



Partnering with Community Sexual Assault Response Teams

A Guide for Local Community Confinement and Juvenile Detention Facilities

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FROM THE DIRECTOR

Community-based sexual assault response teams, or SARTs, emerged in the late 1980s and are now considered a best practice for addressing the needs of victims and holding perpetrators accountable. This is because SARTs coordinate the actions of all initial responders—including law enforcement, prosecution, the forensic examiner, and victim support and advocacy services—with the goal of achieving timely streamlined interventions that deliberately and systematically focus on the needs of the victim.

Recognizing the value of this model, the National Prison Rape Elimination Commission recommended that correctional agencies use a coordinated response for incidents of sexual abuse. Subsequently, the federal standards for implementing the Prison Rape Elimination Act (PREA) mandate such a response to ensure that victims of sexual abuse in confinement settings—including jails, prisons, lockups, and community confinement and juvenile facilities—get the services and care they need. A coordinated response that clearly delineates responders' roles and responsibilities also enables staff to protect the safety and security of the facility and improves the ability to preserve evidence, identify perpetrators, and hold them accountable.

Vera has been involved in PREA-related work since 2006, when our staff assisted the National Prison Rape Elimination Commission in developing draft standards and a final report. We have continued this work, including the Sexual Assault Response Teams in Corrections Project, a three-year pilot program Vera implemented in Johnson County, Kansas. Through this project, Vera helped the Johnson County Department of Corrections form a partnership with the county's SART and develop a comprehensive sexual assault response policy for an adult community confinement facility and a local juvenile facility.

In recent years, two reports by the U.S. Department of Justice's Bureau of Justice Statistics remind us that this work remains critically important: Researchers found that approximately 9.5 percent of adjudicated youth in state juvenile facilities reported having suffered sexual abuse within 12 months of arriving at a facility, with rates as high as 36 percent in specific facilities. And 9.6 percent of former state inmates reported experiencing at least one incident of sexual victimization during their most recent incarceration. These statistics underscore the difficulty of addressing sexual abuse in confinement settings and the need to remain vigilant about the safety of incarcerated adults and youth.

This guide is intended to help other facilities and jurisdictions respond to this serious problem, with a straightforward approach that reflects the lessons we learned in Johnson County. Vera is committed to continuing our work with correctional systems to keep those who live and work within them safe. It is our hope that this guide will help do just that.



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Using the guide

This guide is designed to assist administrators of local community confinement and juvenile detention facilities in collaborating with a community sexual assault response team (SART). A SART is a multidisciplinary interagency team of individuals working together to provide specialized sexual assault services. Partnerships with SARTs can help facilities implement response policies and procedures that address elements of the DOJ's *National Standards to Prevent, Detect, and Respond to Prison Rape Under the Prison Rape Elimination Act* (the "PREA standards"), including the following:

- > developing a written facility plan to coordinate response to an incident of sexual abuse;¹
- > following uniform protocols for evidence and sexual assault medical forensic examinations for victims of sexual abuse, based on the DOJ's [A National Protocol for Sexual Assault Medical Forensic Examinations: Adults/Adolescents](#) (the *National Protocol*);² and
- > providing victims who report sexual abuse with access to outside victim advocates for emotional support.³



What the PREA standards define as sexual abuse is typically called sexual assault by community responders, with the exception of noncontact sexual abuse and harassment.⁴ **This guide mainly uses the term "sexual assault."** Note that legal definitions for sex offenses depend on statutes of the governing jurisdiction(s).

SARTs are widely considered a best practice for responding to sexual assault in the community, but correctional agencies—mainly prisons and jails—have only recently begun to make use of SARTs. Through a cooperative agreement, the Office of Victims of Crimes (OVC), the component of the DOJ within the Office of Justice Programs, funded a pilot Sexual Assault Response Teams in Corrections Project to gain insight into how local correctional facilities can benefit from partnerships with community SARTs. The Vera Institute of Justice worked in Kansas to help the Johnson County Department of Corrections' (DOC) Adult Residential Center and Juvenile Detention Center implement this pilot project. As part of the OVC grant program, a team of Kansas-based researchers conducted an external evaluation of the project. The external evaluator and her team helped guide the development of the project by surveying staff, interviewing residents and key stakeholders, and conducting training evaluations. The evaluation activities helped inform training curricula and material development for the facilities. This guide is based on experiences and lessons learned from that project.

The guide is organized into three sections. Section 1, Background: An over-

view of PREA and SARTs, provides background information on PREA and SARTs and discusses some of the benefits to correctional facilities of partnering with community SARTs. Section 2, A planning tool: How to partner with a community SART, designed to help administrators of local community confinement and juvenile detention facilities partner with a community SART to incorporate a SART approach into their sexual assault response policy and procedures (henceforth referred to as “policy”). It breaks down the collaborative process into four distinct phases:

- 1. gathering information and planning;**
- 2. working with the community SART;**
- 3. incorporating a SART approach in facility policies; and**
- 4. training facility staff**

Finally, Section 3, Partnership in action: The Sexual Assault Response Teams in Corrections Project—Johnson County, Kansas, provides an example of how these principles and phases worked in practice, by describing the experience of the Sexual Assault Teams in Corrections Project in Johnson County, Kansas. This section includes a discussion of the project’s external evaluation and key accomplishments.

Please note that this guide is not intended to highlight all of the issues and potential challenges involved in implementing a coordinated, victim-centered response to sexual assault in correctional facilities. Instead, it offers a practical, streamlined plan to respond to sexual assault in a coordinated and victim-centered way while maintaining facility safety and security. For more background on related issues and challenges, see the following resources:

- > [*Building Partnerships Between Rape Crisis Centers and Correctional Facilities to Implement the PREA Victim Services Standards*](#), Office for Victims of Crime (2013).
- > [*Recommendations for Administrators of Prisons, Jails, and Community Confinement Facilities for Adapting the U.S. Department of Justice’s A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents*](#), Office on Violence Against Women (2013), also known as the Corrections SAFE Guide.
- > [*A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents*](#) (Second Edition), Office on Violence Against Women (2013).

Background: An overview of PREA and SARTs

PREA

In 2003, Congress passed the landmark Prison Rape Elimination Act (PREA), recognizing that sexual abuse is a serious and persistent problem in correctional environments. The National Prison Rape Elimination Commission was formed to study the problem (see its 2009 [final report](#)), and draft standards to address sexual abuse in correctional settings. In 2012, DOJ issued its final ruling on PREA, which built on the work of the commission. DOJ's PREA standards include regulations for [adult prisons and jails](#), [community confinement facilities](#), [juvenile facilities](#), and [lockups](#). Their aim is to facilitate comprehensive facility-based efforts to prevent, detect, and respond to sexual abuse. For more information on sexual assault in corrections, see Appendix 1.

 In this guide and in the PREA standards, “community confinement facilities” refers to community-based, court-mandated residential programs where residents stay overnight. “Juvenile detention facilities” refers to facilities used to confine persons under the age of 18 in accordance with a jurisdiction’s criminal justice or juvenile justice system.

SARTs

SARTs first emerged in the late 1980s and are now widely considered a best practice for responding to disclosures of sexual assault in the community.⁵ The *National Protocol* promotes SARTs as groups that can facilitate an immediate response that is coordinated and victim-centered. “Coordinated response” in this context refers to all initial responders working together with the goal of timely streamlined interventions. “Victim-centered response” refers to an intervention that systematically and deliberately focuses on the needs of the victim. All elements of the immediate response—victim protection, medical care, evidence collection, emotional support, and case investigation—can be coordinated and victim-centered.

Core community SART agencies include the following:

- > local rape crisis centers, for victim support and advocacy services;
- > sexual assault forensic examiner (SAFE) programs/hospitals, which have specially trained staff, often nurses, who conduct medical forensic examinations; and
- > the law enforcement agency that has criminal jurisdiction, for immediate protection, crime-scene evidence collection and documentation, and investigation.⁶

Although SARTs vary in form, membership, and operation, all SARTs should have a protocol that triggers a coordinated victim-centered response across core agencies when a sexual assault is disclosed or discovered. In addition to activating a standardized response in individual cases, SARTs typically hold periodic meetings of their members to conduct case reviews and maintain communication among agencies, address potential or emerging issues, promote training, share resources, and continue to improve team effectiveness.

The SART is activated whenever someone discloses sexual assault victimization to a SART agency, regardless of when the incident occurred. In addition to carrying out its policy on how to respond, the agency follows a protocol for coordinating the response among SART agencies. All SART agencies are prepared to intervene, but the victim's needs guide and determine the services provided in each case. (There are exceptions: For instance, under mandatory reporting laws, responders must report sexual assaults to law enforcement when victims are children or dependent adults.)

PARTNERING WITH COMMUNITY SEXUAL ASSAULT RESPONSE TEAMS (SARTs)

A community SART can be extremely useful to staff at correctional facilities and the people in their care. Effectiveness in responding to sexual victimization depends not only on coordination within the correctional facility, but also between the facility and community agencies. By working with the community SART, correctional facility staff can coordinate their actions with responders from the victim advocacy, medical forensic, and law enforcement fields to help their residents receive the best care available and help build a case for prosecuting the perpetrators. A partnership with the community SART also helps corrections administrators systematically incorporate a victim-centered approach into their facility's response while maintaining safety and security.⁷

Correctional facilities such as community confinement or juvenile detention facilities often have long histories of partnering with local agencies so that residents can draw on their resources. Partnering with a community SART allows facilities to tap local expertise and resources in their response to sexual assault rather than starting from scratch to develop these assets in-house.

If there is a SART that serves the region and a facility wishes to link to its services, the facility leaders and staff will want to do the following:

- > Request that the SART extend its scope to facility residents.
- > Request that the SART review facility policy to ensure that the facility's internal response is appropriately coordinated and victim-centered.
- > Ask the SART to incorporate into its protocol any variations in procedures needed to respond to facility residents.
- > Become an active SART member.
- > Instruct facility staff and SART agencies on the specifics of the facility response policy.

This guide walks administrators of correctional facilities through the steps to achieve these five objectives. Carrying out these objectives can be challenging for administrators. Adopting this approach means that corrections staff must change their attitudes about responding to residents who are sexually victimized, reach out to community professionals for assistance, and include community response in facility policies. This approach also requires that SARTs expand to include a victim population—people in the custody of correctional agencies—that has often been excluded from their response.

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- ✦ Given that every community does not have a SART, references to SART in this guide ultimately mean “a **coordinated victim-centered response**” among facility staff and relevant community agencies. Even without a formal SART, a correctional facility can implement a SART approach in conjunction with local responders.
 - ✦ An essential resource for implementing a SART approach in correctional settings is *Recommendations for Administrators of Prisons, Jails, and Community Confinement Facilities for Adapting the U.S. Department of Justice’s A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents* (the Corrections SAFE Guide).⁸
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A Planning tool: How to partner with a community SART

INTRODUCTION

This planning tool will help facility administrators of community confinement and juvenile detention facilities create partnerships with their community sexual assault response team (SART) and incorporate a SART approach in a facility's sexual assault response policy. This guide is based on the lessons learned from OVC's Sexual Assault Response Teams in Corrections Project (SARTCP), a three-year pilot program implemented by the Vera Institute of Justice in Johnson County, Kansas. Through the SARTCP, Vera helped the Johnson County Department of Corrections (DOC) form a partnership with the county's sexual assault response team and develop a comprehensive sexual assault response policy.⁹ The tool was written to empower facilities and their personnel to accomplish similar goals without the help of a technical assistance provider.

Although the Johnson County DOC's two facilities—the Adult Residential Center and Juvenile Detention Center—serve different populations and operate at different security levels, the process for creating the partnership with the SART was largely the same. Developing a sexual assault response policy required customization to each setting, as it would for any facility crafting policies to comply with the PREA standards. The phases and tasks outlined in the tool are designed to be applicable to community confinement facilities and juvenile detention facilities. The principles and approach in the tool can also be adapted for use in other confinement settings. A few notes about the tool:

- > **Organization:** This guide divides implementation activities into four distinct phases, which are subdivided into objectives and tasks.
- > **Coordination responsibilities:** For the SARTCP pilot, Vera was the coordinator. For correctional facilities undertaking this effort on their own, the staff responsible for PREA implementation should function in the coordinator role—either as an individual or coordinating committee. The planning tool is written with this coordinator/coordinating committee in mind and uses “coordinator” to denote this responsibility.
- > **Time frame:** For purposes of planning and allocating resources, it is helpful to have a target time frame for achieving the phases of this work. Consider issues such as available resources, completion dates for facility PREA audits, the facility's calendar and the SART's calendar, timing issues (if grant funding is supporting the work), and the process for policy change at the facility. The SARTCP was a three-year process; this guide should help correctional administrators significantly reduce implementation time to approximately 12-18 months.
- > **Resources:** Many diverse resources are needed to accomplish the tasks in this guide. Some may be easily accessible; others will require more effort to

figure out how to leverage them. In addition to resources within the facility and from community agencies, facility staff may wish to access state and national resources.

- > **Customization:** Administrators are urged to tailor the steps in this tool to meet their facility-specific needs.

PHASE 1: GATHERING INFORMATION AND PLANNING

The coordinator should spearhead Phase 1 activities but may find it most helpful and efficient to assemble a committee or team to carry out the tasks. Buy-in and participation of facility leaders is crucial during Phase 1. Before the project launches, leaders should spend time educating themselves about sexual assault and becoming familiar with the issues and local service providers. A leader's buy-in and participation should be visible to other staff, as it signals that this effort is a facility priority and sets up the coordinator for success.

POSSIBLE RESPONSIBILITIES FOR COORDINATOR

- > Assist facility leaders in gathering and assessing information to inform project planning and devise a plan to partner with the SART and incorporate a SART approach into the facility's sexual assault response policy.
- > Seek to formalize the collaboration between the facility and the SART.
- > Build partnerships with individual SART agencies to enable the facility to coordinate interventions with them in case the sexual assault of a resident is reported. Address any related coordination issues with relevant advisory or oversight entities or agencies.
- > Oversee the work of incorporating a SART approach into the facility's sexual assault response policy.
- > Coordinate training for facility staff about the new policy. Make sure a plan is in place for training on topics related to sexual assault response.
- > Attend SART meetings and otherwise communicate with the team members about the needs of victims in the correctional facility; seek clarification on how to coordinate with them in the case of a sexual assault of a resident; share the new facility policy; and encourage facility response to be incorporated into the SART protocol.

POTENTIAL SOURCES OF INFORMATION

LOCAL COMMUNITY

- > SART (find out who coordinates it)
- > Victim advocacy
 - Rape crisis center
 - Other agencies that provide related services (for example, for abused youth, domestic violence victims, victims who are lesbian, gay, bisexual, transgender, questioning/queer, or intersex (LGBTQI), victims with disabilities, and victims who are Deaf or need an interpreter or translation services)
 - Hospitals

Try to identify a hospital with a sexual assault nurse examiner or sexual assault forensic examiner (SANE/SAFE) program. If no such programs are near you, identify hospital emergency rooms that can conduct the sexual assault medical forensic exam with your facility's residents.
- > Law enforcement agencies with criminal jurisdiction over the area where the facility is located
- > Prosecutor's office with criminal jurisdiction for the area where the facility is located

STATE/OTHER

- > Victim advocacy
 - State coalition against sexual assault
- > Agencies specific to corrections or protection of children/vulnerable persons
 - Local or state level advisory or coordinating entities (for example, a criminal justice advisory council)
 - Correctional agencies that send their inmates to the facility
 - Agencies that require mandatory reporting of abuse or otherwise have oversight of the facility and investigative responsibilities

Objectives

- > Review the PREA requirements related to facility response regarding disclosure, reports, and discovery of sexual assault.
- > Assess how the facility's current sexual assault response policy will need to change to comply with PREA requirements. See Appendix 2 for the chart "Elements of a Sexual Assault Response Policy."
- > Reach out to the leaders of key community agencies that are potential partners in this effort and hold introductory discussions about functions, services, and how a partnership might work in practice.
- > Explore what additional information you may need after having the discussions described above. In particular, consider surveying facility staff to assess their beliefs and attitudes about sexual assault. (Note that in this tool, "facility staff" refers to employees, contractors, and volunteers.) Consider engaging an outside researcher to conduct interviews with facility residents.
- > Assess the data collected—and based on findings, devise a plan for how to proceed in linking with the SART and developing or revising the facility's sexual assault response policy.

Tasks

GATHER INFORMATION

- Identify people and organizations** outside the facility that can be sources of useful information. (See "Potential Sources of Information," page 11.) When you approach community agencies, understand that they are experts in sexual assault intervention and respect that they have their own language, priorities, and challenges. Be prepared to help those agencies understand the language, priorities, and challenges of your facility with regard to this effort.
- Identify questions** to ask community agencies to gather the information you need. (See "Interview Questions for SART Agencies" in Appendix 3.) Although you may want to interview some people individually, you can also invite them to a group discussion as a way to jump-start cross-agency collaboration.
- Consider surveying facility staff** to gather baseline data on awareness, beliefs, and attitudes about sexual assault. (See "SARTCP Questionnaires" in Appendix 4.) Such data can help identify strengths and gaps in staff knowledge and help shape future training. An anonymous survey may yield the most useful and candid information. A similar follow-up survey could be used to help measure the effectiveness of this effort, exploring whether working with the SART, the policy changes, staff training, and resident education have strengthened facility response, changed beliefs, and/or affected attitudes.

- **Consider engaging an outside researcher** to conduct interviews with facility residents. If feasible, engaging an outside researcher to conduct interviews with facility residents could yield extremely useful information about how prevalent sexual assault and harassment is in the facility, how safe residents feel, and how willing they are to report sexual assault or harassment if it occurs. As part of the interview process, outside researchers must seek informed consent of residents and assure them that the interview and their answers are confidential.
- **Gather additional information online** about state laws, mandatory reporting requirements or other regulations for minors and vulnerable adults, state sexual assault medical forensic examination protocols, and other responsibilities.

★ **See the [Corrections SAFE Guide](#)** for more information about core SART responders and their potential roles in response to victims in correctional settings.

★ **Find your local or regional rape crisis center.** If you're not sure what's near you, go to the National Sexual Assault Resource Center's listing of [state and territory sexual assault coalitions](#). Your state coalition can help identify which centers are close to a particular correctional facility, as well as brainstorm with you about ways to find victim advocates if there is no local or regional center. To identify hospitals that have SANE/SAFE programs, ask the staff at the local rape crisis center.

ASSESS INFORMATION GATHERED AND DEVISE A PLAN

- **Compile the information gathered** through discussions, surveys, and online searches. The following types of information may be particularly helpful:
 - > SART functions and services of SART agencies;
 - > facility staff and SART agencies' awareness of and attitudes toward sexual assault in corrections;
 - > current policies of the SART and each SART agency's role in responding to sexual assault;
 - > current training that SART agency staff receives to prepare them to respond to sexual assault;
 - > additional training that SART agencies might need before working with victims in correctional settings;
 - > training and education that SART agencies might be able to offer to facility staff;
 - > SART agencies' level of interest in collaborating with the facility;
 - > SART agencies' history of and capacity for responding to sexual assault of

correctional facility residents;

- > existing relationships between SART agencies and the facility;
- > a list of any agencies beyond those involved in the SART that could be helpful in a facility's response (for example, community agencies that work with people who are Deaf or LGBTQI); and
- > relevant state laws and requirements: sex offense laws, mandatory reporting requirements, other related regulations for minors and vulnerable adults, and sexual assault forensic-evidence-collection-kit requirements and examination protocols.

Assess data for the main issues and needs related to the facility's collaboration with the SART and incorporating a SART approach into facility policy, including the following:

- > correctional facility's strengths and needs related to its current response to sexual assault;
- > SART agencies' readiness to be involved in response to sexual assault of facility residents;
- > SART agencies' willingness to help incorporate a SART approach in correctional facility policy;
- > existing partnerships with community agencies that will support this effort;
- > new relationships that need to be built;
- > resources for the facility personnel to leverage; and
- > other issues and challenges.

Devise a plan for working with the SART, developing or revising the facility sexual assault response policy to incorporate a SART approach, training facility staff about the policy, and sharing policy information with the SART. (Phases 2-4 of this tool cover those tasks.)

Convene facility leaders to discuss the information gathered and work through the plan for moving forward.

Organize a meeting of facility directors, program directors, training directors, and other key staff to introduce the initiative and plan the next steps for coordinating with the community SART.

PHASE 2: WORKING WITH THE COMMUNITY SART

During Phase 2, the coordinator should complete these two steps:

1. Work with facility leaders and the community SART to establish a formal partnership.
2. Establish working relationships with the SART agencies.

Objectives

- > Organize an interagency meeting of key corrections staff and SART agencies.
- > Provide an opportunity for SART agency representatives to learn about the correctional facility, general operations, and current practices and gaps in sexual assault response. Also ask SART agencies to teach facility leaders about their work and their roles.
- > Seek a formal commitment of the SART, in partnership with facility staff, to respond to sexual assault of facility residents.
- > Become an active member of the SART.
- > Develop memorandums of understanding (MOUs), when needed, to explain or clarify roles and responsibilities.
- > Begin discussions on incorporating a SART approach into facility sexual assault response policy.

Tasks

STATE FORMALLY THE FACILITY'S INTEREST IN PARTNERING WITH THE SART

- Invite community SART members to come together with facility leaders to discuss a partnership**, so that facility residents who experience sexual assault will benefit from a coordinated victim-centered response. Include a SART coordinator, if there is one, and representatives from the rape crisis center, the hospital SANE/SAFE program, law enforcement, and prosecution. Try to schedule this discussion during a regular SART meeting. The SART might be willing to feature the correctional facility-SART partnership at one of its meetings. The facility could also host a SART meeting to discuss this issue.
- Plan the agenda.** Possible topics: a brief overview of PREA and interest in a partnership with the SART (perhaps sharing key findings from Phase 1, the correctional agency's information-gathering and planning phase); introduction to the correctional facility; introduction of SART members and functions; and incorporating a SART approach into the facility's sexual assault response policy. If the meeting takes place at the facility, administrators could offer tours.
- Offer SART agencies background materials** before meeting, to build their knowledge about the topic of sexual assault in corrections and help them think about potential issues and challenges. Encourage them to bring any written information to the meeting they think would be useful for corrections agency representatives.

ESTABLISH WORKING RELATIONSHIPS WITH SART AGENCIES

- **Be active in the SART and strive to attend its regularly scheduled meetings.** Select facility representatives who can share upcoming plans to incorporate a SART approach into the facility's sexual assault response policy, provide progress reports on current activities, and discuss cases that arise.
- **Facilitate cross-agency and multiagency training opportunities** so that staff from the facility and community agencies develop a shared understanding of the issue of sexual assault in correctional settings, the needs of victims, security demands in correctional facilities, and how to work together to respond to such cases.
- **Offer correctional facility tours to staff from community agencies.** Many staff from community agencies are not familiar with how a correctional facility is structured and operates, its resident populations, and how facility operations might affect the response to sexual assault.
- **Request that community agencies provide tours, when relevant, for correctional facility staff** to familiarize themselves with services and procedures. For example, it would be helpful for responding staff to know specifically what occurs when a resident goes to a hospital for a sexual assault medical forensic exam. During a tour of the exam site, it would be useful for facility staff to meet a forensic nurse, a victim advocate, and a detective who can explain their roles in this process. These tours may help staff understand the logistics of the process, visualize coordination with community agencies, and identify any security concerns and possible solutions.

SEEK MOUs WITH SART AGENCIES AS NEEDED

- **Understand the potential utility of written memorandums of understanding (MOUs).** MOUs can supplement the facility's sexual assault response policy. The policy provides response guidelines for the facility, while an MOU can outline the roles of an outside agency in the response to sexual assaults and how the agency will coordinate with facility staff. MOUs should be developed jointly and agreed upon by all of the parties involved and signed by facility leaders and/or policymakers. Ideally, MOUs are crafted at or near the end of the policy development/revision process and then revisited and re-signed on a periodic basis, if needs or services change.
- **Seek an MOU with the rape crisis center.** *PREA Standard 115.253/353(c)* says that in regard to resident access to outside confidential support services, the agency shall maintain or attempt to enter into an agreement with community service providers able to provide residents with confidential emotional support services related to sexual assault. Although it could be equally useful to develop MOUs with other SART agencies, the PREA standards do not require facilities to do so.

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- ★ The PREA Resource Center Library provides examples of MOUs with rape crisis centers (search for “memorandum of understanding”). Note that examples from jails and prisons will need to be adapted for community confinement or juvenile detention settings.
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PHASE 3: INCORPORATING A SART APPROACH IN FACILITY POLICY

After doing the work in Phase 2 to partner with the community SART, it is time to review the facility’s sexual assault response policy and develop or revise it to comply with PREA standards and incorporate a SART approach.

Objectives

- > **Adjust facility policy so that it complies with PREA standards about response to sexual assault.** The PREA standards require three things: a written plan to coordinate responses of the facility and other involved agencies; a uniform evidence and sexual-assault medical forensic examination protocol (based on the [National Protocol](#) and the [Corrections SAFE Guide](#)); and resident access to community victim advocates for emotional-support services related to sexual assault. Also, make sure to **incorporate a SART approach in the facility policy**, consistent with the [Corrections SAFE Guide](#) and the community SART protocol. (See Appendix 2 for the chart “Elements of a Sexual Assault Response Policy.”)
- > **Develop tools** to assist responders at the facility in carrying out the response according to the facility policy. These tools, such as the flowcharts discussed below, can be used in response situations and for training purposes.

Tasks

PREPARE FOR THE WORK AHEAD

- Form a policy committee.** Include at least a facility leader, a policy writer, and front-line staff (such as a case manager, treatment manager, or staff supervisor). Rather than randomly assigning committee work, first seek volunteers from staff who have expressed an interest in this issue, have experience or training in this area, and/or have been effective in aiding residents who have been sexually victimized. Consult with the facility training coordinator as needed to ensure that the policy addresses related training needs of facility staff. Plan for the committee to fulfill the following functions: identify issues; schedule meetings to discuss issues; seek input from SART agencies and facility staff and contractors; build consensus on policy decisions; and draft or revise policies.

- **Request that an advocate from the rape crisis center act in a consulting role to the committee,** to make sure the policy reflects an accurate understanding of sexual assault and appropriate responses to victims. Also consider reaching out to a representative from an organization that provides services to LGBTQI individuals, to ensure that the facility is competent to meet the needs of LGBTQI victims.
- **Assemble the committee for an initial planning session.** The goal is to establish a committee plan that will facilitate drafting the new or revised sexual assault response policy. In addition to identifying key response issues (see chart, page 20), the committee should review existing policies to see how and where simple changes can be made to comply with PREA requirements. The committee should consider creating some planning aids to advance the work and track the group’s progress. For example, the committee may find it helpful to discuss sexual assault response issues by reviewing a list of questions about reporting, first response, and investigation (see Appendix 5, “Questions for Developing Sexual Assault Response Policies”). A planning chart to keep track of committee discussions and progress on needed actions may also be useful.
- **Consider creating a flowchart to map out the facility’s first responses to some identified assault scenarios.** Creating a flowchart or series of flowcharts can be a productive exercise to understand how a facility would respond to sexual assault, help identify gaps in policy or procedure, and acknowledge important variations in potential sexual assault scenarios and their impact on appropriate response protocols. (See Appendix 6, “SARTCP Response Flowcharts.”) The first drafts of flowcharts will likely have many gaps and raise many questions, and will thus require multiple revisions. Because the flowcharts are intended to help the committee through the policy-development process, people should not get stuck on design challenges. You can create flowcharts using simple word-processing software or more elaborate programs, if available. You can also draw them by hand.
- **Discuss confidentiality and informed consent early in the process.** Determining the scope of confidentiality afforded to victims in the aftermath of an assault is challenging for facility staff but essential when developing victim-centered sexual assault response policy. Residents who experience sexual assault may choose not to seek help if they fear that others in the facility will find out about their victimization. Although rape crisis centers can typically protect people’s confidentiality more than corrections staff can, administrators may be concerned that any level of confidentiality afforded to residents that is related to a crime committed in their facility could be detrimental to institutional safety and security. It is critical that residents understand facility policy on confidentiality if they disclose sexual assault, so that they can make well-informed decisions about getting help. An advocate from the local rape crisis center can consult with the policy committee to help its members think through these issues and figure out how to

protect a person's confidentiality while maintaining the facility's safety and security.

- Hold routine meetings, conference calls, or both, to discuss issues.** Each issue should be examined not only from the perspective of the resident and his or her needs after an assault, but also from the perspective of SART agencies and what they need. Identify actions the committee should take to address each policy issue in a victim-centered way, decide who will take the actions, and create a time line for completing the actions.
- Consider whether it is feasible to create a position of victim resource specialist,** a dedicated staff person who will work with victims in the event of a sexual assault, as recommended by the Corrections SAFE Guide. Designating a single individual to do this work helps ensure that victims receive consistent information and guidance during the immediate in-house response and helps them make decisions about getting assistance. This position is meant to complement the role of a victim advocate from the local rape crisis center.
- Complete actions and update the response flowchart.** Identify if and where the policy still has gaps. Ask the victim advocate to participate in this dialogue to assess whether the response is victim-centered and coordinated. Schedule additional meetings and calls as needed to discuss how to address identified gaps.

 Design the facility's sexual assault response policy in a way that addresses victims' needs and concerns, no matter how delayed their reports or disclosures. A sexual assault medical forensic exam can be conducted many days after an incident; it does not have to be immediate, though some evidence may be lost. Even after a delay, medication can be prescribed to prevent sexually transmitted infections, and support and counseling provided to deal with trauma. Facilities should check with local SAFE/SANE programs for the exam cut-off times used in the jurisdiction. Also, if a facility resident discloses that he is having trouble functioning due to memories of a sexual assault that occurred before his detention at the facility, a SART approach can help facility staff quickly provide a referral to appropriate services. Although a victim may not want to report the incident to law enforcement and may not require medical forensic care, the resident may benefit from victim advocate support, mental health counseling, or both.

DRAFT OR REVISE THE RESPONSE POLICY

- Identify who will be responsible and a time frame for drafting or revising the components of the policy.** Once all issues have been brought to the table—even if they are not fully resolved—it is time to shift to drafting or revising the policy.

KEY RESPONSE ISSUES

The exercise below may be helpful to policy committees as they prepare to review their sexual assault response policy and plan to make revisions.

- > Let's say a resident reports to a staff member that he was sexually assaulted by another resident two hours ago. What would happen?
 - First response?
 - Immediate medical/mental health care on-site?
 - Who is notified of reports within the facility? How and when? Outside the facility?
 - Crime-scene evidence collection and investigation?
 - Is a sexual assault medical forensic exam warranted?
 - Transport to and from the exam site?
 - Advocacy services available?
 - Follow-up medical/mental health care?
 - Follow-up victim support services?
 - Placement of victim upon returning to the facility?
- > How would the response be different if a resident reported being sexually assaulted a week ago?
- > How would the response be different if a resident accused a staff member of sexual assault?
- > How would the response be different if the assault was perpetrated at another facility?
- > What are the anticipated challenges in responding to a sexual assault at the facility? How will facility staff overcome the challenges?

- Draft or revise the response policy.** Those responsible for this work can use the chart “Elements of a Sexual Assault Response Policy” (Appendix 2) as a point of reference for merging the best practices of the Corrections SAFE Guide with the PREA standards. (Note that the Corrections SAFE Guide reflects the *National Protocol's* recommendations for coordination and victim-centered care.) People writing or revising must be familiar with the facility's current policy, the committee's decisions on specific issues, and the updated flowchart, to decide how and where to incorporate each standard and best practice into policy.
- Keep language simple and clear.** The language of PREA is legalistic and complex. Avoid cutting and pasting PREA standards or recommendations verbatim from the Corrections SAFE Guide into policy. Tailor policy and

first-responder procedures to the facility's operations, and write them in simple, straightforward language staff can easily understand and apply.

- Ensure that the facility policy incorporates directives to conduct periodic review and revision of the response policy.** One approach is to conduct sexual abuse incident reviews at the conclusion of each investigation and then collectively analyze summary reports on a periodic basis. (See “Update Response Policy Based on Analysis of Sexual Abuse Incident Reviews” on page 22 for more details.) The plan for policy review and revision should include regularly soliciting input from facility staff and SART agencies to identify gaps, weaknesses, or flaws in the policy.

SOLICIT AND INCORPORATE COMMENTS TO FINALIZE POLICY

- Seek input on the draft policy** from relevant facility staff and SART agencies.
- Incorporate comments and suggestions** and then provide the final policy to facility leaders for approval.

CREATE TOOLS TO ASSIST RESPONDERS

- Update response flowcharts to match the steps of the policy.** If starting flowcharts from scratch at this point, see Appendix 6, “SARTCP Response Flowcharts.” Make charts as concise and user-friendly as possible.
- Create checklists for immediate responders,** based on the policy, that explain their specific roles and tasks and note how the response may change in different assault situations and with different populations of victims (for example, adults versus juveniles). Consider developing laminated pocket cards for easy use and reference.
- Create tools for residents.** Develop educational materials for residents that explain facility policy and response protocols, including the services that are available to them from the local rape crisis center, in easy to understand language (ensure that language is age-appropriate for juvenile facilities). Consider developing flowcharts for residents that explain what will happen if a resident is sexually assaulted. (See Appendix 7 for examples from the SARTCP.) Ask an advocate from the rape crisis center and/or the SART to review materials to ensure that they are victim-centered. Also consider developing a post-incident feedback form for residents to complete after an assault. This form could be short and simple and include a few questions about whether the resident felt safe, supported, and informed following an incident and was able to access the services he or she wanted. The purpose is simply to give residents an opportunity after an incident to say what worked well and what didn't. Such feedback could be helpful during post-incident case reviews.
- Provide front-line facility staff easy access** to these tools—online, in a cen-

tral location at the facility, in the form of pocket cards to carry while on the job, or some combination.

UPDATE RESPONSE POLICY BASED ON ANALYSIS OF SEXUAL ABUSE INCIDENT REVIEWS

- **Incorporate sexual abuse incident reviews into the facility's process for reviewing critical incidents.** PREA Standard 115.286/386 requires that facilities conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation and prepare a report of findings and recommendations for improvement. Sexual abuse incident reviews can be useful for a number of reasons, including helping facility administrators and staff identify strengths and weaknesses in the response, areas of policy or training that may need to be supplemented, and blind spots. See Appendix 8 for a sample sexual abuse incident review form.
- **Use information gleaned from sexual abuse incident reviews to improve response policy and protocols.** Convene a committee periodically to analyze summary reports from incident reviews to gain insight regarding trends or ongoing problems. Consider requesting that an advocate from the rape crisis center act in a consulting role to the committee, to ensure that the analysis reflects responses that are appropriate to victims' needs. Ensure that the facility's process for reviewing these incidents includes mechanisms for implementing any necessary changes to policy and training. The process should be flexible enough to allow for immediate revisions and actions when a serious problem is identified, and structured enough to allow for periodic systemic adjustments based on any identified trends or ongoing problems. Also share with the SART any findings that involve or affect the collaboration between the SART and the correctional facility. If changes in facility policy or the SART response occur, make sure they are reflected in applicable flowcharts. See Appendix 8 for a sample sexual abuse incident review form.

PHASE 4: TRAINING FACILITY STAFF

The last phase of the process involves the following:

- > training facility staff to implement the new or revised response policy; and
- > conducting an ongoing dialogue with the SART to ensure readiness to respond to any sexual assault of residents.

Objectives

- > Build staff knowledge about the issue of sexual assault in correctional settings.
- > Increase staff understanding about using a SART approach to respond to a sexual assault.
- > Prepare staff to respond per the policy to reports, disclosures, or discovery of

sexual assault of residents.

- > Prepare SART members to coordinate with facility staff to respond to disclosures of sexual assault of residents, per facility policy.
- > Provide ongoing forums for facility leaders and staff to talk with SART members so that they can overcome any obstacles in responding to sexual assault of residents.

Tasks

DELIVER TRAINING RELATED TO THE RESPONSE POLICY

- Identify a small committee of facility staff** who can assist with planning the training. Ask a victim advocate from the rape crisis center to act in a consulting role to help ensure that the training approach is victim-centered. Advocates can also help describe the services they offer and may be more comfortable speaking about the content than is true of most corrections staff, who are probably less familiar with the issues and dynamics related to sexual assault.
- Identify the training topics** to cover related to a response to sexual assault. Some possible topics regarding general response include the following:
 - > dynamics of sexual assault victimization;
 - > unique needs of victims in community confinement or juvenile detention;
 - > issues facing specific populations (such as youth, females, LGBTQI, Deaf people, or people with disabilities);
 - > applicable laws and regulations related to sexual assault, sexual assault in corrections, mandatory reporting, and requirements for reporting to oversight agencies; and
 - > basic elements of response: addressing victims' needs, providing victims information on the facility's response, maintaining victim safety, reducing trauma, and supporting victims' participation in the investigative process.
- Some training topics regarding the facility-specific response include the following:**
 - > elements of the facility's sexual assault response policy;
 - > roles and functions of various facility staff members when there is a report, disclosure, or discovery of sexual assault; and¹⁰
 - > specific steps and procedures related to coordination between facility staff and community responders, such as the following:
 - roles and services of the rape crisis center;
 - confidentiality issues;
 - roles and services of the forensic examiner and/or hospital, including an

explanation of the sexual assault medical forensic examination; and

- procedures for investigation.

- Identify which staff, contractors, and volunteers to train.**
- Decide on the format of the training program.**
- Identify presenters.** Consider using a mix of on-site trainers, which could include advocates from the rape crisis center, facility managers, and upper-level staff; training webinars; and other distance-learning avenues.¹¹ Using managers and upper-level staff to conduct at least some of the initial training may help to encourage staff buy-in. They can signal to other staff that the facility takes the issue seriously by acting as presenters; they also have the credibility and knowledge to connect the material to the daily lives of their staff.
- Develop training agendas and handouts.** (See the “Excerpted SARTCP Training Agenda” in Appendix 9 and flowcharts in Appendices 6 and 7.)
- Consider teaching methods.** Be sure to incorporate a sufficient number of activities that allow staff to ask questions and apply what they have learned during the training. Role plays are particularly helpful because they give participants a chance to rehearse their response to different scenarios. Provide participants with visual aids and handouts (such as response flowcharts and checklists) to help them implement the response policy properly.
- Be aware that training might be difficult for some staff.** If staff tell their supervisors in advance that this training might be difficult for them due to their own victimization or some other personal reason, it is appropriate for trainers to offer them alternative methods for participating in parts of the training (for example, completing exercises on paper instead of participating in role-plays). Facility leaders should also make victim advocates or other support services available to staff following the training, in case the need arises.
- Decide how to evaluate training sessions.** See the example “Training Feedback Form” in Appendix 4 as well as OVC’s *Guide to Performance Measurement and Program Evaluation*.

FACILITATE ONGOING DIALOGUE WITH THE SART

- Inform SART members of the facility’s policy and engage in ongoing dialogue** to ensure a coordinated response to any incident of sexual assault at a facility. If the SART has a regular meeting schedule, the facility’s SART representatives could simply present policy details to SART members then and take their questions and comments. It might be useful to review a case study to illustrate the coordination procedures with the SART.
- Encourage the SART to incorporate into its protocol any specific parts of the facility policy that deviate from standard community response.**

□ **Devise a plan to facilitate ongoing multiagency dialogue.** The goals are maintaining partnerships, continuing to communicate about individual cases, and building more knowledge and skills for responding to sexual assault of facility residents. Some suggestions for ongoing discussion topics with SART agencies include the following:

- > issues facing specific facility populations (such as LGBTQI residents, youth, Deaf residents, and residents with disabilities);
- > clarification of criminal investigations versus internal investigations;
- > facility security clearance for service providers;
- > *For community confinement facilities:* Discuss how policies can affect residents' interaction with SART agencies (for example, if residents' conditions of release require them to inform the facility of their whereabouts and secure permission from the facility before meeting a provider off-site); and financial responsibilities of the facility, jurisdiction, and residents for medical care associated with the sexual assault and the sexual-assault medical forensic examination; and
- > *For juvenile detention facilities:* Cover the procedures to maintain safety and victim comfort at the exam site (for example, why and when a security presence is necessary; where security officers should stand to minimize intrusiveness; safeguarding medical instruments; and arranging the exam room and waiting area—issues if victims are restrained) and for communicating with parents and guardians.

□ **If the SART has a regular meeting schedule, see if the meeting time can be used periodically to focus on corrections-related topics.** There may be successes or problems in individual cases that naturally spark SART discussion. If the SART does case reviews, its members could examine the response in cases from the facility. Representatives from the facility could also discuss and seek feedback about any trends and issues identified during sexual abuse incident reviews that have implications for the SART. SART members could also role-play how they would respond in hypothetical cases involving residents of the facility and troubleshoot issues, challenges, and potential solutions.

Partnership in action: The Sexual Assault Response Teams in Corrections Project—Johnson County, Kansas

The experience of Johnson County, Kansas, provides a useful example of the principles and steps outlined in this guide. SARTCP was a pilot program funded by OVC from 2011-2014. The SARTCP supported the Johnson County Department of Corrections (DOC) in working with a technical-assistance provider, the Vera Institute of Justice, to form a partnership with the county's sexual assault response team. Johnson County is in northeast Kansas, just south of Kansas City in Wyandotte County.

As discussed earlier, the OVC grant required an external evaluation of the project. The evaluation goals were threefold: 1) to evaluate the process, with special attention to Vera's technical assistance and the development of partnerships; 2) to provide ongoing feedback to Vera and the facilities by identifying what was working and what further efforts or remediation were needed; and 3) to evaluate the effectiveness of the trainings. The focus of evaluation efforts was *not* to assess the DOC's overall effectiveness in dealing with this issue, and as such, the guide does not comment on this. (See "Overview of the External Evaluation," page 34, for more about related activities.)

ABOUT THE JOHNSON COUNTY DEPARTMENT OF CORRECTIONS

The Johnson County Department of Corrections has three major divisions: adult residential, juvenile detention, and adult and juvenile field services. The SARTCP involved the Adult Residential Center (ARC), in New Century, and the Juvenile Detention Center (JDC), located in the county seat, Olathe. A director oversees the DOC and program directors administer the ARC and the JDC and supervise their respective staffs.

 The SARTCP had two parallel project implementation processes—one at a community confinement facility and another at a juvenile detention center. Many correctional agencies that administer community confinement or juvenile detention facilities are structured differently; adult and juvenile facilities are usually administered by different agencies. Still, the recommendations in this guide are generally applicable to community confinement facilities and juvenile detention facilities, regardless of how they are structured.

The Adult Residential Center (ARC)

The ARC is a 398-bed community confinement facility that provides a structured environment for adult male and female offenders who are ordered by the Johnson County District Court to the DOC as a condition of their probation. The ARC also provides work-release services for state and county inmates as an alternative to incarceration and as a transition to post-supervision or time-served release. In addition, the ARC operates a six-month drug treatment program that can accommodate up to 50 residents, who typically have extensive histories of using alcohol and/or other drugs.

ARC residents live in one of three housing units, two of which are co-ed. They wear street clothes, live in dorm-style rooms with other residents, and move freely about the facility and in the community during the day. The typical length of stay for an ARC resident is 90 to 180 days. ARC residents are encouraged to seek medical and mental health care in the community as needed. ARC staff also work with local providers to deliver medical and mental health care at the facility.

The Juvenile Detention Center (JDC)

The JDC is a 102-bed secure detention facility that houses youth ages 10 to 17. It is a short-term holding facility for males and females, though it does not operate co-ed housing units. The JDC holds a number of populations: pre-adjudicated youth in custody who are awaiting a detention hearing; adjudicated youth awaiting sentencing; youth placed in secure confinement due to violations of probation or court orders; youth placed in secure confinement because of outstanding warrants pending further judicial review; and youth in the custody of the Juvenile Services Division of the Kansas Department of Corrections who are awaiting out-of-home placement or commitment to a state juvenile correctional facility.

The JDC consists of two housing units where youth, who wear uniforms, receive direct supervision from custody staff 24 hours a day: a maximum-custody unit that houses youth classified as moderate-high-to-high risk and a low-to-moderate-risk housing unit. Lower-risk youth live in rooms that resemble the dorm-style living quarters at the ARC, whereas rooms in the maximum-custody units more closely resemble jail or prison cells. A typical length of stay is approximately 18 days, but can vary due to a person's circumstances and case. Youth at the JDC receive medical and mental health care on-site.

The JDC is subject to more external oversight than the ARC is. If a youth reports being sexually assaulted while in DOC custody, the DOC must notify the Kansas Department for Children and Families (DCF—the child protective-service program), and the Kansas Department of Health and Environment (KDHE—the state licensing agency for any program providing services to children). Both agencies can conduct investigations if their administrators so choose. DCF also runs the state hotline for reporting abuse and neglect. Any youth or a third party can report sexual assault by calling the hotline.

IMPLEMENTATION IN JOHNSON COUNTY

PHASE 1: GATHERING INFORMATION AND PLANNING

The overarching goal of the project was to help the DOC implement a SART approach to sexual assaults occurring at the two facilities. At the beginning of the project, Vera staff anticipated three ways that a SART could be implemented at the DOC:

- > creating facility-based response teams at both the ARC and the JDC;
- > developing a department-wide team for the entire DOC, with members nimble and flexible enough to respond to victims at both facilities; or
- > adding DOC representation to the Johnson County community SART.

Phase 1 of the project was devoted to gathering information, assessing the feasibility of these three options, and planning for implementation of the most appropriate SART model for the DOC. Vera acted as the principal investigator, conducting outreach to state and local sexual assault victim advocates, meeting with investigators at the Johnson County Sheriff's Office, identifying and meeting with member agencies of the community SART, meeting with the SART coordinator, touring the DOC facilities, and interviewing key DOC staff and leaders. After gathering and assessing this information, Vera recommended that the DOC create a partnership with the community SART.

This option made the most sense for the DOC for a few reasons. First, like many community confinement and juvenile detention facilities, the ARC and JDC are relatively small, and for this reason, DOC leaders expressed concern that the facilities did not warrant facility-based SARTs. Similarly, a key DOC leader thought a department-wide team might lose motivation or atrophy if there were not enough incidents of sexual assault to keep the team engaged or allow members to exercise the skills they would gain from specialized training. After completing the interviews and site visits, it was clear that the majority of Johnson County stakeholders, including the DOC leaders, favored linking the DOC to the community SART. It was determined that working with the SART would enable the DOC to benefit from the expertise and collaboration that already existed among community members and would also help educate them about the DOC. For the ARC, linking to the existing SART was a particularly logical choice because the ARC is based in the community where residents work and see service providers.

PHASE 2: WORKING WITH THE COMMUNITY SART

At the start of Phase 2, Vera convened a stakeholders meeting to bring together the DOC and SART agencies. This meeting began with an overview of PREA, introduced SART members and DOC staff to each other, and provided a forum to discuss the concept of a SART response to reports of sexual assault in facilities. The meeting offered an important training opportunity in which agency leaders and staff learned about DOC facilities and operations and the DOC staff learned about relevant community resources. To finish, participants discussed

how a partnership between the DOC and the SART could be used to facilitate a coordinated victim-centered response when residents in the ARC and JDC report sexual assault.

After the meeting, the DOC sought to become active on the SART and began

A BROAD MIX OF STAKEHOLDERS

Almost 40 people attended the initial stakeholders meeting, representing not only the DOC and SART agencies, but other local and state agencies (such as the local child-advocacy center and the Kansas Coalition Against Sexual and Domestic Violence) that might be involved or could influence response to sexual assault of ARC or JDC residents.

to develop working relationships with SART member agencies. The SART in Johnson County is larger than most, so the following agencies were identified as particularly critical to the sexual assault response in DOC facilities:

- > The Shawnee Mission Medical Center (SMMC) is an area hospital with a well-established sexual assault forensic examiner (SAFE) program, staffed by specially trained and certified sexual assault nurse examiners (SANEs). It has the capacity to perform adult, adolescent, and child sexual-assault medical forensic examinations, so its staff can serve all residents from the ARC and the JDC.
- > The Metropolitan Organization to Counter Sexual Assault (MOCSA) is the rape crisis center for the Kansas City metropolitan area, serving three counties in Kansas and four in Missouri. Among other services, MOCSA operates a 24-hour crisis line, provides advocacy services through all stages of the justice system process (from hospital support through prosecution), and offers short-term crisis intervention, individual counseling, support groups, and other services.
- > The Johnson County Sheriff's Office has investigative authority for reports of criminal activity in DOC facilities.
- > The Johnson County District Attorney's Office is the prosecuting authority for the county. Its Victim Assistance Program coordinates the activities of the county SART.

Partnership-building activities included the following:

- > **The DOC started participating in SART meetings.** A DOC SART representative updated SART members on progress in DOC policy development and training. The JDC also hosted a SART meeting and provided facility tours.
- > **MOCSA became a regular source of information for the DOC about the community response to sexual assault.** MOCSA staff made themselves

available to explain the organization's full complement of services; how DOC residents could access these services; and how its role interconnected with the roles and procedures of other responders. The DOC worked with MOCSA to create a basic memorandum of understanding (MOU) to provide victim services for residents. MOCSA also offered to train DOC staff on sexual-assault victimization issues, and the DOC, the district attorney's office, and MOCSA planned and implemented a cross-training session.

- > **The sheriff's office became the sole investigator of sexual assault at DOC facilities.** Before the project, the Olathe Police Department responded to all calls from the JDC and the sheriff's office responded to all calls from the ARC. Soon after the project started, DOC leaders agreed that it would be more consistent and streamlined to have one law enforcement agency conduct sexual assault investigations at both facilities. Dialogue among the DOC director, the sheriff, and the Olathe police chief led to the decision that the sheriff's office would respond to all reports of sexual assault of residents in DOC facilities.
- > **Facility staff toured the Shawnee Mission Medical Center.** The coordinator of SMMC's Forensic Acute Care Treatment (FACT) Program provided an on-site tour and overview to DOC representatives. The FACT Program has a team of qualified, compassionate physicians and nurses who are specially trained to offer medical and/or forensic care to patients reporting recent sexual abuse or assault.) The tour was especially useful in helping ARC and JDC administrators understand the logistics of the sexual-assault medical forensic examination process and served as a reference point during policy development. The DOC also sought the FACT Program staff's feedback on the facilities' newly developed sexual assault response policies.

STAFF CONCERNS

Mixed in with the positive response to the idea of a DOC-SART partnership was, not surprisingly, some wariness on the part of DOC staff and community agencies. Because the DOC facilities had low reporting rates for sexual assault, some facility staff questioned whether the partnership would have much practical use. On the flip side, some SART members wondered if the partnership would lead to a significant increase in victim disclosures and, if so, whether the team would have the capacity to fully serve this population. Fortunately, these concerns dissipated as relationships developed between the correctional facilities and SART agencies—and as representatives of the organizations talked through the logistics of a coordinated response.

PHASE 3: INCORPORATING A SART APPROACH IN FACILITY POLICY

After meeting with community SART agencies and confirming their support, the leaders and staff of the ARC and the JDC were poised to develop sexual assault policies that would incorporate a SART approach among internal and external responders. To advance this effort, each facility formed a committee composed of a program administrator, a case manager or treatment manager, and a policy writer. Each sought input from the DOC training coordinator as needed. A Vera staff member acted as a coordinator for each committee, helping to maintain the focus on incorporating a SART approach into the policies, in accordance with the PREA standards, the *National Protocol*, and the Corrections SAFE Guide recommendations.

INCLUDING AN ADVOCATE'S PERSPECTIVE

A victim advocate from MOCSA played an essential role in policy discussions. She is well versed in best practices in SART response to sexual assault, and this was extremely valuable, given that not all facility staff were aware of the coordination needed at each point of response or of victim-centered care issues. The MOCSA representative also clarified the role of the advocate and explained the confidential nature of communications between an advocate and a victim.

During an initial meeting, each committee mapped out actions to take in response to disclosures, reports, and discovery of sexual assault; assessed where the facility stood with existing policies; and identified areas where additional information, discussion, and policies were needed. Each committee met periodically for about a year to discuss relevant issues and establish new policies or procedures to address the gaps that had been identified. DOC leaders decided that one of its treatment coordinators should function as a department-wide victim resource specialist, as suggested in the Corrections SAFE Guide. During the course of the project, the treatment coordinator assumed the role of providing victims general information and guidance during the immediate in-house response. The committees used two primary tools to guide this process: planning charts and sexual assault response flowcharts. The policy writers updated planning charts to reflect discussions, actions to take, and due dates to complete actions. They added other details to the flowcharts about appropriate responses.

Communication among facility staff and contractors and SART agencies was critical in clarifying policy provisions, coordination issues, scope and logistics of services, training and education issues, and specific population needs. Many questions arose, including the following:

- > Which procedures does the facility versus a SART agency need to initiate—

and how and when should facility staff and contractors reach out to SART agencies?

- > What are the logistics of the medical forensic examination? Is it necessary for juvenile residents to be shackled while being transported to and from the exam site and during the exam?
- > What is the scope of services and level of confidentiality that MOCSA could offer residents, particularly juvenile residents? What are the logistics involved in offering victim services?
- > What are the confidentiality policies for contracted mental health providers when counseling residents?
- > What information should be relayed to victims during an immediate response, and when is their informed consent needed?
- > Do responses vary depending on when the incident occurred? If yes, how?
- > What offenses require internal investigation versus those that may also involve law enforcement?

Finding answers to these questions sometimes required the ARC, the JDC, and/or SART agencies to consider how to adapt existing policies to address unique issues facing sexual assault victims in the facilities. The Corrections SAFE Guide served as a resource for identifying the response elements to adapt.

The committees began drafting policies while they were still exploring answers to outstanding questions. As they determined the answers, they incorporated the information into their drafts. By early 2014, after a lengthy review and comment period, the DOC, with Vera's assistance, had finalized response flowcharts and reference response checklists for facility staff.

Concurrent with the policy development that occurred in Phase 3, SARTCP

POLICY DEVELOPMENT TAKES TIME

The policy development process took longer than anticipated. A key reason was that the committees were working not only to comply with PREA response standards, but also to weave other PREA standards into their policies (such as those that refer to data collection). Another reason was that incorporating PREA response standards and best practices from the Corrections SAFE Guide in the policy was complicated work that had not been done before in these facilities. The committees had to decide whether each standard or best practice was appropriate for the facility, where to include each one in the policies, and how to tailor PREA and best-practice language so that it was meaningful for their facilities. Based on the experience of the SARTCP, Vera recommends that facilities beginning to grapple with PREA and develop policies allow approximately 6-12 months from start to finish (up to 18 months for the whole process).

evaluators were surveying facility staff and interviewing residents for baseline information on policy awareness, attitudes, and beliefs related to sexual assault in each facility. This information helped guide training efforts in Phase 4 and led to revisions of some of the resident educational materials. Vera recommends that facilities undertake a staff survey at an earlier point in this process, so that they have the opportunity to incorporate the information in project planning and activities. If facility leaders and staff want to understand more about resident awareness, attitudes, and beliefs, they should work with an external researcher to design surveys or interview protocols, conduct the surveys or interviews, and analyze the results. Appendix 4 contains a proposed interview guide for residents that an external researcher can consult when working with a facility. To elicit the most honest feedback and ensure that residents do not feel coerced into responding, outside professionals must conduct resident interviews or surveys.

PHASE 4: TRAINING FACILITY STAFF

In the summer of 2013, Vera coordinated a sexual assault/PREA training for DOC staff that was delivered by a national expert on sexual assault response in the community and in corrections. Prior to developing the training, the expert learned about Johnson County and the DOC's strengths and challenges by accompanying Vera on two early site visits to tour the facilities. She met with DOC leaders and other community representatives from MOCSA and the SART and presented at the stakeholder meeting. The expert developed the curriculum in consultation with Vera, the DOC, and OVC's Training and Technical Assistance Center.¹² ARC and JDC supervisors and front-line staff attended separate trainings to build their knowledge about the following:

- > the basics of sexual assault and of sexual assault in correctional settings;
- > victims' psychological and behavioral reactions to sexual assault and the care and services they typically need;
- > staff responsibilities when a disclosure is made and how to react in a manner that communicates an understanding of trauma and its impact on victims;
- > internal and external reporting methods for residents and barriers to victims reporting; and
- > risks of victimization for lesbian, gay, bisexual, transgender, questioning/queer, and intersex individuals. (See Appendix 9, "Excerpted SARTCP Training Agenda.")

In early 2014, after finalizing the policies, the DOC trained ARC and JDC shift supervisors about them. DOC administrators conducted the training to encourage staff buy-in and demonstrate the importance of the issue. After this training, shift supervisors trained their respective staffs on the response policy, using the flowcharts and pocket checklists developed during the course of the

SARTCP. (See Appendix 6 for the project flowcharts.) The flowcharts were used to map the processes triggered by a disclosure or discovery of sexual assault; the pocket checklists were distributed to line staff so that they could easily reference a short list of concrete actions to take. According to the facility policy, staff will receive a refresher training every year to ensure that they are up to date on any revisions and continue to build related knowledge and skills. Regularly scheduled SART meetings provided the opportunity for the DOC to share the new facility policies with other SART agencies. DOC staff encouraged the SART to incorporate into its protocol details for ARC or JDC that deviated from standard SART response, and to focus periodically on corrections-related topics at its regular meetings.

OVERVIEW OF THE EXTERNAL EVALUATION

During the first year of the project, Vera contracted with an external evaluator to do a process evaluation of the SARTCP. The evaluator and her team of Kansas-based researchers began by observing meetings between Vera staff, facility administrators, and representatives from outside agencies that would be involved in sexual assault response. They also conducted baseline interviews with the administrators and key members of the community SART, including staff from the rape crisis center and the SAFE program coordinator. They continued to observe meetings throughout the project and conducted individual interviews with key personnel a second time, shortly before the project ended. The initial interviews revealed some fault lines in the early collaboration between the DOC

INVOLVING AGENCY STAFF IN TRAINING

Though staff largely responded well to the first PREA training, which was delivered by an outside consultant, they seemed more engaged and receptive to the material during the second training, which the ARC and JDC directors led. Whenever possible, Vera recommends that agencies work in collaboration with consultants or take ownership of trainings altogether. When agency or facility leaders present material (or do so in collaboration with leaders), staff members tend to take it more seriously and understand more easily how the material connects to their day-to-day responsibilities at the facility.

and community partners. The researchers attributed these to misunderstandings at the Phase 2 stakeholders meeting, issues that were cleared up over time.

The project had four major data-collection efforts: in-depth semi-structured interviews with residents of the two facilities; staff surveys; training evaluations; and an analysis of the facilities' critical incident reviews. The following section summarizes the process of these efforts and, out of respect to the DOC, only very broad findings. Detailed findings were shared confidentially with DOC administrators to assist them with future planning related to PREA.

RESIDENT INTERVIEWS

The project's resident interviews focused on the climate in the facility; whether residents were aware of sexual violations of various types (from verbal harassment to rape) committed by residents against other residents or by staff against residents; the likelihood of disclosure of sexual assault; preferred staff members for making potential disclosures; the anticipated response to a disclosure; and types of support services the person would want. The interviewers did not ask about the individual's personal experience of sexual assault. Because of information such interviews may elicit, they should be conducted only by outside professional researchers or evaluators who have experience interviewing survivors of sexual assault and whose work is subject to oversight by an ethics review committee.

The evaluators provided informed-consent forms to the adult participants and to the parents or guardians of juvenile participants. The evaluators explained what informed consent entails, assured residents that there would be no repercussions of participating or not participating, and asked them to sign. Because the JDC interviews required parental consent and assent of the youth, a convenience sample was a necessity.¹³ Evaluators and DOC staff arranged for a counselor to be available in case the interview elicited traumatic memories.

Overall, the interviews did not reveal a sexual assault problem at ARC or JDC. They did uncover some concerns about sexual joking and verbal harassment among residents and by staff. Residents also expressed some wariness about how staff might respond to disclosures of sexual assault and had low expectations of confidentiality in the event of a disclosure—a concern that diminished by the time follow-up interviews were completed. A number of the residents indicated that they would report sexual assault to a staff member, and most said they felt safe at the facilities. Some residents recommended that information about sexual assault and reporting be presented a day or two later, rather than during intake, which is when they typically receive the information, in accordance with the PREA standards. They said that intake can be an overwhelming time and thought they might be able to process the information better afterward.

THE STAFF SURVEY

An online staff survey was conducted once before the first major training and again nine months later. The anonymous survey focused on knowledge of PREA and services for victims; beliefs about sexual assault perpetrated by residents and sexual misconduct by staff; beliefs about obstacles to disclosure; and beliefs about the frequency of false allegations. The survey was lengthy, and less than 50 percent of staff from both facilities responded to the baseline survey. The follow-up had a better response rate, with 57 percent from the ARC and 77 percent from the JDC completing the survey. Facilities that undertake a staff survey might get higher response rates by using a shorter survey.

The surveys revealed three main needs that were addressed in subsequent trainings:

- > Many staff members were not familiar with PREA. This was remedied by the time of the follow-up survey, after staff had attended the consultant-led training and the new sexual assault response policy had been rolled out.
- > Some staff members were misinformed about how administrators handle reports of sexual assault and the scope of information they can legally and ethically share with staff about these reports. The subsequent shift-supervisor training and PREA trainings for line staff addressed these issues.
- > Some staff members were confused about when to report sexual assault—and whether physical injury or other criteria were necessary for reporting or whether verbal sexual harassment would be enough to trigger the reporting requirements under the department’s new policy. Many staff also believed that residents would make false reports to gain some advantage or revenge. Shift-supervisor training and PREA trainings for line staff also addressed these issues.

TRAINING EVALUATIONS

Trainings were evaluated in two ways: with a participant feedback survey (see Appendix 4 for the questionnaire that was used) and through the evaluators’ observations. The survey administered at the end of the training sessions asked the trainees to rate the utility of the training and their satisfaction with various aspects of it and included open-ended questions about the most- and least-useful parts of the training and recommendations for future training. The evaluators’ observations were very informative about how the training was received, gaps in the training, and possible improvements.

An expert on sexual assault and the implementation of PREA in prisons conducted the first training, which covered sexual assault in facilities, PREA, sexual trauma, medical and psychological responses to sexual assault, and vulnerable populations. Although the evaluation team observed a few staff members being disruptive or not paying attention during class, staff nevertheless rated this training positively: Staff were very satisfied with the trainer, the pace, and the applicability to their jobs. They were frustrated that most of the research has focused on prisons and not residential programs. Wanting more information and material that was specific to their facility, they found the flowcharts showing the first-response steps most useful. They suggested printing the charts in color and making them accessible to staff electronically. Their suggestions for improving the training centered on allowing more opportunities for interaction and role plays, as well as incorporating testimonials, case studies, video clips, or some combination, to generate more interest and discussion. They also recommended more discussion of the practical application of the material to their daily job functions.

The directors of the two facilities conducted the second training, which was designed to train supervisors to train and coach the front-line staff. It was a

shorter and more focused training than the first, covering PREA standards, the facilities' newly developed policies, the first-response protocol, and PREA audits. Materials provided included the slides the trainers used, a laminated card with a brief version of the first-response protocol, a flowchart depicting steps of the response for each facility, and MOCSA brochures. The training consisted of a presentation by the directors, group discussions, and role plays.

The supervisor trainees asked many questions for clarification, including questions about confidentiality and privacy, victims' options in declining services, how much a first responder should ask (given that it is not the first responder's role to investigate the complaint), and how to deal with disclosure of a past assault that may have been perpetrated in the community, at another facility, or at home.

The feedback from supervising staff on the training was extremely positive. They considered the training very useful. They thought the role plays were especially instructive, that they generated thoughtful discussion, and that the flowcharts were valuable. Additional needs the supervisors cited were more training and better understanding of the PREA requirements and their integration into DOC policy.

In addition to these two trainings, supervisors at both DOC facilities delivered PREA training to line staff, which the evaluation team observed. Supervisors continue to conduct trainings for new hires and provide annual refresher training to all staff.

The PREA trainings for line staff last approximately 90 minutes and consist of a presentation on PREA and sexual assault response, including the role of first responders, the composition of the local SART, and the ways that victims can report abuse. Following the presentation, participants work in groups to role-play various scenarios. The evaluators have noted that participants have been engaged and attentive during these trainings and that presenters have learned over time how to model empathy for victims.

CRITICAL INCIDENT REVIEWS

In the final year of the project, following the development and implementation of sexual assault response policies and procedures at the two DOC facilities, the evaluators conducted a review of critical incident reports at the JDC and ARC. Reports at the JDC spanned 12 months and reports from the ARC covered 18 months. Reports did not necessarily detail incidents of sexual abuse; rather, they described the facility's response to every allegation or complaint of a sexual nature. The goals of the evaluators' review were to determine how closely the facilities were adhering to their policies and procedures and help them identify any areas for improvement or revision.

The facilities completed the critical incident reviews and issued reports in different ways. At one facility, a single person conducted the investigations and wrote the critical incident reports; at the other, one person investigated and then convened a committee to review the cases. Both approaches were effective, but using a committee to review investigations seemed to result in closer

compliance with policy and procedure and ensure the involvement of administrators in the investigations and reviews.

Overall, the evaluators concluded that responders had taken actions that adhered to stated policies and procedures. But they found a few issues at both facilities that required some clarification or consideration for improvement. In some cases, those issues required a simple note of clarification in a flowchart or policy. In others, like reducing the time lag between an investigation and a review, facility administrators needed to consider modifying a procedure to improve effectiveness and efficiency.

CONCLUSION

With Vera's assistance, the Johnson County Department of Corrections developed a strong partnership with the Johnson County SART, created sexual assault response policies that are coordinated and victim-centered, and trained its staff on sexual assault issues and the facility's response. The following list summarizes these accomplishments and others:

- > The DOC explored how a partnership with the county SART and a SART approach could be useful in implementing PREA standards related to response to sexual assault of ARC and JDC residents.
- > The agency linked with the SART by becoming a member and creating partnerships with SART agencies.
- > The ARC and JDC incorporated a SART approach in their respective facility sexual assault response policies based on the PREA standards, the *National Protocol*, and the Corrections SAFE Guide.
- > The DOC identified a central hospital for sexual-assault medical forensic examinations of residents disclosing sexual assault and a single law enforcement agency to conduct criminal investigations in these cases.
- > The DOC sought help from the local rape crisis center in assessing whether facility policies were victim-centered and ensuring that residents had ready access to advocate support.
- > Each facility created response checklists and flowcharts that clarified tasks and responsibilities of facility staff.
- > The DOC created flowcharts for residents and revised their educational materials.
- > With the SART, DOC administrators trained facility staff on issues of sexual assault in correctional settings and facility response policies.
- > As recommended by the Corrections SAFE Guide, the DOC created and filled the position of internal victim resource specialist by adding this role to an existing staff person's duties.
- > The DOC shared the facilities' new policies with the SART.
- > DOC leaders provided facility tours to SART agencies to help their staff

became familiar with the correctional environment, needs of residents, and various responder roles.

In the process of accomplishing these tasks, the Johnson County DOC made significant progress in implementing the PREA standards. Though Vera provided assistance to the DOC for this project, other correctional facilities can achieve success in similar efforts without a technical assistance provider by using the planning tool in Section 2, which embodies the lessons learned in Johnson County, as described in Section 3 of this guide.

Appendix 1: Overview of sexual assault in corrections

INCIDENCE AND PREVALENCE

A growing body of research documents the incidence and prevalence of sexual victimization (as defined by PREA) in prisons and jails. For example, see two studies by the U.S. Department of Justice Bureau of Justice Statistics (BJS):

- > From February 2011 through May 2012, an estimated 4 percent of state and federal prison inmates and 3.2 percent of jail inmates reported experiencing one or more incidents of sexual victimization by another inmate or facility staff in the 12 months preceding the study—or since admission to the facility, if less than a year ago.¹⁴
- > A 2008 study found that 9.6 percent of former state inmates reported experiencing at least one incident of sexual victimization during their most recent incarceration.¹⁵ The same study reported that an average of 2 percent of former state inmates serving time in a community-based correctional facility reported being sexually abused by staff or another resident while there. Note that former state inmates are just one of the populations in community confinement.

Information continues to emerge regarding the sexual victimization of juveniles in correctional settings. For example, a BJS study found that 9.5 percent of youth in juvenile confinement facilities reported experiencing one or more incidents of sexual victimization in the year preceding the study—or since their admission, if less than a year.¹⁶ Some highlights of the study are as follows:

- > About 2.5 percent of youth reported an incident involving another youth and 7.7 percent reported an incident involving facility staff. About 3.5 percent reported having sex or sexual contact with staff as a result of force, while 4.7 percent reported sexual contact with staff without any force, threat, or other explicit form of coercion.
- > Male residents (8.2 percent) were more likely than female residents (2.8 percent) to report sexual activity with facility staff, while young women (5.4 percent) were more likely than young men (2.2 percent) to report forced sexual activity with another youth. More than 90 percent of youth who reported staff sexual misconduct said they had been victimized by female facility staff.
- > Youth who identified their sexual orientation as something other than heterosexual had significantly higher rates of sexual victimization by other youth (10.3 percent) than heterosexual youth did (1.5 percent).
- > Youth who had experienced prior sexual assault were more than seven times likelier to report sexual victimization by another youth in the facil-

ity than was true of young people who did not report a history of sexual assault.

 The [National PREA Resource Center Library](#) is a good place to learn more about research on the incidence and prevalence of sexual assault in correctional settings.

Little research has been done on sexual victimization in adult residential and nonresidential community corrections facilities. Journalists have reported on sexual assault in community corrections (see *The Impact of National PREA Standards on Community Corrections*), but more research is needed to assess the scope of the problem in these settings.

SEXUAL ASSAULT IN THE CORRECTIONAL ENVIRONMENT

Most sexual assault in community confinement and juvenile detention facilities can be categorized as resident-on-resident assaults or as staff sexual misconduct:¹⁷

- > **Nonconsensual sexual contact between residents in the facility.** An individual housed in a correctional facility may coerce another resident into sexual activity. For example, a resident may acquiesce to sexual contact as a result of being threatened, intimidated, or bribed, or to pay off debts for protection, items, or services. Sexual assault may involve physical violence or the threat of it, but not always. Residents and facility staff may not initially perceive sexual contact as sexual assault if it does not involve a threat of violence.
- > **Staff sexual misconduct.** No sexual activity between corrections staff (employees, contractors, and volunteers) and residents in the facility is consensual, even if one or both parties believe it to be. Given the custodial authority that corrections staff have over individuals in their facilities, there is an unequal power dynamic that makes true consent impossible.

Residents in community confinement who have some level of freedom to leave the facility may experience sexual victimization in the community. Residents in community confinement and juvenile detention may have experienced sexual victimization before arriving at the facility, while in another correctional setting, or in the community.

BARRIERS TO VICTIM REPORTING

Like victims who are not in custody, individuals in correctional settings often have fears and concerns about reporting sexual assault. Some specific concerns of victims in correctional settings may include the following:¹⁸

- > fear of retaliation by perpetrators;

- > fear of being placed in isolation in the facility as a protective measure or being sent back to jail or prison from a community confinement facility;
- > fear of losing privileges or freedoms within the facility;
- > fear of being further targeted by sexual predators in the facility;
- > fear of being labeled a “snitch” or “rat” by others in the facility;
- > fear that corrections officials will not respond appropriately or will ignore their report; and/or
- > fear (for boys and men) of being labeled weak, less masculine, gay, or bisexual, and as such, facing significant risk for further sexual assault.

These and other fears and concerns can lead victims in correctional settings not to report or to delay reporting to facility staff, law enforcement, or both. Many are reluctant or choose not to report because of self-blame, feelings of shame, a desire to put the event behind them and move on with their lives, or some combination of those. In addition, they may not identify coerced sexual contact as abusive and may not think to report it.

POTENTIAL REPERCUSSIONS FOR VICTIMS

The impact of sexual assault on a victim can vary greatly, because each individual deals with the experience of victimization differently. That said, victims may have common symptoms and reactions to sexual assault:¹⁹

- > **Emotional reactions.** These may include depression, shock and disorientation, spontaneous crying, self-blame, despair, anxiety and panic, fearfulness, suicidal thoughts, feeling out of control, irritability, anger, emotional numbness, memory lapses, difficulty making decisions and concentrating, hyperactivity, and impulsivity.
- > **Self-harming behavior.** Abuse of alcohol or other drugs, self-mutilation, and suicide attempts are common among victims.
- > **Physiological reactions.** These may include changes in sleep, eating, and hygiene patterns, and aversion to touch.
- > **Social behavior.** Victims of sexual assault often withdraw from relationships; avoid certain individuals, places, or both; change the way they dress (for example, wearing multiple layers of clothing in public); and may demonstrate aggressive behavior, regression, sexually inappropriate behavior, excessive attachment, or some combination.
- > **Physical symptoms and concerns.** These may include physical injuries from the assault; pregnancy risk (for women); and exposure to HIV and other sexually transmitted infections.



To get a sense of the range of experiences of victims of corrections-based sexual assault, see Just Detention International’s [survivor testimony](#).

TRAUMA AFTER SEXUAL ASSAULT

A variety of factors influence an individual's experience of emotional trauma in reaction to sexual assault, including the severity and frequency of the event; his or her personal history (for example, if a prior victimization took place); the person's coping skills, values, and beliefs; and the level of support the individual has to help him or her heal.^a

Many factors may exacerbate the emotional trauma experienced by sexual assault victims in correctional settings, including the following:^b

- > continuous contact with perpetrators;
- > repeated sexual assault, as well as degradation and threats of violence;
- > general distrust and a perception that seeking help is a risk to personal safety;
- > lack of privacy and control over the environment;
- > physical consequences of the sexual assault;^c
- > punitive consequences imposed by the institution for aggressive or self-destructive reactions to sexual assault; and
- > negative mental health effects of being placed in isolation for protection.

Recovery from sexual abuse can obviously be difficult, especially in correctional facilities. For many people living in these settings, survival is the focus and healing is not yet a consideration. But with support and by using the resources a SART offers, recovery can progress to healing.

^a Santa Barbara Graduate Institute, Center for Clinical Studies and Research and LA County Early Intervention and Identification Group, *Emotional and Psychological Trauma: Causes and Effects, Symptoms and Treatment*. (Reprinted from helpguide.org, 2005).

^b J. Yarussi and B. Smith, *The Impact of National PREA Standards on Community Corrections* (Washington, DC: National Institute of Corrections and American University, Washington College of Law, Project on Addressing Prison Rape, 2013); and Office on Violence Against Women (OVW), *Recommendations for administrators of prisons, jails, and community confinement facilities for adapting the U.S. Department of Justice's A national protocol for sexual assault medical forensic examinations, adults/adolescents* (Washington, D.C.: OVW, 2013).

^c Victims in corrections settings may be at greater risk than others are for physical assault and subsequent injury during a sexual assault. They may also experience multiple incidents and perpetrators, both of which may contribute to physical injury and heightened risk for contracting HIV and other sexually transmitted infections. (Note that numerous communicable diseases are more prevalent among incarcerated populations.) C. Abner, *Preventing and Addressing Sexual Abuse in Tribal Detention Facilities* (Lexington, KY: American Probation and Parole Association, 2011); Robert W. Dumond, "Confronting America's Most Ignored Crime Problem: The Prison Rape Elimination Act of 2003," *The Journal of the American Academy of Psychiatry and the Law* 31, no. 3 (2003): 354–360; and James E. Robertson, "Rape Among Incarcerated Men: Sex, Coercion and STDs," *AIDS Patient Care and STDs* 17, no. 8 (2003): 423–430.

Appendix 2: Elements of a sexual assault response policy

Use this reference sheet as you revise your facility's sexual assault response policy. This chart briefly describes the components of facility response from the PREA standards, along with the recommendations for implementation in the Corrections SAFE Guide (which adapts the recommendations for victim-centered care and coordination from the National Protocol for correctional settings). Note that in many instances the Corrections SAFE Guide echoes the directives of specific PREA standards, though in other cases, it reflects best practices. Recommendations are numbered and are referenced parenthetically with either a "V" or "C" preceding the number. The "V" refers to a recommendation for providing victim-centered care; the "C" refers to a recommendation for promoting a coordinated team approach. You will also need to consider how state laws will affect your facility and team's response. Note: In instances when the Corrections SAFE Guide doesn't provide a recommendation, only the standard is listed.

	PREA Standard	Corrections SAFE Guide
Responsive Planning	115.221/321 <i>Evidence protocol and forensic medical examinations</i>	<ul style="list-style-type: none"> > Victims should have access to SANEs or SAFEs to perform the medical forensic exam. Consider utilizing independent forensic examiners not employed by or under contract with correctional facility. (V7) > Victims should be offered a medical forensic exam when appropriate. To determine whether an examination is appropriate in a specific case, consider the victim's health needs and concerns; jurisdiction-accepted time frame for evidence collection; and specific circumstances of the assault. The victim should not assume financial cost related to evidence collection. (V8) > Make every reasonable effort to involve community-based sexual assault victim advocates in response. (V5)
	115.222/322 <i>Policies to ensure referrals of allegations for investigations</i>	
Official Response	115.261/361 <i>Staff/agency reporting duties</i>	Exercise discretion to avoid the victim's embarrassment at being identified by others in facility as a victim, and to increase their safety and comfort in seeking help. Consider the extent of victim information each responder requires to intervene. Avoid sharing victim information unless it is critical to response. (V4)
	115.263/363 <i>Reporting to other confinement facilities</i>	Ensure that policies are in place for reporting sexual assault occurring in other correctional facilities: If a resident reports being sexually assaulted while housed at another correctional facility, the facility that receives the report has a duty to notify the institution where it occurred, regardless of the amount of time that has lapsed since the incident. The facility where the resident is housed should obtain/receive information about investigative findings from the institution where the assault occurred (and offer services to victims). Victims reporting sexual assault occurring at another correctional facility should have access to the same coordinated response as other victims. (C6)
	115.264/364 <i>Staff first responder duties</i>	In the case of sexual assault by another resident, immediately separate victims and perpetrators. If a staff perpetrator is named, that person should not be involved in facility's response. (V2)
	115.265/365 <i>Coordinated response</i>	<ul style="list-style-type: none"> > Ensure that victims have access to all specialized services they may need after reporting sexual assault. (V1) > If both victims and perpetrators are sent out for medical forensic exams, do not transport them together or have them arrive or wait at the exam site simultaneously. Following an immediate response, strive to keep victims separated from perpetrators. (V2)

	PREA Standard	Corrections SAFE Guide
Official Response (Continued)	115.265/365 <i>Coordinated response (continued)</i>	<ul style="list-style-type: none"> > Consider ways for victims to seek protection and services as confidentially as possible; strictly limit who within the facility needs to know about a report. (V3) > Make every reasonable effort to include community-based sexual assault victim advocates in the immediate response. Develop a memorandum of understanding (MOU) that delineates the relationship/coordination needed between the facility and the advocacy program. (V5) > Train at least one facility staff member to serve as an internal victim resource specialist, to provide general information and guidance to victims during the immediate response and beyond. This position should dovetail with the role of the community-based victim advocate. (V6) > Ensure that victims have access to SANEs/SAFEs to perform the medical forensic exam. (V7) > Offer a medical forensic exam to victims whenever it is appropriate: To determine whether an exam is appropriate, consider the victim's health needs and concerns; jurisdiction-accepted time frame for evidence collection; and specific circumstances of the assault. (V8) > For secure confinement: Shackle or restrain only if necessary for security. (V9) > To the extent possible, facilitate victims' access to their personal support persons (such as family members and clergy) if requested. (V10) > Offer victims information following the report, disclosure, or discovery of sexual assault. (V12)
	115.267/367 <i>Agency protection against retaliation</i>	To the extent possible, protect victims without taking measures they may perceive as punitive. Thoughtfully consider ways to avoid curtailing victims' privileges and freedoms while protecting them from additional violence or retaliation. (V3)
	115.268/368 <i>Post-allegation protective custody</i>	In community confinement facilities, do not send victims back to secure confinement in the name of safety. In secure settings, segregation should be a last resort and, if used, it should be only a short-term arrangement. Also avoid automatically transferring victims to another facility if they cannot be housed anywhere other than a segregation unit, because a transfer may disrupt an investigation, service provision, or victim access to personal support persons. (V3)
Reporting	115.251/351 <i>Resident reporting</i>	Devise facility practices that address victims' concerns related to reporting and encourage reporting to the facility and outside criminal authorities: (a) Educate all corrections staff and responding community agencies of facility's zero-tolerance policy. (b) Ensure that corrections staff and community agencies are trained to routinely respond in a way that demonstrates to residents that staff takes reports of sexual assault seriously and will strive to help victims and hold offenders accountable. (c) Upon intake, provide residents with information on sexual assault. (d) Make facility policies on reporting as easy, private, and secure as possible. (e) Ensure that there is at least one way for victims in correctional facilities to report to an outside entity that is not part of the facility. (f) Use case-by-case assessment, including consulting with security staff and talking with victims about their safety concerns and possible precautions, to reduce protective actions that victims could perceive as punitive. (g) Whenever possible, provide victims with access to victim advocates for confidential emotional support. (h) Strictly limit who in the facility and community can access information about the report/victim. (V11)
	115.253/353 <i>Resident access to outside support services and legal representation</i>	Make every reasonable effort to involve community-based sexual assault victim advocates in response. Develop an MOU that delineates the specific relationship/coordination needed between the facility and the advocacy program; see the section above on coordinated response (115.265/365) for what to include. (V5)
Investigations	115.271/371 <i>Criminal and administrative investigations</i>	<ul style="list-style-type: none"> > With victims' permission, advocates can accompany and support victims through investigative processes. (V5) > Train at least one facility staff person (an internal victim resource specialist) to provide victims with brief and general information during the immediate response about what they should expect during related investigation processes. (V6)

	PREA Standard	Corrections SAFE Guide
Investigations (Continued)	115.273/373 <i>Reporting to residents</i>	<ul style="list-style-type: none"> > Inform victims in a timely manner about issues related to criminal and administrative investigative processes, the status of their case in both systems, and case outcomes. (V12) > Victims reporting sexual assault that occurred in other correctional facilities should have access to information about investigative findings related to that assault. (C6)
Training	115.231/331 <i>Employee training</i>	<ul style="list-style-type: none"> > Ensure that all core responders are appropriately trained. Core responders need to be trained on general issues and dynamics of corrections-based sexual assault and on specifics of how to intervene in a sexual assault of a resident. Conduct initial and refresher trainings. (C3)^a > Facilitate cross-training between corrections staff and forensic examiners on coordinating the exam. (V7)^b > Facilitate cross-training between corrections staff and community sexual assault victim advocates. (V5) > Devise facility practices that address victims' concerns related to reporting: Educate all corrections staff and responding community agencies about the facility's zero-tolerance policy. (V11)
	115.232/332 <i>Volunteer and contractor training</i>	
	115.234/334 <i>Specialized training: Investigations</i>	
	115.235/335 <i>Specialized training: Medical and mental health care</i>	
	115.233/333 <i>Resident education</i>	Upon intake, provide residents with information on sexual assault. Make accommodations as needed to ensure access to this information for all residents. (V11).
Medical & Mental Health Care	115.282/382 <i>Access to emergency medical and mental health services</i>	See roles of corrections medical/mental health staff (Appendix D of Corrections SAFE Guide): Assess acute care needs and coordinate care; preserve forensic evidence to the extent possible while providing acute care; communicate with other responders to ensure optimal coordination of interventions; and provide/coordinate follow-up health care.
Data Collection & Review	115.286/386 <i>Sexual abuse incident reviews</i>	Initiate regular clinical reviews of the facility's response to sexual assault and responder performance to determine strengths, weaknesses, and gaps, as well as areas where additional training or revisions to policy are indicated. In addition to corrections staff, involve outside community-based victim advocates and/or SART members in these reviews whenever possible for perspective and guidance. (C7)

^a General training topics related to corrections-based sexual assault include the dynamics of sexual victimization in confinement settings; issues facing specific populations at high risk for sexual assault; the necessity and benefits of helping victims stay safe and heal; and the usefulness of a coordinated team approach in responding to sexual assault. Specific topics on how to intervene include facility/outside agency policies and specific roles of responders; responsibilities to coordinate a response across agencies; and elements of effective immediate response.

^b Topics for corrections staff include purpose and steps of the exam; jurisdictional policies related to the exam and the evidence-collection kit; role of the forensic examiner; areas and tasks that require coordination between the facility and examiner/exam site. Topics for forensic examiners include dynamics of corrections-based sexual assault; facility policies related to the exam process; security issues, if applicable; and areas and tasks that require coordination between the facility and examiner/exam site.

Appendix 3: Interview questions for SART agencies

Consider asking core SART agencies—rape crisis centers, sexual-assault medical forensic examiner programs/hospitals, law enforcement, and prosecution—some or all of the following questions, to gather information as you plan your partnership with the SART and incorporate a SART approach in facility policy. Tailor the questions and prompts as needed.

Describe your agency/program and what services you provide.

A. SEXUAL ASSAULT POLICY AND PROCEDURE

1. Describe the different ways that a sexual assault victim might access your services or assistance. What is the most common way?
2. Describe your agency's role when responding to a disclosure of sexual assault. What steps would your agency take in response to the disclosure of such an assault?
3. How often do you encounter male sexual-assault victims? Are the services you offer different from those you offer female victims? If yes, how so?
4. Do you provide services and assistance to juvenile victims? If so, are they different from those you offer adult victims? If yes, how so? Are there specific privacy precautions you take with juvenile victims?
5. Do you ever NOT provide services or assistance to victims? If so, how do you screen victims to determine whether to provide services?
6. What do you think are your biggest challenges in serving victims of sexual assault? How have you overcome those challenges? Or: What would help you overcome those challenges?
7. *For the medical forensic examiner:* If a sexual assault victim goes to the hospital for a medical forensic exam, how is the forensic examiner notified? Who notifies you? What is the time frame for notification and response? What training does someone in your position receive to perform exams?
8. *For the victim advocate:* If a sexual assault victim goes to the hospital for a medical forensic exam, how is the rape crisis center notified to provide advocacy there? Who notifies you? What is the time frame for notification and response? Who goes—paid staff versus volunteers? What kind of training do the rape crisis center's staff and volunteers receive?
9. *For the law-enforcement representative:* If a victim wishes to make a criminal report, at what point is crime scene evidence collected and a preliminary victim interview conducted? If a medical forensic exam is done but the victim is undecided about reporting, does your agency have provisions for secure storage of evidence? Do investigators receive specialized sexual assault training? If yes, please describe.

B. COMMUNITY SART

1. How has being part of the SART affected the way your agency responds? What aspects of the SART, if any, are particularly useful? Please describe them.
2. What kinds of trainings does the SART plan for its members? How are training topics decided?
3. Do you think SART operations have changed over time? If so, how and why?
4. How is the SART's effectiveness measured? Are there periodic evaluations or reviews? If yes, describe. Have there been changes to SART operation due to evaluations or reviews? Can you give some examples?

C. INTERACTION WITH THE CORRECTIONAL AGENCY

1. Does your agency currently work with the correctional agency in any capacity? With any other correctional agencies? Did your agency do this in the past? If yes, please describe. Have you experienced any successes or significant challenges the agencies had working together? How did the agencies address challenges, if there were any? Were there any unique challenges in working with the juvenile facility? If so, how were those challenges addressed?
2. *For the law-enforcement representative:* Does your agency investigate alleged crimes committed at the correctional facility? If yes: What types of offenses do you investigate? How are you notified? Who sees your reports and findings? How is the relationship between your agency and the correctional agency managed (for example, through an MOU, contract, or verbal agreement)? What special challenges, if any, do you face when investigating alleged criminal activity in a correctional facility? Can you describe any challenges when investigating corrections-based sexual assault? Do you conduct investigations differently when the victim is a juvenile and not an adult? If yes, please explain.
3. *For the prosecutor:* How was/is the relationship between the correctional agency and the prosecutor's office governed (for example, an MOU, contract, or verbal agreement)? Has the prosecutor's office ever received a case of sexual assault alleged to have occurred at the correctional facility? If so, what happened in the case or cases?
4. *For the law-enforcement representative and prosecutor:* What, if anything, do you know about how internal investigations are conducted at the correctional facility? Do you ever coordinate with internal investigators if they believe criminal activity took place? If yes, describe.

D. WORKING WITH VICTIMS WHO ARE RESIDENTS OF CORRECTIONAL FACILITIES

1. What do you know about sexual assault in correctional settings? Have you heard about PREA—the Prison Rape Elimination Act—and its regulations? Any thoughts or concerns? What do you think would make PREA initiatives

more effective (from a SART perspective)?

2. What kind of sexual assault training would you suggest corrections staff receive for responding to a sexual assault? Are there any special trainings you would recommend for working with adult versus juvenile victims, male victims versus female victims, or special populations (such as victims who are LGBTQI, Deaf, or who have disabilities)?
3. *For the victim advocate and forensic examiner:* Has your agency provided services to victims in detention? If yes, did you experience any challenges in working with them? If yes, please describe. Does your staff receive any special training or information about working with individuals housed in correctional facilities? What kind of training would you want your staff to receive before working with sexual assault victims from the correctional facility? Do you think forensic examiners and victim advocates are willing to provide services to these victims?
4. *For the law-enforcement representative:* What, if any, specialized training do investigators receive about the correctional environment? Juvenile detention? Corrections-based sexual assault?

E. CAPACITY

1. What resources do you think you can offer to the correctional facility to enhance response to sexual assault of its residents? What additional resources, if any, do you think you would need to support these victims? Do you think you will have any different needs or require different resources to provide services to victims in the juvenile detention setting?
2. Do you think you will need to invest more resources or add more personnel—or both—to serve victims in this setting? Why or why not?
3. What service limitations or issues do you anticipate, if any, in working with victims of corrections-based sexual assault?

Appendix 4: SARTCP questionnaires

A. STAFF SURVEY

The following survey is an abbreviated version of the survey administered to staff at the Johnson County Department of Corrections to gain information about attitudes, beliefs, and knowledge about sexual assault in the facilities. For facilities whose leaders are interested in conducting a similar survey of staff, please note the following:

- > The survey should be anonymous. Do not ask for information that would identify a particular staff member or allow people to guess about the person's identity.
- > One way to administer this survey is to use a web-based survey tool like Survey Monkey, which offers a variety of plans and features. It is fairly easy to create surveys using this kind of tool, and the link to the survey is e-mailed to the potential respondents. Two advantages of this route are that anonymity is easier to preserve and Survey Monkey generates a report with analysis of the responses. This allows easy identification of problem areas to address in training as well as existing strengths.
- > A low-cost alternative to administering a survey is to use paper and pen and to have a locked drop box where staff can put completed surveys. The trade-off is that someone must calculate responses by hand. If you do this, it is best to keep the survey short and avoid open-ended questions.

Staff Survey

Date: _____

This survey is anonymous. Please do not put your name on your survey. Responses will be kept confidential. Results will be analyzed and used in aggregate only. (That is, analysts won't look at any one individual's answers, but the combined answers of everyone who completes the survey.)

1	How long have you worked at this facility?
	A. 1 year or less
	B. 2 to 5 years
	C. 6 to 9 years
	D. 10 or more years
2	What is your role at this facility? (Please use a general characterization rather than a specific title)
	<input type="text"/>
3	Please indicate your gender identity.
	A. Female B. Male C. Transgender D. Intersex
4	Please indicate your age:
	A. 18-25 B. 26-35 C. 36-45 D. 46-55 E. 56-65 F. 66 or older
5	Do you believe that there are ever incidents of sexual assault, sexual harassment, or other nonconsensual sexual interaction among residents (clients) at this facility?
	A. Yes B. No

6 If yes, which incidents have occurred here? (Circle all that apply.)

- A. Unwanted sexual comments or jokes
- B. Invasion of privacy (looking at another resident's sexual organs or attributes)
- C. Unwanted touching
- D. Pressure for sexual favors or exchanges
- E. Forced oral sex
- F. Rape/forced anal or vaginal intercourse
- G. Other (including exposure such as mooning or exposing genitals)

7 How often do residents bring false allegations of sexual harassment or sexual assault against another resident?

- A. Daily B. Weekly C. Monthly D. A few times a year E. Once a year F. Every few years
- G. Every five to 10 years H. Never I. Not sure

8 Are you aware of flirtations or sexual interactions between staff and residents? Do they occur:

- A. Daily B. Weekly C. Monthly D. A few times a year E. Once a year F. Every few years
- G. Every five to 10 years H. Never I. Not sure

9 Which sorts of interactions occur between staff and residents? (Circle all that apply.)

- A. Flirting B. Sexual comments C. Touching D. Kissing E. Making dates for after the resident is released
- F. Sexual intercourse

10 Do you believe that there are ever incidents of sexual assault, sexual harassment, OR other sexual misconduct BY STAFF MEMBERS, VOLUNTEERS, OR CONTRACT PERSONNEL WITH RESIDENTS at the facility?

- A. Yes B. No

11 If yes, which incidents have occurred here? (Circle all that apply.)

- A. Unwanted sexual comments or jokes
- B. Invasion of privacy that goes beyond the requirements of the job (such as walking into a room unannounced or unauthorized viewing of a resident in the bathroom)
- C. Touching that goes beyond the requirements of the job (touching that might be considered sexual or inappropriate)
- D. Pressure for sexual favors; exchanges of favors for sex
- E. Forced oral sex
- F. Rape/forced anal or vaginal intercourse
- G. Other (including exposure such as mooning or exposing genitals)

12 How often do residents bring false allegations of sexual misconduct against staff?

- A. Daily B. Weekly C. Monthly D. A few times a year E. Once a year F. Every few years
- G. Every five to 10 years H. Never I. Not sure

13 If a resident disclosed that he or she was a victim of sexual assault by, or unwanted sexual attention from ANOTHER RESIDENT, what would you do? (Circle all that apply.)

- A. Nothing until I was convinced that the resident wasn't making it up to get attention or privileges or as revenge against another resident
- B. Nothing until I learned whether the contact might have been consensual
- C. Investigate the victim's allegation by talking to the alleged perpetrator
- D. Intervene to prevent any further activity and separate the victim and alleged abuser
- E. Immediately report to my supervisor
- F. Immediately report to the victim resource coordinator or PREA coordinator

- G. Immediately report to medical or mental health staff
- H. Immediately report to law enforcement (sheriff's department or police)

14 Does a resident have a choice in whether an incident you learn about is investigated?

- A. Yes
- B. No

15 If a resident disclosed that he or she was a victim of sexual assault, sexual harassment, or sexual misconduct BY A STAFF MEMBER, VOLUNTEER, OR CONTRACT WORKER, what would you do? (Circle all that apply.)

- A. Nothing until I was convinced that the resident wasn't making it up to get attention or privileges or as revenge against a staff member
- B. Investigate the victim's allegation before reporting it to anyone else
- C. Intervene to prevent further activity and to ensure the safety of the victim
- D. Immediately report to my supervisor
- E. Immediately report to the agency director
- F. Report it to human resources
- G. Immediately report to law enforcement (sheriff's department or police)

16 How familiar are you with the Prison Rape Elimination Act (PREA)?

- A. Not at all familiar
- B. Somewhat familiar
- C. Very familiar

17 How did you learn about or become aware of PREA? (Circle all that apply.)

- A. Through training at this facility
- B. Through training at a previous job
- C. Through the media/Internet
- D. Through another source
- E. I am not familiar with PREA.

18 If you somehow found out about a sexual assault, sexual harassment, or sexual misconduct—or such behavior was reported to you—how sure are you about the protocol to follow?

- A. Unsure
- B. Somewhat sure
- C. Very sure

19 In the past year, have you received training on how to handle sexual misconduct or sexual assault?

- A. Yes
- B. No

20 What SUPPORT SERVICES are available to residents who are suffering from emotional trauma from a recent or past sexual assault? Please identify the specific programs or agencies.

21 What MEDICAL SERVICES are available to a resident within a week of being sexually assaulted? Please identify the specific services, tests, and providers.

22 How likely do you think a resident would be to disclose sexual harassment or sexual assault BY ANOTHER RESIDENT?

- A. Very unlikely
- B. Somewhat unlikely
- C. Somewhat likely
- D. Very likely

23 What do you think are the MAIN reasons that a resident would not disclose unwanted sexual attention or sexual assault BY ANOTHER RESIDENT? (Circle all that apply.)

- A. Fear of retaliation by the perpetrator(s) or the perpetrator's (perpetrators') friends
- B. Fear of not being believed
- C. Not trusting staff to handle the situation well
- D. Belief that services would not help
- E. Not wanting to snitch
- F. Belief that nothing will be done even if reported
- G. Fear about how he or she will be perceived
- H. Feeling ashamed about what happened
- I. Feeling that it is his or her own fault
- J. Fear of consequences from the institution (for example, loss of privileges or an invasive medical exam)

24 What do you think are the MAIN reasons that a resident would not disclose sexual misconduct or sexual assault BY A STAFF PERSON? (Circle all that apply.)

- A. Fear of retaliation by the perpetrator(s) or the perpetrator's (perpetrators') friends
- B. Fear of not being believed
- C. Not trusting staff to handle the situation well
- D. Belief that services would not help
- E. Not wanting to snitch
- F. Belief that nothing will be done even if reported
- G. Fear about how he or she will be perceived
- H. Feeling ashamed about what happened
- I. Feeling that it is his or her own fault
- J. Fear of consequences from the institution (for example, loss of privileges or an invasive medical exam)

25 Please indicate whether the items below are mostly true or mostly false.

	Mostly true	Mostly false
Sexual taunting and propositions are just part of the culture and cannot be changed.	<input type="checkbox"/>	<input type="checkbox"/>
Gay men are more likely to engage in consensual sex with other male residents, so their complaints of victimization should be regarded with some skepticism.	<input type="checkbox"/>	<input type="checkbox"/>
Residents who complain repeatedly of sexual victimization are trying to gain some advantage.	<input type="checkbox"/>	<input type="checkbox"/>
Transgender residents should be housed with the sex they identify with, even if they have not had genital reconstruction.	<input type="checkbox"/>	<input type="checkbox"/>
Verbal sexual harassment is a violation of PREA standards.	<input type="checkbox"/>	<input type="checkbox"/>
A sexual assault forensic exam (SAFE) is invalid two days after the alleged assault.	<input type="checkbox"/>	<input type="checkbox"/>
The perpetrator of a sexual assault does not need a SAFE exam.	<input type="checkbox"/>	<input type="checkbox"/>

26 Of the following, which groups of people are most vulnerable to sexual assault? Check all that apply.

	Yes	No
Transsexual residents	<input type="checkbox"/>	<input type="checkbox"/>
Latino residents	<input type="checkbox"/>	<input type="checkbox"/>
Lesbian residents	<input type="checkbox"/>	<input type="checkbox"/>

Younger residents		
Older residents		
Attractive female residents		
Attractive male residents		
African American male and female residents		
Gay male residents		
White male and female residents		
Victims of previous assaults/incest		
Female staff		

Note that in other jurisdictions it will be relevant to ask about additional racial and ethnic groups.

27 **If you would like to make any additional comments about the questionnaire, additional staff training needed, your facility's policies and protocols on sexual assault, sexual harassment or sexual misconduct, or issues at the facility, please write them here:**

Thank you for your time and cooperation.

B. FOR EXTERNAL RESEARCHERS: PROPOSED INTERVIEW GUIDE FOR CORRECTIONAL FACILITY RESIDENTS

Facilities interested in collecting information from the resident population should contact a regional college or university or other local professionals to see if they might be interested in taking on this evaluation project. If they use a web-based survey, the professionals don't need to be local. Only outside professionals can conduct these interviews. Before beginning the interview, the external researcher must discuss the consent form with the resident. For youth, researchers would discuss an assent form and the young person's parent or guardian must give informed consent. These forms provide information about how the information would be used, describe confidentiality, and give the resident information on how to skip questions they may not want to answer for any reason.

Date: _____

Start time: _____

End time: _____

Location: _____

Interviewer: _____

This project is focused on safety for residents and on staff training. The goal is to make it easy for residents to report any problems with other residents or with staff, and to receive services that are confidential and accessible.

We are interested in your perceptions of sexual harassment, sexual misconduct, and sexual abuse in this facility. We are also interested in your opinions about how to make it most comfortable for a resident to report any sort of sexual victimization and your opinions about services for victims. We will not ask you any questions about your personal experiences. The interview should take approximately 30 to 45 minutes.

I'd like to begin with some background questions that will allow me to know a little more about you. Again, everything we talk about will be kept confidential and you don't have to answer any questions you don't feel comfortable discussing. *(Note: Assent and consent forms have been signed prior to the interview beginning.)*

1	How long have you been at this facility?	
2	For purposes of comparison, have you been at other correctional facilities?	
	IF YES: <i>Was that a county jail, state prison, or juvenile detention?</i>	
	If more than one prior incarceration, ask about the most recent: <i>How long were you there?</i>	
3	How old are you?	

Now I'd like to ask some questions about this facility and the things that happen here.

4	How would you describe the environment in this facility? (What it is like to be here? Loud, chaotic, violent, calm, peaceful, etc.?)	
5	Do you believe this is a safe facility? (Do you feel safe here? Do you believe others are safe here? Why or why not?)	
6	In general, how do the residents get along with one another?	
	IF THEY GET ALONG FINE/WITHOUT SERIOUS PROBLEMS: <i>WHY DO YOU THINK THAT IS? (for example, staff control, residents don't get into arguments and fights, absence of gangs, busy with programs/work/school, etc.?)</i>	
	IF THEY DON'T GET ALONG/LOTS OF PROBLEMS: <i>WHY DO YOU THINK THAT IS? (for example, staff doesn't intervene when problems occur, residents cause problems/instigate problems, etc.)</i>	
7	In general, how do the residents and staff get along with one another?	

(USE SIMILAR PROMPTS AS FOR QUESTION 6.)

8	Are there ever problems between residents?	
	IF SO: <i>WHAT KINDS OF PROBLEMS?</i>	
	<i>HOW OFTEN DO THEY HAPPEN?</i>	
	<i>HOW HAVE THE PROBLEMS WORKED OUT? (Do they just persist? Do they get settled?)</i>	
9	Are there ever any problems between residents that are sexual in nature?	
	ASK ABOUT THE FOLLOWING:	
	A. Unwanted sexually explicit comments	
	B. Unwanted touching	
	C. Demands for sexual favors	
	D. Sexual threats	
	E. Pressure to have sex	
	F. Forced oral sex	
	G. Rape/forced sex	
	H. Residents invading privacy, such as while undressing or while showering	

ADDITIONAL PROMPTS IF ANY OF THE ABOVE OCCURS:

HOW OFTEN DOES THIS HAPPEN?

WHERE DO THESE INCIDENTS USUALLY HAPPEN?

DOES THE STAFF KNOW ABOUT THESE INCIDENTS?

HOW DO STAFF RESPOND?

DO OTHER RESIDENTS KNOW?

IF SO, HOW DO THEY FIND OUT?

HOW DO THEY RESPOND?

10 Are there ever problems between the residents and staff?

IF SO: WHAT KINDS OF PROBLEMS?

HOW OFTEN DO THEY HAPPEN?

HOW HAVE THE PROBLEMS WORKED OUT? (DO THEY JUST PERSIST?
DO THEY GET SETTLED?)

11 Are there ever any problems between residents and staff that are sexual in nature?

ASK ABOUT THE FOLLOWING:

A. Unwanted sexually explicit comments

B. Unwanted touching

C. Demands for sexual favors

D. Sexual threats

E. Pressure to have sex

F. Forced oral sex

G. Rape/forced sex

H. Staff invading privacy, such as while undressing or while showering

ADDITIONAL PROMPTS IF ANY OF THE ABOVE OCCURS:

HOW OFTEN DOES THIS HAPPEN?

WHERE DO THESE INCIDENTS USUALLY HAPPEN?

DO OTHER STAFF KNOW ABOUT THESE INCIDENTS?

HOW DO THEY RESPOND?

12 Is there ever any sexual contact between staff members and residents that you wouldn't classify as unwanted (for example, sexual relationships, romantic relationships, flirting, comments about a person's sexual attributes)?

13 If a **RESIDENT** in the facility were to approach you sexually when you didn't want that, would you tell a staff member or counselor—someone who works here? It could be anything from looking at your body, sexual comments, touching you, putting pressure on you to have sex with them, or forcing you.

ANSWER MAY VARY DEPENDING ON THE BEHAVIOR. USE THE FOLLOWING PROMPTS:

IF YES:	WHO WOULD YOU FEEL THE MOST COMFORTABLE TELLING ABOUT IT? (For example, would you talk to a case manager, shift supervisor, mental health counselor, nurse, volunteer, or outside person, such as your lawyer? With JDC residents, ask about teachers or a parent.)	
	WHAT WOULD YOU WANT DONE OR EXPECT TO HAPPEN IF YOU TOLD SOMEONE WHO WORKS HERE ABOUT IT?	
IF NO:	WHY WOULD YOU NOT TELL SOMEONE WHO WORKS HERE?	
	Would you consider it snitching?	

14 Would you trust that such a report would be confidential, that is, it would be kept private so that other residents or staff wouldn't know?

--

15 If a **STAFF MEMBER** in the facility were to approach you sexually, would you tell someone else who works here? This could be flirting, touching you sexually, sexual remarks, pressure to have sex, offering favors in exchange for sex, or forcing you.

IF YES:	WHO WOULD YOU FEEL THE MOST COMFORTABLE TELLING ABOUT IT? (For example, would you talk to a case manager, shift supervisor, mental health counselor, nurse, volunteer, or outside person, such as your lawyer? (With JDC residents, ask about teachers or a parent.)	
	WHAT WOULD YOU WANT DONE OR EXPECT TO HAPPEN IF YOU TOLD SOMEONE WHO WORKS HERE ABOUT IT?	
IF NO:	WHY WOULD YOU NOT TELL SOMEONE WHO WORKS HERE?	
	Would you consider it snitching?	

16 Would you trust that such a report would be confidential, that is, it would be kept private so that other residents or staff wouldn't know?

--

17 Many cases of sexual assault, sexual harassment, and sexual abuse go unreported. What do you think could be done to increase the reporting of this type of behavior in this facility?

--

18 Do you think some residents are more likely to be victims of sexual abuse?

IF SO:	WHAT MAKES THEM MORE VULNERABLE OR LIKELY TO BE SEXUALLY ASSAULTED OR ABUSED?	
	WHAT COULD FACILITIES DO TO BETTER PROTECT THEM FROM SEXUAL ABUSE?	

19 Do you think some residents or other people in the facility are more likely to be perpetrators of sexual abuse?

--

20	<p>What do you think should be done if a resident tells someone in authority that they had sexual contact with another resident when they didn't want to?</p>	
<p>WHAT DO YOU THINK SHOULD BE DONE FOR THE VICTIM? (GIVE PROMPTS REGARDING WHAT SERVICES SHOULD BE AVAILABLE OR ARE AVAILABLE.)</p>		
<p>WHAT DO YOU THINK SHOULD BE DONE TO THE PERSON WHO DID THIS?</p>		
21	<p>What do you think should be done if residents tell someone in authority that they were sexually assaulted by a staff member?</p>	
<p>WHAT DO YOU THINK SHOULD BE DONE FOR THE VICTIM? (GIVE PROMPTS REGARDING WHAT SERVICES SHOULD BE AVAILABLE OR ARE AVAILABLE.)</p>		
<p>WHAT DO YOU THINK SHOULD BE DONE TO THE PERSON WHO DID THIS?</p>		
22	<p>Would you be more likely to tell someone in authority about a sexual assault if you could tell someone outside the facility?</p>	
23	<p>Have you received any information at this facility regarding sexual assault, sexual harassment, and staff sexual misconduct? Do you know what to do if you are victimized? How did you get that information? (For example, orientation, a pamphlet, handbook, or staff explained it? Do you know your options?)</p>	
24	<p>What is the best way to give residents this information so that they know what to do?</p>	
25	<p>Would you be more likely to tell someone about a sexual assault or sexual misconduct if the perpetrator were another resident or if they were a staff person? What about if it were a volunteer? (FOR RESIDENTS WHO GO OUT IN THE COMMUNITY:) What if it were someone outside the facility?</p>	
26	<p>Are there any other things related to the content of this interview that I didn't ask that you would like to talk about?</p>	
27	<p>Before we end our interview, could you identify yourself racially/ethnically? Do you mind telling me how you identify in terms of gender and sexual orientation?</p>	

Thank you for your time. I appreciate it.

C. TRAINING FEEDBACK FORM

Date: _____ Start time (Circle one.): 8 am 1 pm

Training topic: _____ Facility: _____

Please answer the questions below regarding the training you just completed. Thank you for your time and honesty. Please note that this is an *anonymous* survey, so do not put your name on the form.

1 Describe your thoughts on the training you just received by indicating whether you Strongly Agree (SA), Agree (A), Disagree (D), or Strongly Disagree (SD) with the following statements:				
	SA	A	D	SD
I will be able to apply what I've learned today to my work.				
I believe others in my profession will benefit from this training.				
I do not believe this training will help me much in my work.				
2 How would you rate your overall satisfaction with the training you received today? (Circle one.)				
A. Very Satisfied B. Satisfied C. Somewhat Dissatisfied D. Not at all Satisfied				
3 How would you rate your satisfaction with the training materials? (Circle one.)				
A. Very Satisfied B. Satisfied C. Somewhat Dissatisfied D. Not at all Satisfied				
4 Please check the appropriate box based on your level of satisfaction with specific aspects of the training.				
	Highly Satisfied	Somewhat Satisfied	Not at all Satisfied	
Pace of training				
Efficiency of training				
Opportunities to ask questions				
Openness to/comfort level with asking questions or voicing concerns				
Presenter's ability to clearly explain the topics covered in the training				
Presenter's use of materials to demonstrate points covered in the training (such as video, testimonials, handouts, etc.)				
5 What aspects of the training did you find to be MOST helpful? Why?				
6 What aspects of the training did you find to be LEAST helpful? Why?				
7 What additional training or information do you think would help you understand and respond to sexual assault allegations at your facility?				

8 How could the training be changed to make it better for future participants? (Consider topics, opportunities for participation, format, pace, etc.)

--

9 Identify three strategies you will use as a result of the training you received today. Please be specific.

1.	
2.	
3.	

Appendix 5: Questions for developing sexual assault response policies

If you start the process of developing or revising your policy with a meeting that explores resident reporting and facility first response, potential discussion questions follow below.

Note: CSG = Corrections SAFE Guide; PS = PREA standards. Note that for PREA standards, the number before a slash mark pertains to adult facilities and the number after a slash mark pertains to juvenile facilities.

A. REPORTING BY RESIDENTS

1. What fears and concerns might residents have that prevent them from reporting sexual assault? (For reference, see CSG: pages 24-25.)
2. How can policies/procedures address those fears and concerns to encourage reporting among residents? (See PS: 115.251/351: Resident Reporting; 115.216/316: Residents with Disabilities and Residents Who Are Limited English Proficient; 115.254/354: Third-Party Reporting; 115.267/367: Agency Protection Against Retaliation; 115.261/361: Staff and Agency Reporting Duties; and CSG: pages 44-45.)
 - a.) What are the ways a resident can report an assault?
 - b.) Does the facility have a grievance procedure?
 - c.) Do residents know how to report? Is anonymous reporting an option? What kind of outside reporting options do residents have?
 - d.) What steps should the facility take to protect residents and staff who have reported retaliation?
 - e.) What does the employee code-of-conduct policy say about retaliation?

B. FIRST RESPONSE

1. A resident reports that he or she has been sexually assaulted. What should the first responding staff member do? (See PS: 115.231/331: Employee Training; 115.264/364: Staff first responder duties; and CSG: pages 58-61.)
 - a.) Review PREA standard 115.264/364. What, if anything, would you add to this list? Consider how you would do some of these things in practice.
 - b.) Do the steps change depending on who receives the report—for example, staff versus a contractor or a volunteer?
 - c.) How do the steps change based on the perpetrator of the assault—for example, if the perpetrator is on staff or if the perpetrator is someone in the community, such as an employer or co-worker?

C. REPORTING TO INVESTIGATORS

(See PS: 115.261/361: Staff and Agency Reporting Duties.)

1. When should the agency's internal investigator be notified? Who notifies that person and how?
2. When should the law enforcement agency be notified? Which agency has jurisdiction? Who notifies the agency and how?
3. For a juvenile detention facility, if and when should the child protective service agency be notified? Who notifies the agency and how? Do other state regulators also need to be notified (such as an agency that oversees residential facilities licensed in the state)? Who notifies them and how?
4. What are the mandatory reporting requirements for medical and mental health practitioners? For minor residents? For residents who are considered vulnerable adults?
5. For the juvenile detention facility, when should the following be notified? Who notifies each one and how?

(See PS 115.361.)

- a.) Parents or legal guardians, unless the facility has official documentation showing that they should not be notified?
- b.) Victim's caseworker, if the child is under the guardianship of the child welfare system?
- c.) Victim's attorney or legal representative, if the child is under the jurisdiction of the juvenile court system?
- d.) Is there anyone else who needs to be notified?

D. FORENSIC MEDICAL EXAMS

(See PS: 115.221/321: Evidence Protocol and Forensic Medical Examinations; and CSG, pages (41-44.)

1. Who evaluates the resident and decides whether he or she should be offered a forensic medical exam?
2. What evidence collection is done on-site, if any, before the resident goes to the hospital? Who collects it?
3. Will the facility notify the hospital before transporting a resident for a forensic medical exam?
4. Who will be responsible for transporting residents to the hospital for a forensic medical exam?
5. How will victims be secured during transport, if at all?
6. Where will facility staff be during the exam?
 - a.) Waiting area?
 - b.) Providing a security presence in the exam room?
7. What role will the facility play, if any, in notifying a community sexual assault victim advocate to come to the hospital?
8. How will any treatment plans, instructions for follow-up tests, or prescriptions travel back to the facility?

E. VICTIM SERVICES

(See PS: 115.221/321: Evidence Protocol and Forensic Medical Examinations; 115.253/353: Resident Access to Outside Confidential Support Services/Resident Access to Outside Support Services and Legal Representation; and CSG: pages 36-41.)

1. What is the scope of services that the community sexual assault advocacy organization will provide? Consider the scope of services for both immediate reports of abuse and delayed reports of abuse.
 - a.) Hospital advocacy
 - b.) Hotline/crisis intervention
 - c.) Follow-up services
2. What kind of coordination needs to take place between the facility and the advocacy organization to ensure easy access to services? Is a formal MOU necessary?
3. For juvenile detention facilities, what role will the state child welfare agency play, if any, in providing services to residents who are abused at the facility?

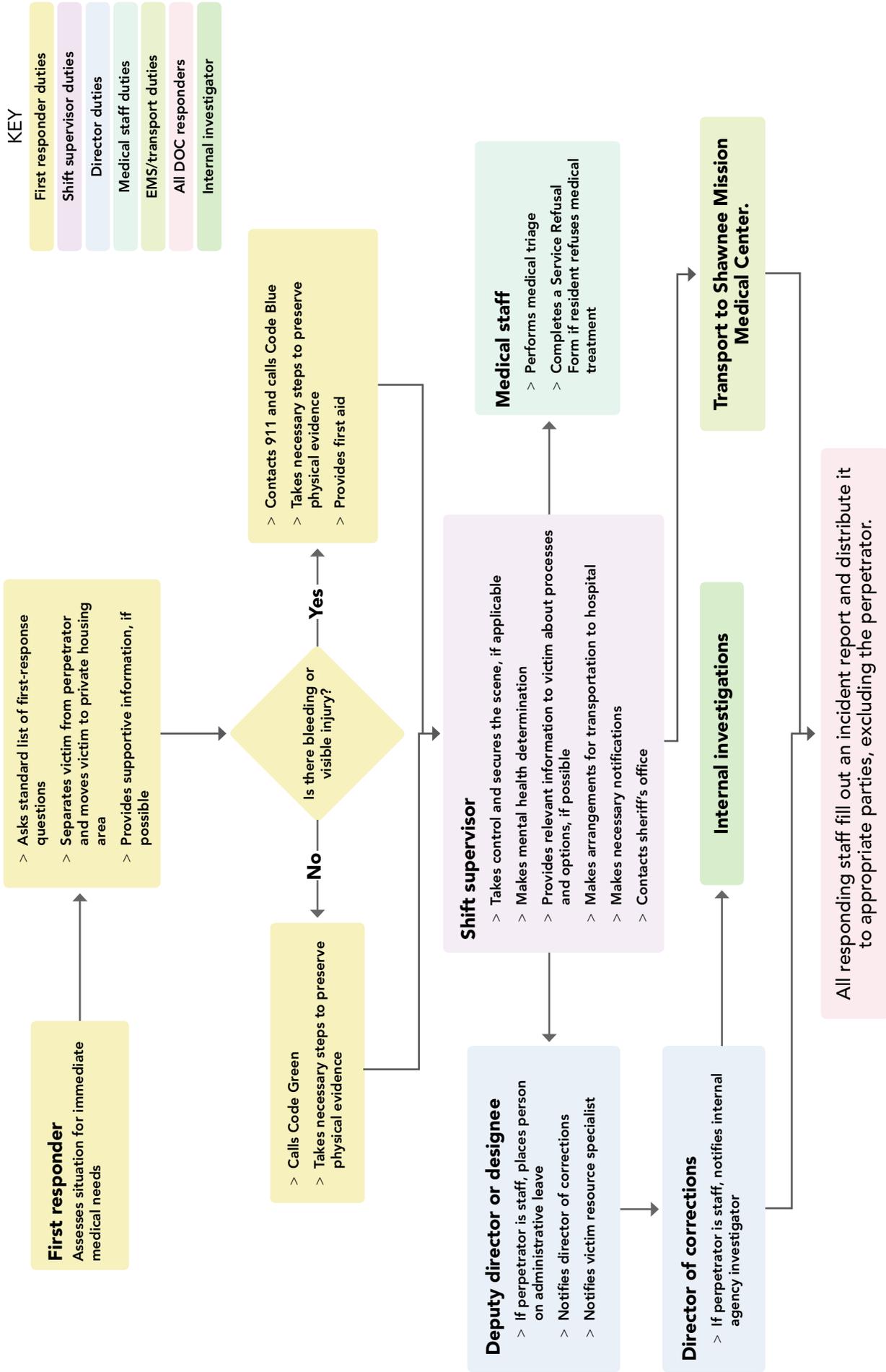
F. IN-HOUSE MEDICAL AND MENTAL HEALTH SERVICES

(See PS: 115.282/382: Access to Emergency Medical and Mental Health Services.)

1. What medical and mental health services are available to residents? Consider services for both immediate reports of abuse and delayed reports of abuse.
2. How do residents access these services?

Appendix 6: SARTCP response flowcharts

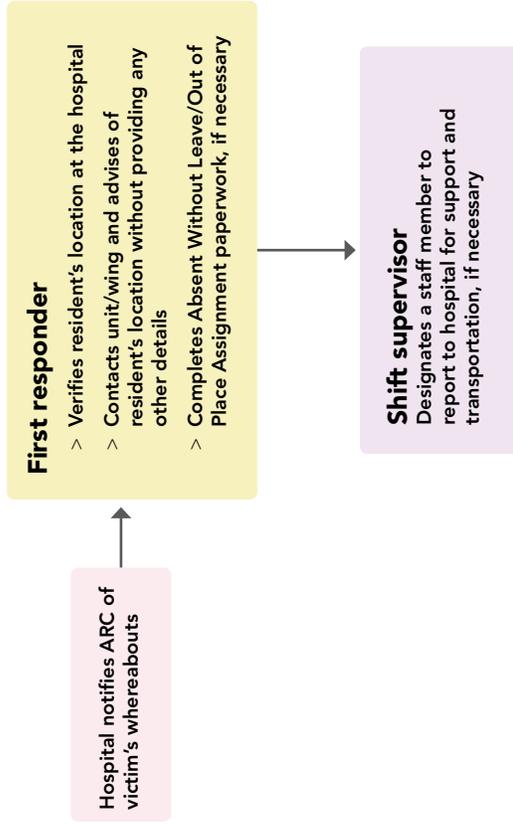
ARC: First Response for Resident Sexual Abuse Reported or Discovered Within Seven Days of Occurrence



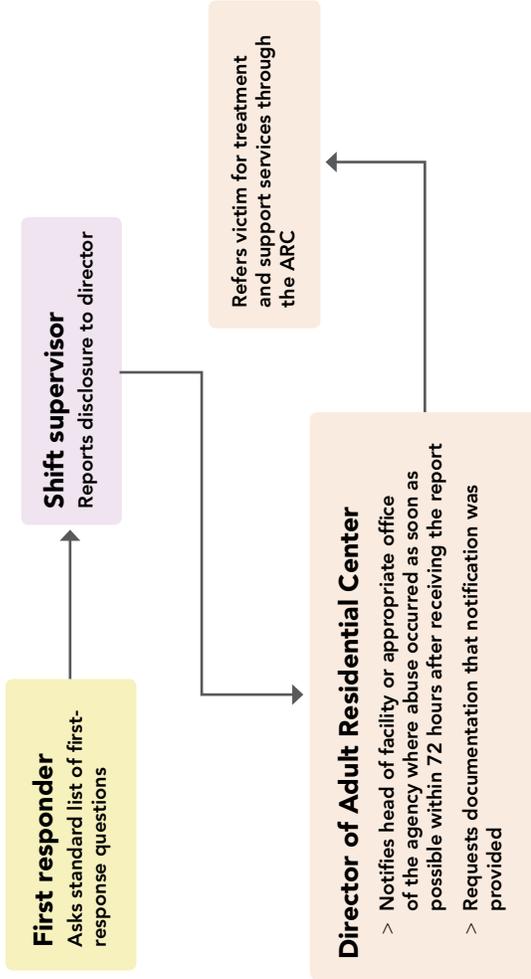
This flowchart was adapted from documents developed for the Johnson County Department of Corrections, in Kansas.

ARC: Procedures After Sexual Abuse Disclosures in Other Circumstances

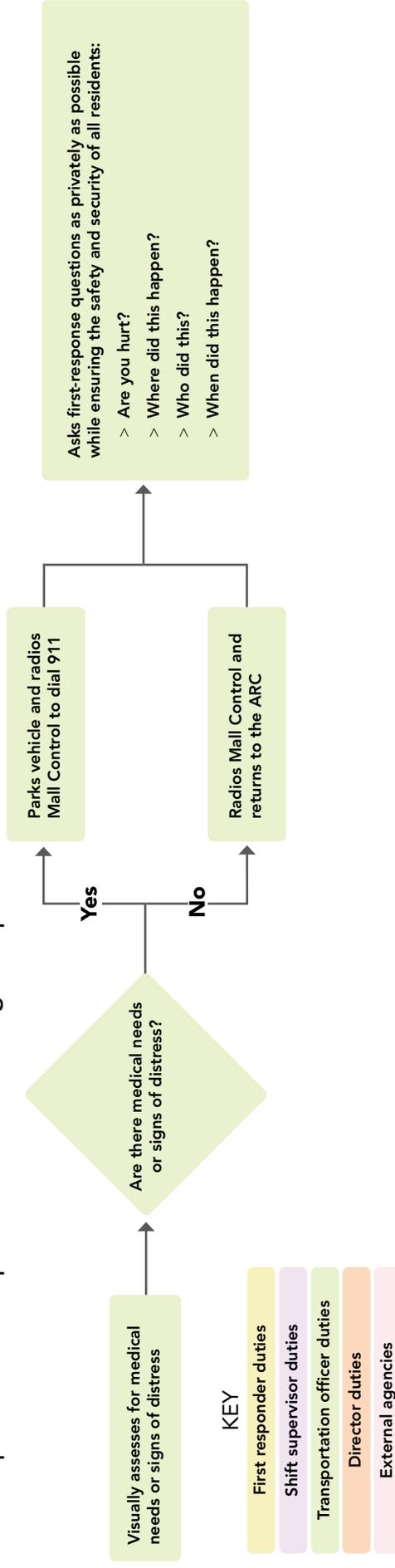
Victim reports at a hospital:



Victim reports to ARC abuse that occurred at another facility:



Victim reports to a transportation officer during transport:

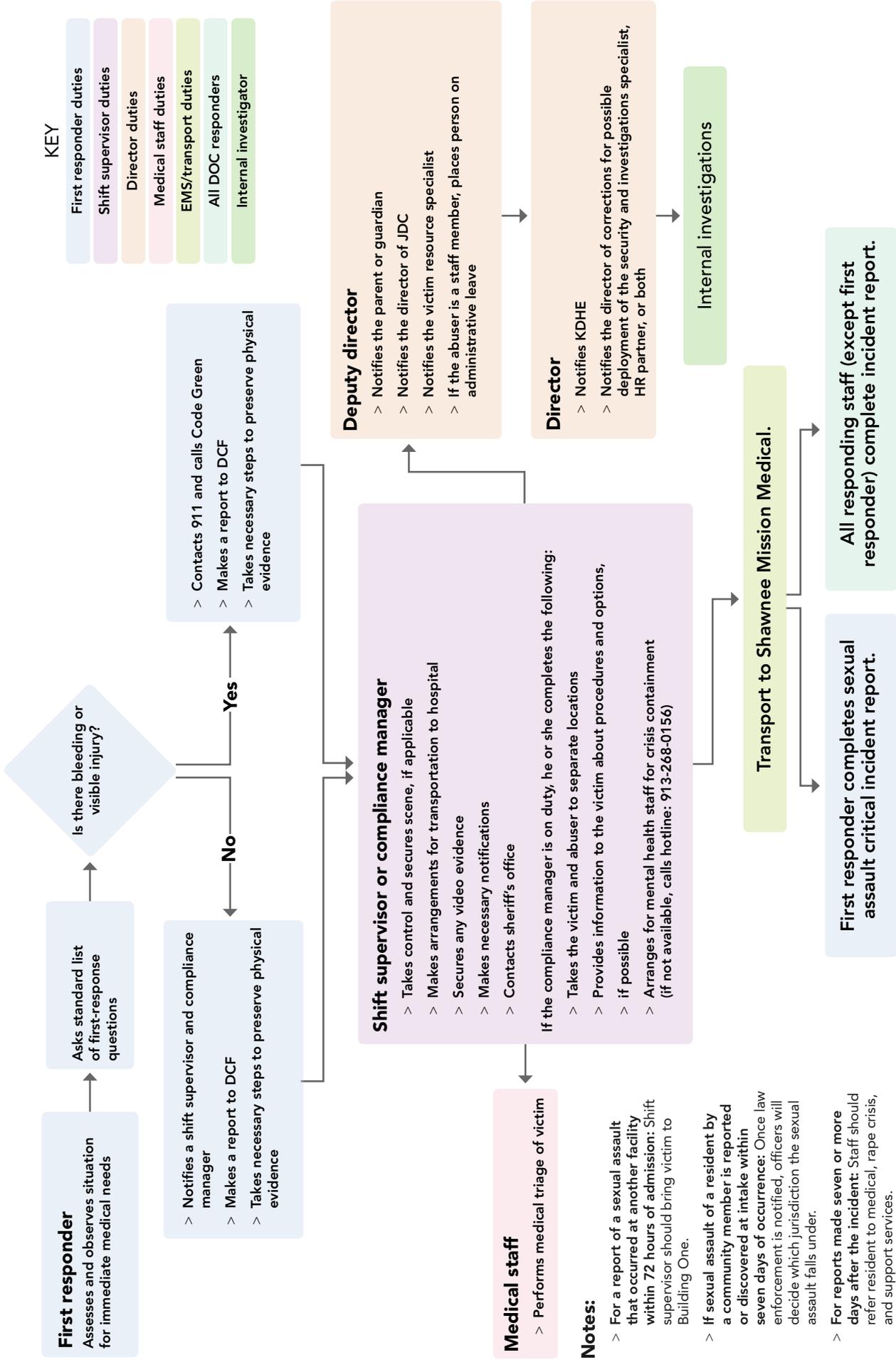


KEY

- First responder duties
- Shift supervisor duties
- Transportation officer duties
- Director duties
- External agencies

This flowchart was adapted from documents developed for the Johnson County Department of Corrections, in Kansas.

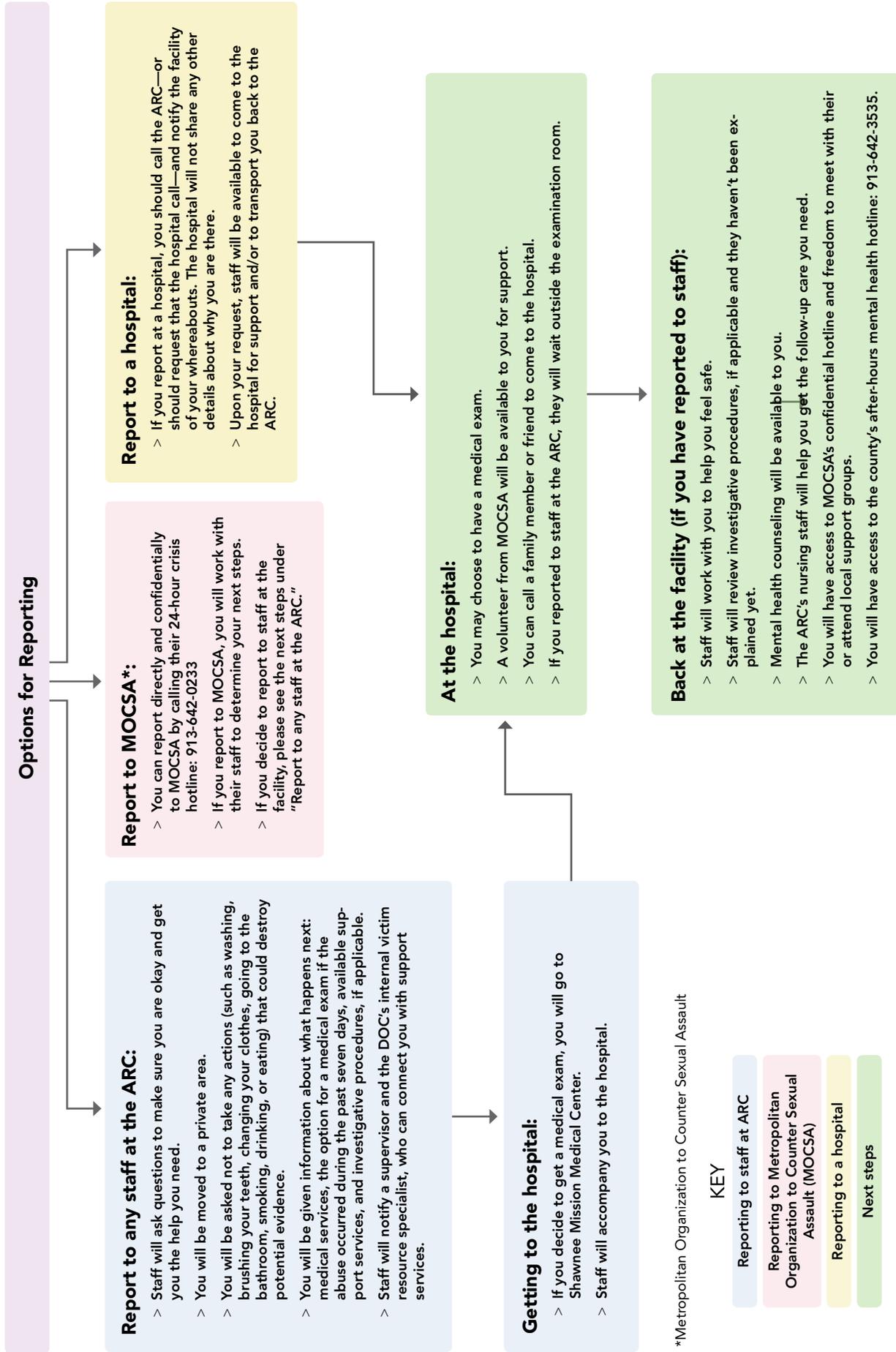
JDC: First Response Procedures for Resident Sexual Assault Reported or Discovered Within Seven Days of Occurrence



This flowchart was adapted from documents developed for the Johnson County Department of Corrections, in Kansas.

Appendix 7: Resident flowcharts

What Happens If I'm Sexually Abused While Residing at the ARC?



This flowchart was adapted from documents developed for the Johnson County Department of Corrections, in Kansas.

What Happens If I'm Sexually Abused at the JDC?

Options for Reporting

Report to any staff at the JDC:

- > Staff will ask questions to make sure you are okay and get you the help you need.
- > You will be moved to a private area.
- > You will be asked not to take any actions (such as washing, brushing your teeth, changing your clothes, going to the bathroom, smoking, drinking, or eating) that could destroy potential evidence.
- > You will be given information about what happens next: medical services, the option for a medical exam if the abuse occurred during the past seven days, available emotional support services, and investigative procedures, if applicable.
- > Staff will notify one or more supervisors, the DOC's internal victim resource specialist and the Department of Children and Families.
- > In most cases, a facility director will notify your parent or guardian.

Report by completing an Informal Communication Form (ICF):

- > You may fill out an ICF and place it in the secure box.
- > ICF forms are collected once per shift.
- > Once staff receive your report, please see steps under "Report to any staff at the JDC."

Report outside the JDC:

- > You can report directly and confidentially to MOCSA* by calling their 24-hour crisis hotline: 913-642-0233
 - If you call MOCSA, you can report anonymously if you just want to talk to someone.
 - You will work with MOCSA to determine your next steps.
- > You can report to the Kansas Child Abuse Hotline/Kansas Protection Report Center: 800-922-5330
 - The facility will be notified.
- > You can notify Olathe School District personnel.
 - The facility will be notified.
- > If the facility is notified or if you decide to report at the facility after contacting MOCSA, please see steps under "Report to any staff at the JDC."

Getting to the hospital:

- > If you decide to get a medical exam, you will go to Shawnee Mission Medical Center.
- > Two staff will accompany you to the hospital.
- > Staff will bring extra clothes and toiletries for you.

At the hospital:

- > Staff will wait outside the examination room.
- > A volunteer from MOCSA* will be available to you for emotional support.

Back at the facility:

- > Staff will work with you to help you feel safe.
- > Mental health counseling will be available to you.
- > The JDC's nursing staff will ensure that you get the follow-up care you need.
- > You will have access to MOCSA's* confidential hotline and follow-up services, if needed.

*Metropolitan Organization to Counter Sexual Assault

KEY

Reporting to staff at JDC

Reporting through ICF

Reporting outside JDC

This flowchart was adapted from documents developed for the Johnson County Department of Corrections, in Kansas.

Appendix 8: Sample sexual abuse incident review forms

A. SEXUAL ABUSE INCIDENT REVIEW CHECKLIST

This sample checklist can help guide the process of reviewing known incidents and reported allegations, as required by PREA. Note that PREA Standard 115.286/386 requires agencies to conduct reviews of every sexual abuse investigation. Sexual abuse incident reviews must take place within 30 days of an investigation, whether the allegation was substantiated or was not.

This sample checklist was adapted from “Alvis House Community Corrections Center Sexual Assault Response Team (SART) Checklist.”

Sexual Abuse Incident Review Checklist

Date: _____

Names of review team members (check if present at the meeting):

1. [NAME] : _____

5. [NAME] : _____

2. [NAME] : _____

6. [NAME] : _____

3. [NAME] : _____

7. [NAME] : _____

4. [NAME] : _____

8. [NAME] : _____

Summary of incident, including date and time:

RESIDENT SAFETY

1 Did a team member respond to the victim at the time of the incident?
 Yes No

2 List name of responding staff person, date, and time of contact with client/victim:
Responding staff member:
Date: Time:

3 Did the client/victim require medical care?
 Yes No
If yes, list the name and address of the medical provider, and the date and time that treatment was received.

4 Was the client/victim informed of services offered by [insert name of rape crisis center/victim advocacy program], such as counseling?
 Yes No

5 Did the client/victim agree to receive in-house services?
 Yes No

6 Was the client/victim informed of community-based services related to his or her specific area of need?
 Yes No

7 Were mental health services recommended?
 Yes No
If yes, did the client/victim agree to receive mental health services?
 Yes No

POLICIES AND PROCEDURES

8 Was the client/victim informed of confidentiality and duty to report?
 Yes No

9 Was the perpetrator identified?
 Yes No
If yes, List the name, status (resident or staff person), and facility location.

10 Did the client/victim indicate feeling uncomfortable with any specific client or employee in the facility?
 Yes No

If yes, list name, job title (if relevant), and facility location of all persons named by the client/victim. Also, state why the client feels uncomfortable around the named individuals.

11 Did the facility employee(s) respond to the incident according to agency policies?

Yes No

12 Is any additional employee training recommended to improve understanding of, or response to, client sexual victimization?

Yes No

If yes, indicate areas in which training is recommended.

REPORTING

13 Was the response to the client/victim timely?

Yes No

If no, what caused a delay in services to the client/victim?

14 Were the client/victim's emergency contacts notified?

Yes No

15 Was law enforcement contacted?

Yes No

If yes, which agency?

16 Did law enforcement respond to the scene of the incident?

Yes No N/A

17 Was the location of the alleged sexual assault secured?

Yes No N/A

18 Was evidence removed from the scene by law enforcement?

Yes No N/A

If yes, list known items removed from the scene:

19 Were documents related to this incident completed accurately?

Yes No

20 Was any pertinent information overlooked or omitted?

Yes No

If yes, please identify:

21 Please list the whereabouts of the client/victim as of the date of this document. (Check all that apply.)

- Removed from the program
- Transferred to _____ facility
- Client hospitalized (name of hospital: _____)
- Other (specify): _____

22 Please list the whereabouts of the perpetrator as of the date of this document. (Check all that apply.)

- Transferred to _____ facility
- Placed in secure custody
- Unknown
- Other (specify): _____

PROCESS REVIEW

23 Did someone conduct an on-site review of the location where the incident occurred?

Yes No

24 Who conducted the review? List names and job titles.

25 Did the review identify any physical vulnerabilities in the facility?

Yes No

If yes, please identify the vulnerabilities noted and planned action steps, including time lines:

26 Are you aware of any media coverage related to this incident?

Yes No

If yes, list the type of media coverage:

RECOMMENDED IMPROVEMENTS

- 1** Based on the incident and the agency's response, please list any policies that should be revised. State what changes are recommended and how they would improve our response to, or prevention of, client sexual victimization at facility.

- 2** Based on the incident and the agency's response, please list any improvements to facility security where the violation occurred.

- 3** Based on the incident and the agency's response, please list any services not currently provided that may improve resident safety and protection from sexual victimization.

- 4** Based on the incident and the agency's response, could any changes be made to assist victims who disclose sexual victimization (such as designating a person to receive reports or ensuring privacy)?

- 5** Will the incident be included in statistics reported to the U.S. Department of Justice? That is, was it deemed "founded"?

Yes No

If yes, was it deemed a "PREA incident"? Yes No

If the answer to either question is no, why not?

- 6** If the incident was founded and substantiated, did possible motives include the victim's social or sexual identity or perceived identity, including race; ethnicity; gender identity or sexual orientation; gang membership; or other group dynamics at the facility?

Yes No

If yes, please explain:

Name & job title of person completing this document:

PRINTED NAME

JOB TITLE

Signature: _____

B. QUARTERLY/BIANNUAL SEXUAL ABUSE INCIDENT REVIEW CHECKLIST

Sexual abuse incident reviews conclude with recommendations for changes. Depending on the frequency of incidents reviewed, the Sexual Abuse Incident Review Checklists could be reviewed twice or four times a year, but they must be conducted at least annually, to determine whether any problems were rectified and recommendations adopted, and, if not, to address any identified issues. This questionnaire can help staff complete the annual report on incidents and corrective actions required under PREA Standard 115.288/388: Data Review for Corrective Action.

Quarterly/Biannual Sexual Abuse Incident Review Checklist

Date of review: _____

Review period: Beginning date _____ End date: _____

How many incidents or reports were reviewed? _____

How many were deemed founded/substantiated? _____

How many will be reported to the U.S. Department of Justice as "PREA incidents"? _____

How many were reported to law enforcement? _____

How many have been referred for prosecution or investigated for prosecution? _____

How many were prosecuted? _____

Were any founded incidents motivated by the actual or perceived gender identity or sexual orientation of the victim?
No ___ Yes ___ How many? _____

Describe: _____

Were the recommendations implemented?

List all problems identified and all recommendations.

Consider the following possible categories:

- > Timeliness of review and participation of all responders, including the SART
- > Policies
- > Staff training
- > Resident education
- > Notification of emergency contacts
- > Notification of law enforcement/Involvement of SART in response
- > Timeliness of response
- > Treatment of victim
- > Treatment of alleged perpetrator
- > Facility safety

1. Problem:

Recommendation(s):

Recommendation implemented?

Yes Date of implementation _____

No What obstacles are interfering with the needed improvements?

How will the problem be addressed?

When will the problem be addressed?

2. Problem:

Recommendation(s):

Recommendation implemented?

Yes Date of implementation _____

No What obstacles are interfering with the needed improvements?

How will the problem be addressed?

When will the problem be addressed?

Overall appraisal:

Are recommendations usually implemented in a timely fashion? If so, please describe the process. If not, are recommendations unrealistic given financial, logistical, staffing, or population issues? Are there systemic issues that need to be addressed, such as communication, leadership, or time?

Appendix 9: Excerpted SARTCP training agenda

Below is an excerpt from the SARTCP training agenda that was used for an introductory training session on PREA for line staff.

Objective	Estimated Time	Content Outline and Notes
	15 minutes	<p>Introduction</p> <ul style="list-style-type: none"> > Introduction of trainer > Introduction of students > Housekeeping issues > Lesson overview > Objectives for the lesson
<p>Define strategies of the Prison Rape Elimination Act (PREA).</p> <p>Identify at least three types of sexual assault.</p> <p>Define sexual assault in a confinement setting.</p>	24 minutes	<p>Lesson 1: Basic Sexual Assault Education</p> <p>PREA Basics/History</p> <ul style="list-style-type: none"> > PREA legislation history > PREA strategies > Applications, goals, and definitions <p>Facilitated Discussion</p> <ul style="list-style-type: none"> > What are your definitions of sexual assault? > How do you expect a victim to react to being sexually assaulted? > How would you handle it, if someone disclosed to you right now? <p>Three Types of Sexual Assault</p> <ul style="list-style-type: none"> > Stranger sexual assault > Non-stranger sexual assault > Institutional sexual assault <p>Definitions of Sexual Assault</p> <ul style="list-style-type: none"> > Inmate-on-inmate sexual assault > Staff-on-inmate sexual assault > Sexual harassment > Definition of vulnerable populations
Describe reactions victims may have.	9 minutes	<p>Reactions of Victims</p> <ul style="list-style-type: none"> > Withdrawal, depression, feelings of guilt > Angry, aggressive, combative behavior > Overly sexualized > Changes in behavior and personality
List differences in sexual assault in a confinement setting.	9 minutes	<p>Three Ways Sexual Assault Is Different in Confinement</p> <ul style="list-style-type: none"> > Victim lives with the perpetrator in most cases. > It is difficult to access services confidentially. > Victim must worry about retaliation from others.

Objective	Estimated Time	Content Outline and Notes
List service options for victims/ survivors.	8 minutes	<p>Typical Services Available for Sexual Assault Victims/Survivors</p> <ul style="list-style-type: none"> > Hotline > Information and referral > Individual and group counseling > Medical and legal advocacy and accompaniment <p>Facilitated Discussion:</p> <ul style="list-style-type: none"> > What services can be provided in the institutional setting? What services cannot be provided?
<p>Identify the importance of trauma-informed reactions to disclosures.</p> <p>Discuss the importance of words and physical response to a disclosure.</p>	8 minutes	<p>Lesson 2: First Responder Duties</p> <p>Trauma-Informed Response</p> <ul style="list-style-type: none"> > Victims need to know that they are believed. > Knowledge is powerful for victims/survivors. It is important for them to know what is going to happen for reporting. <ul style="list-style-type: none"> • Who will they talk to? • Where will they go? • What is the process? <p>Physical Reaction to a Disclosure</p> <ul style="list-style-type: none"> > Try to stay relaxed. > Don't appear to close yourself off from the victim/survivor; for example, do not fold your arms in front of your chest. > Don't step back from the victim. <p>Importance of Choice of Words</p> <ul style="list-style-type: none"> > Do not make victim-blaming statements/questions. <ul style="list-style-type: none"> • "What were you doing with that loser?" • "You should know better than to trust him/her." • "What did you think would happen if you were acting that way?" > Intonation should be a normal conversational tone; no yelling or raising your voice.
<p>Identify responsibilities when a disclosure is received.</p> <p>Identify follow-up responsibilities to a disclosure.</p>	12 minutes	<p>Adult Rehabilitation Center Staff Section</p> <p>Basic Responsibilities When Receiving an Immediate Disclosure (within the past seven days)</p> <ul style="list-style-type: none"> > Separate the victim and the alleged perpetrator by taking them to separate locations. > Determine whether there is any immediate medical need. If so, contact 911. > Ask basic questions: <ul style="list-style-type: none"> • Are you hurt? • Where did this happen? • Who did this? • When did this happen? > Talk to the victim/survivor about not doing the following actions that could destroy possible evidence: <ul style="list-style-type: none"> • washing • brushing teeth • changing clothes • urinating

Objective	Estimated Time	Content Outline and Notes
		<ul style="list-style-type: none"> • defecating • smoking • drinking • eating <p>Responsibilities When Receiving a Delayed Disclosure (more than seven days ago)</p> <ul style="list-style-type: none"> > Separate the victim and the alleged perpetrator by taking them to separate locations, if applicable. > Notify the shift supervisor. <p><i>It is important to review all six flowcharts. Each one is different, depending on who the alleged perpetrator is.</i></p> <p>Follow-up with the Victim/Survivor</p> <ul style="list-style-type: none"> > The victim/survivor chose you to disclose to and it is important to acknowledge that. > It is important to remind victims that there is help for them.
<p>Identify responsibilities when a disclosure is received.</p> <p>Identify follow-up responsibilities to a disclosure.</p>	<p>12 minutes</p>	<p>Juvenile Detention Center Staff Section</p> <p>Responsibilities When Receiving an Immediate Disclosure (within the past seven days)</p> <ul style="list-style-type: none"> > Separate the victim and the alleged perpetrator by taking them to separate locations. > Determine whether there is any immediate medical need. <ul style="list-style-type: none"> • If so, contact 911 and call Code Green and make a report to DCF (child protection agency). > Ask basic questions: <ul style="list-style-type: none"> • Are you hurt? • Where did this happen? • Who did this? • When did this happen? > If the incident occurred within the past seven days, the first responder should talk to the victim/survivor about not doing the following actions that could destroy possible evidence: <ul style="list-style-type: none"> • washing • brushing teeth • changing clothes • urinating • defecating • smoking • drinking • eating <p>Responsibilities When Receiving a Delayed Disclosure (more than seven days ago)</p> <ul style="list-style-type: none"> > Separate the victim and the alleged perpetrator by taking them to separate locations. > Notify the shift supervisor. > Make a report to DCF (child protection agency). <p>Follow-up with the Victim/Survivor</p> <ul style="list-style-type: none"> > The victim/survivor chose you to disclose to, and it is important to acknowledge that. > It is important to remind victims that there is help for them.

Objective	Estimated Time	Content Outline and Notes
<p>Describe confidentiality in the adult setting.</p> <p>Discuss appropriate actions to take with regard to confidentiality.</p>	20 minutes	<p>Lesson 3: Confidentiality in the Adult Setting</p> <p>Confidentiality</p> <ul style="list-style-type: none"> > No matter who the alleged perpetrator is, it is important that as few people as possible become aware of the details. > Be clear with the victim/survivor about what you as a staff member are required to report and who you are required to report to. <p><i>Thank you so much for trusting me to tell me about this. I am required to report this, but I will not talk about this with anyone other than the people I am required to report this to. (Indicate the types of people who must be notified.)</i></p> <p>It is important to understand the confidentiality policies of the victim service provider that may come into the facility or that the inmate may go to see in the community.</p> <p>Facilitated Discussion:</p> <ul style="list-style-type: none"> > What are the differences in the confidentiality policy of the DOC and that of the victim service provider? > How could these two policies/philosophies clash? > How would you handle that?
<p>Describe confidentiality in the juvenile setting.</p> <p>Discuss appropriate actions to take with regard to confidentiality.</p>	20 minutes	<p>Lesson 3: Confidentiality in the Juvenile Setting</p> <p>Confidentiality</p> <ul style="list-style-type: none"> > No matter who the alleged perpetrator is, it is important that as few people as possible become aware of the details. > Be clear with the victim/survivor about what you as a staff member are required to report and who you are required to report to. <p><i>Thank you so much for trusting me to tell me about this. I am required to report this, but I will not talk about this with anyone other than the people I am required to report this to. (Indicate the types of people who must be notified.)</i></p> <ul style="list-style-type: none"> > It is important to understand the confidentiality policies of the victim service provider that may come into the facility or that the inmate may go to see in the community. > Know the differences for those over and under the age of 14 when it comes to the services a victim service provider can offer. <i>(Note: This varies from state to state.)</i> <p>Facilitated Discussion:</p> <ul style="list-style-type: none"> > What are the differences in the confidentiality policy of the DOC and that of the victim service provider? > How could these two policies/philosophies clash? > How would you handle that?
<p>Identify the positions/people who are likely to be disclosed to.</p>	7 minutes	<p>Lesson 4: Internal Reporting Options</p> <p>Facilitated Discussion:</p> <ul style="list-style-type: none"> > What staff positions do you think victims/survivors might be likely to report to? > Why do you think so? What makes that position/person one who may be reported to?

Objective	Estimated Time	Content Outline and Notes
<p>Identify methods residents can use to report internally.</p> <p>Identify how residents are informed of these options.</p>	8 minutes	<p>Internal Reporting Options – Adult Facility</p> <p>Methods of Reporting:</p> <ul style="list-style-type: none"> > Report to a staff member verbally. > Report by filling out an Informal Communication Form and putting it in the secure box. <p>Notification of Reporting Methods</p> <ul style="list-style-type: none"> > ARC handbook
<p>Identify methods residents can use to report internally.</p> <p>Identify how residents are informed of these options.</p>	8 minutes	<p>Internal Reporting Options – Juvenile Facility</p> <p>Methods of Reporting:</p> <ul style="list-style-type: none"> > Report to a staff member verbally. > Report by filling out an Informal Communication Form and putting it in the secure box. <p>Notification of Reporting Methods</p> <ul style="list-style-type: none"> > JDC handbook
<p>Identify methods residents can use to report externally.</p> <p>Identify how residents are informed of these options.</p>	20 minutes	<p>Lesson 5: External Reporting Options – Adult Setting</p> <p>Methods of reporting:</p> <ul style="list-style-type: none"> > Olathe Police Department > Johnson County Sheriff’s Department <p>Notification of reporting methods</p> <ul style="list-style-type: none"> > ARC handbook > DOC website
<p>Identify methods residents can use to report externally.</p> <p>Identify how residents are informed of these options.</p>	20 minutes	<p>Lesson 5: External Reporting Options – Juvenile Setting</p> <p>Methods of Reporting:</p> <ul style="list-style-type: none"> > KDHE (health department) > Kansas Child Abuse Hotline/Kansas Protection Report Center > Olathe school personnel <p>Notification of Reporting Methods</p> <ul style="list-style-type: none"> > JDC handbook > DOC website
<p>Identify reasons victims/survivors don’t report.</p> <p>Identify additional barriers to reporting for incarcerated victims.</p>	20 minutes	<p>Lesson 6: Fears/Concerns About Reporting</p> <p>Reasons Victims Do Not Report</p> <ul style="list-style-type: none"> > fear that no one will believe them > fear that they will lose friends and/or loved ones > fear that no one will understand > fear that no one else has to deal with this <p>Additional Barriers that Incarcerated Victims Face</p> <ul style="list-style-type: none"> > retaliation from other inmates > retaliation from staff members

Objective	Estimated Time	Content Outline and Notes
<p>Discuss sexual orientation and gender identity.</p> <p>Identify risks relating to sexual assault for this population.</p>	20 minutes	<p>Lesson 7: Working with LGBTQI residents</p> <p>Definitions and Terms</p> <ul style="list-style-type: none"> > Asexual > Bisexual > Gay > Gender expression > Gender identity > Gender nonconforming > Intersex > Lesbian > Queer/questioning > Sexual orientation > Straight/heterosexual > Transgender <p>Risk Factors for This Population in a Facility Setting</p> <ul style="list-style-type: none"> > often a more vulnerable segment of inmate population > sometimes more feminine in appearance and demeanor > often considered a potential threat by other inmates, staff, or both > often perceived as a molester, whether true or not, by other inmates, staff, or both > often a potential target for physical and psychological abuse by other inmates, staff, or both
<p>Identify retaliation methods used in a facility setting.</p> <p>Identify potential perpetrators.</p>	15 minutes	<p>Lesson 8: Protecting Victims from Retaliation</p> <p>Retaliation Methods</p> <ul style="list-style-type: none"> > physical abuse > verbal harassment > psychological abuse > repeat victimization <p>Potential Perpetrators</p> <ul style="list-style-type: none"> > friends of the accused perpetrator on the inside > friends or relatives of the accused perpetrator on the outside > head inmate of the unit and/or block > staff member
	30 minutes	<p>Conclusion</p> <ul style="list-style-type: none"> > Summary review of information covered in this lesson > Q&A session to check learning > Lesson wrap-up/summary

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SOME RELATED NATIONAL AND STATE RESOURCES

In their efforts to eliminate sexual abuse in confinement, the National [PREA Resource Center](#) (PRC) provides assistance to those responsible for state and local adult prisons and jails, juvenile facilities, community corrections, lockups, tribal organizations, and inmates and their families. The PRC serves as a central repository for research trends, prevention and response strategies, and best practices in corrections. Technical assistance and resources are available through the center's coordinated efforts with its federal partners. The PRC is taking the lead in helping the corrections field to implement the PREA standards.

State and territory departments of corrections: [Locate a specific agency.](#)

State and territory sexual assault coalitions: [Locate a specific organization.](#)

These **national victim advocacy organizations** work to improve services for sexual assault victims and increase resources for coalitions and rape crisis centers:

- > [National Sexual Violence Resource Center](#)
- > [National Network to End Domestic Violence](#)
- > [Rape, Abuse & Incest National Network](#)
- > [Resource Sharing Project](#)
- > [Sisters of Color Ending Sexual Assault](#)

National advocacy organizations: Sexual assault victims in corrections

- > [Just Detention International](#)

National corrections organizations

- > [American Correctional Association](#)
- > [American Jail Association](#)
- > [Association of State Correctional Administrators](#)
- > [Council of Juvenile Correctional Administrators](#)
- > [International Community Corrections Association](#)
- > [National Commission on Correctional Health Care](#)
- > [National Association of Victim Service Professionals in Corrections](#)
- > [National Institute of Corrections](#)

These **federal agencies** address issues related to corrections-based sexual assault:

- > [Bureau of Justice Assistance](#)
- > [National Institute of Corrections](#)

- > [Office of Juvenile Justice and Delinquency Prevention](#)
- > [Office for Victims of Crime](#)
- > [Office on Violence Against Women](#)

Other organizations have been involved in PREA implementation at the national level:

- > [Abt Associates](#)
- > [AEquitas](#)
- > [American Probation and Parole Association](#)
- > [American University Washington College of Law, Project on Addressing Prison Rape](#)
- > [Center for Innovative Public Policies](#)
- > [Commission on Accreditation of Law Enforcement Agencies](#)
- > [International Association of Forensic Nurses](#)
- > [International Community Corrections Association](#)
- > [International Association of Chiefs of Police](#)
- > [The Moss Group](#)
- > [National Association of State Mental Health Program Directors](#)
- > [National Sheriffs' Association](#)
- > [Vera Institute of Justice](#)

ENDNOTES

- 1 *28 Code of Federal Regulations* § 115.265, and § 115.365: Official Response—Coordinated Response.
- 2 28 C.F.R. § 115.221, and § 115.321: Responsive Planning—Evidence Protocol and Medical Forensic Exams. Check with your [state sexual assault coalition](#) or a local rape crisis center to see if there is a state and/or community immediate-response protocol that incorporates the recommendations of the *National Protocol*.
- 3 28 C.F.R. § 115.253 and § 115.353: Reporting—Resident Access to Outside Support Services.
- 4 See [28 C.F.R. § 115.6](#).
- 5 See the Office for Victims of Crime’s (OVC) [SART Toolkit](#) for more general information on SARTs.
- 6 A prosecutor’s office is also a core member of a SART. This office may be involved in the immediate response in an advisory capacity. More often, however, its function is to support and sometimes even provide coordinating leadership to the SART, recognizing that SART involvement may make it more likely that a case will move successfully through the justice system.
- 7 For information on collaborating with advocates to implement victim-centered responses, see OVC’s [Building Partnerships Between Rape Crisis Centers and Correctional Facilities to Implement the PREA Victim Services Standards](#) and the National PREA Resource Center webinars [Creating a Safe Space: PREA and Victim Services in Community Confinement](#) (Just Detention International, or JDI), and [Developing Partnerships with Community-Based Service Providers – Part I and Part II](#) (JDI and Vera Institute for Justice). A resource for rape crisis centers is JDI’s [Hope Behind Bars: An Advocate’s Guide to Helping Survivors of Sexual Abuse in Detention](#).
- 8 Also see the National PREA Resource Center webinar [Sexual Assault Forensic Protocol Guide for Corrections: Working Together to Provide a Collaborative Victim-Centered Response](#).
- 9 Note that rather than incorporating the community SART approach into facility policies, some correctional facilities have formed facility-based SARTs. For more on such an approach, see the webinar [Developing Facility-Level Sexual Assault Response Teams \(SARTs\)](#), presented by Just Detention International and the National PREA Resource Center. See also the upcoming JDI publication *No One Left Behind: Building a Victim Services Program for Incarcerated Survivors of Sexual Abuse*.
- 10 See Appendix D, “Possible Roles of Core Responders,” in the [Corrections SAFE Guide](#) for more information on the differences among various facility and community responders.
- 11 Facility leaders and staff might find it helpful to consult the PREA Resource Center’s website (www.prearesourcecenter.org) for upcoming and archived webinars and training curricula. The PREA Resource Center and the [National Institute of Corrections](#) also have resources for working with incarcerated LGBTQI individuals.
- 12 See <http://www.ovcttac.gov> for more information on OVC’s Training and Technical Assistance Center (OVC TTAC) and opportunities for assistance. You can also contact OVC TTAC or the PREA Resource Center (www.prearesourcecenter.org) for help identifying potential trainers.
- 13 A “convenience sample” uses the most available subjects, typically volunteers. This type of sample runs the risk of not representing the whole population if one group is more accessible or more likely to volunteer than another group is. For example, younger residents might be warier than older residents; residents participating in more activities might be less available than others who have more unstructured time.
- 14 A. Beck, M. Berzofsky, R. Caspar, and C. Krebs, [Sexual Victimization in Prisons and Jails Reported by Inmates, 2011-12](#) (Washington, DC: Bureau of Justice Statistics, 2013). This survey study was conducted in 233 state/federal prisons, 358 local jails, and 15 other correctional facilities (operated by U.S. Armed Forces, Indian tribes, or U.S. Immigration and Customs Enforcement) in 2011 and 2012, with a survey sample of 92,449 inmates ages 18 or older and 1,738 respondents who were ages 16 and 17.
- 15 A. Beck and C. Johnson, [Sexual Victimization Reported by Former State Prisoners, 2008](#) (Washington, DC: Bureau of Justice Statistics, 2012).
- 16 A. Beck, D. Cantor, J. Hartge, and T. Smith, [Sexual Victimization in Juvenile Facilities Reported by Youth, 2012](#) (Washington, DC: Bureau of Justice Statistics, 2013). This study was conducted in 326 juvenile confinement facilities with a random sample of 8,707 youth.
- 17 C. Abner, J. Browning, and J. Clark, [Preventing and Responding to Corrections-Based Sexual Abuse: A Guide for Community Corrections Professionals](#) (Lexington, KY: American Probation and Parole Association, with the International Community Corrections Association and Pretrial Justice Institute, 2009).
- 18 National Prison Rape Elimination Commission, [National Prison Rape Elimination Commission Report](#) (Washington, DC: NPREC, 2009); and Vera Institute of Justice, summary memos for the sexual assault forensic protocol in prison, jail, and community confinement work-group meetings (unpublished memos, Feb. 25 and March 15, 2011).
- 19 West Virginia Sexual Assault Free Environment Partnership, [WV S.A.F.E. Training and Collaboration Toolkit: Serving Sexual Violence Victims with Disabilities](#) (West Virginia Foundation for Rape Information and Services, Northern West Virginia Center for Independent Living, and West Virginia Department of Health and Human Resources, 2010). References are drawn from the sections “Indicators of Sexual Violence” and “Understanding and Addressing Emotional Trauma.”

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