

Module 3 - How to Respond Professionally and Effectively to Victims of Sexual Abuse and Sexual Harassment During Incarceration

I'm a healthcare consultant but I have worked in corrections with a professional background as a school psychologist but managing programs and as health services administrator in jails and prisons for more than twenty years. I also served some time with the National Institute of Corrections with their jails division, which was previously in Boulder.

So I want to talk to you today to focus on how we can apply all of this information that we've heard this morning to your facilities and what does all of this mean to you?

First of all, let's recap what we've looked at this morning. Okay, based on the PREA standards, we've covered how to detect and assess signs of sexual abuse, who is likely to be targeted, physical and psychological signs and symptoms, and the forensic medical examination, and preservation of evidence.

How many do we have in the room, just show of hands, who are health administrators? Oh, quite a few, good. What about nurses? Lots of nurses, right. Any physicians? Okay, good. And mental health? Don't wanna leave out mental health... good, okay, well this is the group.

We're going to look at first responder duties, identify some protocols and coordinate immediate responses, respond to the victims' physical and emotional needs, and just how do we do that? And also take a look at conducting appropriate follow-up steps, resources, and referrals.

So I want to give you some protocols and tools today to help if you are the first responder. We'll discuss some immediate actions and coordination with your system to assist the victim and know how to protect evidence, as Kim mentioned is vitally important. And some timelines.

So first let's just get a show of hands- how many of you have had this experience as a first responder working in the facility and having an inmate tell you or having someone brought to you? It's not a very frequent occurrence but I'm glad to see that we have had some people with this experience.

We're going to look at immediate assessment and crisis intervention as well as some short term measures. We'll address issues of confidentiality, cultural competency, consent, and documentation of the encounter.

There are a lot of things that need to be done before you send off the patient or the inmate to the community or to a SANE or safe representative. We're going to discuss the referral process to safe or SANE teams of a local hospital, some services, some follow-up of medical and mental health services, and some further actions.

Okay. Let's take a look at the PREA standard. It requires a PREA coordinator for each agency and each facility. So, as health care staff, it's important for you to take an active role in this process, to be a part of the development, and to be active participants.

Health care is not tangential to PREA, it's an essential element. But for those of you and those of us who have worked in prisons and jails and facilities for a long time, we know that that doesn't always occur. How many of you have seen where policies are handed down to medical and mental health staff and you had no input into the development of that policy?

A good example of that is emergency disaster planning. How vital and critical is medical and mental health to emergency disaster planning? But how many of you have actually taken an active role and been invited to participate in the development of that?

So this is very important to make sure that your agency works with you as well as health care professionals to work in development of the policies and the protocols. You want to provide input into your own goals and your own duties. They're very important so please keep that in mind.

The plan should define actions of first responders and coordination of medical, mental health practitioners, investigators, and facility managers. You and your staff should know this process and the policy step-by-step.

Okay. Here are some initial steps as health care professionals. How might this be reported to you if you are the first point of contact?

Anyone have any suggestions? What's happened to you in your own experiences as to how a sexual abuse was reported to you? Yes?

Listens to audience member, replies

Okay, they were caught in the act. Okay so you were... we were you right there as the first responder?

She listens

Okay, okay yes. Absolutely. Okay. Okay. Can you say that a little louder please?

Audience member talks again

Okay, so did everyone get that? I know we have some people in the back of the room. I just want to remind you that I know that there are some spots up here at the tables. I know no one likes to sit in the front row but if you would like to come up, please feel welcome.

uh... yes says uh... as in a mental health encounter, that's absolutely one of the ways the inmate may come to the clinic.

You may be a nurse administering medications in the housing units and an inmate says something to you, an officer may bring an inmate to you, which is probably the most common occurrence, and in fact, one of the recent BJS studies has shown that the most common way of inmates reporting sexual abuse is to tell an officer... but there are many ways. You may find to... come in contact as a first responder with sexual abuse issues and you also want to be aware and encourage a dialogue with the patient if you happen to be doing an encounter with the patient, you want to look at behavior that may be indicative of an assault and Karla talked about that at length this morning- for example maybe making vague requests for cell changes that might come to you, changes in behavior, some self-harm... so there's a lot of indicators and actually some additional ones for youth. So you want to, if you are the first responder, you want to act upon all disclosures.

If you detect signs during a routine exam, as we mentioned, discuss your concerns with your patient. Assure protection, support, and safety for the patient. Alert custody immediately- remember custody is our partner in this. Be familiar with your agency's policies and internal protocols, as we just mentioned, and work cooperatively in a team effort.

Safety issues- I just want to mention this for a minute. It includes separation from the perpetrator and what does that separation actually mean? It can mean isolation, and isolation can be problematic. So what about the perpetrator if it's a staff member? Has anyone had that experience? We know it happens. Yes, and it's there. So there are some rather complex issues that need to be worked out in terms of a process in advance so that you understand what the policy is with your facility regarding that. Remember, it's a coordinated effort.

Okay so you want to be discreet and make sure that other inmates are not within sight or sound of the encounter. If this happens and you are not in the clinic with the inmate, then make sure that you have the inmate escorted there. You want to inform the inmate of your responsibility to report any knowledge or suspicion or information on a sexual assault to the agency. It's important that you keep calm and you try to calm the inmate as well as support them in their needs, remain with him or her to preserve the crime scene or evidence until custody arrives. Now, this may depend on what the situation is and where you are in terms of where in the facility that you may encounter this problem... so you want to always follow the facilities' evidence protocols and ensure that the physical evidence survives the outside transport.

As we mentioned, it may be possible that you find yourself dealing with the perpetrator and with the victim at the same time, for example the response we just had where they were caught in the act- so probably both of them may be brought to medical at the same time.

A stigma may be attached to male sexual victimization and so you want to make sure that you allow for open discussion if possible.

We talked a little about this, that health care staff are mandatory reporters by law. It's a criminal act. It refers to 115.61. There are additional reporting requirements for staff of juvenile facilities and they fall under the vulnerable person statute and Bob's going to talk some more about reporting in just a few minutes.

So is it your duty to report previous sexual abuse? What about something that happened prior to incarceration? You would need a consent for that if it is outside of the facility. If there is previous sexual abuse that occurred from another facility, the protocol would be to inform your warden or superintendent and have that warden or superintendent contact the superintendent of the facility where that occurred.

Okay so you want to conduct an immediate assessment to determine acute medical and mental health needs. As we mentioned, be aware of the reported time period and circumstances that allow for the collection of evidence and for the referral. The timeframes vary depending on your jurisdictional policy, so it's important for you to know that in advance.

Most likely, reporting sexual assault at a later date may occur because that's very common as well, especially in a in a mental health encounter where you may have someone say, "well this has been going on for quite a period of time and I want you to know this happened again to me two weeks ago." What do you do at that point? Well, you still proceed and confer with SAFE or SANE experts and also with the rape crisis center. Do you send them out? That's going to be based on the amount of time that has elapsed and based on your coordination with the safe or SANE person. Still, do a physical exam, a mental health exam, and some prophylaxis follow-up.

So it's important to know the contact process for SAFE and SANE for your referral to your local hospital and your rape crisis center. The best practice that we talked about is that inmates have access to trained forensic examiners and I do believe that, truly, that is not something institutions want to take upon themselves. So all facility health care staff should have documented training in these initial preliminary protocols. It's not a substitute for being a forensic expert but what you may do to include your input and to have participation and development of the training curricula, of policies, and of the protocols is to help write them, help develop the curricula. You may offer to do some training. And PREA does not mandate that you contract with a forensic expert but, as Kim mentioned earlier, you must document your efforts if you choose not to do so or if none is available in your area.

One thing I want to caution you with too is that we know many of these things happen on weekends, at nights- and who's usually at the facilities at that time? Possibly registry staff, per diem nurses... it's very important that those persons are included in your training, that they receive that orientation. They may be the first responder or point of contact and they may be working fairly alone or by themselves in the facility so make sure that you include them in your training process.

Okay, so you've previously heard about how not to disturb evidence and you want to discuss confidentiality and protection in the facility as a positive step. So discuss your role with the victim and prepare him or her for the following process: discuss possible fear of retaliation and confirm that he or she will be monitored and safely placed and that an investigation will be conducted.

As Kim mentioned, oftentimes the inmate doesn't know what's going to happen to them next and it's very important that this process be defined to them. Allow the inmate to have a sense of control or be part of a decision, not segregated or punished. Balance the inmate's need for protection yet not as punishment and segregation. Now, we all know that the final decision is going to rest with security because safety is of primary importance in the facility... but get the patient's input into the decision if you can and try to not make this a punitive measure. The patient's perceptions about where would be the safest place for them should be taken into account. For example, some people might feel safer in isolation than housing and some might find it terrifying.

Now, one point of caution that I want to mention- this isn't a neat little package and we know that all of these steps are not going to happen in any particular order. When you're in a facility it's very different and everything is going to depend on the individual situation and you need to look at all of these factors on a case-by-case basis. But while you do that, keep in mind that's important to know what steps are necessary, even if they're not in any particular order.

So during the acute phase: let's insure and coordinate necessary care, such as emergency contraception, HIV testing and counseling, medications that might be given once more information is gathered on the initial screening results. Still during the acute phase: coordinate tests for STD and prophylactic treatment... and this is something that would be done at the facility or offered in the community, so that is again something that needs to be coordinated and well-defined. Inform the inmate that there will be no co-pay or cost incurred for treatment. Document all encounters in the health record. Fill out an incident report, consent, and release of information, and make relevant information available to the inmate/resident/detainee about what PREA is about.

Let's talk about health record documentation for a minute and what kind of specifics need to be included. The patient's identification, their statement, findings,

description of the assault, presence of cuts, bruises, scratches, trauma... this is if you are the first responder and we're still talking about the acute phase at this point.

The mental health assessment - if they're an acute involvement with mental health, you want to make sure that you document this in counseling progress notes.

Important to note: do not indicate any results or conclusions regarding criminal activity. That's something that needs to be discussed more further in-depth with Bob and he will be talking about the incident reports in greater detail with you.

Okay, so let's continue on. The victims need to be assured that they receive some emotional support and crisis intervention. Develop a plan with the facility staff when no medical or mental health staff are on duty. Make sure that's a part of your protocol and that you address it and assess for suicide risk.

A rape crisis advocate may be made available through phone or through contact if there is none available locally- so prepare for that as well, depending on the remoteness of your facility.

Offer services of a victim advocacy from a local service such as a rape center, a crisis center... inform your patient that a victim advocate can be present during the exam and any interviews and can provide counseling and referrals and I think that Kim went into that in... pretty in depth... this morning and it's important to know that they can have an advocate by their side going through this ordeal. The medical and mental health staff can be an important part in setting up the relationship with the rape crisis center.

In many states, the right to a victim advocate is a legal right of all crime victims and states also... rape crisis counselors may have a protected role that we heard that includes being present during the interview and examinations without being part of the investigatory team. So we want to engage principles of cultural competency to support victims from other countries, youth, people with disabilities, and limited english proficiency as well as LGBTI... and I won't define everything for the sake of time right now- I think we're all well aware of that acronym. Staff does not have to be the same sex or same race or religious background in order to appear to work with the victim unless it becomes an issue or interferes with communication.

Culture may influence health care beliefs- how many of you have federal ICE detainees in your facilities? Well I know from experience and from seeing many of these detainees come from third world countries, they've already come into the system with post-traumatic stress, haven't they? They've experienced sexual abuse on a very wide scale, many of them... for generations and extended families. And it's very prevalent. So that's something to be aware of and have concern with... I know Karla talked about some of the risks. These people are more at risk, obviously, and we've already seen some of the effects of that. Dealing with native Americans, for example, they may be reluctant... you know their culture is not one of a verbal

culture. They don't engage in a lot of social workers as we do and perhaps you need to find a way to talk and discuss with them if you're working with Indian Health Services, so allow...

And for presenting and being aware of any rape trauma syndrome indicators and symptoms- you know avoidance, sadness, hopelessness... we've covered a lot of that but be aware of the rape trauma syndrome- there are many phases and incarceration just makes healing a little more difficult. There's a lot of literature on that and we will address that in the resources that we give you hopefully sometime soon. And I would really advise you to read up on some of these issues and some of the symptoms and ways that you can increase communication and respond to the various cultural and... be sensitive to their issues.

Persons with disabilities also are at a higher risk for victimization. Okay so we want to account for particular vulnerabilities to ensure effective communication and understanding of these sensitive issues. Take reasonable steps to interpret, listen, remain objective and non-judgmental, enlist interpretation services, be cognizant of cultural or gender stigmas- sometimes culturally specific assistance may be needed and provide the inmate with some education materials.

From experience, I can tell you that it's very important to be aware of possible prejudices and even attitudes from staff. I had a high-profile case one time, and I'll just share this real quickly with you, when I was working as a health administrator in a facility that had a large intake system and this man came in who was high-profile who had been involved with the rape of a juvenile and a very qualified, very well respected psychiatric nurse came to me and said, "I can't work with him. I just..." And she had so much emotion, so much feeling about this because it had been all over the newspapers and radio before he was apprehended that she just could not be in his presence and... so we talked about that a little, but I needed to first replace that person with a staff that could be objective. And so this is real, this happens and I think it's very important to know that if you do you have these issues with staff, you need to have these kinds of discussions with your staff- has anyone had these discussions with staff? Have you experienced this?

She waits for audience response

Yes. I mean we're all human and that is going to occur, so think it's worth mentioning. We know the people who come in, for example, as child molesters are higher targets and it's very important to go through this process as objectively as possible.

So, let's look at some continuing steps. Once emergency treatment is assessed and the inmate is referred to the local services, SANE or safe, or a local hospital- you want to remain with the victim until he or she is escorted outside of the facility.

The agency may attempt to utilize a victim advocate from the community but generally if the person is taken to a hospital, they'll call the rape crisis center in advance and... to have the advocate present.

Know how to initiate the procedures for transporting victims outside or bringing qualified medical examiners into the facility for forensic medical exams. It's important... I know we talked about the process but share your policies, your procedures with the local hospital or if you have an MOU, an MO of Understanding, with a rape crisis center, make sure that they also know from your end what happens at the facility before they receive the patient or the victim. They also need to know what your process is, as well as you knowing what they're going to do once they receive your patient.

So the best practice would be a three-tiered system- officers to inform the victim of the facility process and legal actions, forensic examiners providing information, medical forensic issues, and trained victim advocates to explain subsequent systems and reactions and recovery options.

And again, I just want to mention, we talked about this earlier... when you do coordinate the transport of the inmate to the outside, to the community, make sure that that coordination is there, that the phone call takes place and so the inmate is not left sitting with the deputy in the emergency room or emergency department for hours, which we know happens quite frequently.

Okay, so let's talk about some appropriate follow-up steps and available resources. Mental health should offer ongoing services and monitor the patient's adjustment. Schedule follow-up clinic visits and coordinate any outside consults and referrals. Make sure that you allow this inmate to have priority to your scheduling so that they don't get pushed back if they put in requests to be seen in the clinic. Repeat the blood tests at about RPR at three months- your STDs and other communicable diseases, HIV testing, and possibly pregnancy testing if that's needed.

You want to have your standards consistent with the what's available in the community. For sexual assault, one of these provisions would be that services are at no cost, as we mentioned, there is no co-pay, regardless of whether the victim gives names of the abusers or participates in the investigation- that has no bearing on their treatment.

Another piece of the standard of 115.83 that comes up and, this can be very real and challenging is- how do you manage both? That's going to happen in your clinics or you have had that experience. You must follow the appropriate steps for both the perpetrator and the victim.

Optimal counseling is to offer rape crisis advocate counseling or participation in a group that's led by the rape crisis counselor. Always have the responsible physician, your chief medical officer, and the health services administrator participate in the

sexual abuse incident reviews. Put this into your training plans and preventive strategies- they're an important piece of this.

Thank you very much.