Written instructions that guide the implementation of policies.

**Report:** Any allegation of sexual abuse. See definition of *allegation*.

**Resident:** Any person under the jurisdiction of or committed by the juvenile court and confined or detained in a juvenile facility.

**Sexual abuse:** Encompasses (1) resident-on-resident sexual abuse, (2) resident-on-resident sexual harassment, (3) staff-on-resident sexual abuse, and (4) staff-on-resident sexual harassment.

**(1) Resident-on-resident sexual abuse:** Encompasses all incidents of resident-on-resident sexually abusive contact and resident-on-resident sexually abusive penetration.

**Resident-on-resident sexually abusive contact:** Non-penetrative touching (either directly or through the clothing) of the genitalia, anus, groin, breast, inner thigh, or buttocks without penetration by a resident of another resident without the latter's consent, or of a resident who is coerced into sexual contact by threats of violence, or of a resident who is unable to consent or refuse.

**Resident-on-resident sexually abusive penetration:** Any sexual penetration by a resident of another resident. The sexual acts included are:

- Contact between the penis and the vagina or the anus;
- Contact between the mouth and the penis, vagina, or anus; or
- Penetration of the anal or genital opening of another person by a hand, finger, or other object.

(2) **Resident-on-resident sexual harassment:** Repeated and unwelcome sexual advances, requests for sexual favors, verbal comments, or gestures or actions of a derogatory or offensive sexual nature by one resident directed toward another.

(3) **Staff-on-resident sexual abuse:** Encompasses all occurrences of staff-on-resident sexually abusive contact, staff-on-resident sexually abusive penetration, staff-on-resident indecent exposure, and staff-on-resident voyeurism. Staff solicitations of residents to engage in sexual contact or penetration constitute attempted staff-on-resident sexual abuse.

**Staff-on-resident sexually abusive contact:** Non-penetrative touching (either directly or through the clothing) of the genitalia, anus, groin, breast, inner thigh, or buttocks by a staff member of a resident that is unrelated to official duties.

**Staff-on-resident sexually abusive penetration:** Penetration by a staff member of a resident. The sexual acts included are:

- Contact between the penis and the vagina or the anus;
- Contact between the mouth and the penis, vagina, or anus; or
- Penetration of the anal or genital opening of another person by a hand, finger, or other object.

**Staff-on-resident indecent exposure:** The display by a staff member of his or her uncovered genitalia, buttocks, or breast in the presence of a resident.

**Staff-on-resident voyeurism:** An invasion of a resident's privacy by staff for reasons unrelated to official duties or when otherwise not necessary for safety and security reasons, such as peering at a resident who is using the toilet in his or her cell/room; requiring a resident to expose his or her buttocks, genitals, or breasts; or taking images of all or part of a resident' naked body or of a resident performing bodily functions and distributing or publishing them.

(4) **Staff-on-resident sexual harassment:** Repeated verbal comments or gestures of a sexual nature to a resident by a staff member. Such statements include demeaning references to gender, sexually suggestive or derogatory comments about body or clothing, or profane or obscene language or gestures.

**Staff:** Employees and volunteers.

**Strip search:** A search that requires a person to remove or arrange some or all of his or her clothing so as to permit a visual inspection of the underclothing, breasts, buttocks, or genitalia of such person.

**Substantiated allegation:** An allegation that was investigated and the investigation determined that the alleged event occurred.

**Transgender:** A term describing persons whose gender identity and/or expression do not conform to the gender roles assigned to them at birth.

**Unfounded allegation:** An allegation that was investigated and the investigation determined that the alleged event did not occur.

**Unsubstantiated allegation:** An allegation that was investigated and the investigation produced insufficient evidence to make a final determination as to whether or not the event occurred.

**Victim advocate:** An individual, who may or may not be affiliated with the agency, who provides victims with a range of services during the forensic exam and investigatory process. These services may include emotional support, crisis intervention, information and referrals, and advocacy to ensure that victims' interests are represented, their wishes respected, and their rights upheld.

**Video monitoring system:** An integrated security system consisting of installed cameras monitored by employees, which augments and/or enhances the ability of employees to provide the sight and sound security necessary to prevent, detect, contain, and respond to incidents of sexual abuse.

**Visual body cavity search:** A visual inspection of a body cavity, defined as a rectal cavity, or vagina, for the purpose of discovering whether contraband is concealed in it.

**Volunteer:** An individual who donates his or her time and effort on a recurring basis to enhance the activities and programs of the agency.



# I. PREVENTION AND RESPONSE PLANNING

## Prevention Planning (PP)

### PP-1 Zero tolerance of sexual abuse

The agency has a written policy mandating zero tolerance toward all forms of sexual abuse and enforces that policy by ensuring all of its facilities comply with the PREA standards. The agency employs or designates a PREA coordinator to develop, implement, and oversee agency efforts to comply with the PREA standards.

Assessment Checklist	YES	NO
(a) Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse?		
(b) Does the agency ensure that all of its facilities comply with the PREA standards?		
(c) Does the agency employ or designate a PREA coordinator to develop, implement, and oversee agency efforts to comply with the PREA standards?		

#### Discussion

Eliminating sexual abuse in confinement requires first and foremost a commitment to safety as a core mandate of confinement operations. Agency and facility heads will be responsible not only for ensuring that staff and residents are informed of the agency's zero-tolerance policy toward sexual abuse but for setting a tone that signals true commitment to an institutional culture of safety and security for all residents and staff. The agency head will also be responsible for employing or designating a PREA coordinator to manage and oversee the agency's efforts to comply with the PREA standards. The PREA coordinator's job should include: (1) developing written policies that follow juvenile justice best practices and meet the intent of the PREA standards; (2) developing and implementing a training plan that fulfills the PREA training standards; (3) monitoring resident screening procedures, investigations, and medical and mental health care treatment according to the PREA standards; (4) supervising the agency's data collection efforts; and (5) providing appropriate access and materials to auditors. By definition, the PREA coordinator will be a senior-level position reporting directly to the agency head. In that capacity, the PREA coordinator should provide routine updates to the agency head, including at executive-level meetings, on his or her areas of responsibility, progress reports on standards implementation and compliance, and notice of any problems or challenges that need to be addressed.

To ensure successful compliance with the PREA standards, the PREA coordinator may need to develop strategies to address the culture of the agency or facility(ies) to determine the levels of staff and resident resistance or openness to PREA standards implementation. Examples of strategies may include conducting or coordinating assessments by surveying staff members and residents to understand their attitudes, beliefs, and values that support or conflict with a "reporting" culture that creates safety and security. Based on the results of the assessment, the PREA coordinator and facility head(s) should work with key staff on all levels to design strategies that create a cultural "readiness" for change (e.g., development of new policies, staff briefings, video briefings from leadership for staff, and strategic planning meetings), training programs, and other systems to change the culture to one in which staff and residents embrace the goals and values of PREA and institutional safety.



## PP-2 Contracting with facilities for the confinement of residents

If public juvenile justice agencies contract for the confinement of their residents, they do so only with private agencies or other entities, including other government agencies, committed to eliminating sexual abuse in their facilities, as evidenced by their adoption of and compliance with the PREA standards. Any new contracts or contract renewals include the entity's obligation to adopt and comply with the PREA standards and specify that the agency will monitor the entity's compliance with these standards as part of its general monitoring of the entity's performance.

Assessment Checklist	YES	NO
(a) Does the public agency contract for the confinement of residents only with private companies and other entities, including other government agencies, that agree to adopt and comply with the PREA standards?		
(b) Do all new contracts and contract renewals include an obligation to adopt and comply with the PREA standards?		
(c) Do all new contracts and contract renewals specify that the public agency will monitor the entity's compliance with the PREA standards as part of its monitoring of the entity's performance?		

### Discussion

The goal of this standard is to ensure that all residents, regardless of whether they are housed in public or private confinement settings, are protected from sexual abuse. Public agencies that contract with private agencies or other entities, including other government agencies, to confine their residents are responsible for ensuring such protection of all residents by contracting only with those companies or other entities that adopt and comply with PREA standards.

## PP-3 Resident supervision

Direct care staff provides the resident supervision necessary to protect residents from sexual abuse. The facility administrators and supervisors responsible for reviewing critical incidents must examine areas in the facility where sexual abuse has occurred to assess whether there are any physical barriers that may have enabled the abuse, the adequacy of staffing levels during different shifts, and the need for monitoring technology to supplement direct care staff supervision (DC-1). When problems or needs are identified, facility administrators and supervisors take corrective action (DC-3).

Assessment Checklist	YES	NO
(a) Does direct care staff provide the supervision of residents necessary to protect them from sexual abuse?		
(b) Do the facility administrators and supervisors responsible for reviewing critical incidents examine areas in the facility where sexual abuse has occurred to assess the following?		
• Physical barriers that may have enabled the abuse		
• Adequacy of staffing levels during different shifts		
• Monitoring technology needs		
(c) When problems or needs are identified, do facility administrators and supervisors take corrective action? (Attach description of corrective actions taken.)		

## Discussion

Adequate direct care staff supervision of residents is an essential component of any agency's sexual abuse prevention strategy. It enables direct care staff to identify aggressive or coercive resident behavior before it escalates to sexual abuse, to identify signs of inappropriate staff relationships developing with residents before they become abuse, to respond immediately to prevent or end incidents of abuse by residents or staff, and, when an incident does occur, to rapidly take the steps necessary for an effective response. However, the importance of adequate security supervision should never be used to justify inappropriate staff behavior, such as staff voyeurism of residents. For many facilities, adequate direct care staff supervision is achieved by using a direct supervision model to manage the resident population. Direct supervision, widely extolled as a best practice, is a method of resident management whereby direct care staff are in continuous direct contact with residents, enabling them to interact with and observe residents at all or most times. When feasible, given the security level of the resident population and any constraints stemming from the physical design of the facility, the Commission recommends that facilities strive to meet this standard by employing a direct supervision model.

Additionally, to ensure that any deficiencies in resident supervision are promptly identified and corrected, the standard requires the facility administrators and supervisors responsible for reviewing critical incidents to examine known areas where sexual abuse has occurred to assess and take corrective action regarding any physical barriers that may have enabled the abuse, any problems with staffing levels in those areas at different times of the day, and any needs for monitoring technology to supplement direct care staff supervision. In examining known areas where sexual abuse has occurred, for example, they may find blind spots or inadequate staffing patterns on particular shifts, which require new or different staff deployment schemes and/or the addition or adjustment of cameras. More sophisticated video security monitoring systems and/or radio frequency identification systems may also be useful tools for monitoring staff and resident movement and location. The group of administrators and supervisors may also discover that, to remedy the risk posed by physical barriers, other creative adaptations to facility design may be required. They ought to examine each area carefully and take corrective action to ensure that residents in all areas of the facility are safe from sexual abuse. Moreover, when patterns of abuse have been identified in reviews (DC-1, DC-3), either at a given time of day, in a particular area, or involving certain types of residents, facility leadership should take action to ensure increased supervision during those times, in those areas, or for those groups of residents.

## PP-4 Limits to cross-gender viewing and searches

Except in the case of emergency, the facility prohibits cross-gender strip and visual body cavity searches. Except in the case of emergency or other extraordinary or unforeseen circumstances, the facility restricts nonmedical staff from viewing residents of the opposite gender who are nude or performing bodily functions and similarly restricts cross-gender pat-down searches. Medical practitioners conduct examinations of transgender individuals to determine their genital status only in private settings and only when an individual's genital status is unknown.

Assessment Checklist	YES	NO
(a) Except in the case of emergency, does the facility prohibit cross-gender searches of the following types?		
• Strip		
• Visual body cavity		
(b) Except in the case of emergency or other extraordinary or unforeseen circumstances, does the facility restrict cross-gender viewing by nonmedical staff of residents who are nude or performing bodily functions?		
(c) Except in the case of emergency or other extraordinary or unforeseen circumstances, does the facility restrict cross-gender pat-down searches?		
(d) Are examinations of transgender individuals to determine their genital status conducted only by medical practitioners in private settings and only when an individual's genital status is unknown?		

### Discussion

The goal of this standard is to protect the privacy and dignity of residents and to reduce opportunities for staff-on-resident sexual abuse by prohibiting cross-gender strip and visual body cavity searches, setting limits on cross-gender viewing of residents by nonmedical staff, and restricting cross-gender pat-down searches.

This standard imposes a strong prohibition on cross-gender strip and visual body cavity searches, except in the case of emergency. Performance of these more intrusive strip searches and body cavity searches should be undertaken only by specially trained, designated employees of the same gender and conducted in conformance with hygienic procedures and professional practices. Agencies without adequate security staff of the same gender as the resident population may want to consider training non-direct care staff to conduct these searches.

This standard does not place a prohibition on cross-gender pat-down searches and viewing of residents, but requires these actions to be strictly limited in practice and only in the case of emergency or other extraordinary or unforeseen circumstances. The Commission recognizes that many State and local laws already restrict cross-gender viewing of residents and encourages agencies to consult and follow their relevant State and local laws. The Commission likewise acknowledges that cross-gender supervision, in general, can prove beneficial in certain confinement settings and in no way intends for this standard to limit employment (or post assignment) opportunities for men or women.

Agencies are encouraged to use a number of tools to aid compliance with this standard, including the use of privacy panels for shower and toilet areas and making verbal announcements when a staff member of the opposite gender is in an area. Also, in addition to prohibiting cross-gender strip and visual body cavity searches, each agency is encouraged to have a strong, legally based policy regarding all searches (including same-gender searches) that gives proper regard to the resident's rights to privacy and dignity.

In some facilities, employees conduct strip or body cavity searches of transgender individuals ostensibly to determine their genital status. All too frequently, such examinations are not necessary because the individual's genital status was already determined at an initial medical screening. To protect the privacy and dignity of transgender individuals, this standard prohibits examinations to determine genital status when that status has already been ascertained.

Additionally, this standard requires examinations to determine genital status be conducted in private and by medical practitioners.

## PP-5 Accommodating residents with special needs

The agency ensures that residents who are limited English proficient (LEP), deaf, or disabled are able to report sexual abuse to staff directly, through interpretive technology, or through non-resident interpreters. Accommodations are made to convey all written information about sexual abuse policies, including how to report sexual abuse, verbally to residents who have limited reading skills or who are visually impaired.

Assessment Checklist	YES	NO
(a) Are all LEP, deaf, and disabled residents able to report sexual abuse to staff directly, through interpretive technology, or through non-resident interpreters?		
(b) Are accommodations made to convey all written information about sexual abuse policies, including how to report sexual abuse, verbally to residents with limited reading skill or who are visually impaired?		

### Discussion

The ability of all residents to communicate effectively and directly with staff, without having to rely on resident interpreters, is crucial for ensuring that they are able to report sexual abuse as discreetly as possible. It is never desirable or sufficient for residents to serve as interpreters or translators for other residents to report abuse because it compromises confidentiality and places some residents in a position of undue influence over others. It is likewise critical that all residents be informed of the agency's policies, including how to report, in a way and format that they understand. If the language and communication needs of the resident population are unknown, the facility head or PREA coordinator may need to conduct an assessment of those needs and develop policies and protocols to address them. Having strong policies and protocols will help staff ensure the safety of LEP, deaf, and disabled residents as well as those residents who have limited reading skills or who are visually impaired. The facility should also consider the same issues with regard to communicating with residents' families, bearing in mind that the families' language abilities may be different from those of the residents.

## PP-6 Hiring and promotion decisions

The agency does not hire or promote anyone who has engaged in sexual abuse in an institutional setting or who has engaged in sexual activity in the community facilitated by force, the threat of force, or coercion. Consistent with Federal, State, and local law, the agency makes its best effort to contact all prior institutional employers for information on substantiated allegations of sexual abuse; must run criminal background checks for all applicants and employees being considered for promotion; and must examine and carefully weigh any history of criminal activity at work or in the community, including convictions for domestic violence, stalking, child abuse and sex offenses. The agency also asks all applicants and employees directly about previous misconduct during interviews and reviews.

Assessment Checklist	YES	NO
(a) Consistent with Federal, State, and local law, does the agency make its best effort to contact all prior institutional employers for information on substantiated allegations of sexual abuse?		
(b) Does the agency disqualify applicants or employees being considered for promotion upon learning of any history of substantiated allegations of sexual abuse in an institutional setting or history of engaging in sexual activity in the community facilitated by force, the threat of force, or coercion?		
(c) Does the agency run criminal background checks for all applicants and employees being considered for promotion?		
(d) Does the agency carefully consider any history of criminal activity, at work or in the community, including the following?		
• Any convictions for domestic violence		
• Any convictions for child abuse		
• Any convictions for stalking		
• Any convictions for sex offenses committed in the community		
(e) Does the agency ask all applicants and employees directly about previous misconduct during interviews and reviews?		

### Discussion

An agency will not be able to meet its zero-tolerance goal if it employs or promotes anyone who has engaged in sexual abuse in an institutional setting or who has engaged in sexual activity facilitated by force, the threat of force, or coercion. Coercion includes but is not limited to using a position of authority or power to compel someone to engage in sexual activity. Changing institutional culture and eliminating sexual abuse can be difficult enough without adding the unnecessary additional risk of hiring or retaining individuals whose conduct has demonstrated a lack of personal commitment to PREA's goals. In addition to making its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse, the agency should have a consistent, proactive policy on asking applicants and employees directly about previous misconduct during interviews or reviews. In jurisdictions in which prospective employers are limited in their inquiry of previous employment or criminal background, the agency should consider having job applicants sign waivers, if not prohibited by law, stating that they waive their legal rights to claim libel, defamation, or slander regarding any information given during reference checks about their disciplinary history involving sexual abuse.

Although many agencies already run routine criminal background checks for applicants, the standard requires agencies to run criminal background checks, where allowable by law, both for all applicants and for employees being considered for promotion to ensure that agencies are always up-to-date on any criminal activity perpetrated by applicants or employees since gaining employment. The standard does not prescribe how to evaluate criminal histories because the Commission recognizes that the agency will have to consider each criminal history on a case-by-case basis and within a larger context of the person's background, life experiences, and work history. When considering previous criminal activity, the agency will have to weigh a number of factors, including the nature and number of offenses and how much time has passed since any convictions, to determine whether to hire or promote an individual.

## PP-7 Assessment and use of monitoring technology

The agency uses video monitoring systems and other cost-effective and appropriate technology to supplement its sexual abuse prevention, detection, and response efforts. The agency assesses, at least annually, the feasibility of and need for new or additional monitoring technology and develops a plan for securing such technology.

Assessment Checklist	YES	NO
(a) Does the agency use video monitoring systems and other cost-effective and appropriate technology to supplement its sexual abuse prevention, detection, and response efforts?		
(b) At least annually, does the agency assess the feasibility of and need for new or additional monitoring technology and develop a plan for securing such technology?		

### Discussion

Video monitoring systems and other technology are invaluable tools for eliminating sexual abuse. Video monitoring systems, when properly designed, managed, maintained, updated, and fully integrated into the agency's various other security systems, can serve as highly objective mechanisms for preventing, detecting, and responding to sexual abuse. The Commission recognizes, however, that some agencies may not have the resources immediately available to acquire and implement new technology solutions or improve existing ones and so requires those agencies to conduct an annual assessment of technology needs and to develop a plan to secure new or additional monitoring technology if needed. For all agencies, technology should be adapted to the population as well as to the age and design of each particular facility.

## Response Planning (RP)

### RP-1 Evidence protocol and forensic medical exams

The agency follows a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. The protocol must be adapted from or otherwise based on the 2004 U.S. Department of Justice's Office on Violence Against Women publication "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," subsequent updated editions, or similarly comprehensive and authoritative protocols developed after 2004. As part of the agency's evidence collection protocol, all victims of resident-on-resident sexually abusive penetration or staff-on-resident sexually abusive penetration are provided access to forensic medical exams performed by qualified forensic medical examiners who are trained in the unique psychological and emotional conditions of younger victims of sexual abuse. Forensic medical exams are provided free of charge to the victim. The facility makes available a victim advocate to accompany the victim through the forensic medical exam process.

Assessment Checklist	YES	NO
(a) Has the agency developed a written protocol adapted from or otherwise based on the U.S. Department of Justice's "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," any subsequent updated editions, or similarly comprehensive and authoritative protocols developed after 2004?		
(b) Does the facility provide victims of inmate-on-inmate sexually abusive penetration or staff-on-inmate sexually abusive penetration with access to a forensic medical exam?		
(c) Are all forensic medical exams provided by the facility performed by a qualified forensic medical examiner trained in the unique psychological and emotional conditions of younger victims of sexual abuse?		
(d) Are forensic medical exams provided free of charge to the victim?		
(e) Does the facility make available a victim advocate to accompany the victim through the forensic medical exam process?		

### Discussion

At the time of publication of this body of standards, the 2004 U.S. Department of Justice's Office on Violence Against Women publication "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents" is considered the "gold standard" of sexual assault evidence protocols by both the law enforcement and the forensic medical examiner communities. The protocol can be found electronically at the following Web address: <http://www.ncjrs.gov/pdffiles1/ovw/206554.pdf>. The agency head should review the national protocol or a subsequent updated edition and incorporate it into the agency's current protocol or use it to develop a new agency protocol by adapting the national protocol to fit the agency's needs, resources, and policies. The agency head may find it particularly helpful to consult Appendix A of the national protocol, which provides guidance on how jurisdictions can customize the national protocol to meet specific local needs, challenges, policies, and statutes.

The agency head should ensure that all medical and mental health practitioners who treat resident victims of sexual abuse understand the importance of conducting prompt examinations to identify medical and mental health needs and minimize the loss of evidence. It is critical that victims' acute medical and mental health needs be evaluated and addressed before evidence is collected on-site or before they are transported off-site for evidence collection. Key elements of proper evidence collection, discussed at length in the national protocol, include: (1) instructing victims not to wash, brush their teeth, change their clothes, urinate, defecate, smoke, drink, or eat until they have been initially evaluated by a forensic medical examiner and (2) educating individuals involved in the handling, documentation, transfer, and storage of evidence about how to preserve evidence and maintain the chain of custody.

Additionally, the forensic medical exam is an important element of both evidence collection and treatment for recent sexual abuse victims. When possible, it is considered best practice to transport victims to outside health care providers for forensic medical exams to avoid any conflict or appearance of conflict of interest regarding potential evidence or treatment of the victim. If a facility does not have access to any community providers able to perform forensic medical exams or a specific resident in need of an exam has been deemed a flight risk or too dangerous to transport out of the facility, it should take steps to contract with qualified independent medical practitioners to perform the forensic exams at the facility. When an individual resident has been deemed a flight risk or too dangerous to transport out of the facility, the facility head should document in writing at the time the decision is made the factors that led to the decision not to transport the resident off-site. Please see Appendix A for more on the responsibilities of forensic medical examiners.

Any medical practitioner who examines a resident should also be trained in the safety precautions to take when treating a resident as well as the unique psychological and emotional conditions of younger victims of abuse. For example, many residents may not previously have had a pelvic or anal exam, and undergoing this exam for the first time after being sexually abused may feel like a particularly invasive and traumatizing experience.

As required by the standard, the facility must make available a victim advocate to accompany the victim through the forensic medical exam process. Ideally and when possible, victim advocates who work with residents should have training and experience in working with adolescent and/or child victims of sexual or other abuse.

## RP-2 Agreements with outside public entities and community service providers

The agency maintains or attempts to enter into memoranda of understanding (MOUs) or other agreements with an outside public entity or office that is able to receive and immediately forward resident reports of sexual abuse to facility heads (RE-1). The agency also maintains or attempts to enter into MOUs or other agreements with community service providers that are able to: (1) provide residents with emotional support services related to sexual abuse and (2) help victims of sexual abuse during their transition from incarceration to the community (RE-3, MM-3). The agency maintains copies of agreements or documentation showing attempts to enter into agreements.

Assessment Checklist	YES	NO
(a) Does the agency maintain an agreement or attempt to enter into an agreement with an outside public entity or office that is able to receive and immediately forward resident reports of sexual abuse to facility heads?		
(b) Does the agency maintain or attempt to enter into agreements with community service providers that are able to do the following?		
• Provide residents with emotional support services related to sexual abuse		
• Help victims of sexual abuse during their transition from incarceration to the community		
(c) Does the agency maintain copies of agreements or documentation showing attempts to enter into agreements?		

### Discussion

Working to establish partnerships with outside public entities and community service providers will enable the agency to meet the requirements of standards RE-1, RE-3, and MM-4 most effectively. Forging these partnerships will allow the agency to provide the range of services available in the community and will give residents the choice to speak to someone not affiliated with the agency if they feel more comfortable doing so. When an agency establishes an MOU with an outside public entity or office to receive residents reports of sexual abuse, it should make clear that the outside entity is responsible for forwarding those reports back to the agency immediately upon receipt (RE-1). For cases in which facilities are located in areas lacking adequate community service providers willing to provide transition services to residents, the agency head should consider researching regional or national agencies or groups that residents may be able to access by telephone or, if no other alternative is possible, by mail and provide residents with that contact information. For cases in which facilities are located in areas lacking



adequate community service providers willing to provide victim support services to residents, the agency or facility head is required by RE-3 to identify regional and/or national agencies or groups that residents may be able to access by telephone or, if no other alternative is possible, by mail and provide residents with that contact information.

Although the Commission recognizes that juvenile justice agencies may not be able to persuade outside public entities or community service providers to enter into agreements, it nonetheless requires agencies to try to enter into agreements. For juvenile justice agencies that successfully enter into agreements with outside entities and community service providers, the Commission recommends that agreements contain the following elements: (1) the purpose of the agreement; (2) the respective roles and responsibilities of the juvenile justice agency and outside entity or provider; (3) the procedures for how and when community service providers are able to gain entry into a facility; (4) the level of security supervision community service providers will have while in a facility; (5) the safety precautions that community service providers should take when working with residents; and (6) any laws, rules, and/or regulations relevant to the service being provided, including relevant State or local laws governing mandatory reporting requirements for disclosures about sexual abuse made to community service providers.

### RP-3 Agreements with outside law enforcement agencies

If an agency does not have the legal authority to conduct criminal investigations or has elected to permit an outside agency to conduct criminal or administrative investigations of staff or residents, the agency maintains or attempts to enter into a written MOU or other agreement specific to investigations of sexual abuse with the law enforcement agency responsible for conducting investigations. The agency also maintains or attempts to enter into an MOU with the designated State or local services agency with the jurisdiction and authority to conduct investigations related to the sexual abuse of children within confinement facilities. When the agency already has an existing agreement or long-standing policy covering responsibilities for all criminal investigations, including sexual abuse investigations and child abuse investigations conducted by a designated State or local services agency, it does not need to enter into new agreements. The agency maintains copies of its agreements or documentation showing attempts to enter into agreements.

Assessment Checklist	YES	NO
(a) If the agency does not have the legal authority to conduct criminal investigations or has elected to permit an outside agency to conduct criminal or administrative investigations of staff or residents, has the agency established or attempted to establish a written MOU or other agreement specific to investigations of sexual abuse with the law enforcement agency responsible for conducting investigations?		
(b) Has the agency established or attempted to establish an MOU with the designated State or local services agency with the jurisdiction and authority to conduct investigations related to the sexual abuse of children within confinement facilities?		
(c) Does the agency maintain copies of the agreements or documentation showing attempts to enter into agreements?		

#### Discussion

Standing agreements between juvenile justice agencies and outside law enforcement agencies outlining how they will work together while investigating an incident of sexual abuse

are important for ensuring that investigations into allegations of sexual abuse are timely and effective. Although the Commission recognizes that juvenile justice agencies may not be able to persuade outside law enforcement agencies to enter into agreements, it nonetheless requires agencies to try to enter into agreements. For juvenile justice agencies that successfully enter into agreements with outside law enforcement agencies, the Commission recommends that agreements contain the following elements: (1) the criteria, protocol, and timetables for referring an allegation of sexual abuse to the outside law enforcement agency for investigation; (2) the respective roles and responsibilities for conducting sexual abuse investigations; (3) the respective roles and responsibilities of the juvenile justice or law enforcement agencies for collecting evidence in accordance with the juvenile justice or law enforcement agency’s evidence protocol; (4) detailed information on how criminal, administrative, and/or other investigations will be coordinated between the agencies; (5) description of what information will and will not be shared between agencies; (6) the protocol for reporting progress on investigations to juvenile justices officials; (7) the location of where closed case files will be maintained; (8) the protocol for informing the victim of the progress and outcome of the investigation(s); and (9) a schedule of regular meetings between the agency and law enforcement supervisors to review the efficacy of the agreement and to recommend or make any changes, as necessary.

Under State or local law, an outside services agency, whether it is child protective services, an ombudsperson, or another State agency, will likely have the authority and jurisdiction to conduct separate investigations into allegations of sexual abuse committed against youth in confinement. Therefore, the standard requires the agency to enter into or attempt to enter into an MOU with the State or local services agency, as they would with any law enforcement agency with the authority to conduct investigations. If the relationship between the State or local services agency and the juvenile justice agency is already established by State or local law or longstanding agreement/policy, a new agreement and/or MOU is not necessary.

## RP-4 Agreements with the prosecuting authority

The agency maintains or attempts to enter into a written MOU or other agreement with the authority responsible for prosecuting violations of criminal law. The agency maintains a copy of the agreement or documentation showing attempts to enter into an agreement.

Assessment Checklist	YES	NO
(a) Has the agency established or attempted to establish a written MOU or other agreement with the authority responsible for prosecuting violations of criminal law?		
(b) Does the agency maintain a copy of the agreement or documentation showing attempts to enter into an agreement?		

### Discussion

Greater collaboration and communication between juvenile justice agencies and prosecutors can dramatically affect the success of sexual abuse prosecutions, improving accountability and preventing the recurrence of incidents of sexual abuse. The Commission urges the agency head to maintain regular, ongoing discussions with prosecutors about issues related to any allegations of criminal conduct in the agency.

Although the Commission recognizes that juvenile justice agencies may not be able to persuade prosecuting authorities to enter into agreements, it nonetheless requires agencies to try to enter

into agreements. For juvenile justice agencies that successfully enter into agreements with prosecutors, the Commission recommends that agreements contain the following elements: (1) the purpose of the agreement (e.g., to ensure effective prosecution of sexual abuse in confinement settings); (2) identification of the liaison position within each agency/office; (3) a schedule for joint training of investigators and prosecutors; (4) objective criteria for prosecution referral; (5) a description of the necessary evidence and relevant paperwork prosecutors will need from the agency to prosecute a case of sexual abuse; (6) timeframes for submission of criminal cases to prosecutors; (7) a requirement that prosecutors report back to juvenile justice agencies after each case is reviewed; (8) the respective roles and responsibilities of the juvenile justice agency and the prosecuting authority if the prosecutor decides to prosecute; and (9) a schedule of regular meetings between the agency and prosecution supervisors to review the efficacy of the agreement and to recommend or make any changes, as necessary.

## II. PREVENTION

### Training and Education (TR)

#### TR-1 Employee training

The agency trains all employees to be able to fulfill their responsibilities under agency sexual abuse prevention, detection, and response policies and procedures; the PREA standards; and under relevant Federal, State, and local law. The agency trains all employees to communicate effectively and professionally with all residents. Additionally, the agency trains all employees on a resident's right to be free from sexual abuse, the right of residents and employees to be free from retaliation for reporting sexual abuse, the dynamics of sexual abuse in confinement, and the common reactions of sexual abuse victims. Current employees are educated as soon as possible following the agency's adoption of the PREA standards, and the agency provides periodic refresher information to all employees to ensure that they know the agency's most current sexual abuse policies and procedures. The agency maintains written documentation showing employee signatures verifying that employees understand the training they have received.

Assessment Checklist	YES	NO
(a) Do employees receive the training necessary to fulfill their responsibilities under agency sexual abuse prevention, detection, and response policies and procedures; the PREA standards; and relevant Federal, State, and local law?		
(b) Does the agency train all employees to communicate effectively and professionally with all residents?		
(c) Does the agency train all employees on the following topics?		
• A resident's right to be free from sexual abuse		
• The right of residents and employees to be free from retaliation for reporting sexual abuse		
• The dynamics of sexual abuse in confinement		
• The common reactions of sexual abuse victims		
(d) Does the agency provide periodic refresher training to ensure that all employees are educated on the agency's most current sexual abuse policies and procedures?		
(e) Following training, does the agency require employees to sign documentation stating that they understand the training they have received and maintain documentation of these signatures?		

#### Discussion

Under this standard, each agency must provide employees with the knowledge and skills to prevent sexual abuse from occurring, to identify signs that sexual abuse may be occurring, and to take the appropriate actions when they learn of recent or historical incidents of sexual abuse. Additionally, it is important that all employees are trained to communicate effectively and professionally with all residents, including those of different races, ethnicities, cultural or religious backgrounds, ages, genders, and sexual orientations, as well as residents with differing cognitive abilities. Good communication encourages greater trust between employees and residents, which may remove one of the obstacles to resident reporting of sexual abuse.

Employee training can take place in multiple venues, including roll calls, on-the-job training, new employee orientations, and pre-service or in-service academies. It is recommended that an agency’s sexual abuse training programs be accompanied by clear sexual abuse prevention policies developed with an eye toward overcoming any anticipated employee resistance to or concerns about such policies. When putting together a training plan, agency administrators and/or PREA coordinators may find it helpful to consult the many resources and training materials already available, including those developed by other local, State, and Federal juvenile justice agencies; the National Institute of Corrections (NIC); and the Bureau of Justice Assistance (BJA).

A full list of suggested employee training topics and procedures is provided in Appendix B. Although Appendix B is not an exhaustive or exclusive list, agencies may wish to use these items as a starting point for developing their own employee training curriculum and programs.

## TR-2 Volunteer and contractor training

The agency ensures that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency’s sexual abuse prevention, detection, and response policies and procedures; the PREA standards; and relevant Federal, State, and local law. The level and type of training provided to volunteers and contractors is based on the services they provide and level of contact they have with residents, but all volunteers and contractors who have contact with residents must be notified of the agency’s zero-tolerance policy regarding sexual abuse. Volunteers must also be trained in how to report sexual abuse. The agency maintains written documentation showing volunteer and contractor signatures verifying that they understand the training they have received.

Assessment Checklist	YES	NO
(a) Does the agency ensure that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency’s sexual abuse prevention, detection, and response policies and procedures; the PREA standards; and relevant Federal, State and local law?		
(b) Does the agency tailor its training for volunteers and contractors based on the services they provide and the level of contact they have with residents?		
(c) Are all volunteers and contractors who have contact with residents notified of the agency’s zero-tolerance policy regarding sexual abuse?		
(d) Are all volunteers trained in how to report sexual abuse to direct care staff and/or other parties, when appropriate?		
(e) Following training, does the agency require volunteers and contractors to sign documentation stating that they understand the training they have received and maintain documentation of these signatures?		

### Discussion

Because many volunteers have frequent contact with residents, it is important that all volunteers for the agency receive basic training on the PREA standards, the agency’s zero-tolerance policy, and their responsibilities for reporting sexual abuse to direct care staff. Additionally, any contractors who have any contact with residents, however minimal, will also need to be trained on the agency’s zero-tolerance policy. The agency may choose to provide more detailed training for all or some subset of volunteers in their facilities, including many of the same topics suggested for employee training in Appendix B.

Volunteers may be trained off-site by their volunteer organization as long as the organization's training program meets the minimum requirements outlined in this standard. In these instances, the facility must verify that the off-site training meets the requirements of this standard and maintain documentation that volunteers have received and understand this training, as mandated by the standard. If the agency trains volunteers, agency administrators and/or PREA coordinators may find it helpful to consult the many resources and training materials already available, including those developed by other local, State, and Federal juvenile justice agencies; NIC; and BJA.

### TR-3 Resident education

During the intake process, staff informs residents of the agency's zero-tolerance policy regarding sexual abuse and how to report incidents or suspicions of sexual abuse in an age-appropriate fashion. Within a reasonably brief period of time following the intake process, the agency provides comprehensive, age-appropriate education to residents regarding their right to be free from sexual abuse and to be free from retaliation for reporting abuse, the dynamics of sexual abuse in confinement, the common reactions of sexual abuse victims, and agency sexual abuse response policies and procedures. Current residents are educated as soon as possible following the agency's adoption of the PREA standards, and the agency provides periodic refresher information to all residents to ensure that they know the agency's most current sexual abuse policies and procedures. The agency provides resident education in formats accessible to all residents, including those who are LEP, deaf, visually impaired, or otherwise disabled as well as inmates who have limited reading skills. The agency maintains written documentation of resident participation in these education sessions.

Assessment Checklist	YES	NO
(a) During the intake process, does staff inform residents of the agency's zero-tolerance policy regarding sexual abuse in an age-appropriate fashion?		
(b) During the intake process, does staff tell residents how to report incidents or suspicions of sexual abuse?		
(c) Does the agency provide comprehensive, age-appropriate education to residents within a reasonably brief period of time following the intake process?		
(d) Does the comprehensive, age-appropriate education for residents include the following topics?		
• A resident's right to be free from sexual abuse and free from retaliation for reporting abuse		
• The dynamics of sexual abuse in confinement		
• The common reactions of sexual abuse victims		
• Agency sexual abuse response policies and procedures		
(e) Does the agency provide periodic refresher training to ensure that all residents are educated on the agency's most current sexual abuse policies and procedures?		
(f) Does the agency make training information available in formats accessible to all residents, including those who are LEP, deaf, visually impaired, or otherwise disabled and residents who have limited reading skills?		
(g) Does the facility verify resident attendance at training sessions and maintain this written verification?		

## Discussion

Residents need to be educated about the agency's sexual abuse policies so they understand how to protect themselves against sexual abuse, how to report sexual abuse, what will happen following a report, and the consequences for committing sexual abuse. A strong resident education program will send a message to residents that sexual abuse is taken seriously and that the agency will protect residents who report incidents of sexual abuse and refer investigations for disciplinary action and/or criminal prosecution. Due to the wide age range of residents in some facilities, agencies should ensure that this information is delivered in an age-appropriate fashion. For example, a very young resident will have a much different reaction than an older resident to such information; the young resident may become frightened or not understand the terms and concepts used when he or she is informed of the agency's sexual abuse policies. In such cases, staff may choose to inform residents of the agency's zero-tolerance policy by telling them that no relationships beyond friendship are permitted. The delivery of such information should always be tailored to the specific needs and age/maturity level of the residents receiving the information.

In addition to determining an appropriate time frame for providing comprehensive education to new residents, the agency should develop a plan for providing the resident education program to current residents to ensure that training is provided within a reasonable period of time after the adoption of the PREA standards, as required by this standard. Staff conducting the training should consider using some of the following tools, depending on the learning needs of the population they are training: videos, written materials, and structured discussions. As with developing an employee or volunteer training program, when putting together a resident training plan, agency administrators and/or PREA coordinators may find it helpful to consult the many resources and training materials already available, including those developed by other local, State, and Federal juvenile justice agencies; NIC; and BJA. Staff may need to train residents in small groups and in settings with few distractions due to the sensitive nature of the material. In addition to training sessions provided at specific times, the agency should ensure key information is continually and readily available and/or visible to the resident population through posters, resident handbooks, or other written formats.

## TR-4 Specialized training: Investigations

In addition to the general training provided to all employees (TR-1), the agency ensures that agency investigators conducting sexual abuse investigations have received comprehensive and up-to-date training in conducting such investigations in confinement settings. Specialized training must include techniques for interviewing young sexual abuse victims, proper use of *Miranda*- and *Garrity*-type warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral. The agency maintains written documentation that investigators have completed the required specialized training in conducting sexual abuse investigations.

Assessment Checklist	YES	NO
(a) Does the agency ensure that all agency investigators conducting sexual abuse investigations have received training in conducting such investigations in confinement settings?		
(b) Does specialized training for sexual abuse investigators include the following?		
• Techniques for interviewing young sexual abuse victims		
• Proper use of <i>Miranda</i> - and <i>Garrity</i> -type warnings		
• Sexual abuse evidence collection in confinement settings		
• Criteria and evidence required to substantiate a case for administrative action or prosecution referral		
(c) Does the agency verify that investigators have completed specialized training in conducting sexual abuse investigations and maintain written verification?		

### Discussion

Substantiating and resolving incidents of sexual abuse in confinement settings requires highly competent investigations. Sexual abuse investigations in confinement settings are complicated, and an agency will not be successful in addressing abuse if it does not ensure that investigators are sufficiently trained.

Because the trauma of sexual abuse can be especially devastating to victims in custody who may already feel powerless and isolated, special care should be given to the quality and training of the investigator to ensure that victims and witnesses are treated in a manner that facilitates both victims' recovery and cooperation. It is critically important for sexual abuse investigators to be trained in how to interview young sexual abuse victims and witnesses, who may be reluctant to speak to investigators or generally uncooperative. Young victims are less likely to understand the investigator's role or feel comfortable describing the details of the abuse to an authority figure, especially if the victim feels threatened. Training on strategies for communicating effectively and professionally with young victims, as well as making sure that all victims and witnesses are interviewed in locations where they feel comfortable talking about the incident, will help investigators complete their responsibilities without re-traumatizing young victims. Additionally, all investigators should know how and when to administer *Miranda*- and/or *Garrity*-type warnings to subjects of investigations.

Collecting evidence in a confinement setting requires that investigators understand where to look for evidence in these settings, including DNA evidence, and how direct care staff will secure and preserve crime scenes. Sexual abuse investigators should also know how and when to photograph injuries. In addition to knowing how to collect evidence in a confinement setting, investigators also need to know how to evaluate that evidence according to the different standards of proof required to substantiate a case for administrative action or prosecution referral. It may also be helpful for investigators to have an understanding of how cases are evaluated for prosecutorial merit.

When developing training curricula for investigators, the agency may find it helpful to consult training materials developed by other Federal, State, and local juvenile justice agencies; NIC; and BJA. In the event investigators have previously received the comprehensive training described above, the agency does not need to re-train the investigators. In such instances, the agency will need to verify the investigators' preexisting knowledge and understanding of the requirements listed in this standard and their responsibilities under agency policy; the PREA standards; and Federal, State, or local law.



## TR-5 Specialized training: Medical and mental health care

The agency ensures that all full- and part-time medical and mental health care practitioners working in its facilities have been trained in how to detect and assess signs of sexual abuse and that all medical practitioners are trained in how to preserve physical evidence of sexual abuse. All medical and mental health care practitioners must be trained in how to respond effectively and professionally to young victims of sexual abuse and how and to whom to report allegations or suspicions of sexual abuse. The agency maintains documentation that medical and mental health practitioners have received this specialized training.

Assessment Checklist	YES	NO
(a) Does the agency ensure that all full- and part-time medical and mental health care practitioners working in its facilities have been trained in how to detect and assess signs of sexual abuse?		
(b) Does the agency ensure that all full- and part-time medical practitioners working in its facilities have been trained in how to preserve physical evidence?		
(c) Are all full- and part-time medical and mental health care practitioners trained in how to respond effectively and professionally to young victims of sexual abuse?		
(d) Does the agency provide training in how and to whom to report allegations or suspicions of sexual abuse?		
(e) Does the agency verify that all full- and part-time medical and mental health practitioners have received specialized training in detecting, assessing, and responding to sexual abuse victims and maintain this written verification?		

### Discussion

Residents are often more likely to report sexual abuse to medical or mental health practitioners rather than direct care staff. It is therefore critical that agencies provide training for medical and mental health practitioners on how to detect sexual abuse and how to elicit, receive, and forward reports of sexual abuse. Additionally, medical and mental health practitioners should be trained and experienced in working with children and young victims of sexual abuse, including how to address the unique developmental and psychosocial needs of confined youth. Youth in confinement are often reluctant to speak with practitioners or confused about the services they are receiving, and many have prior histories of sexual abuse in the community that should be dealt with and discussed in a sensitive manner. Medical and mental health practitioners will be better suited to deliver effective and comprehensive services if they have the proper training to treat young victims.

This standard requires that all full- and part-time practitioners who regularly work at a facility, whether contractors or staff, be specially trained. The Commission recognizes that there may be occasions in which a practitioner works at the facility on an extremely short, ad hoc basis. For example, a practitioner may be serving as an emergency substitute for a sick staff member. The standard does not require the agency to ensure such practitioners have received the special training, although it may want to do so to guarantee that at least one specially trained practitioner is on duty at all times.

In the event medical and mental health care practitioners have previously received the training described above, the agency does not need to re-train the medical and mental health care staff. In such instances, the agency will need to verify the staff members' preexisting knowledge and understanding of the requirements listed in this standard, and their responsibilities under agency policy; the PREA standards; and Federal, State, or local law.

## Assessment and Placement of Residents (AP)

### AP-1 Obtaining information about residents

During intake and periodically throughout a resident's confinement, employees obtain and use information about each resident's personal history and behavior to keep all residents safe and free from sexual abuse. At a minimum, employees attempt to ascertain information about prior sexual victimization or abusiveness; sexual orientation and gender identity; current charges and offense history; age; level of emotional and cognitive development; physical size/stature; mental illness or mental disabilities; intellectual/developmental disabilities; physical disabilities; and any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents. This information may be ascertained through conversations with residents at intake and medical and mental health screenings; during classification assessments; and by reviewing court records, case files, facility behavioral records, and other relevant documentation from the residents' files. Medical and mental health practitioners are the only staff permitted to talk with residents to gather information about their sexual orientation or gender identity, prior sexual victimization, history of engaging in sexual abuse, mental health status, and mental or physical disabilities. If the facility does not have medical or mental health practitioners available, residents are given an opportunity to discuss any safety concerns or sensitive issues privately with another employee.

Assessment Checklist	YES	NO
(a) During intake and periodically throughout a resident's confinement, do employees attempt to ascertain information about the following?		
• Prior sexual victimization or abusiveness		
• Sexual orientation or gender identity		
• Current charges and offense history		
• Age		
• Level of emotional and cognitive development		
• Physical size/stature		
• Mental illness		
• Mental or physical disabilities		
• Intellectual or developmental disabilities		
• Any other specific information about individual residents that may indicate the need to separate them from other residents		
(b) Is information about residents ascertained through multiple channels, including conversations with residents at intake and medical and mental health screenings; during classification assessments; and by reviewing court records, case files, facility behavior records, and other relevant documentation?		
(c) Are medical and mental health practitioners the only staff permitted to talk with residents to gather information about their sexual orientation or gender identity, prior sexual victimization, history of engaging in sexual abuse, mental health status, and mental or physical disabilities?		

## Discussion

Under this standard, during intake screenings and subsequently, employees must attempt to ascertain information about previous sexual victimization and abusiveness, sexual orientation and gender identity, and other enumerated factors that may be helpful to know in keeping all residents safe while confined. Currently, there is little known about what makes certain residents more vulnerable to sexual abuse or to being sexually abusive. As such, employees should make individualized determinations regarding placement of youth and use their professional judgment to protect all youth in the facility. The Commission strongly recommends that agencies consult emerging research periodically to determine if there are new factors or considerations that research has identified as being useful for making assessments about future victimization or abusiveness.

Knowing that a young person is lesbian, gay, bisexual, or transgender can help facilities plan for the youth's safety. Research on victimization outside of the juvenile justice area suggests that certain characteristics, such as openly identifying as lesbian, gay, bisexual, or transgender; having a history of victimization or mental illness; or having a mental disability, may make some residents more vulnerable to harassment, bullying, physical violence, or even sexual abuse. However, it is generally not appropriate for employees to ask direct questions about sexual orientation or gender identity as part of initial intake or to discuss these sensitive issues in non-private areas. Rather, the agency should create an atmosphere of acceptance in which youth are more likely to reveal such information voluntarily. Therefore, this standard requires that any information regarding sexual orientation and other sensitive issues, such as gender identity, be ascertained by medical and mental health practitioners during private medical and mental health intake and reception screenings and in accordance with their professional judgment, taking into account the resident's age and other developmental factors (MM-1).

## AP-2 Placement of residents in housing, bed, program, education, and work assignments

Employees use all information obtained about the resident at intake and subsequently to make placement decisions for each resident on an individualized basis with the goal of keeping all residents safe and free from sexual abuse. When determining housing, bed, program, education and work assignments for residents, employees must take into account a resident's age; the nature of his or her offense; any mental or physical disability or mental illness; any history of sexual victimization or engaging in sexual abuse; his or her level of emotional and cognitive development; his or her identification as lesbian, gay, bisexual, or transgender; and any other information obtained about the resident (AP-1). Residents may be isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged.

Assessment Checklist	YES	NO
(a) Do employees use all information obtained about a resident at intake and subsequently to make placement decisions on an individualized basis with the goal of keeping all residents safe and free from sexual abuse?		
(b) When determining housing, bed, program, education, and work assignments for residents, do employees take into account all the known information about the resident?		
(c) Are residents isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged?		

**Discussion**

Ensuring that employees make deliberate, informed decisions about how and where to place residents, rather than, for example, making decisions solely based on available bed space, will go a long way toward keeping all residents safe from sexual abuse. Decisions regarding housing are particularly important, and when assigning a resident to shared rooms or pods, as is necessary in many facilities, employees ought to take special care to consider all the information known about the resident and to determine the appropriate pairing or pod assignment. Due to differences in cognitive and emotional development, employees should make every effort to house younger residents with residents close to their age, rather than with older residents. Similarly, individuals who are placed in a facility for status offenses should be housed separately from other residents when possible.

Although this standard mandates using all information known about a resident early in his or her confinement to inform housing, bed, program, education, and work assignments, this information can change over time, and more information could become available during the course of a youth's confinement. As such, resident case managers and other staff should check in periodically with residents to make sure their placements are appropriate; that residents feel comfortable; and that residents are not experiencing any unwanted sexual behavior or threats from staff or other residents.

Facilities should be able to keep residents safe without relying on isolation or prolonged room confinement for potential or actual victims or abusers. Isolating a youth from others for safety reasons should only be undertaken as a last resort and then only for as short a time as possible. If prolonged isolation is the only option for keeping residents safe, the facility should consider transfers to other facilities. Transfers should also be considered for residents who request them for safety reasons.



### III. DETECTION AND RESPONSE

#### Reporting (RE)

##### RE-1 Resident reporting

The facility provides multiple internal ways for residents to report easily, privately, and securely sexual abuse, retaliation by other residents or staff for reporting sexual abuse, and staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse. The facility also provides at least one way for residents to report the abuse to an outside public entity or office not affiliated with the agency that has agreed to receive reports and forward them to the facility head (RP-3). Staff accepts reports made verbally, in writing, anonymously, and from third parties and immediately puts into writing any verbal reports.

Assessment Checklist	YES	NO
(a) Does the facility provide multiple internal ways for residents to report easily, privately, and securely sexual abuse, retaliation by other residents or staff for reporting sexual abuse, and staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse (e.g., locked drop boxes in common areas for reports or requests; grievance procedures; sick-call systems; access to a central or headquarters office)? (Please attach documentation explaining the specific internal reporting mechanisms the facility has in place.)		
(b) Does the facility provide at least one way for residents to report sexual abuse to an outside public entity or office not affiliated with the agency that has agreed to receive reports and forward them to the facility head (e.g., ombudsperson; outside law enforcement agency; inspector general's office; attorney general's office; child protective services) (RP-3)? (Please attach documentation explaining the specific outside reporting mechanism(s) the facility has made available to residents.)		
(c) Does staff accept reports made verbally, in writing, anonymously, and by third parties?		
(d) Does staff immediately put into writing any verbal reports?		

#### Discussion

The agency should make reporting sexual abuse as easy, private, and secure as possible. The more the agency demonstrates through policy, practice, and staff behaviors its commitment to protecting sexual abuse victims and punishing abusers, the more victims will feel safe coming forward. Although a potential increase in disclosures and investigations may initially tax juvenile justice resources, increased reporting may also signal that residents are becoming more trustful of the system, which, in turn, may deter potential abusers from engaging in sexually abusive behaviors. Over time, the agency's initial investment in efforts to make reporting easier and to conduct thorough investigations will serve everyone's interests. Victims will be better supported, abusers will be held accountable, and staff and residents will ultimately be able to live and work in safer, more secure environments.

The facility should take seriously all reports of sexual abuse, regardless of the form or format in which they were conveyed. Although the facility may choose to provide different mechanisms for internal reporting, including locked drop boxes in common areas for residents to drop reports, requests, or grievances or dedicated phones or programmed phones with toll-free hotline numbers to internal investigative departments, staff should be prepared to accept and respond to all types of reports and manners of reporting. For example, a resident

who scrawls a note and passes it to an officer should be treated the same way as a resident who files a formal grievance.

The standard’s requirement that the agency enable residents to report to at least one outside public entity or office not affiliated with the agency will signal to residents that the agency’s chief concern is making sure that residents feel safe and comfortable reporting sexual abuse. The agency may choose to meet this requirement by allowing residents to report directly to the designated State or local services agency that has the authority to conduct investigations into allegations of sexual abuse involving child victims (RP-3). In addition to developing numerous avenues for receiving reports, staff should be trained and expected to take proactive steps to talk to residents periodically about any unwanted sexual behaviors or threats they may be experiencing from other residents or staff (SC-2).

## RE-2 Exhaustion of administrative remedies

Under agency policy, a resident has exhausted his or her administrative remedies with regard to a claim of sexual abuse either (1) when the agency makes a final decision on the merits of the report of abuse (regardless of whether the report was made by the resident, made by a third party, or forwarded from an outside official or office) or (2) when 90 days have passed since the report was made, whichever occurs sooner. A report of sexual abuse triggers the 90-day exhaustion period regardless of the length of time that has passed between the abuse and the report. A resident seeking immediate protection from imminent sexual abuse will be deemed to have exhausted his or her administrative remedies 48 hours after notifying any agency staff member of his or her need for protection.

Assessment Checklist	YES	NO
(a) Does agency policy reflect that a resident has exhausted administrative remedies with regard to a claim of sexual abuse under the following circumstances?		
• When the agency makes a final decision on the merits of the report of abuse (regardless of whether the report was made by the resident, made by a third party, or forwarded from an outside official or office) or		
• When 90 days have passed since the report was made, whichever occurs sooner		
(b) Does agency policy reflect that a resident seeking immediate protection from imminent sexual abuse has exhausted administrative remedies 48 hours after notifying any agency staff member of his or her need for protection?		

### Discussion

Currently, under the Federal Prison Litigation Reform Act (PLRA), juvenile justice agencies are able to raise a resident’s “failure to exhaust administrative remedies” as an affirmative defense against a resident’s legal claims brought in Federal court. The purpose of this requirement in PLRA is to ensure that agencies have an opportunity to respond to a resident’s complaint before that resident files a lawsuit. Agencies are free to determine the procedures by which a resident “exhausts administrative remedies” by policy. In practice, many agencies have adopted policies that require a resident to file a grievance within a relatively short timeframe after the incident of abuse and then to make multiple appeals of the agency’s response within specific timeframes to satisfactorily exhaust the agency’s administrative remedies. Policies that require residents to navigate a complicated grievance procedure within a short time after the abuse can result in the dismissal of meritorious legal claims by victims of sexual abuse. Although the statute

of limitations to file a lawsuit may be one year or two depending on the type of claim and the jurisdiction, residents who fail to file a grievance within one or two weeks after being abused may be permanently barred from court for failing to “exhaust administrative remedies.”

Victims of sexual abuse are particularly vulnerable to having their claims dismissed for this reason because the trauma of sexual abuse and fear of retaliation often prevent them from reporting the incident shortly after it occurs. This is especially true for young victims of abuse, who are not only afraid of retaliation, but also often confused about or unaware of their legal options and rights. Furthermore, because grievance procedures are generally not designed as the sole or primary method for reporting incidents of sexual abuse by residents to staff, victims who do immediately report abuse to authorities may not realize they need to file a grievance as well to satisfy agency exhaustion requirements. For example, a victim might call the agency’s sexual abuse reporting hotline immediately but fail to file a grievance within the short timeframe allowed and later be barred from bringing a valid legal claim because of that failure.

This standard recognizes agencies’ legitimate interest in having a reasonable opportunity to respond to notice of abuse before being required to defend themselves in court. It also recognizes that PREA’s goals are not furthered if residents are deemed to have forfeited their ability to seek judicial redress for abuse because they have not reported the abuse within a set timeframe after it occurs. The standard requires agencies to adopt policies by which a resident is deemed to have exhausted his or her administrative remedies no later than 90 days after a report of sexual abuse is made and regardless of the time that has elapsed between the abuse and the report. Any report of sexual abuse should trigger a response by the agency, including an investigation into the merits of the allegation (IN-1, IN-2), the provision of appropriate medical and mental health treatment (MM-2, MM-3), and efforts to protect the alleged victim and other residents from retaliation and future abuse (RP-1). It is possible that the agency will not have completed its investigation into the report within 90 days, but that is ample time within which the agency can take appropriate steps to protect the resident and to demonstrate its efforts to find the truth for the purposes of defending against a lawsuit.

Finally, the standard recognizes that there may be urgent, emergency situations when a resident seeks an immediate injunction from the court to provide protection from imminent harm. In such cases, the standard requires an exception to the 90-day waiting period. Because it is incumbent on the agency to provide protection immediately to a resident who reports a risk of imminent harm, the agency shall deem the resident’s administrative remedies exhausted 48 hours after such a report is made to any agency employee. A court can determine whether the resident’s request merits an injunction, but the resident seeking the court’s protection should not be required to wait more than 48 hours since the nature of such a request is urgent. If the agency has in fact responded properly to the report or if the report was of such a nature that it did not warrant action on the part of the agency, a court can make that determination at the time the injunction is sought.

### **RE-3 Resident access to outside support services and legal representation**

In addition to providing on-site mental health care services, the facility provides residents with access to outside victim advocates for emotional support services related to sexual abuse. The facility provides such access by giving residents the current mailing addresses and telephone numbers, including toll-free hotline numbers, of local, State, and/or national victim advocacy or rape crisis organizations and enabling reasonable communication between residents and



these organizations. The facility ensures that communications with such advocates are private, to the extent allowable by Federal, State, and local law. The facility informs residents, prior to giving them access, of the extent to which such communications will be private, confidential, and/or privileged. The facility also provides residents with unimpeded access to their attorney or other legal representation and their families.

Assessment Checklist	YES	NO
(a) In addition to providing on-site mental health care services, does the facility provide residents with the current mailing addresses and telephone numbers, including toll-free hotline numbers, of local, State, and/or national victim advocacy or rape crisis organizations and enable reasonable communication between residents and these organizations? (Please attach documentation explaining how the facility provides residents with access to outside confidential support services related to sexual abuse.)		
(b) Are residents able to communicate with outside victim advocates privately in settings where conversations cannot be overheard?		
(c) To ensure privacy of communication, is staff prohibited from reading correspondence to or from victim advocates?		
(d) Does the facility explain to residents, prior to giving them access to outside support services, the rules governing privacy, confidentiality, and/or privilege that apply for disclosures of sexual abuse made to outside victim advocates, including any limits to confidentiality under relevant Federal, State, or local law?		
(e) Does the facility provide residents with unimpeded access to their attorney or other legal representation and their families?		

### Discussion

Victims of sexual abuse, whether confined or not, often require the support of an advocate. Working with these advocates, such as rape crisis counselors, is not only an essential part of treatment for some victims, but can also help victims overcome any reluctance to report the incident to the appropriate officials. This is especially true for young victims. The Commission recognizes that in most jurisdictions, outside providers will be unable to provide truly confidential support services due to State or local mandatory child abuse reporting laws. In these jurisdictions, residents who have been victims of abuse in a facility should still have the opportunity to access outside support services if they do not feel comfortable using the services provided within the facility. Although the agency might have qualified mental health practitioners on staff who can treat sexual abuse victims, some victims may be reluctant to confide in those practitioners because they see them as part of the institution that failed to protect them from the abuse. By giving residents the option to communicate with outside advocates, the agency will ensure that victims have the greatest access to necessary care.

To meet the requirements of this standard, an agency may need to enter an MOU with a community service provider and may find it useful to provide regular opportunities for residents to meet face-to-face with advocates (RP-3). In addition to these opportunities, free hotlines that connect residents to rape crisis service groups and/or other victim advocacy groups are encouraged. Agencies that have limited community resources to draw from should at a minimum provide residents with contact information for regional and/or national human rights, advocacy, and/or counseling organizations. Telephone use to contact outside advocates and/or letters to service organizations should not be subject to any rules or restrictions governing telephone use or mail. Administrators need to make certain that residents are able to access outside confidential support services as easily and privately as possible. Residents should never have to explain

to staff members their reasons for wanting to speak or write to outside advocates before being allowed to communicate with those providers.

In addition to giving residents access to outside support services, under this standard the agency must ensure that residents also have unimpeded access to their attorney or other legal representation and to their families. Residents are often unaware of their rights in confinement, and most juvenile facilities do not provide residents with legal materials or a law library. Providing residents with unimpeded access to legal representation and to their families will not only help them navigate the legal process, if they need that help, but it will also give them greater access to adults in the community who may be able to help them if they're experiencing sexual threats or abuse.

## RE-4 Third-party reporting

The facility receives and investigates all third-party reports of sexual abuse and refers all third-party reports of abuse to the designated State or local services agency with the authority to conduct investigations into allegations of sexual abuse involving child victims (IN-1 and RP-4). At the conclusion of the investigation, the facility notifies in writing the third-party individual who reported the abuse and the resident named in the third-party report of the outcome of the investigation. The facility distributes information on how to report sexual abuse on behalf of a resident to residents' parents or legal guardians, attorneys, and the public.

Assessment Checklist	YES	NO
(a) Does the facility receive and investigate all third-party reports of sexual abuse?		
(b) Does the facility refer all third-party reports of sexual abuse to the designated State or local services agency with the authority to conduct investigations into allegations of sexual abuse involving child victims?		
(c) At the conclusion of the investigation, does the facility notify in writing the individual who reported the abuse and the resident named in the third-party report of the outcome of the investigation?		
(d) Does the facility distribute publicly information on how to report sexual abuse on behalf of a resident?		

### Discussion

Information about how to report sexual abuse on behalf of a resident should be available in multiple languages and in a convenient, easily accessible format. Information may be made available on a Web site; as part of any preliminary information provided to visitors; or in brochures, in flyers, or on posters in visiting areas. Regardless of how facilities chooses to distribute the information, it should convey: (1) the contact information for the corrections official, department, or unit responsible for receiving and responding to third-party allegations; (2) instructions for what information to include when reporting sexual abuse; (3) notice that the allegation will be discussed with the victim named in the report; (4) a statement explaining the allegation will be disclosed only to those who need to know to ensure victim safety and to investigate the allegation; and (5) notice that the facility will inform the individual who reported the abuse of the outcome of the investigation. The facility should periodically review and update, if necessary, the information distributed regarding third-party reporting.

## Official Response Following a Resident Report (OR)

### OR-1 Staff and facility head reporting duties

All staff members are required to report immediately and according to agency policy and relevant State or local mandatory child abuse reporting laws any knowledge, suspicion, or information they receive regarding an incident of sexual abuse that occurred in an institutional setting; retaliation against residents or staff who reported abuse; and any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or retaliation. Apart from reporting to designated supervisors or officials and designated State or local services agencies, staff must not reveal any information related to a sexual abuse report to anyone other than those who need to know, as specified in agency policy, to make treatment, investigation, and other security and management decisions. Medical and mental health practitioners are required to report sexual abuse to designated supervisors and officials as well as the designated State or local services agency and must inform residents of their duty to report at the initiation of services. Upon receiving any allegation of sexual abuse, the facility head must immediately report the allegation to the agency head, the juvenile court that handled the victim's case or the victim's judge of record, and the victim's parents or legal guardians, unless the facility has official documentation showing the parents or legal guardians should not be notified. If the victim is involved in the child welfare system, the facility head reports to the victim's caseworker instead of the victim's parents or legal guardians.

Assessment Checklist	YES	NO
(a) Do staff members report immediately and according to agency policy and relevant State or local mandatory child abuse reporting laws any knowledge, suspicion, or information they receive regarding an incident of sexual abuse that occurred in an institutional setting, including any knowledge of retaliation against residents or staff who reported abuse and any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or retaliation?		
(b) Do staff members limit information related to any incident of sexual abuse to those who need to know, as specified in agency policy, to make treatment, investigation, and other security and management decisions?		
(c) Do medical and mental health practitioners know and follow their reporting duties, including their duty to inform residents of their duty to report at the initiation of services?		
(d) Upon receiving an allegation of sexual abuse, does the facility head immediately notify the following?		
• The agency head		
• The juvenile court that handled the victim's case or the victim's judge of record		
• The victim's parents or legal guardians, unless there is official documentation showing the parents or legal guardians should not be notified		
• The victim's caseworker if the victim is involved in the child welfare system		

#### Discussion

Attaining compliance with this standard will require that facility leadership effectively convey to staff that under agency policy and relevant State or local mandatory child abuse reporting laws, all staff members are mandatory reporters with no discretion to decide whether to report sexual abuse allegations or any other knowledge or suspicion of sexual abuse or harassment. The agency should make it clear through policy and practice that the agency tolerates neither a staff code of silence nor the mishandling or inappropriate sharing

of information (i.e., spreading rumors or conveying information to individuals who have no need to know), and staff should be trained on the difference between spreading rumors and proper reporting. Additionally, it is critical that all staff members understand exactly what, when, how, and to whom they are required to report, including whether their responsibilities differ based on the type of offense or the persons involved.

Under relevant State or local mandatory child abuse reporting laws, all staff members, including medical and mental health care practitioners in most jurisdictions, are considered mandatory reporters and must report allegations of abuse to the designated State or local services agency with the authority to conduct investigations into allegations of sexual abuse involving child victims (RP-4). Additionally, under this standard, medical and mental health care practitioners need to inform residents of their duty to report at the initiation of services. Informing residents of their duty to report at the initiation of services is critical so that residents know up front what they can expect to be kept confidential and what they can expect will be reported. Although the Commission recognizes that some medical and mental health practitioners may be reluctant to report because of fears that victims will not seek treatment, it nonetheless requires medical and mental health practitioners to report to protect the overall safety and security of the facility as well as the safety of the individual being abused or threatened with abuse.

Apart from the requirement for staff to report allegations to the appropriate supervisors or officials according to agency policy and to the designated State or local services agency under applicable mandatory child abuse reporting laws, this standard mandates additional reporting responsibilities for the facility head. Under this standard, upon receiving an allegation, the facility head must immediately report to the agency head, the juvenile court or the judge of record, and the victim’s parents or legal guardians. However, in some cases, there may be documentation showing that the parents or guardians should not be notified, such as when parental rights have been terminated or when reporting to the victim’s family may place the victim in specific identifiable danger or otherwise interfere with his or her treatment or recovery. In these instances, the facility should refrain from notifying the victim’s parents or legal guardians. If the victim is part of the child welfare system, the victim’s caseworker should be notified in place of the victim’s parents.

## OR-2 Reporting to other confinement facilities

When the facility receives an allegation that a resident was sexually abused while confined at another facility, the head of the facility where the report was made notifies in writing the head of the facility where the alleged abuse occurred. The head of the facility where the alleged abuse occurred ensures the allegation is investigated.

Assessment Checklist	YES	NO
(a) When the facility receives an allegation that a resident was sexually abused while confined at another facility, does the head of the facility where the report was made notify in writing the head of the facility where the alleged abuse occurred?		
(b) If the facility head receives notice that a former resident has alleged sexual abuse while confined at his or her facility, does he or she ensure that the allegation is investigated?		

**Discussion**

Residents who have been sexually abused while confined at a detention facility may feel safer reporting the abuse once they are no longer housed at the facility where the abuse occurred. For example, a resident who was sexually abused at a pre-adjudication short-term confinement facility may wait until he or she is transferred to his or her post-adjudication long-term placement to report. Similarly, someone abused while confined in juvenile detention may choose to report once he or she is in the custody of a community corrections agency. The head of the facility where the report is made needs to be prepared to notify the appropriate authorities immediately. By the same token, as required by the standard, the head of the agency or facility where the alleged abuse occurred must ensure that the allegation is investigated. This effort to communicate and share information across agencies and facilities should improve safety and security for all residents and staff.

**OR-3 Staff first responder duties**

Upon learning that a resident was sexually abused within a time period that still allows for the collection of physical evidence, the first direct care staff member to respond to the report is required to (1) separate the alleged victim and abuser; (2) seal and preserve any crime scene(s); and (3) instruct the victim not to take any actions that could destroy physical evidence, including washing, brushing his or her teeth, changing his or her clothes, urinating, defecating, smoking, drinking, or eating. If the first staff responder is a non-direct care staff member, he or she is required to instruct the victim not to take any actions that could destroy physical evidence and then notify direct care staff.

Assessment Checklist	YES	NO
(a) Upon learning of an incident of sexual abuse that occurred within a time period that still allows for the collection of physical evidence, does the first direct care staff member to respond separate victims from abusers; seal and preserve any crime scene(s); and instruct victims not to wash, brush their teeth, change their clothes, urinate, defecate, smoke, drink, or eat?		
(b) If a non-direct care staff member is the first staff responder to an incident of sexual abuse, does he or she instruct victims not to wash, brush their teeth, change their clothes, urinate, defecate, smoke, drink, or eat and then notify direct care staff?		

**Discussion**

In addition to reporting the abuse according to agency policy and relevant State or local mandatory child abuse reporting laws, the first direct care staff member who learns of a resident being sexually abused is responsible for ensuring that the victim is safe and any physical evidence is preserved until an investigator arrives. At the time of publication of this body of standards, the commonly accepted time limit for collecting physical evidence is 96 hours. To carry out their duties effectively, direct care staff members will need to be able to counsel victims who may be in distress while maintaining security and control over the crime scene(s). In the event that a non-direct care staff member is the first staff responder, he or she needs to be prepared to instruct victims not to take any actions that could destroy physical evidence and then immediately notify direct care staff.

## OR-4 Coordinated response

All actions taken in response to an incident of sexual abuse are coordinated among staff first responders, medical and mental health practitioners, investigators, victim advocates, and facility leadership. The facility's coordinated response ensures that victims receive all necessary immediate and ongoing medical, mental health, and support services and that investigators are able to obtain usable evidence to substantiate allegations and hold perpetrators accountable.

Assessment Checklist	YES	NO
(a) Are all actions taken in response to an incident of sexual abuse coordinated among staff first responders, medical and mental health practitioners, investigators, victim advocates, and facility leadership?		
(b) Does the facility's coordinated response ensure that victims receive all necessary immediate and ongoing medical, mental health, and support services?		
(c) Does the facility's coordinated response ensure that investigators are able to obtain usable evidence to substantiate allegations and hold perpetrators accountable?		

### Discussion

In the community, coordinated sexual assault response teams (SARTs) are recognized as a best practice for responding to incidents of rape and other sexual abuse because they enable key responders from the medical, advocacy, and law enforcement fields to coordinate their actions and share information, helping the victim receive the best care and providing the investigator with the best chance to find the perpetrator. SARTs are generally composed of representatives from the medical and mental health fields, victim advocacy groups (usually from local or regional rape crisis centers), and law enforcement agencies. Although some juvenile justice agencies already use some version of a SART or specialized first response team, or they participate in an existing specialized community response team, the Commission recognizes that not all agencies are equipped to organize a specialized team or spearhead a community SART. The Commission urges those agencies to work toward developing such a team by working with community or regional law enforcement agencies, outside medical and mental health providers, and sexual abuse advocacy groups to establish a coordinated plan to address victims' needs and improve sexual abuse investigation outcomes. At the time of publication of these standards, the Commission recommends agencies consult the 2004 U.S. Department of Justice's Office on Violence Against Women publication "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents" for guidance and ideas on developing an approach to a coordinated response to sexual abuse.

Regardless of whether or not the agency uses a designated response team or participates in a community SART, the standard requires that all actions taken in response to an incident of sexual abuse be coordinated among staff first responders, medical and mental health practitioners, investigators, victim advocates, and facility leadership. To ensure the best treatment for victims and the greatest likelihood of holding perpetrators accountable, a number of actions should be coordinated, including: (1) assessing the victim's acute medical needs to determine if he or she needs to be stabilized and/or treated for injuries, conditions, or potential risks; (2) informing the victim of his or her rights under relevant Federal and/or State crime victims' rights laws; (3) giving the victim the option of undergoing a forensic medical exam for the purpose of collecting and documenting physical evidence of abuse; (4) having a victim advocate available to the resident victim during the forensic medical exam; (5) providing crisis intervention counseling for the victim before and after the forensic medical exam; (6) interviewing victims and witnesses; (7) collecting evidence; and (8) providing for any special needs a victim might have. The coordinated response should also take into

account the unique needs of young victims of sexual abuse, who may be particularly frightened, traumatized, and confused by the forensic medical exam and evidence collection process. As such, the use of a victim advocate who has experience in working with youth will be particularly helpful for ensuring that the agency is able to collect evidence, treat the victim’s injuries, and provide the victim with appropriate and effective crisis intervention counseling.

## OR-5 Agency protection against retaliation

The agency protects all residents and staff who report sexual abuse or cooperate with sexual abuse investigations from retaliation by other residents or staff. The agency employs multiple protection measures, including housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services for residents or staff who fear retaliation for reporting sexual abuse or cooperating with investigations. The agency monitors the conduct and/or treatment of residents or staff who have reported sexual abuse or cooperated with investigations, including any resident disciplinary reports, housing, or program changes, for at least 90 days following their report or cooperation to see if there are changes that may suggest possible retaliation by residents or staff. The agency discusses any changes with the appropriate resident or staff member as part of its efforts to determine if retaliation is taking place and, when confirmed, immediately takes steps to protect the resident or staff member.

Assessment Checklist	YES	NO
(a) Does the agency employ the following measures to protect residents and staff from retaliation for reporting sexual abuse?		
• Housing changes or transfers for resident victims or abusers		
• Removal of alleged staff or resident abusers from contact with victims		
• Employee assistance services or other resources for staff who may need psychological or emotional support		
• Available support services for residents who may need psychological or emotional support		
(b) Does the agency monitor the conduct and/or treatment of residents or staff who have reported sexual abuse or cooperated with investigations, including any resident disciplinary reports, housing changes, or program changes, for at least 90 days following their report or cooperation to see if there are changes that may suggest possible retaliation by residents or staff?		
(c) When changes have been identified, does the agency discuss those changes with the appropriate resident or staff member as part of its efforts to determine if retaliation is taking place?		
(d) When retaliation has been confirmed, does the agency immediately take steps to protect the resident or staff member?		

### Discussion

Fear of retaliation prevents many residents and staff from reporting sexual abuse and impedes the ability of the agency to protect the safety and security of its facilities. Retaliation can take many forms. For example, one or more residents may assault another resident for “snitching.” An accused staff member or his or her staff allies may suddenly start giving disciplinary tickets to the resident who made the allegation. A staff member who reports abuse by another staff member may find that he or she is being snubbed or isolated by other staff. The agency should use every means possible, from information conveyed in training sessions to strict reporting policies to strong disciplinary sanctions for retaliation, to discourage retaliation in any form.

The agency should be alert to the possibility of retaliation from the outset and should initiate and maintain protective measures for as long as it deems necessary. The agency will have to weigh a number of circumstances when deciding how best to protect residents and staff members who report sexual abuse. When collective bargaining agreements limit an agency’s ability to remove accused staff members from contact positions with residents who have alleged staff-on-resident sexual abuse or harassment, the agency should develop and implement alternative protective measures. In general, agencies should try to secure collective bargaining agreements that do not limit their ability to protect residents or staff from retaliation.

The agency’s protective measures can be adjusted throughout the investigation as necessary, but this does not obviate the agency’s obligation to take immediate and continuing steps to guard against retaliation. Although addressing the situation may require a housing transfer, facility officials should make every reasonable effort to minimize the disruption caused to the resident’s daily life, including access to education, programs, and other facility privileges.

## Investigations (IN)

### IN-1 Duty to investigate

The facility investigates all allegations of sexual abuse, including third-party and anonymous reports, and notifies victims and/or other complainants in writing of investigation outcomes and any disciplinary or criminal sanctions, regardless of the source of the allegation. If additional parties were notified of the allegation (OR-1), the facility notifies those parties in writing of investigation outcomes. All investigations are carried through to completion, regardless of whether the alleged abuser or victim remains at the facility and regardless of whether the source of the allegation recants his or her allegation.

Assessment Checklist	YES	NO
(a) Does the facility investigate all allegations of sexual abuse from all sources, including third-party and anonymous reports?		
(b) Does the facility notify victims and other complainants in writing of investigation outcomes and any disciplinary or criminal sanctions?		
(c) If additional parties were notified of the allegation (OR-1), does the facility notify those parties in writing of investigation outcomes?		
(d) Are all investigations carried through to completion, regardless of whether the alleged abuser or victim remains at the facility?		
(e) Are all investigations carried through to completion, regardless of whether the source of the allegation recants his or her allegation?		

### Discussion

One of the challenges agencies face when investigating allegations of sexual abuse is resident and staff reluctance to report the abuse, whether as victims or as witnesses. This reluctance to report leads to delayed reporting, changed stories, noncooperation, and difficulties obtaining physical evidence. By investigating all allegations of sexual abuse and carrying those investigations through to completion, agencies send a strong message that sexual abuse is taken seriously and will not be tolerated, thereby encouraging all residents to report.



Carrying investigations through to completion means making sure that an investigation continues even if the source of the report recants his or her allegation; an alleged staff perpetrator transfers, resigns, or retires; or an alleged resident perpetrator or victim is transferred or released from custody during an investigation. Many times, residents may come forward with a report and then quickly recant due to fear of retaliation or confusion or fear of the investigation process. Consistent application of these practices helps assure the reporting party and others who may be considering reporting sexual abuse or cooperating with the investigation that reports and cooperation will not be fruitless. This assurance is critical given the risks often inherent to reporting sexual abuse and cooperating in an investigation of sexual abuse, both for staff and residents. Continuing investigations after the alleged abuser has left the facility helps ensure that an abuser does not escape accountability and will not remain undetected in another facility or in another jurisdiction and thus can be critical to preventing further abuse. This should be an important risk management consideration for any agency.

This standard requires that victims and complainants be notified of the final investigative outcome (e.g., unfounded/unsubstantiated/substantiated) and any disciplinary or criminal sanctions imposed pursuant to a substantiated allegation of sexual abuse. When the investigative outcome is modified pursuant to review, appeal, or arbitration after notification has taken place, the victim/complainant should be notified of the modified outcome.

The “source” of an allegation of sexual abuse that triggers the duty to investigate may come in the form of evidence obtained during the investigation of a violent incident, or even death, within the facility that does not appear to have any connection to sexual abuse. Facilities should be attuned to the fact that sexual abuse may be the motivating factor behind seemingly unrelated assaults, suicides, and homicides within their facilities. Forensic autopsies should be employed whenever possible to determine whether sexual abuse occurred prior to the act of violence or suicide being investigated.

Lastly, if the facility head reported the allegation to the victim’s parents or legal guardians, the juvenile court or the judge of record, or the child welfare system caseworker, as required by standard OR-1, the facility head must follow up with these parties and report the investigation outcomes to them in writing. Because all these parties have a stake in the child’s welfare and safety while he or she is confined, they have a right to know what the investigation concluded about the allegation. Moreover, notifying them in writing of investigation outcomes gives them an opportunity to advocate on behalf of the child if they have any reservations or concerns about the investigative finding.

## **IN-2 Criminal and administrative agency investigations**

Agency investigations into allegations of sexual abuse are prompt, thorough, objective, and conducted by investigators who have received special training in sexual abuse investigations involving young victims (TR-4). When outside agencies investigate sexual abuse, the facility has a duty to keep abreast of the investigation and cooperate with outside investigators (RP-4). Investigations include the following elements:

- Investigations are initiated and completed within the time frames established by the highest-ranking facility official, and the highest-ranking official approves the final investigative report.

- Investigators gather direct and circumstantial evidence, including physical and DNA evidence when available; interview alleged victims, suspected perpetrators, and witnesses; and review prior complaints and reports of sexual abuse involving the suspected perpetrator; and potentially corroborating physical or other evidence.
- When the quality of evidence appears to support criminal prosecution, prosecutors are contacted to determine whether compelled interviews may be an obstacle for subsequent criminal prosecution.
- Investigative findings are based on an analysis of the evidence gathered and a determination of its probative value.
- The credibility of a victim, suspect, or witness is assessed on an individual basis and is not determined by the person’s status as resident or staff.
- Investigations include an effort to determine whether staff negligence or collusion enabled the abuse to occur.
- Administrative investigations are documented in written reports that include a description of the physical and testimonial evidence and the reasoning behind credibility assessments.
- Criminal investigations are documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and provides a proposed list of exhibits.
- Substantiated allegations of conduct that appears to be criminal are referred for prosecution.

Assessment Checklist	YES	NO
(a) Are agency investigations of allegations of sexual abuse conducted only by investigators who have received special training in sexual abuse investigations involving young victims (TR-4)?		
(b) When outside agencies investigate sexual abuse, does the facility keep abreast of the investigation and cooperate with outside investigators (RP-4)?		
(c) Are investigations of allegations of sexual abuse initiated and completed within prompt timeframes established by the facility?		
(d) Do investigations include a review of all direct and circumstantial evidence, including physical and DNA evidence when available; interviews of alleged victims, suspected perpetrators, and witnesses; and prior complaints and reports of sexual abuse or misconduct involving the suspected perpetrator?		
(e) Does the facility contact prosecutors when the quality of evidence appears to support criminal prosecution to determine whether compelled interviews may be an obstacle for subsequent criminal prosecution?		
(f) Are investigative findings based on the analysis of the evidence gathered and a determination of its probative value?		
(g) Do investigators assess the credibility of a victim, suspect, or witness on an individualized basis, rather than using the person’s status as resident or staff to assess credibility?		
(h) Do investigations include an effort to determine whether staff negligence or collusion enabled the abuse to occur?		
(i) Are administrative investigations documented in written reports that include a description of the physical and testimonial evidence and the reasoning behind credibility assessments?		
(j) Are criminal investigations documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and provides a proposed list of exhibits?		
(k) Are substantiated allegations of conduct that appear to be criminal referred for prosecution?		

## **Discussion**

This standard addresses criminal and administrative investigations carried out by the agency or outside law enforcement agencies. It does not address the third type of investigation that local or State service agencies may have the jurisdiction and authority to conduct. There are significant differences in how criminal and administrative investigations are conducted, and it is critically important to keep these investigations separate. However, certain elements are important to both types of investigation, and the standard addresses these elements.

The standard requires that effective investigations be initiated and completed promptly so that physical evidence is available and usable and before memories have faded. Prompt investigations also give credence to an agency's zero-tolerance commitment to end sexual abuse. Prompt investigations improve facility safety and morale by ensuring that wrongly accused subjects are exonerated as quickly as possible and that abusers are detected and removed and/or handled as quickly as possible. Agencies or facilities should ensure that established timelines provide sufficient time for investigators to complete the investigation and for the review process to be completed. However, investigations and their reviews should be completed within the constraints imposed by statutes of limitation or terms and conditions of collective bargaining agreements so as to ensure that the facility has the ability to impose discipline when allegations are substantiated.

This standard also reflects the importance of investigations being conducted by investigators with the skills, objectivity, and sensitivity to resolve allegations credibly and with well-documented evidence. As the standard reflects, investigators must always be trained in conducting sexual abuse investigations involving young victims (TR-4). This includes using interview techniques that are specific and sensitive to young victims, who may find it especially difficult to trust an investigator and openly discuss their victimization.

In cases of alleged staff-on-resident sexual abuse or harassment, the agency will need to make extra efforts to ensure that those investigations are objective and thorough and should consider using outside investigators whenever possible to ensure the appearance as well as the reality of impartiality.

Because sexual abuse often has no witnesses and does not leave visible injury, investigators must be assiduous in searching out other kinds of direct and circumstantial evidence. To be successful, this requirement, like the other requirements of this standard, will need to be bolstered by investigator training and strong facility policies.

The type of direct and circumstantial evidence that can be gathered and analyzed will vary depending on the nature of the allegation. When forced intercourse or similar abuse is alleged, for example, properly conducted forensic exams may yield DNA evidence. When staff-resident relationships are alleged, investigators should search for potentially corroborating evidence, such as telephone records, gifts, letters, and similar items. Investigators should also conduct a review of prior complaints of sexual abuse as well as disciplinary findings in those cases—including from other facilities or jurisdictions, whenever possible—as such information may suggest repeated patterns of behavior that bear on the credibility of the suspected abuser. Unless State law specifies otherwise, agencies or facilities should maintain those records for the duration of the resident's sentence or staff member's employment.

Credibility assessments play an important role in the investigation of sexual abuse, as in any other investigation, and particularly so when there is no physical evidence. Properly trained investigators and agency officials must assess the truthfulness of alleged victims, suspected

abusers, and witnesses (if there are any) based on a careful consideration of individual factors pertinent to each person (e.g., his or her possible motivations, opportunity, prior history of truthfulness, consistency of statements, etc.). Assumptions about truthfulness should not be based simply on the fact that a person is a resident or member of the staff. The Commission especially cautions against automatically believing staff and disbelieving residents when their statements contradict each other.

As this standard reflects, an important aspect of investigations of sexual abuse allegations is determining whether any staff negligence or collusion may have played a role in facilitating or causing the sexual abuse. This inquiry is critical to preventing future sexual abuse and is an important risk management tool for agencies.

As do several other standards, this standard recognizes the importance of coordinating with prosecuting authorities in cases involving sexual abuse allegations. This standard does not advocate delaying the initiation of the administration investigation until the decision of whether to prosecute has been made. However, to avoid compromising criminal investigations, investigators must contact prosecuting authorities before taking any compelled statements of subjects in potentially criminal cases. Agencies also must refer criminal cases for prosecution whenever the evidence indicates that the abuse appears to be criminal.

### IN-3 Evidence standard for administrative investigations

Allegations of sexual abuse are substantiated if supported by a preponderance of the evidence.

Assessment Checklist	YES	NO
(a) Are allegations of sexual abuse substantiated if supported by a preponderance of the evidence?		

#### Discussion

The goal of this standard is to ensure that the agency uses a standard of proof that is fair to all parties and appropriate for administrative action. This standard of proof applies to both administrative hearings as well as resident disciplinary hearings, and requires investigators to use the preponderance of the evidence standard that is commonly used in administrative investigations as well as in civil suits involving sexual abuse. The preponderance of the evidence standard requires that an allegation be substantiated when the evidence shows that it is more likely than not that the alleged abuse occurred. Administrative cases do not require that allegations be proven beyond a reasonable doubt.

Some facilities may establish lower thresholds for substantiating allegations of sexual abuse. This standard does not require that such facilities raise the threshold to the preponderance of evidence standard.

When available evidence is insufficient to substantiate an allegation, it may also be insufficient to prove that the alleged abuse did not occur. Such allegations may be determined to be unsubstantiated but cannot properly be categorized as unfounded. Where there are numerous unfounded allegations in a facility, administrators may want to review the quality of the investigations and closely scrutinize policies and protocols because numerous unfounded incidents may indicate problems with the way investigations are being conducted or reveal unknown incidents that actually did occur.

## Discipline (DI)

### DI-1 Disciplinary sanctions for staff

Staff is subject to disciplinary sanctions up to and including termination when staff has violated agency sexual abuse policies. The presumptive disciplinary sanction for staff members who have engaged in sexually abusive contact or penetration is termination. This presumption does not limit agency discretion to impose termination for other sexual abuse policy violations. All terminations for violations of agency sexual abuse policies are to be reported to law enforcement agencies and any relevant licensing bodies.

Assessment Checklist	YES	NO
(a) When staff has violated agency sexual abuse policies, has the staff member received sanctions up to and including termination?		
(b) Do the disciplinary sanctions imposed indicate that the presumptive disciplinary sanction for staff who has engaged in sexually abusive contact or penetration is termination?		
(c) Does the agency report to law enforcement agencies and any relevant licensing bodies all individuals terminated by the agency for violating agency sexual abuse policies?		

#### Discussion

Imposing significant disciplinary sanctions for sexual abuse is a critical component of communicating an agency's zero-tolerance of sexual abuse and developing a culture of safety and accountability. The goal of this standard is to ensure fair and consistent accountability for staff members who have violated agency sexual abuse policies and procedures, regardless of whether they are found guilty in criminal proceedings. Violations that require disciplinary sanctions pursuant to this standard include engaging in actual or attempted abuse or harassment, failing to report an incident of sexual abuse, failing to limit information received about an allegation to those who need to know, failing to cooperate with a sexual abuse investigation, engaging in retaliation against residents or staff who report abuse, and failing to follow any other agency policy regarding sexual abuse in which staff was trained.

Disciplinary hearings for adjudicating allegations of attempted or actual staff-on-resident sexual abuse or sexual harassment should be fair, and sanctions should be proportional to the nature and circumstances of the accused staff member's conduct, his or her disciplinary history, and the sanctions meted out for comparable offenses by other staff with similar histories. Sanctions may entail training and counseling. The sanctions should be sufficiently serious in all cases to communicate to all staff and residents the agency's refusal to tolerate sexual abuse or any conduct that impedes its efforts to eliminate it.

This standard requires that termination be the "presumptive" but not the mandatory sanction for certain types of sexual abuse in recognition of the fact that disciplinary sanctions must be determined on a case-by-case basis. Establishing termination as a presumption places a heavy burden on the staff person found to have committed the abuse to demonstrate why termination is not the appropriate sanction. This presumption also requires that termination should be the rule for the referenced types of sexual abuse, with exceptions made only in extraordinary circumstances. As the standard reflects, although termination is not the presumption for all types of sexual abuse, it may be the appropriate sanction for instances of sexual abuse less severe than sexually abusive contact or penetration.

This standard is not meant to increase the employment rights of staff who are at-will employees.

## DI-2 Interventions for residents who engage in sexual abuse

Residents receive appropriate interventions if they engage in resident-on-resident sexual abuse. Decisions regarding which types of interventions to use in particular cases, including treatment, counseling, educational programs, or disciplinary sanctions, are made with the goal of promoting improved behavior by the resident and ensuring the safety of other residents and staff. When imposing disciplinary sanctions in lieu of or in addition to other interventions, the facility informs residents of their rights and responsibilities during the disciplinary process, including how to appeal sanctions, and only imposes sanctions commensurate with the type of violation committed and the resident's disciplinary history. Intervention decisions must take into account the social, sexual, emotional, and cognitive development of the resident and the resident's mental health status.

Assessment Checklist	YES	NO
(a) Do residents receive appropriate interventions if they engage in resident-on-resident sexual abuse with the goal of promoting improved behavior by the resident and ensuring the safety of other residents and staff?		
(b) When imposing disciplinary sanctions in lieu of or in addition to other interventions, does the facility inform residents of their rights and responsibilities under the disciplinary process, including how to appeal sanctions?		
(c) When imposing disciplinary sanctions in lieu of or in addition to other interventions, does the facility only impose sanctions that are commensurate with the type of violation committed and the resident's disciplinary history?		
(d) Does the facility take into account the following when determining the appropriate interventions for a resident who engages in resident-on-resident sexual abuse?		
• Social, sexual, emotional, and cognitive development of the resident		
• Resident's mental health status		

### Discussion

Under this standard, facilities are required to provide a range of interventions to residents who engage in sexual abuse, including treatment, counseling, special education or life skills programs, increased supervision, or disciplinary sanctions. The interventions should be designed to encourage better behavior by the resident and foster a safer environment for other residents and staff. By giving the resident positive tools, support, and supervision, these interventions should help the resident develop a sense of responsibility and accountability for his or her actions. If a facility decides to impose disciplinary sanctions on a resident, those sanctions should be proportional to the accused resident's conduct, his or her disciplinary history, and the sanctions meted out for comparable offenses by other residents with similar histories. Under this standard, discipline should only be meted out after residents have been provided with due process.

The agency's process for determining whether to impose disciplinary sanctions and which sanctions to impose should take into consideration any mental health problems that may have contributed to the resident's abusive behavior. Further, isolation as a disciplinary sanction is harmful for all residents, especially residents with mental illness, because the isolating conditions may have the potential to aggravate symptoms of mental illness and/or limit their access to needed mental health services. As such, disciplining a resident with prolonged periods of isolation is potentially very dangerous for the resident and is strongly discouraged.

Additionally, appropriate interventions for residents should take into consideration the normal course of adolescent psychosocial and sexual development, which often includes periods of increased sexual desires, sexual experimentation, and masturbation. Residents will experience

numerous physiological and emotional changes during their period of confinement, including physical maturation and development, an increase in hormone levels, and an increased desire to engage in sexual activity. Additionally, residents may engage in masturbation or self-experimentation, and such actions should not be subject to disciplinary sanctions unless they purposefully occur in front of staff, are directed toward other residents, or are otherwise disruptive in nature. Direct training on adolescent development will enable staff to understand and better differentiate normal adolescent experimental behavior from sexually aggressive and dangerous behavior (TR-1).

## MM-1 Medical and Mental Health Care (MM)

### Medical and mental health intake screenings

During medical and mental health reception and intake screenings, qualified medical or mental health practitioners talk with residents to ascertain information regarding the resident’s sexual orientation, gender identity, prior sexual victimization or history of engaging in sexual abuse (whether it occurred in an institutional setting or in the community), mental health status, and mental or physical disabilities. Such conversations are conducted in the manner that the medical or mental health practitioner deems appropriate for each resident in light of the resident’s age and developmental status according to the practitioner’s professional judgment and use inclusive language that avoids implicit assumptions about a young person’s sexual orientation. The information obtained during these screenings is strictly limited to medical and mental health practitioners, with information provided to appropriate staff on a need to know basis to the extent needed to inform all housing, bed, program, education, and work assignments for the resident (AP-2). If a resident discloses prior sexual victimization or abusiveness during a medical or mental health reception or intake screening, the practitioner reports the abuse according to agency policy and relevant State or local mandatory child abuse reporting laws (OR-1) and provides the appropriate treatment or referral for treatment, based on his or her professional judgment.

Assessment Checklist	YES	NO
(a) During medical and mental health reception and intake screenings, do qualified medical or mental health practitioners talk with residents to ascertain information regarding the resident’s sexual orientation, gender identity, prior sexual victimization or history of engaging in sexual abuse (whether it occurred in an institutional setting or in the community), mental health status, and mental or physical disabilities?		
(b) Are such conversations conducted in a manner that the medical or mental health practitioner deems appropriate for each resident according to the practitioner’s professional judgment, using inclusive language that avoids implicit assumptions about a young person’s sexual orientation?		
(c) Is the information ascertained during medical and mental health reception and intake screenings used by appropriate direct care staff to inform all housing, bed, program, education, and work assignments for the resident (AP-2)?		
(d) If a resident discloses prior sexual victimization or abusiveness during a medical or mental health reception or intake screening, does the practitioner report the abuse according to standard OR-1 and provide appropriate treatment or referral for treatment based on his or her professional judgment?		
(e) Do medical and mental health practitioners strictly limit information obtained during medical and mental health reception or intake screenings to the medical and mental health care staff, with information provided to direct care staff on a need to know basis, as required by agency policy and Federal, State, or local law, to inform treatment plans and placement decisions?		

## **Discussion**

Facilities typically perform a brief health screening of each resident upon his or her arrival, followed by a more comprehensive assessment within seven days after admission. Before asking residents questions about prior sexual victimization, engaging in sexual abuse, or the resident's sexual orientation or gender identity, medical and/or mental health practitioners should inform residents that they are not required to answer sensitive questions if they would prefer not to. Not all residents will feel comfortable answering such questions, and practitioners should respect refusals to answer those questions and not press for answers. During intake screenings or subsequently, a resident may disclose information about victimization that occurred, whether in a confinement setting or in the community. Incidents of abuse that happened many years ago might still require treatment, and medical and mental health practitioners should exercise their professional judgment to determine what treatment to recommend. Similarly, mental health practitioners should exercise their professional judgment to determine whether a resident who discloses prior sexually abusive behavior, regardless of when it occurred, requires treatment such as counseling or other therapeutic interventions.

If a resident discloses an incident of sexual abuse that occurred within a time period in which physical evidence may still be collected, the medical and/or mental health practitioner is required to provide access to emergency medical treatment and crisis intervention services (MM-2) and follow the agency's evidence protocol (RP-2). At the time of publication of this body of standards, 96 hours is the timeframe commonly accepted and used by medical and mental health practitioners, corrections professionals, and criminal investigators.

When discussing sexual orientation and gender identity with residents, medical and mental health practitioners should use their professional judgment and appropriate interview techniques with residents. Lesbian, gay, bisexual, and transgender youth may be in various stages of awareness and comfort with their sexual orientation and gender identity, and they may not have resolved these issues in their own minds. Facility staff should anticipate the understandable reticence of young people to disclose this information, particularly if they do not know what the consequences of disclosure will be, and staff should use their professional judgment to determine how best to talk with each child. In general, it is best to avoid direct questions and instead use an approach that helps residents feel safe enough to disclose information about themselves. For example, practitioners might use open-ended questions that do not make implicit assumptions about a young person's sexual orientation. No practitioner should ask questions that convey value judgments about or bias toward any orientation. Because residents may be experiencing fear or confusion associated with their first hours of confinement, practitioners may decide that some questions should be asked again during any comprehensive medical and mental health assessment as well as during any follow-up medical or mental health screenings.

The information obtained during medical and mental health reception and intake is vital to keeping residents safe and should therefore be considered carefully by the appropriate staff when determining housing, bed, program, education, and work placements for residents (AP-2). It is recommended that medical and mental health practitioners work in conjunction with direct care staff to determine the most appropriate placements for residents. By having medical or mental health care practitioners ask questions about sexual orientation, gender identity, prior sexual victimization, history of abusiveness, mental health status, and physical disabilities, the facility can ensure that the information needed to keep the residents safe is asked and known by the appropriate people in nonthreatening, private environments. To ensure that the sensitive information shared with medical and mental health practitioners is helpful to keeping residents safe and does not place the resident in danger of bullying, harassment, or further victimization



during confinement, the information obtained through intake and reception screenings is only shared with direct care staff on a need to know basis to determine the appropriate placements within the facility and is otherwise kept private in accordance with agency policy and Federal, State, or local law.

## MM-2 Access to emergency medical and mental health services

Victims of sexual abuse have 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. Treatment services must be provided free of charge to the victim and regardless of whether the victim names the abuser. If no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, direct care staff first responders take preliminary steps to protect the victim (OR-3) and immediately notify the appropriate medical and mental health practitioners.

Assessment Checklist	YES	NO
(a) Do residents have timely, unimpeded free 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?		
(b) Are treatment services provided free of charge to the victim?		
(c) Are treatment services provided regardless of whether the victim names the abuser?		
(d) If no qualified medical or mental health practitioners are on duty at the time a report is made, do direct care staff first responders take preliminary steps to protect the victim (OR-3) and immediately notify the appropriate medical and mental health practitioners?		

### Discussion

Under this standard, the facility is required to provide emergency medical treatment and crisis intervention services free of charge to victims of sexual abuse. Such services may include, but are not limited to: (1) assessing the victim’s acute medical and mental health needs as soon as possible; (2) obtaining consent for treatment from the victim, unless the victim is under 18; (3) treating the victim’s acute medical and mental health needs as soon as possible; (4) documenting the victim’s acute medical and mental health needs and treatment provided as soon as possible; (5) providing support and crisis intervention services; and (6) providing access to a forensic medical exam and, if the victim agrees to an exam, ensuring agency protocol is followed whenever there may be physical evidence of sexual abuse (RP-2).

The standard’s requirement that medical and mental health services be provided even when the victim refuses to name the abuser means that victims must be able to meet with medical or mental health practitioners without having to disclose details of the abuse to an officer or other direct care staff member. As such, agencies may need to adapt their sick-call policies to allow residents to access medical and mental health care practitioners without having to describe their victimization.

### MM-3 Ongoing medical and mental health care for sexual abuse victims and abusers

The facility provides ongoing medical and/or mental health evaluation and treatment to all known victims of sexual abuse. The evaluation and treatment of sexual abuse victims must include appropriate follow-up services, treatment plans, and, when necessary, referrals for continued care following their release from custody. The level of medical and mental health care provided to resident victims must match the community level of care generally accepted by the medical and mental health professional communities. The facility conducts a mental health evaluation of all known abusers and provides treatment, as deemed necessary by qualified mental health practitioners.

Assessment Checklist	YES	NO
(a) Does the facility provide ongoing medical and/or mental health evaluation and treatment to all known victims of sexual abuse?		
(b) Does the evaluation and treatment of victims include the following?		
• Appropriate follow-up services		
• Treatment plans		
• When necessary, referrals for continued care for sexual abuse victims following their release from custody		
(c) Does the level of medical and mental health care provided to resident victims match the level of care generally accepted by the medical and mental health professional communities?		
(d) Does the facility conduct a mental health evaluation of all known abusers?		
(e) Does the facility provide treatment for abusers, as deemed necessary by qualified mental health practitioners?		

#### Discussion

Victims of sexual abuse can experience a range of physical injuries and emotional reactions, even long after the abuse has occurred, that require medical or mental health attention. As required by this standard, the facility must be able to ensure that all victims receive the appropriate medical and/or mental health services recommended by qualified practitioners. Follow-up evaluations, assessments, and treatment may include the following actions: (1) reviewing any medical and mental health treatment provided immediately following the incident, including whether a forensic medical exam was performed; (2) diagnosing any lingering acute or non-acute physical injuries, including oral trauma; and (3) assessing the psychological impact of the victimization, including the risk of suicide or self-harm and any resulting mental health treatment needs. These follow-up evaluations and assessments will enable mental health and medical practitioners to determine and provide the most appropriate treatment for the resident, which could include mental health treatment, medical treatment, or both. Reviewing and adjusting victim treatment plans at regular, clinically appropriate intervals will allow the agency to provide the most comprehensive and appropriate care for as long as treatment is required.

Victims and perpetrators of sexual abuse, whether recent or historical, are at risk for sexually transmitted infections (STIs), including HIV. Regardless of whether a resident has accepted prevention or treatment for STIs, medical practitioners ought to offer and strongly encourage him or her to be tested for HIV and viral hepatitis six to eight weeks following the sexual abuse. Young victims may be particularly traumatized or confused by certain treatments, such as STI testing. All treatments should be age appropriate, and efforts should be made to thoroughly explain any treatment or test before administering it to residents.

In accordance with this standard's requirement to provide victims with the level of care generally accepted in the medical and mental health professional communities, if there has been vaginal penetration, victims who have been recently abused should be offered pregnancy tests, when appropriate, at the time of the medical evaluation and, if the test is negative, should be offered retesting approximately six weeks thereafter. Victims who have positive tests should receive counseling and have access to all pregnancy-related medical services that are lawful in the community.

Additionally, this standard requires mental health evaluation and treatment, when appropriate, of all known abusers. Mental health practitioners may find that ongoing mental health treatment, including counseling, group programs, or other therapeutic interventions, may be beneficial to abusers. Providing mental health treatment to abusers may help them develop better control over their actions and improve their conduct; in doing so, such treatment may help reduce the likelihood of recidivism and thereby improve facility safety. As noted in the standard, the agency's mental health practitioners must use their professional judgment to determine the appropriate treatment and services for individuals with a recent or previous history of sexual abusiveness.

## IV. MONITORING

### Data Collection and Review (DC)

#### DC-1 Sexual abuse incident reviews

The facility treats all instances of sexual abuse as critical incidents to be examined by a team of upper management officials, with input from line supervisors, investigators, and medical/mental health practitioners. The review team evaluates each incident of sexual abuse to identify any policy, training, or other issues related to the incident that indicate a need to change policy or practice to better prevent, detect, and/or respond to incidents of sexual abuse. The review team also considers whether incidents were motivated by racial or other group dynamics at the facility. When incidents are determined to be motivated by racial or other group dynamics, upper management officials immediately notify the agency head and begin taking steps to rectify those underlying problems. The sexual abuse incident review takes place at the conclusion of every sexual abuse investigation, unless the allegation was determined to be unfounded. The review team prepares a report of its findings and recommendations for improvement and submits it to the facility head.

Assessment Checklist	YES	NO
(a) Does a team of upper management officials, with input from line supervisors, investigators, and medical/mental health practitioners, review the details of each incident of sexual abuse following every sexual abuse investigation, unless the allegation was determined to be unfounded?		
(b) Does the team use the review of each incident of sexual abuse to identify any policy, training, or other issues related to the incident that indicate a need to change policy or practice to better prevent, detect, and/or respond to incidents of sexual abuse?		
(c) Does the review team consider whether incidents were motivated by racial dynamics or any existing racial tensions at the facility?		
(d) When incidents are determined to be motivated by racial dynamics or tensions, do upper management officials immediately notify the agency head and begin taking steps to rectify those underlying problems?		
(e) Does the review team prepare a report of its findings and recommendations for improvement and submit it to the facility head?		

#### Discussion

Sexual abuse incident reviews provide the facility with the opportunity to identify policies or practices that may have contributed to or failed to prevent sexual abuse as well as any deficiencies in the facility's response. By examining the facility's prevention planning and response efforts following the occurrence of sexual abuse, the facility can prevent future incidents by making the necessary changes to policies or practices that endangered staff and residents in the past.

Comprehensive sexual abuse incident reviews should include the following: (1) an analysis of any security failures that may have contributed to the incident; (2) an examination of the timeliness and quality of the response; (3) the various interventions provided to the victim and/or perpetrator, including medical and mental health care,; and (4) the quality of the administrative and/or criminal investigation. Additionally, the review team should determine

whether victim(s) or witness(es) faced any obstacles to prompt and safe reporting of the incident. Finally, the team should review the files of the perpetrator(s) and victim(s) to determine whether changes to the facility’s process for screening residents for risk of sexual victimization or abusiveness may be appropriate. Having identified underlying problems, the facility can then make the necessary changes to policies or practices that endanger staff and residents.

## DC-2 Data collection

The agency collects accurate, uniform data for every reported incident of sexual abuse using a standardized instrument and set of definitions. The agency aggregates the incident-based sexual abuse data at least annually. The incident-based data collected includes, at a minimum, the data necessary to answer all questions from the most recent version of the BJS Survey on Sexual Violence. See Appendix C for a list of recommended data elements. Data are obtained from multiple sources, including reports, investigation files, and sexual abuse incident reviews. The agency also obtains incident-based and aggregated data from every facility with which it contracts for the confinement of its residents.

Assessment Checklist	YES	NO
(a) Does the agency collect uniform data for every reported incident of sexual abuse using a standardized instrument and set of definitions?		
(b) Does the agency aggregate the incident-based sexual abuse data at least annually?		
(c) Does the agency collect the incident-based data necessary to answer all questions from the most recent version of the BJS Survey on Sexual Violence?		
(d) Does the agency obtain data from multiple sources, including reports, investigation files, and sexual abuse incident reviews?		
(e) Does the agency also obtain incident-based and aggregated data from every facility with which it contracts for the confinement of its residents?		

### Discussion

The agency is required to collect incident-based data on all incidents of sexual abuse to examine the specific circumstances of each incident and track any possible patterns.

The BJS Survey on Sexual Violence asks agencies to answer questions using their aggregated data and their incident-based data collection policies. The data collection items listed in Appendix C include all the data that must be collected and aggregated to be able to answer the BJS survey questions. The most recent version of the BJS survey can be accessed electronically from the BJS Web site at <http://www.ojp.usdoj.gov/bjs/abstract/dcprea03.htm>. Appendix C also identifies additional information that the agency might want to consider incorporating into its incident-based sexual abuse data collection instrument. Such elements may be of assistance to the agency as it reviews, revises, and develops sexual abuse prevention and response policies and procedures. The agency may also decide to collect data not enumerated in Appendix C. Some incident-specific information may not be available during the initial data collection process but may become available over time. As more incident-specific information becomes known and available, it should be added to the other data collected for that incident.

Aggregating collected incident-based data on an annual basis will provide the agency with data descriptive of trends and patterns among reported incidents of sexual abuse that took place within the agency and its individual facilities during the previous year.

### DC-3 Data review for corrective action

The agency reviews, analyzes, and uses all sexual abuse data, including incident-based and aggregated data, to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training. Using these data, the agency identifies problem areas, including any racial dynamics or other group dynamics underpinning patterns of sexual abuse, takes corrective action on an ongoing basis, and, at least annually, prepares a report of its findings and corrective actions for each facility as well as the agency as a whole. The annual report also includes a comparison of the current year's data and corrective actions with those from prior years and provides an assessment of the agency's progress in addressing sexual abuse. The agency's report is approved by the agency head, submitted to the appropriate legislative body, and made readily available to the public through its Web site or, if it does not have one, through other means. The agency may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility, but it must indicate the nature of the material redacted.

Assessment Checklist	YES	NO
(a) Does the agency review, analyze, and use all sexual abuse data, including incident-based and aggregated data, to assess the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training?		
(b) Does the agency use the data to assess problem areas, including any racial dynamics underpinning patterns of sexual abuse?		
(c) Does the agency take corrective action on an ongoing basis, based on the problem areas indicated by the analysis of the data?		
(d) Does the agency prepare a report at least annually of its findings and corrective actions for each facility as well as the agency as a whole?		
(e) Does the annual report include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse?		
(f) Is the agency's report approved by the agency head and submitted to the appropriate legislative body?		
(g) Is the agency's report made readily available to the public through its Web site or, if it does not have one, through other means?		

#### Discussion

The process of reviewing and analyzing incident-based and aggregated data allows agencies to detect patterns and trends that should be addressed as they review and revise their sexual abuse policies, practices, and training. For instance, sorting or filtering data by the victim's gender, race, security level, and type of incident may allow the agency to identify specific causation of these events. This analysis may also reveal racial dynamics underpinning certain patterns or trends of sexual abuse. Equipped with that knowledge, agency and facility heads can work together to begin changing those dynamics by reviewing and modifying existing policies and practices for keeping residents safe. Using the conclusions and results from the data analysis to take this kind of corrective action will make all facilities safer.

Comparing the current year’s aggregated data to previous years’ data will also yield valuable information about progress, including validation of implemented preventive measures. For example, the agency may observe a decrease in the number of allegations in an area where additional security measures were implemented and monitoring was enhanced. The agency must include incident-based and aggregated data from all facilities with which it contracts for the confinement of its residents in its review and analysis as part of its overall efforts to monitor the safety of residents in contracted facilities (PP-2).

This standard also requires that the agency’s annual report on its data analysis and corrective actions be made readily available to the public. If the agency has a Web site, the report should be published on it. Otherwise, the agency should make other arrangements, for example, providing paper copies upon request, to ensure that members of the public can easily and promptly obtain the report. Members of the public should not have to identify themselves or provide a reason for wanting to see the report as a precondition to obtaining it.

## DC-4 Data storage, publication, and destruction

The agency ensures that the collected sexual abuse data are properly stored, securely retained, and protected. The agency makes all aggregated sexual abuse data, from facilities under its direct control and those with which it contracts, readily available to the public at least annually through its Web site or, if it does not have one, through other means. Before making aggregated sexual abuse data publicly available, the agency removes all personal identifiers from the data. The agency maintains sexual abuse data for at least 10 years after the date of its initial collection unless Federal, State, or local law allows for the disposal of official information in less than 10 years.

Assessment Checklist	YES	NO
(a) Does the agency ensure that the collected sexual abuse data are properly stored, retained, protected, and destroyed?		
(b) Does the agency make all aggregated sexual abuse data, from facilities under its direct control and those with which it contracts, readily available to the public at least annually through its Web site or, if it does not have one, through other means?		
(c) Are all personal identifiers removed from the aggregated data before it is made publicly available?		
(d) Does the agency maintain sexual abuse data for at least 10 years after the date of its initial collection unless Federal, State, or local law allows for the disposal of official information in less than 10 years?		

### Discussion

The agency’s data collection efforts will be useful to track trends and contribute to a national understanding of sexual abuse in juvenile facilities only if the agency stores the data in a manner that protects data integrity and retains the data for an adequate length of time. The requirement that data be securely retained and protected is meant to ensure the privacy of individuals involved in sexual abuse incidents and the integrity of the data. It is important that collected data be maintained in a way that protects the confidentiality of victims and alleged perpetrators. Thus, once data are aggregated, all unique identifiers pertaining to victims and alleged perpetrators should be removed.

The public has a legitimate interest in the data collected by agencies that serve the public. The data agencies are required to collect and publish under these standards will enable the public to understand the nature and level of safety in juvenile justice facilities. Agency sexual abuse data may also inform research and efforts to improve safety. Aggregated data with personal identifiers removed should thus be readily available to the public. Publishing the data on the agency's Web site, if it has one, is the easiest way for the public to obtain them. Absent a Web site, an agency may choose other feasible means to make the data public, such as providing paper copies to members of the public who request them. Members of the public should not have to identify themselves or provide a reason for seeking the data as a precondition to obtaining copies.

With regard to incident-based data, the Commission recommends that agencies balance privacy interests against the legitimate public interest in safe juvenile justice institutions by establishing a non-burdensome process to allow researchers, academics, journalists, and others access to such data.

## AU-1 Audits (AU)

### Audits of standards

The public agency ensures that all of its facilities, including contract facilities, are audited to measure compliance with the PREA standards. Audits must be conducted at least every three years by independent and qualified auditors. The public or contracted agency allows the auditor to enter and tour facilities, review documents, and interview staff and residents, as deemed appropriate by the auditor, to conduct comprehensive audits. The public agency ensures that the report of the auditor's findings and the public or contracted agency's plan for corrective action (DC-3) are published on the appropriate agency's Web site if it has one or are otherwise made readily available to the public.

Assessment Checklist	YES	NO
(a) Are comprehensive audits conducted at least every three years?		
(b) Are auditors independent and qualified?		
(c) Are independent auditors able to do the following, as deemed appropriate by the auditor?		
• Enter and tour facilities		
• Review documents		
• Interview staff and residents		
(d) Are audit reports and corrective plans published on the appropriate agency's Web site if it has one or otherwise made readily available to the public?		

### Discussion

Publicly available audits allow agencies, legislative bodies, and the public to learn whether facilities are complying with the PREA standards. Audits can also be a resource for the Attorney General in determining whether States are meeting their statutory responsibilities. Public audits help focus an agency's efforts and can serve as the basis upon which an agency can



formulate a plan to correct any identified deficiencies. These corrective action plans should be made public as well so that the public is fully informed as to whether the agency is taking appropriate steps to prevent sexual abuse. If the agency has a Web site, the audit should be published on it; otherwise, the agency may choose other feasible means to ensure the public has ready and easy access to the audit, such as providing paper copies to members of the public who request them. Members of the public should not have to identify themselves or specify a reason for seeking the audit as a precondition to obtaining it.

The transparency achieved by public audits and corrective action plans can enhance community confidence in the steps agencies are taking to prevent sexual abuse in juvenile justice facilities and can help generate public support for providing an agency with the resources it needs to prevent abuse more effectively. Publicly available audits and corrective action plans also help ensure that oversight bodies, including legislative bodies and community advocates, have the data necessary to decide whether and how to take action to improve sexual abuse prevention efforts.

For audits to serve these purposes effectively, they must be based on reliable and comprehensive information and be conducted by individuals or teams with the skills and objectivity necessary to take the following actions: (1) identify and gather the data that must be analyzed, (2) employ proper professional judgment when analyzing the data, and (3) work effectively with jurisdictions in planning audits. The requirements of this standard are designed to ensure that the audit process meets minimum audit standards while providing appropriate flexibility to the subject facility or agency regarding the identity of the auditor. Under this standard, an audit must be conducted by an individual or group of individuals who are independent of the agency, with no current direct reporting relationship to the head of the corrections agency being audited.

## APPENDIX A: RESPONSIBILITIES OF FORENSIC MEDICAL EXAMINERS

The Commission directs all agency and facility heads to the U.S. Department of Justice's national protocol for extensive information on the appropriate qualifications and responsibilities of forensic medical examiners.<sup>1</sup> However an agency decides to adapt the national protocol, the Commission strongly recommends that the agency use the following description of responsibilities of the forensic medical examiner as a blueprint for the qualifications an agency should be considering when developing memoranda of understanding or entering into contracts with forensic medical examiners.

### **Forensic medical examiner responsibilities**

1. Obtain forensic histories from victims.
2. Use sexual assault evidence collection kits that are standardized and meet or exceed minimum guidelines for contents.
3. Use the proper and age-appropriate equipment and supplies to perform the exam (e.g., anoscope, colposcope with photographic capability, microscope, toluidine blue dye, in addition to standard exam room equipment and supplies).
4. Take initial and follow-up photographs of injuries, as appropriate, according to jurisdictional policy.
5. Maintain evidence integrity according to jurisdictional policies for drying, packaging, labeling, and sealing the evidence.
6. Maintain the chain of custody for all evidence collected.
7. Follow jurisdictional protocol for transferring the evidence in the custody of an authorized agent from the exam site to a crime laboratory or a secure storage area with the proper climate control.
8. Document all services provided, including recommendations for continued care regarding sexually transmitted infection examinations, testing, immunizations, post-exposure prophylaxis, and treatment.
9. Transfer copies of the resident's medical file back to the facility/agency, if the exam is conducted off-site.

<sup>1</sup> U.S. Department of Justice, Office on Violence Against Women, A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents (NCJ 206554), Washington, DC: U.S. Department of Justice, September 2004. This protocol is available electronically at <http://www.ncjrs.gov/pdffiles1/ovw/206554.pdf>.



## APPENDIX B: TRAINING TOPICS AND PROCEDURES

The National Institute of Corrections (NIC) has developed a number of Prison Rape Elimination Act (PREA) training resources. The Commission directs all agency and facility heads to NIC's Web site (<http://www.nicic.org>) to learn more about existing resources and opportunities for training. However an agency or facility decides to deliver training, the Commission strongly recommends that the following topics be included for employee training. Some may also be appropriate for volunteer and resident training.

Following the list of topics, the Commission has made some procedural recommendations for ensuring that agency and facility heads deliver the most effective sexual abuse and PREA training to employees, volunteers, contractors, and residents.

### I. Recommended training topics

#### A. General education and awareness topics

1. An overview of PREA.
2. A description of the inalienable right of all residents to be free from sexual abuse.
3. The role of corrections officials to protect and enforce the human right to be free from sexual abuse.
4. Definitions and examples of prohibited and/or illegal behaviors and language that are considered sexual abuse.
5. Examples of conduct, circumstances, and "red flags" that may be precursors to sexual abuse or which suggest sexual abuse is occurring
6. The agency's anti-retaliation policy.
7. Common reactions by victims of sexual abuse.
8. The agency's liability for sexual abuse of persons in custody (criminal, civil, and administrative).
9. A discussion of how sexual abuse is used to gain power and control in confinement settings.
10. The agency's policy regarding residents who knowingly make false allegations of staff-on-resident sexual abuse or staff-on-resident sexual harassment.
11. Common myths and perceptions of sexual intimidation and abuse in confinement settings.
12. Professional boundary setting, including issues related to personal associations with residents, consent, and imbalances of power, and appropriate vs. inappropriate touching.
13. Information on adolescent emotional, physical and sexual development.
14. Strategies for promoting effective prevention and intervention of staff-on-resident sexual abuse and staff-on-resident sexual harassment.
15. Strategies for removing a victim or witness of sexual abuse from any public or semipublic area without arousing the suspicion of other residents or staff members.
16. Strategies for protecting the safety of vulnerable populations, including but not limited to lesbian, gay, bisexual, and gender-nonconforming residents (including transgender and intersex); deaf, speech impaired, or visually impaired residents; developmentally disabled residents; residents with limited English proficiency; mentally ill residents; residents with past histories of sexual abuse; residents with personality disorders; and young residents.

## B. Sexual abuse reporting duties

1. Staff members' duty to report sexual abuse and their liability if they fail to report.
2. The process staff members should use to report sexual abuse.
3. The process that residents should use to report sexual abuse.
4. Medical and mental health practitioners' reporting duties and the process they should use to report sexual abuse.
5. Relevant State or local mandatory child abuse reporting laws and staff responsibility under such laws to report sexual abuse to a designated State or local services agency with the authority to conduct investigations into abuse against children in confinement.
6. Facility head's duty to report such abuse to the juvenile court or victim's judge of record, the victim's caseworker in the child welfare system, if applicable, and the victim's parents or legal guardians, absent official documentation showing they should not be notified.

## C. Medical and mental health care

1. The range of victims' services available to residents, including free medical and mental health care for injuries and/or trauma resulting from sexual abuse, and how residents gain access to those services.
2. Rules governing forensic medical exams.
3. How to detect sexual abuse during medical and mental health exams.

## D. Investigations and discipline

1. The investigative process for allegations of sexual abuse, including the importance of preserving evidence.
2. The legal and disciplinary sanctions for residents who engage in resident-on-resident sexual abuse or resident-on-resident sexual harassment.
3. The legal and disciplinary sanctions for staff who engage in actual or attempted staff-on-resident sexual abuse or staff-on-resident sexual harassment.
4. Victims' rights based on relevant State or Federal law.
5. The rights of a staff member who is the subject of an investigation based on relevant Federal or State law or, if applicable, under collective bargaining agreements.

## II. Recommended procedures for delivering training

### A. General guidance

1. Train existing staff prior to training residents.
2. Train new staff members before they have contact with residents.
3. Prohibit staff members from working with residents until they can demonstrate knowledge of the agency's sexual abuse policies and procedures.
4. Ensure that staff members, contractors, and residents have access to copies of the agency's sexual abuse policies.

5. Use multiple mechanisms for presenting the information, including lectures, dialogues, role-play/scenario-based training, and other interactive techniques.
6. Ensure training materials are up to date by reviewing them at least annually and making revisions, if necessary, to address changes in laws, policies, or protocols.
7. Provide refresher training to staff members, contractors, and residents following any changes to law or policy.
8. Provide annual continuing education on sexual abuse that includes a review of the agency's sexual abuse data from the previous year.

## B. Testing and evaluation

1. Test staff members following training.
2. Ask staff, contractors, and residents to provide feedback on training, including suggestions for improving training tools and materials.
3. Evaluate staff members who conduct training at least annually to ensure that they are qualified and able to provide training effectively.



## APPENDIX C: INCIDENT-BASED DATA COLLECTION

Standard DC-2 requires agencies to collect incident-based data for every incident of sexual abuse. Under this standard, the agency is required to collect data sufficient to answer all of the questions from the Bureau of Justice Statistics' (BJS') Survey on Sexual Violence. Collecting data on the following items would allow the agency to answer the questions posed on the BJS survey and should help it to reach the broader goal of eliminating sexual abuse and keeping residents safe.

### **I. Victim information**

1. Sex and gender identity.
2. Race/ethnicity.
3. Age.
4. Security level.
5. Height and weight.
6. Classification assignment, when applicable.
7. Previous sexual victimization.
8. Previous sexually abusive behavior.
9. Prior relationship with the alleged perpetrator.
10. Gang affiliation outside and/or inside the facility.
11. HIV/AIDS status.

### **II. Perpetrator information**

#### **A. Resident perpetrator**

1. Sex and gender identity.
2. Race/ethnicity.
3. Age.
4. Security level.
5. Height and weight.
6. Classification assignment, when applicable.
7. Previous sexual victimization.
8. Previous sexually abusive behavior.
9. Prior relationship with the victim.
10. Gang affiliation outside and/or inside the facility.
11. HIV/AIDS status.

#### **B. Staff perpetrator**

1. Sex and gender identity.
2. Race/ethnicity.
3. Age.
4. Position held within the agency.



5. Relationship with victim.
6. Prior history of allegations and/or substantiated incidents of sexual abuse or harassment in current and prior employment.
7. Prior history of failure to comply with the agency's sexual abuse policies.

### **III. Other incident information**

#### **A. Reporting**

1. The date and time of the report.
2. The date, time, and location of the incident.
3. The reporting mechanism used.
4. Who made the report.
5. To whom the report was made.
6. Details of the incident alleged to have occurred.
7. The time lapse between when the incident took place and when the report was made.
8. The time lapse between when the report was made and when an investigation was initiated.
9. The time lapse between when the report was made and when the resident received medical/mental health care, if applicable.

#### **B. Medical and/or mental health care**

1. Whether the victim received medical and/or mental health care.
2. Any injuries sustained by the victim.

#### **C. Investigations**

1. Type of investigation pursued: criminal and/or administrative and/or child abuse investigation by State or local services agency.
2. Name of investigator(s).
3. Dates of the initiation and conclusion of the investigation(s).
4. Outcome of the investigation(s)/if the investigation(s) is ongoing.
5. Violations of administrative and/or criminal codes.
6. If the case is referred for prosecution, whether the prosecutor accepted or declined the investigation and, if accepted, the case disposition.
7. If administrative actions against staff member(s) or resident(s) are pursued, details about the sanctions.

## APPENDIX D: NPREC STANDARDS DEVELOPMENT EXPERT COMMITTEE MEMBERS

During the standards development process, the Commission convened expert committees comprised of diverse stakeholders with broad correctional expertise to provide information and guidance. The Commission thanks the members of the expert committees for their participation and contribution.

Organizational affiliations are provided for identification purposes only; committee members were not necessarily acting as representatives of their organizations. This list reflects each committee member's organizational affiliation at the time of participation and may not represent that person's current position. The Commission's standards do not reflect the official views of any of the organizations referenced here.

**Carrie Abner**, Research Associate, American Probation and Parole Association

**Aaron Aldrich**, Chief Inspector, Rhode Island Department of Corrections

**James Austin**, President, JFA Institute

**Roy F. Austin, Jr.**, Partner, McDermott Will & Emery

**Chris Baker**, Lieutenant, Corrections Supervisor/Jail Administrator, Van Buren County Sheriff's Office, Michigan

**David Balagia**, Major, Travis County Sheriff's Office, Texas

**Joe Baumann**, Corrections Officer, California Rehabilitation Center Chapter President, California Correctional Peace Officers Association

**Jeffrey Beard**, Secretary, Pennsylvania Department of Corrections

**Theodis Beck**, Secretary, North Carolina Department of Correction

**Art Beeler**, Warden, Federal Correctional Complex, Federal Bureau of Prisons, U.S. Department of Justice

**Andrea Black**, Coordinator, Detention Watch Network

**Charma Blount**, Sexual Assault Nurse Examiner, Texas Department of Criminal Justice

**Tim Brennan**, Principal, Northpointe Institute for Public Management, Inc.

**Lorie Brisbin**, Program Coordinator, Prisons Division, Idaho Department of Correction

**Barbara Broderick**, Director, Maricopa County Adult Probation Department, Arizona

**Roger Canaff**, Deputy Chief, Sex Offender Management Unit, Office of the Attorney General, New York

**Susan Paige Chasson**, President, International Association of Forensic Nurses

**Gwendolyn Chunn**, Immediate Past President, American Correctional Association

**Suanne Cunningham**, National Director, Corrections/Criminal Justice Program, Heery International

**Karen Dalton**, Director, Correctional Services Division, Los Angeles County Sheriff's Department

**Kim Day**, SAFE Technical Assistance Coordinator, International Association of Forensic Nurses

**Gina DeBottis**, Executive Director, Special Prosecution Unit, Texas Youth Commission

**Kathleen Dennehy**, Superintendent, Security Operations, Bristol County Sheriff's Office, Massachusetts

**Gary Dennis**, Senior Associate, The Moss Group, Inc.

**Ruth Divelbiss**, Captain, Ford County Sheriff's Office, Kansas

**Mark Donatelli**, Partner, Rothstein, Donatelli, Hughes, Dahlstrom, Schoenburg, and Bienvenu LLP

**Sarah Draper**, Director of Investigations, Office of Investigation and Compliance, Internal Investigation Unit, Georgia Department of Corrections

**Dr. Richard Dudley**, Private Practice of Clinical and Forensic Psychiatry

**Robert Dumond**, President and Licensed Clinical Mental Health Counselor, Consultants for Improved Human Services, PLLC

**Earl Dunlap**, Chief Executive Officer, National Partnership for Juvenile Services

**Maureen Dunn**, Director, Unaccompanied Children's Services, Office of Refugee Resettlement, Administration for Children and Families, U.S. Department of Health and Human Services

**Teena Farmon**, Retired Warden, Central California Women's Facility

**Lisa Freeman**, Staff Attorney, Prisoners' Rights Project, Legal Aid Society, New York City

**Vanessa Garza**, Associate Director for Trafficking Policy, Office of Refugee Resettlement, Administration for Children and Families, U.S. Department of Health and Human Services

**Michael Gennaco**, Chief Attorney, Office of Independent Review, Los Angeles County Sheriff's Department

**Karen Giannakoulis**, Forensic Interviewer/Victim Advocate, U.S. Attorney's Office, Washington, D.C.

**Steve Gibson**, Administrator, Youth Services Division, Montana Department of Corrections

**Simon Gonsoulin**, Former Director, Louisiana Office of Youth Development

**Kathleen Graves**, Director, Community Corrections Services, Kansas Department of Corrections

**Robert L. Green**, Warden, Montgomery County Correctional Facility, Montgomery County Department of Correction and Rehabilitation, Maryland

**Dr. Robert Greifinger**, Correctional Health Care and Quality Management Consultant

**David Guntharp**, Director, Arkansas Department of Community Correction

**Karyn Hadfield**, Training Specialist, Day One: The Sexual Assault and Trauma Resource Center

**Dee Halley**, PREA Program Manager, National Institute of Corrections, Federal Bureau of Prisons, U.S. Department of Justice

**Greg Hamilton**, Sheriff, Travis County, Texas

**Patrick M. Hanlon**, Partner, Goodwin Proctor LLP

**Patricia Hardyman**, Senior Associate, Association of State Correctional Administrators

**Rachel Harmon**, Associate Professor of Law, University of Virginia School of Law

**Michael Hennessey**, Sheriff, City and County of San Francisco, California

**Andrew Jordan**, Consultant, Migima, LLC; Retired Chief of Police, Bend Police Department, Oregon

**Thomas Kane**, Assistant Director, Information, Policy and Public Affairs Division, Federal Bureau of Prisons, U.S. Department of Justice

**Cliff Keenan**, Assistant Director, District of Columbia Pretrial Services Agency

**Jacqueline Kotkin**, Field Services Executive, Probation and Parole, Vermont Department of Corrections

**Deborah LaBelle**, Attorney

**Madie LaMarre**, Consultant

**Neal Langan**, Senior Research Analyst, Office of Research and Evaluation, Federal Bureau of Prisons, U.S. Department of Justice

**Dori Lewis**, Senior Supervising Attorney, Prisoners' Rights Project, Legal Aid Society, New York City

**Cheryl Little**, Executive Director, Florida Immigrant Advocacy Center, Inc.

**Jennifer Long**, Director, National Center for the Prosecution of Violence Against Women

**Christy Lopez**, Partner, Independent Assessment and Monitoring, LLP

**Margaret Love**, Attorney; Consulting Director, American Bar Association Commission on Effective Criminal Sanctions

**Bobbi Luna**, Captain, Multnomah County Sheriff's Office, Oregon

**Martha Lyman**, Director of Research, Hampden County Correctional Center, Massachusetts

**Bob Maccarone**, Director, New York State Division of Probation and Correctional Alternatives

**Cindy Malm**, Consultant, Retired Jail Administrator, Rocky Mountain Corrections

**Michael Marette**, Assistant Director of Corrections, American Federation of State, County, and Municipal Employees

**Jenifer Markowitz**, Forensic Nurse Consultant, DOVE Program, Summa Health System

**Steve Martin**, Attorney/Corrections Consultant

**Susan McCampbell**, President, Center for Innovative Public Policies, Inc., McCampbell & Associates, Inc.

**Ron McCuan**, Captain, U.S. Public Health Service; Public Health Analyst, National Institute of Corrections, Federal Bureau of Prisons, U.S. Department of Justice

**Linda McFarlane**, Mental Health Program Director, Just Detention International

**Jeff McInnis**, PREA Coordinator, District of Columbia Department of Youth Rehabilitation Services

**John Milian**, Detention and Deportation Officer, Criminal Alien Program, Office of Detention and Removal, Immigration and Customs Enforcement, U.S. Department of Homeland Security

**Phyllis Modley**, Correctional Program Specialist, Community Corrections Division, National Institute of Corrections, Federal Bureau of Prisons, U.S. Department of Justice

**Jean Moltz**, Correctional Health Care Consultant

**James Montross**, Director of Mental Health Monitoring, Texas Department of Criminal Justice

**Marcia Morgan**, Consultant, Migima, LLC

**John Moriarty**, Inspector General, Texas Department of Criminal Justice

**Anadora Moss**, President, The Moss Group, Inc.

**Gail D. Mumford**, Juvenile Detention Alternatives Initiative, Annie E. Casey Foundation

**Melissa Nolan**, Executive Assistant, Policy and Public Affairs Division, Federal Bureau of Prisons, U.S. Department of Justice

**Christopher Nugent**, Senior Counsel, Community Services Team, Holland & Knight LLP

**Barbara Owen**, Professor of Criminology, California State University, Fresno

**David Parrish**, Colonel, Commander, Department of Detention Services, Hillsborough County Sheriff's Office, Florida

**T.J. Parsell**, Human Rights Activist, Author of *Fish: A Memoir of a Boy in a Man's Prison*

**Dr. Farah M. Parvez**, Director, Office of Correctional Public Health, New York City Department of Health and Mental Hygiene; National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention

**Susan Poole**, Criminal Justice Consultant; Retired Warden, California Institution for Women

**Roberto Hugh Potter**, Centers for Disease Control and Prevention

**Eugenie Powers**, Director, Probation and Parole, Louisiana Department of Public Safety and Corrections

**Judy Preston**, Deputy Chief, Civil Rights Division, U.S. Department of Justice

**J. Michael Quinlan**, Senior Vice President, Corrections Corporation of America

**Jeffrey Renzi**, Associate Director, Planning and Research, Rhode Island Department of Corrections

**Denise Robinson**, President and CEO, Alvis House; Past-President, International Community Corrections Association

**Melissa Rothstein**, East Coast Program Director, Just Detention International

**David Roush**, Director, National Partnership for Juvenile Services, Center for Research and Professional Development, National Juvenile Detention Association

**Elissa Rumsey**, Compliance Monitoring Coordinator, Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice

**Timothy Ryan**, Director, Miami-Dade County Corrections and Rehabilitation Department

**Teresa Scalzo**, Senior Policy Advisor, Sexual Assault Prevention and Response Office, U.S. Department of Defense

**Vincent Schiraldi**, Director, District of Columbia Department of Youth Rehabilitation Services

**Margo Schlanger**, Professor of Law, Washington University in St. Louis School of Law

**Karen Schneider**, Legal Consultant

**Dana Shoenberg**, Senior Staff Attorney, Center for Children's Law and Policy

**Linda Smith**, Research Consultant

**Donald Specter**, Director, Prison Law Office

**Mai-Linh Spencer**, Deputy State Public Defender, Office of the State Public Defender, California

**Richard Stalder**, Former Secretary, Louisiana Department of Public Safety and Corrections

**Lovisa Stannow**, Executive Director, Just Detention International

**Lara Stemple**, Former Director, Just Detention International; Director, Graduate Studies, University of California, Los Angeles, School of Law

**Tom Stickrath**, Director, Ohio Department of Youth Services

**Victor Stone**, Special Counsel, Office of Enforcement Operations, Criminal Division, U.S. Department of Justice

**Robert Sudlow**, Chief Probation Officer, Ulster County Probation Department, New York

**Anjali Swinton**, Director of Outreach, National Clearinghouse for Science, Technology, and the Law, Stetson University College of Law; President and CEO, SciLaw Forensics Ltd.

**Robin Toone**, Attorney, Foley Hoag LLP

**Cynthia Totten**, Program Director, Just Detention International

**Ashbel T. Wall, II**, Director, Rhode Island Department of Corrections

**Kelly Ward**, Former Warden, David Wade Correctional Center, Louisiana Department of Public Safety and Corrections

**Richard White**, Deputy Commissioner of Operations, City of New York Department of Correction

**Anne Wideman**, Clinical Psychologist

**Reginald Wilkinson**, Executive Director, Ohio Business Alliance for Higher Education and the Economy; Former Director, Ohio Department of Rehabilitation and Correction

**Margaret Winter**, Associate Director, National Prison Project, American Civil Liberties Union

**Jason Ziedenberg**, Consultant; Former Director, Justice Policy Institute



## APPENDIX E: STANDARDS IMPLEMENTATION NEEDS ASSESSMENT

During the public comment period, the Commission conducted a Standards Implementation Needs Assessment (SINA). The Commission created the SINA process to provide feedback on the draft standards through a series of “case studies” at particular facilities. More than 40 facilities from around the country applied to participate in the SINA process. The Commission selected 11 sites that reflected ranges in capacity, populations, and geographic settings and that included jails and prisons; facilities for men, women, and juveniles; and community corrections facilities. Each site visit took place over one and a half days and included a facility tour and five structured interviews: one with the Warden or Superintendent, and the others with small groups of staff to discuss general issues, training, medical/mental health, and investigations. These group interviews involved a variety of staff with experience relevant to the particular topic. When possible, we also spoke with inmates detained in the facilities.

### **Pilot Site**

Montgomery County Correctional Facility, Montgomery County Department of Correction and Rehabilitation, Boyds, MD  
April 22–23, 2008

### **Jails**

Suffolk County House of Correction, Suffolk County Sheriff’s Department, Boston, MA  
May 22–23, 2008

Washington County Jail, Washington County Sheriff’s Office, Hillsboro, OR  
June 5–6, 2008

### **Juvenile Facilities**

Cuyahoga Hills Juvenile Correctional Facility, Ohio Department of Youth Services, Highland Hills, OH  
July 9–10, 2008

Lynn W. Ross Juvenile Center, Tarrant County Juvenile Probation Department, Tarrant County Juvenile Services, Fort Worth, TX  
June 24–25, 2008

### **Prisons for Men**

James Allred Unit, Texas Department of Criminal Justice, Iowa Park, TX  
June 22–23, 2008

Northern Correctional Facility, West Virginia Division of Corrections, Moundsville, WV  
July 7–8, 2008



**Prisons for Women**

New Mexico Women's Correctional Facility, New Mexico Corrections Department, Grants, NM  
June 26–27, 2008

Valley State Prison for Women, California Department of Corrections and Rehabilitation,  
Chowchilla, CA  
June 3–4, 2008

**Community Corrections Facilities**

Southwestern Ohio Serenity (SOS) Hall, Hamilton, OH  
August 1, 2008

Talbert House, Cincinnati, OH  
July 30–31, 2008

