

## PREA and Medical and Mental Health Care

My name is Christine Kregg and I am a program director at Just Detention International.

What we're really going to get into here in our last sixty minutes together, sniff sniff, is about... now that you're the experts of all experts on trauma, what the heck do we do with this information, right? What do we do in our actual... in the practices you have in your treatment and care to survivors, how do you integrate it, both facility wide and sort of agency wide... and so that's what we're really going to be talking about.

And honestly, more importantly, I want to know how you're already doing with this, right? I forgot to mention at the last session I am not a medical mental health provider, right? I am a rape crisis counselor. Everything I know is directly from survivors and directly from the field and so you don't see letters after my name and so I defer to you completely in your professional education, expertise, and credentials so you tell me how you're already doing this and how this can really be useful to you. So as we go through here today together and talk about the basics of, again, I have no money, no interest commercially or otherwise except that I care about all of you and that's it.

But what we're going to be really talking about is one of the basics of a trauma-informed approach and what does that actually mean? What are the benefits of it, right, to survivors but also to your institutions and departments...

And finally, how do we kind of develop an action plan, right, to really implement this agency wide? So, trauma-informed approach, right? We're strengthening patient care, your client care through survivor centered responses. Right?

Again we have a picture here- this is from one of our postcard campaigns from a number of years ago. There's still some interest in it though, which is really cool. On the left it says, "Would you joke about this person being raped?" Right? A guy, sort of plainclothes... on the right he's in the jumpsuit and it says "how about now?" So again, just looking at some of those disparities, discrepancies between how we perceive rape survivors in the community compared with in custody.

And also I want to echo what you said about the work you all do- just know the tremendous respect we have for the work you all do and the challenges you face as medical mental health practitioners in corrections settings. Like we know from our work that all the public health and mental health and all the issues in our community are magnified in custody. You've got people for sometimes an extremely short period of time, sometimes for the rest of their lives... and it's on you, per the constitution and per a whole set of standards and guidelines, to provide them with optimal care and services, often with a tremendous lack of resources.

We know your case loads are crazy huge, we know the issues you confront are enormous and so just please know you have our profound respect and if anything I say here today implies that you're not doing the best possible jobs you can be doing, that's not my... that's not where I come from. I'm an ally here, I respect you greatly, but I will be sharing directly from some survivor perspectives about lack of adequate care that they have received. So just know that that's where that perspective comes from but I have tremendous respect for all of you and, frankly, I like you a lot... so just know that that's where I come from, ok?

All right, who wasn't here for the last session? No embarrassment needed but anyone not attend the trauma? Okay. So I'm going to put it to my attendees who were here last time 'cause frankly I'm sick of talking- how would you describe in a couple of sentences what is trauma? What's a trauma reaction? What's sort of going on in the body? Some brave soul from the audience want to tell your beautiful colleagues? What do I mean by trauma? What am I talking about?

*Audience member responds: Amygdala*

*Christine laughs.*

Amygdala. Key word- amygdala.

Yeah. So when we talk about trauma, just know that what we're talking about is any experience that overwhelms someone's ability to cope. I'm trying to identify those of you that weren't here last time... overwhelms the ability to cope and that, essentially, trauma hijacks the brain.

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Instead of using that cerebral cortex, frontal lobe, higher levels of cognitive functioning, our brain is hijacked- we're bypassed, we're moving to the amygdala, in the fear center and victims are not responding, they are reacting. Ok? So we know that that's what's going on when someone's experiencing trauma. We know it has a profound effect on a survivor's sense of self.

We didn't talk much about memory so let me... give me two seconds on that one. What we know about typical memories, right, and again, there's a lot we don't know... is anyone who has an interest in sort of neurology, right? We know there's a lot we don't know about memory and memory production and memory storage.

But one thing that we do know is about disruptions in memory because of trauma. So typical memories, especially pleasurable ones... I'm going to ask you all to think about the last time you had ice cream or some other dessert you love (for me it's ice cream.) I can actually probably tell you in a great bit of detail- "Mmm. Yeah, I went to that fro-yo place, I got the peanut butter sauce, I got sea salt 'cause I'm crazy... I sat down and read a magazine and it took me about twenty minutes; it was fabulous,"

right? I can actually describe, in fairly rich detail, that experience in a fairly chronological, narrative fashion- again that's how most of our memories are stored- normal memories.

When we talk about trauma memories, what happens is: when that body is going through the physiological trauma response, those elevated hormones, right, that additional release- adrenaline, cortisol, right, when we have that hyper arousal, it actually affects the brain's ability to store memories, so it actually affects memory storage.

So what we know... and if any of you work with sexual assault survivors, you've experienced this (or any other trauma survivors): oftentimes memories are incomplete, right? There are lapses in memories? Many times you'll have survivors remembering very specific details rather than the actual narrative, so you might get somebody coming in your clinic who makes a rape disclosure who says... who's in shock, right? You might say, "so can you tell me what happened? What happened, Mr. Thomas?" Right? And he says, "I have no idea, I just know I'm remembering the smell of soap and some guy coming up behind me." and you might say "well what did he look like, can you describe?" "I don't know, I have no idea, I can't remember, I don't even know what his face looked like." The reason for that is, again, during a trauma, hyper arousal, the body moves into often something called a perceptual narrowing- where we're not using our full five senses, or six senses if you believe in that- oftentimes there's a narrowing of... maybe there's a particular sense of smell that's very acute, vision might be more acute. That also means some of the other senses are less primary.

So again, if you're thinking about trauma and about memories, you want to ask, again I'm just putting this out there as a practical tool for you in your surveys, in assessments, when you're meeting with someone, ask about sensory memories. Don't just ask about, "What happened? What did he do to you? Where were you? Where did you go?" You can say, "How were you feeling? What do you remember hearing? Was there any smell in the air?"

Again, this is what I do and I train investigators too. If you can't corroborate where it occurred 'cause they don't remember, but they say "I smelled meatballs cooking that day, I don't know..." Okay, it happened near the chow hall, right? It's a way of really gathering information that's not necessarily linear or chronological. And just know survivors often have a tremendous amount of shame around that lack of memory.

What we know from research is that any recall from a traumatic memory, you're going to need a minimum of two sleep cycles. What I mean is- what we've shown is that when we're calling trauma, especially research they've done, frankly, with law enforcement... so say it's your colleagues that they were studying, OK? Exposure to trauma they found that if they did sort of an initial interview, that initial kind of... initial statement, if you will, from what happened with law enforcement- their capacity to remember what was going on was at about twenty percent without a

sleep cycle. So say it happened at six o'clock in the morning, I'm interviewing you at noon, I've got about twenty percent that I can recall.

If you wait one sleep cycle- let the officer sleep it off, send them home, interview them the next day for a supplemental report- memory retention's about fifty percent. They can recall about fifty percent of the details. You allow two sleep cycles, that's where your likelihood of 100% recall is going to increase.

So if you've got a survivor and you've got your investigators coming in, right, the ISU- "Tell us what happened, we're going to do our initial report." Some agencies actually finalize their administrative investigations within 72 hours. While I appreciate the desire to quickly resolve an incident, if you're trauma-informed, not a best practice- because frankly you're not getting whole story. So as practitioners knowing that's part of why the standards call for follow-up care, right?

It's not enough to sit down with someone initially after the abuse and say, "how are you doing? What's going on?," especially if y'all are assessing for what kind of medical care is needed, right? Maybe they don't even remember a certain trauma or injury or abuse that they suffered, right? They might not have even remembered that there was perhaps some amount of penetration. So, again, when thinking about providing comprehensive treatment, we want to be checking in again with that survivor... and if you're talking to investigators tell them to delay their final report. They can do a supplemental or initial report- they want to delay that final report for at least two sleep cycles.

We know trauma is compounded by incarceration. Why is that, my experts who were here last session? Why does incarceration make it worse?

*An audience member shouts out an answer*

Lack of control, absolutely. What else?

*Another audience member responds*

That's right. The constant reminders, you better believe it. How about safety concerns? Contact with perpetrators, yep. Can't go home and take a bubble bath. As a rape crisis counselor, I can't tell you how often I would say to someone in community, "Can you go for a walk? Can you go get yourself your favorite magazine? Can you curl up and take a nap?" When someone's in custody? No, no, and no... well, maybe you could take a nap with a cacophony of noises, right? So, again, choices are limited.

And then finally, what we know about trauma is what? There's a tremendous need for immediate, short-term, long-term care and treatment- again that's why you all are here. K?

So let's move on. This is where you're not going to like me very much after this but then I'll earn back your warm fuzzies, I hope. Let's talk about what JDI hears, day in, day out from survivors of sexual abuse regarding medical mental health care. These are their concerns, again from their perspective.

First is lack of provider experience or sensitivity. So in the best-case scenarios, what we've heard from some survivors is that they'll say, "I've got a mental health staff member therapist who will say to me flat out, 'I don't have any training in PTSD. I know you're suffering, I know you have this diagnosis but I can't treat you. I don't actually have the clinical experience. I'm sorry, we don't offer that here.'" Other ones who say "that's not covered, it's not required, it's not considered a major mental illness, therefore we're not obligated to provide you with treatment for PTSD or Rape Trauma Syndrome." In other scenarios, we have providers actually say to somebody, "I don't believe you. We don't treat faggots here. It's not my problem. We're not a state hospital, I don't know what you expect from me." And so again we hear from survivors who express those concerns and you heard it from Joe, the first nurse he went to was asking him... I don't know... his weight, his BMI, I don't know what she was asking him. But she wasn't asking him relevant questions related to the sexual abuse.

So just know we know your sensitivity, your care, your compassion, but unfortunately there are folks in the field where survivors feel tremendously invalidated and very alone. Because if you won't help them, who will? If you're not qualified, who is?

Other thing we hear is inadequate care, frankly, for injuries or for chronic medical mental health conditions. So we hear some survivors are flat-out refused treatment, as I just told you. Others just simply don't get the follow-up. So maybe they'll get a prescription for something and never get to meet with the provider again to have any follow through.

The others issue is when you're talking about prisoner rape, very frequently there is a transfer that happens. Hopefully facilities are moving away from sort of a default transfer because for many survivors that actually can be reached re-traumatizing. Many would prefer to remain in their facility and have the perp moved out. But in the case of transfers, you all know the challenges of continuity of care, particularly if someone discloses a sexual assaults. So we find if there can be stops and spurts and restarts... Again, thinking like a trauma survivor, if I have to retell every single mental health practitioner on multiple shifts what happened to me, if I have to re-explain myself over and over again, that can be really re-traumatizing. So we want to minimize that through proper coordination and follow-up services.

So there are some survivors who... I would agree and I think in many cases... that's absolutely... the case some will say, "Get me out of here. Do what you have to do. I don't want to be here, I'm totally, I'm losing my mind in here," but the most

important thing a trauma-informed practice is: ask the person. Right? If they've any degree of control or say over it, say, "Would you feel safest staying here and we can move you to ad seg? We've got this other jail, we've got a cooperative agreement with Broward county and we can send you there... where do you want to be? Where would you feel safest?" But you're absolutely right, George, those are some really primary concerns.

Again, when we also talk about inadequate care, I want you all to think about the worsening, as we talked about last time of the psychiatric symptoms, so again if you've got a bipolar person you're working with and you're perceiving sort of a manic episode, just be aware that for practitioners to be trained in trauma... if they're not trained, they might be missing some of hyper arousal, for example, sort of conflating or confusing various symptoms- so it takes it does take specialized training and experience to kind of parse out what's going on for someone, particularly if they already are mentally ill. So we know that that's something many survivors are concerned about.

Over-reliance on meds. Look, we've got folks who otherwise are functioning quite well who are having a normal reaction to trauma- difficulty sleeping or nightmares or headaches- who may need a rape crisis intervention, short term counseling, they may not necessarily need treatment with medication... again, I'm not a medical provider, I'm not saying that medication is never advisable, certainly it can be particularly for short term stabilization, but I will say a lot of the survivors we talked to say, "I got a prescription and nothing else." In that case, we know that won't be effective. We know that won't be effective in short-term or long-term in addressing the trauma they went through, so that's a concern we hear about- write me a drug and leave me be.

Lack of confidentiality. As we talked about last time, medical mental health practitioners, you all, are mandated reporters, right? Is there anyone in here who doesn't fall under that?

Ok. Yeah, so around the country you all, if you suspect have any knowledge of or witness sexual abuse, you have to report it. And so in Joe's case- say, for example, he only felt safe disclosing the most recent rape. We work with a lot of survivors who will be abused over a period of time who don't feel safe, for whatever reason, reporting that it was ongoing... who only want to say it happened once. Well, if you're a medical provider or mental health practitioner, is it going to affect your treatment knowing the duration of the abuse? Probably. Will it affect your treatment, knowing what actually occurred, the actual incidents, the actual abuse that occurred? Of course it would. However, if I'm that survivor and for whatever reason I don't feel safe telling you that because I know you're going to tell custody...

you may not have the whole picture, right? And so we know that, for some survivors, that lack of confidentiality... also them knowing when they talk to you that becomes part of their medical record, right? Or possibly some of them fear it will be

part of their custody record, right? So we know there are those concerns.

Minimal access to exams. Around the country, survivors not unlike Joe will report and not be offered the exam or simply they aren't available, so that's another concern we hear.

And then finally, lack of safety or lack of trust, right? So we know certainly some staff perpetrators are medical or mental health staff, so of course for them to trust you, to confide in you... and it may be one of your colleagues who abuse them... can be really difficult.

We work with one survivor named Policarpio Medina. His testimony's on our website. Policarpio was abused by a psychiatric technician over a period of time. He was coerced into the abuse by staff, or, I'm sorry, by inmate gang members. They were sort of all in cahoots together and Policarpio had a really difficult time accessing services from mental health staff. That was one of the places where they refused treatment for PTSD, claiming that they simply weren't required to provide, it wasn't a major mental illness, so just know in his case, he bravely reported and sought services but from the colleagues and supervisors of the psych tech who sexually assaulted him, so just know those challenges.

You all don't work in a vacuum, right? What I mean is if custody, if someone's safety and security, if those needs aren't being addressed, how effective can your interventions be, right? Say you provide exceptional counseling and intervention but your client, your patient is Joe Booth who gets moved in a cell in ad seg next to his rapist. How effective can you be ensuring his well-being if the institution has decided to put him right next to his rapist?

So I appreciate that point so much because that's why we have to be coordinated when working together is you can't be successful or you... you'll be more successful if you have the coordination cooperation of custody- of course, of course.

*An audience member asks a question*

Yes. Absolutely and that's, of course, more often than not the case- inmates and staff become aware even though, best practice in the PREA standards, they should be need-to-know basis. You all know better than anyone how quickly and easily information and misinformation can travel throughout custody settings, so you're absolutely right. It's sort of like no matter where they go, they're not safe. We hear that especially in Texas. For whatever reason, TDCJ, they've got more prisons than I can even conceive of but they're all these kinda teeny little fiefdoms and we'll have Prison rape survivors transferred five, six seven, eight, nine, ten times and no matter where they go, they're not safe, gang members, everybody knows everybody. They just can't escape it. So yeah, you know that's a really great point.

You all are on point! Especially at the end of these days, you're amazing me. I'd be napping right now.

Okay. If you aren't already convinced why a trauma-informed approach is the way to go, I'm going to give you a couple of reasons. And I see some handouts going out, which is great.

The first thing is, right, the obvious one- it's a recognized best practice, right? There are some uh... I want to say agencies, that's not what I'm thinking of... some industries, if you will, that I think have done a really good job of bringing in more of a trauma-informed approach. I'm thinking, for example, alcohol and drug treatment centers- a lot of these places have these sort of trauma... sort of trauma-informed support groups, if you will... or sort of approaches. We know V.A., the Veterans Administration has made tremendous strides in addressing trauma, right, being more trauma informed. Are they perfect? Absolutely not. And I also want to pat on the back anyone working for juvenile detention agencies- they've made some tremendous strides, I'd say especially in the past ten, fifteen years and really bringing in that component.

But look, we all know corrections- I love you guys, but you can be, we can be resistant to change, right? When we're talking about safety and security, when we're talking about community safety, it can be difficult to try things a new way for fear of, right, turning over the apple cart... all of a sudden we're going to have inmate escapes if we address trauma, right? There can be kind of this holding on, let's not change anything... so I want to give a lot of credit to those agencies and facilities that are really looking at the forefront of how we can be more trauma-informed. It's not easy but we know it works because a trauma-informed approach, all that means, is it gives staff the tools to really integrate an understanding of trauma into your policy and practice- frankly to make the facility safer and to improve the well-being of the inmates in your care. That's why we want to do it. It also, of course, reduces the impact on survivors.

Look, I think like Joe so clearly demonstrated- he sort of demonstrated what happens when survivors don't get trauma-informed, compassionate services but when survivors do, what the research tells us, and again e-mail me if you want the citations, if you take two groups of people who were sort of similarly exposed to trauma... there's been some really interesting research studies done... folks coming out of sort of natural disasters or genocide, right, who escape. One group went to a more supportive community where they were reunited with families, their abuse and the trauma they experienced was recognized, validated, they were supported, perhaps most importantly they were believed. So that's kinda group A. Group B was placed in one of these sort of refugee camps, not given any services, their abuse was minimized... it was like, "look, we've all been through hell and back, what do you want us to do about it?" No access to services... and let's say that's Group B. Group B, the rates of PTSD- through the roof, right? Most of them were developing some kind of Post-Traumatic Stress Disorder, anxiety disorders, right? We saw clearly



the effects of trauma in Group B who had no access to services. Group A? What do you think the PTSD rates were? In this one study- no one. There was no diagnosable PTSD in that group of trauma survivors. They went through the same stuff.

And so I know Bob Dumond talked about this on Sunday- the first few responses survivors get can have the most profound impact on their healing, positively or negatively. So for you all as medical mental health practitioners, in a well-run facility, a survivor is going to come see you before they get transported out, before they see many other people, right, again that's the way it should work. So how you respond, what you say, how you say it... and we're going to talk about what you say and how you say it today... can have the most profound affect on their healing. Just know you are, you can be the first step in their healing. You have that kind of power and so I greatly respect your being here and your taking that seriously.

We know that trauma-informed care can strengthen health outcomes, right? Of course. You helping to ensure survivors get the services they need, we know that you can help to reduce that long-term impact of trauma. It's really important.

We know of course this approach is consistent with the PREA standards, everything we buzzed through a couple minutes ago- coordinated response, emergency medical care, access to exams, advocates- that's all trauma-informed, folks, right? That's all survivor-centered stuff.

And finally, here's like the collateral benefit, right? When agencies adopt a more trauma-informed approach, it just so happens you guys actually have to talk to each other in order to do that, right? No one can work in their silos, we can't have a medical practitioner filling out prescriptions sort of not talking to anybody else- not that you do that... I know I talk to my colleagues just 'cause I love to gossip so believe me, we talk... no, I'm kidding.

But one of the benefits of trauma-informed is that you've got to actually coordinate, you have to actually communicate and so what we've found in agencies that are serious about this approach... as it just so happens, you're having better staffed coordination and communication- it's an awesome collateral benefit, it's sort of an additional kick in the butt for those colleagues who aren't excited, shall we say, about trauma-informed.

You're also going to save some money, right, of course. If we're really providing the kind of care, they leave, they're much better able to program and successfully reintegrate.

I would say Joe discharged parole and is doing extremely well in spite of the fact that he is a prison rape survivor. Many, many, many of the survivors we work with are living lives that are shattered and hobbled by the abuse they've suffered. It's insurmountable to begin to build a normal life following custody so he is the exception and of course I think he's exceptional but just know his ability to do what

he does is remarkable many, many survivors are just simply not capable of what... of what Joe does... but thank you for sharing that, sorry to put you on the spot, Shannon.

Cool, OK. Again, rubber hitting the road. Let's be really practical, let's talk about what this looks like, right? I don't want to have a lot of foo foo stuff for you today, I really want to be as pragmatic and reality-based as we can be about what trauma-informed looks like.

So you're sitting there, you're talking to your administrator, you are an administrator... ok, trauma-informed, cool, how do I actually do that?

First step is to think about, and take into account, trauma at these multiple levels, right? So sort of in your philosophical or agency approach to the care and treatment you provide, meaning- are you looking for the effects of trauma, the incidents of trauma and the long longer term impacts in your practices, right? So not just kind of any immediate follow-up services but overall as an agency- are you looking for it, right? Are you paying attention to trauma? In your policies, right, are you incorporating the effect of trauma and really looking at addressing healing and facilitating accountability? Those are sort of some of those overarching goals of a trauma-informed approach... again, whether that's medical or mental health care.

And the thing about trauma... you all have a colleague who was here on Sunday- Doctor Bell, I want to say, who talked about resiliency and he talked about the fear of sort of catastrophizing, if you will, a sexual assault.

[I] have to say, I'm sort of on the other side of that which is that I actually believe that in the vast majority of cases, certainly the survivors we hear from, there is no threat of you all catastrophizing a sexual assault. If anything, at every step of the way that abuse tends to be minimized if not ignored or outright negated, right? Actually them told... denied, right? "That didn't happen to you, you're making it up." So as medical mental health providers I think you taking very seriously any potential suspicion or allegation of sexual abuse will set them up for greater functioning and greater healing and it's not the reverse, again that's just in my own experience and work with survivors. For me to say to someone... I've said it five thousand times to Joe... "I'm so sorry that happened to you. You didn't deserve that." That can lay a stronger foundation of healing than me saying "but you're a strong guy, you'll get through it." Survivors don't need to hear that; they're going to hear that from everybody else. You can be one of the few people who can look at them and say, "I'm so sorry that happened. That had to have been awful. I'm here to help. I believe you. I care about you." Those are some of those phrases you can put in your back pockets- "sorry to hear that," "you didn't deserve that," "I care about you." I don't know if in your professional background you're allowed to say "I believe you," but if you believe them and you can say it please tell 'em that, cuz they're going to think you think they're a liar, right?

We all know this phrase, I say this in trainings all the time: how do you know an inmate's lying? Their mouth is moving. Yeah, over and over again, every training I do, around the country- it doesn't matter who I'm talking to, I ask custody that, everybody has the same answer. You are looking at me blankly- that's a good thing and it maybe that's not your that philosophy, right, but just know inmates know that, they know that- detainees, residents know staff think that about them. So again if they bravely disclose or come to you, you actually kind of giving them the benefit of the doubt can really help with their healing.

The other thing you can as medical mental health staff is help to give them some structure and some safety, especially sort of mental, psychic safety (*she hits the mic* oooo, sorry) and helping them to sort of assess what they need in order to feel safe and regain some of that structure.

Ok, let's again, let's... I'm going to give you some specific examples here and I'm also going to involve you in sort of a little quick quiz about whether or not practices are trauma-informed and what you think. But, ok, so for agencies... I basically already said this but you're looking at not just how trauma affects people who've been traumatized but the staff members, witnesses, anyone involved in a system, the entire institution is affected whenever there's sexual trauma. So if I'm trauma-informed, I'm asking myself, "Is this practice in line with what I've learned about trauma?" Right? That's the question- "Is this practice, is this approach in line with what I've learned about trauma?" If you're not sure, chances are it probably isn't, right?

So, ok, I'm going to give you some examples and I want to hear what you all think. These are some pretty common correctional practices, medical mental health practices. I want to know sort of where you think these fall. So I want you to let me know: do you think this is trauma-informed, not trauma-informed, or not sure?

So I'm a mental health practitioner. I'm doing a follow up with someone who alleged sexual assault. Say it's maybe been about a week. Instead of talking to them on their unit or outside the cell, I'm going to take a couple extra minutes to pull them out and bring into the clinic to talk to them privately. Does that sound trauma-informed, not trauma-informed?

*An audience member responds*

Okay, why?

*An audience member responds*

Ok, separation from other inmates, OK.

*Audience member continues talking*

Sense of safety, some structure... other thoughts?

*A different audience member responds*

Shame... get them away from that environment... get to talk privately...

*Another response*

So what she said is it depends on the situation. What if they're abused by the mental health practitioner? They might not be safe going off and talking to you privately.

Bingo. You're all right. So here's the thing- everybody's right, right? It depends on the situation. I would say as a general practice it is often re-traumatizing to be asking someone to disclose something in the presence of other inmates.

A best practice? Again, trying to give some control or choice back. I'm going up to Joe, "Hey Joe, good to see you again. I wanted to follow up with you today on what we talked about last week. Would you like to stay here and talk or can we go somewhere else?" If he says, "yeah, get me out of here," say "Great. We can go talk in the clinic or we can go sit... we can go sit out on the yard. What do you prefer? Where would you feel more comfortable?" Or you pull him out and then you say, "I've got two options for you today. What sounds good to you?" Or say, "I can talk to you now, right here or I can pull you out later and take you to the clinic." Right?

Sometimes, you all know, your caseloads... if you're doing your rounds, you've got 57... I mean, thinking about the prison psychologist we work with- a caseload of 32 follow-ups she had to do that day. It might not be an option in that moment when you're doing follow-up to pull them out, but say "Joe, I'm here for you. We're going to do that follow up. If you want me to pull you out, I'll take care of that at 3:00. Does that work for you?" As much as possible those micro decisions give survivors a chance, again, to regain that sense of control.

So trauma-informed: whenever possible giving them the option and as you said other inmates are going to be kind of potentially on high alert- "Why are you pulling this guy out? What's going on?"

Just "Hey Joe, just wanting to follow up with you." Not, "I'm here to follow up on the PREA violation from the..." Right? Come on. Right? And just thinking as much as possible: need-to-know basis. Officer says "Why are you talking to Scott?" "Just doing a medical follow-up." Right? We don't have to disclose it, it's about sexual assault.

Okay another practice: someone is reporting suicidal... not necessarily ideation but they say to you, "Sometimes I think about killing myself." You probe a little bit. No concrete plan, no means to do so, they say to you, "I'm in so much pain, I wish I weren't here anymore." Are you moving them into a suicide cell immediately?

Yes? No? Maybe? You need more information? You're sitting there like, "I'm a practitioner, I have seventeen points that I have to ask them about, I don't know yet." Okay, how about default placing people in ad seg when they make an allegation? Is that trauma-informed? To automatically move them to ad seg?

*The audience responds*

No. And again, sometimes it is, right? But again, giving someone as much choice as possible... We know that when you ask somebody, when you say, "Would you feel safer if we move you somewhere safe?" Joe talked about to me... again when we were practicing for today... he said to me, he said, "When I got moved to ag seg or when I was in seg," he's like, "sometimes that was the only time I felt safe. It was quiet, I was alone..." and when he was alone in the cell he was like, "I felt some degree of control. That felt safe for me." Other times, in other periods of his incarceration, it was deeply traumatizing and he decompensated really quickly.

So I think that's where your assessments and your involvement is so critical. You all will know in your conversations and assessing your work with your patients if add seg is likely to increase their hyper arousal and fear and anxiety or if potentially that's a little bit of a timeout that they might actually need to regain some of their functioning. Again, that's where kind of working together is really important.

Give you one more example: a survivor makes an allegation. It's assess that they are eligible for the forensic exam. They get stripped out before they go to the hospital. Trauma-informed? Not trauma-informed?

*The audience responds*

Right. Why not?

Reliving- potentially, yep. Re-traumatizing. How about evidence loss? Yeah, right? If we're talking about the potential for forensic evidence and we're having someone take off their jumpsuit, kick it across the clinic, and put on something else, or putting on... maybe you have a different set of clothes you have them wear for transport, some jurisdictions do that... yeah, absolutely not.

What we recommend in the jurisdictions we work with is if there's any leeway on this... and I know it's not your call, necessarily, as medical staff... is to treat sexual assault as you would any other medical emergency.

So if your agency strip-searches people who are having a heart attack, ok, maybe there's not a whole lot of pushback you can do but I've never, so far, worked with any jurisdictions who are strip-searching someone who has a medical emergency- someone in labor, for example. Ok? So if the default practice is not to do that, maybe thorough pap search- again gloves, gloves, please always gloves- keep those for the

evidence collection. Again, trauma-informed: assessing for the situation, recognizing sexual abuse as a medical emergency.

So, you all did a great job, wonderful. I feel like I'm wasting your time and mine but I like you so much we'll keep going.

*She looks at a clock.* Ok, 4:22.

Ok agency understand how traditional responses and investigations can actually exacerbate trauma, right? Gave you a couple of examples of that... just keeping in mind that sometimes our normal way of doing things inadvertently can make someone less likely to want to participate in an investigation or feel less safe or like their needs aren't being met.

Here's going to me my... again, I'm trying to be really practical here... here's my pragmatic suggestion with that: For you all as practitioners, I would really see sexual assault as an opportunity to really create or write a new treatment plan. So if you haven't already done so, in the aftermath of an allegation... I don't care, ya'll if the abuse happened two years ago... I think whenever you have an allegation, it's an opportunity to take a look at what's going on for your patient, to look at offering your input in housing situations, in programming, certainly in the treatment and care they're receiving... because what I'm going to say is: sexual assault never doesn't affect those areas of functioning, but we know is the level of degree, of course, differs depending on the severity, depending on that individual survivor... but you can never really say, "Oh, so-and-so isn't affected by the rape." If they're in acute denial, is that still an effect? Absolutely. Those survivors who are suppressing the memories, who aren't talking about it, who claim they're fine- for me as an advocate, those are the ones I'm the most concerned about. The ones who are crying, expressing their feelings, expressing anger, reaching out for services- those are ones that I'm like, "All right. We've got some hope for them. They're gonna be ok." They're reaching out for services, they're acknowledging what's going on, we're good. It's the ones, ya'll, who seem fine, who seem like they don't need anything- oh, no change in programming, their classification, they're all good- that probably need the most intervention, right, 'cause they're kind of holding it in and again that can compound the trauma, they're not expressing it.

Ok, other, third piece of this is the agency's looking at practices to make sure that re-traumatization is minimized, right, that's what we talked about. Again, when someone is in custody here's the good news; I'm going to put it to you this way-

as an advocate, would I prefer that someone be locked up in the aftermath of a rape? No, not generally. Generally, I'd like them to be able to kind of leave and be able to go and be with family or friends, our caller at Chris' hotline... but here's the thing: if they are incarcerated, if they can't just get up and leave, what an opportunity to offer and in some cases to reoffer ('cause they might decline you at first) follow-up or ongoing mental health and medical care and treatment and needed services. It's

an opportunity that you all can have to change the course of their health care for the rest of their life; to actually have a positive impact across their life span because the fact is untreated, unresolved, un... kind of explored rape and sexual assault will have a negative impact on their health across their lifetimes. It's not... it's not an if, it's a when. So just, again, know what a tremendously rich and important opportunity you all have and so again, if you didn't already think your job was important enough, there's something else to tell your boss why you deserve a raise. Say, "Christine Kregg from JDI said that I should get a ten percent raise immediately in recognition of..." Okay.

All right, let's keep it going. I'm looking at the time here-we wrap up at 4:45, right? K. 20 minutes. Let's rock and roll.

K, duh but I just want to say it: trauma-informed care is survivor-centered care. If stories and perspectives from victims like Joe aren't at the forefront of your mind as you're thinking about these policies and practices, we're missing the boat. So I really encourage and welcome you to visit JDI's website to just take a look at some of our survivor testimonies, we have survivor audio, we of course have survivor speakers, like Joe, you can talk some of our staff, of course, to bounce ideas off of... but just take a few moments or even at your next staff meeting if you want to printout a testimony and say, "Hey guys, wanna take a couple minutes just to kind of remind us of the importance of our work and of what happens when we don't provide adequate care," happy to send you some that particularly relate to medical mental health care, just let me know... but those are available for free to download, share, print, do what you want with them, we're happy to have to use those- and again that's [justdetention.org](http://justdetention.org).

Something else I want to offer you is a handbook we have for working with prisoner rape survivors. It's called *Hope for Healing* – also in Spanish, *Esperanza en la Recuperación*, for my bilingual staff in here- it's available on our website, it's a PDF, downloadable, printable, it's something we send, again, *Hope for Healing*. It's under our "resources" tab at the top of the page. It's something we send to every single prisoner rape survivor who contacts us. We also are happy to provide it to you, happy to mail you some copies, just contact me. The reason why it's so useful, ya'll, is that it's essentially the first three sessions with a rape crisis counselor distilled into a booklet. It's basic, simple language to understand and it goes through common reactions during sexual assault, the effect on sexuality, it looks at issues of, for example, some male survivors in particular experience sexual arousal during a rape- that can be really confusing. So the booklet talks about what survivors' rights are, how to access care, and how to take care of themselves- it has some basic coping skills.

For my mental health practitioners in the room, but also medical staff, if you're looking at sort of coping skills and stabilization, what I recommend sort of as an advocate is any type of self-contained exercises or tools you can offer. So what we know works pretty darn well with prisoner rape survivors... I've actually done some

short-term crisis counseling with incarcerated survivors is things like writing, especially if they can flush it, get rid of it, 'cause it can be scary for them sort of keep a journal. If you can... I don't know if you can keep it in your file in your office, give it back to them, it's something to consider. Breathing exercises, grounding exercise is really, really helpful and if any of you noticed prior to Joe talking but he was trembling and he and I were talking about how he was feeling and he was getting quite activated, understandably. We just quickly did a five minute grounding exercise where he sat there and I encouraged him to really feel his back against the chair, to feel his feet against the ground, to sense into his buttocks against the seat... if you're... and so... and that... to just start breathing and slowly you'll notice that breath deepening as they're tuning into those points of contact that feel safe. If you've got someone that's really hyper-aroused, perhaps curled up in a ball, sobbing, really hyper, kind of... more acute case, effective grounding can be to have them sense into any part of their body that feels safe.

So not telling them, "feel your feet, feel your back, but rather asking them, "is there any part of your body that feels safe?" Sometimes it's the tip of a fingernail sometimes if that very... that coccyx bone sitting against the seat... more often than Not, they're not going to want to go anywhere in the organs. Oftentimes... none of that, none of the parts that were affected by the abuse feel safe. They might say the very top of their head feel safe, the very tips of their feet, the tip of their nose for some survivors can really feel safe. By asking them to do that, again, you're just retraining that nervous system to come back down into that resiliency zone and building in tools and a process they can use if they go back in their cell and they're freaking out, right, or if they go and get released, they're out with their community all of a sudden, they're having a flashback, they don't know what to do... those grounding exercises are available online, lots of great tools, I'm happy to send you some if you're more curious about that but if, say, for example, you're doing a medical assessment and they're starting to get activated, take a couple minutes just to ground. it can really help you to first of all make that survivor feel more comfortable but you're gonna have better interactivity too. 'Cause when someone's aroused, they're already in panic mode, survival mode. So Joe knew he wanted to talk to you, but first he had feel safe in his body, right, or else he can't even concentrate on what he's saying... so... pretty darn effective; can be really useful.

What else do I want to say to you? Okay so the first point here treating survivors with dignity- keeping them informed about and connected to their treatment. Again, we talked about power and control giving survivors back that sense of choice it can really help them to feel empowered. If nothing else as medical practitioners for you to say, "You know what, Joe? We've got a couple different options. I'm really concerned about the nightmares. Let's talk about a couple different approaches here. What do you think?" Or, "Here's what I recommend but I want to get your feedback," right? Again, involving them as much as possible decreases anxiety, shows them you respect them and care about their welfare.



Of course we know there needs to be training to understand that relationship between trauma and survivor health. Putting it back on you guys, what are some of the medical mental health effects of sort of chronic hyper arousal, of trauma, we already talked about PTSD. What are some other sort of psycho-somatic or other effects you know of that you see in your patients?

*She waits for audience response*

Migraines, headaches- potentially. How about auto-immune disorders? Lots of research connecting, right, fibromyalgia, M.S. to exposure to trauma, right, suffering trauma.

How about digestive disorders? Heck yeah- what were you going to say, George? I stole it! Missed your hand. Right? Course. We're going to want to look at that.

How about chronic pain? Absolutely, right? Again, the fraying of those nerves, the hyper arousal- of course PTSD, of course potentially anxiety disorders... how about Dissociative Identity Disorder, yeah, AKA old school Multiple Personality Disorder, right? Absolutely, particularly childhood trauma but again that can be triggered or compounded through exposure and custody. So again, the more you know about those connections to trauma and medical mental health outcomes, the better you can interrupt the development of those conditions and start your treatment much earlier.

Finally, and I said this before, we know you've got to, and I want you, to work in collaboration with others. You cannot do this alone. You cannot ensure someone's health, well-being, and safety without working with others, especially those members of a survivor support system. Survivor says to you, "I wrote to JDI about this." Can you call me up and ask what's going on or ask for some help? Absolutely. Of course we have confidentiality on our end so we'll just do a quick little release and I'll chat with you but if we can be helpful at all, community rape crisis advocates- they're there to assist you in the work that you're doing. They're not there to duplicate your work but that they can be a really helpful resource, so please do consider using those folks. [It] doesn't mean you're failing at your job, it means you're succeeding if you recognize you can't do it all alone, guys, especially with the resources and the demands on your time- they're just tremendous and I know that. Anything you all would add to this? Your own perspective from your own agencies, trauma-informed...?

*No one responds*

Ok. must mean I'm doing my job right.

Again I want to be really pragmatic and give you some concrete examples of trauma-informed practices sort of at various stages of your work and of the treatment you're providing.

So in patient communication, right? This might seem obvious but whenever possible, let's avoid those "Why?" questions as those can feel really victim-blaming. Again, I know you're not in an investigative capacity, but if someone comes and talks to you and you say, "Why did you wait to tell?" What does that sound like to someone? "What's wrong with you for not telling? Shame on you. What were you thinking?"

Now you all know from the research that it's more likely for survivors to delay a report. Joe is the... he's the anomaly. It's not as common for someone to report within that acute window. More often than not, survivors will delay a report for weeks if not months and we talked about the reasons for that.

So again, trauma-informed is to expect a delay in reporting. Instead of saying, "Why'd you wait so long," what's something you could say differently? Instead of "why'd you wait," what could you say?

*The audience responds*

"Glad you came!"

"I'm glad you told me that."

"Wow, that couldn't have been easy to say, I'm really glad you told me."

"I'm here to help; thanks for letting me know."

Open ended questions, right, so instead of the "why?" asking, "Can you tell me what happened?" Or, "How are you feeling right now?" "What can I do to help?" "What do you need," right- sort of keeping it open.

Exams and assessments- just remember the PREA standard specify what needs to be happening at your intake screening so just know to please incorporate those aspects that look for victimization or likelihood of perpetration, those are important. As far as I know, you guys, there isn't an objective screening instrument- those are the words from the standard- that I know of that exists yet that takes into account all the pieces that the standards require- that's the bad news.

The good news is I'm hoping those are in development. I know that compass... any of your agencies using compass for classification? No, okay, then you won't get excited about this.

Anyway, as far as I know, they're incorporating PREA which is really good. Bam, ok these earthquakes- it like freaks me out when things fall 'cause I'm originally from Chicago so moving to California I would so much prefer a tornado, that's what basements are for... earthquakes, you're screwed, like there's just nowhere to go.

So anyway, when things are falling I'm like, "ooh! I'm traumatized." Okay,

*Audience member speaks-* Those of us from California don't think twice.

*Christine:*

Exactly. The earth shaking? That's normal for you guys, that's why you're wierdos and I love you.

Ok. Exams and... *(Joking)* I know, I'm trying to offend as many of you as I can today. Regional insults, I'll get ya anyway I can.

Okay, we've got ten minutes I'm going to fly by here a little bit.

Exams and assessments: when you're doing a physical exam, when you're having physical contact with that patient, trauma-informed or not to tell them what you're going to do their body? Yes, trauma-informed. I'm saying to someone, "I'm gonna lift your scrotum and take a look. I want to see how you're doing. I'm going to spread your butt cheeks, take a look at your anus; I want to see how you're doing. I'm going to take a look inside your ear. I'm going to take your blood pressure now; I'm going to put some pressure on your arm." As much as possible, folks, and this isn't just for trauma survivors, this is anyone you're providing care to, two big reasons I'm going to ask you to do that if you're not already: the first is, again, it reduces that likelihood of trauma, the unwanted touch, you're communicating, you're letting them know what to expect from you, that's reason number one. Other reason is: after an exam, if somebody goes and alleges that you have sexually abused them during that exam, if you have verbally communicated everything you're doing, the likelihood of them being able to say, "Then they digitally penetrated me with a scope," okay, maybe, maybe there's evidence of that, but if you're saying to them, "Here's what I'm going to do today, Mr. Richards- I'm going to go ahead and feel your scalp, I'm going to press on your lymph nodes..." or whatever it is, again it just helps them to know what to expect from you, helps them to feel safer. 'Cause they might say, "No." Right? And they have that right. They can say "Don't touch me on my head. I don't want you to touch my feet. That hurts today." Right? So again... or you can just say flat out "Is there any place you don't feel safe with me touching today?" That's sort of your shortcut method, but i would again encourage verbally communicating and getting consent [for] any touch of your patients. It's just... takes two extra seconds... takes two extra seconds, two extra seconds and you're really going to help to minimize any potential re-traumatization. So that's a little trick for ya'll in your care and treatment.

Joe talked about this when he said, "If someone had just listened to me..." I know I love to talk so when I'm working with the survivor I have to deliberately bite my tongue sometimes and just do a lot of, "Uh huh. Uh huh, nope. Yep. Uh huh. Yep. Absolutely." And again I know if you're doing an assessment, the clock is ticking and you gotta get someone in and out, figuring out what's going on but even giving them twenty seconds, thirty seconds to give you a little bit of a narrative. If they're complaining about headaches, right, just giving a second to kind of talk through, "And then my cellmate said this, and the lights were going off and on, and then I had

to go to chow and I wasn't even hungry, my stomach was upset..." You might want to pause them when they say "I had head pain" because you're ready to treat it. "Come on, I got things to do, I'm busy." Allowing just a little bit more time, especially for a sexual assault survivor, leads them to believe that they are understood, which lead them to believe that they're cared about. So hearing, feeling believed, feeling cared about. If we leave off that listening, that hearing, you're not going to get to believe and cared about 'cause you don't have time, nobody gives a crap, in out, in out, right? Again, I know how busy you are, but just littlest bit can make a real difference. But don't worry I rush people off the phone all the time so I'm no saint, ok? I know how hard that is.

Okay, finally, and this is an obvious one but you're the only ones who can do this looking; always being on the lookout for signs of trauma during exams, right? Of course this seems obvious, but now what you know about some of those physiological responses and the symptoms they describe- difficulty sleeping, all of a sudden they've lost appetite, attitude changes, especially hyper arousal... looking for, if you will, the two ends of that nervous system activation so if you're looking for someone who's jumpy, irritable, angry, outbursts, right? That end as well as that more depressive repression side of kind of holding things in, digestive issues, depressed, they're sleeping a lot. They might come in about a headache but you might be able to assess there's something else going on.

I want to just invite... I don't know if we have time but I'll invite Mary, right?

If you all want a sec, Mary has some really great examples of where folks have come in reporting some issues in your interventions it's totally trauma-informed... I just want to applaud you for that, of really looking at what's underlying, the underlying cause, right? We never know if coercive sex or sexual abuse could be a part of what's going on for someone and you're probably the only one who's going to hear those kinds of symptoms. So if you're not watching it, who is, right? Ok, so keeping that in mind...

I think we essentially already talked about this, this is just kind of a wrap up everything we talked about, about the importance of best practices. From your sense, guys, how trauma-informed or not would you say your agencies are before we jump into this? Just honestly and I'm not putting this on you, but anyone feel like their agency is like totally on board with this? Others feel like, "woo, we've got a lot of work to do." *She shakes and nods her head.* I'm seeing heads like this.

*An audience member responds*

Work to do.

*Another audience member responds*

Work to do. Ok. And you all are going to take a leadership role in doing

that, right? Cool. Ok, awesome. Glad to hear it.

In the next, I don't know, couple days, week or so, if you've got, you know, twenty, thirty minutes, talk with your colleagues. Consider these following factors, if you want to sort of get a sense of how trauma-informed your agency is or your facility specifically. So anyone here from sort of above a facility level- administrator, sort of...

*An audience member raises their hand*

Okay woohoo. So for you, you're going to be thinking more agency-wide. For folks in your facility, again, certainly you can bump your recommendations up but I would just give some thought to... and I know I'm going to lose you because you're going to be reading this and that's fine... but essentially, what is your agency's overall approach to addressing inmates or residents who've been sexually abused? Right, sort of what's the guiding philosophy, even? And that's more of a cultural question- what is your sense of that? I'm not looking for necessarily a written policy but how do staff treat it, right, particularly medical mental health staff?

Number two what's the general level of staff training or experience on the issue? Have most of your colleagues gone through the PREA specialty training? Is PREA considered a four-letter word, right, in your agency? Sort of what's the level of comfort? Your practitioners have experience in sexual abuse prevention and response, right? Or is this really kind of new and emerging for your staff? Medical mental health involvement- so is it de facto that medical mental health are involved in responding? Are you already providing care, are you assessing and making recommendations? Or is your role seen as more marginal and secondary to custody concerns, right? So that's a question, trauma-informed... What's the process for providing emergency and ongoing care? I'm wondering especially about accountability, follow-up, is anyone monitoring that follow-up is being done for survivors? Does anybody know, especially if someone's transferred or moved around? And finally what is your level of involvement with community service providers, again particularly for medical mental health staff, do you know how to get in touch with the advocate? Do you have the numbers handy for mandatory reporters, right? Do you know who your law enforcement agencies are? Who would investigate a sexual assault? So those of the various components again, I know in all your infinite free time but I'd just encourage if this is something you want to follow up on... then, okay you've got your little assessment, you've done it. Gulp, it's not where you want it to be. What you do about it? So I would note sort of your feedback, your recommendations, again please don't minimize the expertise you have and the expertise of your colleagues who are here today. Please consider us resources.

Propose some trauma-informed ideas. The more practical, the better, right? I've given you, I hope, some today but if there are others you think of... and then a plan to share it, right? Even if it's in a staff meeting, guys, even if you fill this out and you

say to your boss, "Hey, could we take 15 minutes... JDI told me to do this and I'm afraid if I don't do it, it will make us look bad..." Just kidding, we won't, but you can tell them that. Just, right, say, "I really want to talk about this, really want to address that this is too important for us to ignore," right, it's just too important. It's too much good work we can be doing. And a lot of these changes... how painful would it be to add a few extra words to your, right, to your treatment process, for example? To say, "I'm going to touch your wrist now." That's a free, easy reform, so to speak, that you can make, right? But for some practitioners if you just don't know about it, how are you going to know to do it? So sharing this with your colleagues...

Okay, take care, safe travels, thank you.