

AFTERNOON SESSION

FRIDAY, AUGUST 19, 2005; 1:11 P.M.

CHAIRMAN WALTON: Good afternoon. I apologize for being a little late, but we'll reconvene the hearing at this time.

Our next panel is addressing the problem of the at-risk mental-health population behind the prison walls. We have at least one person here to testify. Hopefully, we'll have two.

Dr. Terry Kupers, who is an institute professor in the Graduate School of Psychology of the Wright Institute and distinguished fellow of the American Psychiatric Association.

Thank you, Dr. Kupers, for being here. We appreciate your taking time out of your busy schedule to appear here to testify before the Commission. We know that you have information that will be very helpful as we proceed with our mandate given to us by Congress. So thank you for your presence.

DR. KUPERS: Thank you. Thank you for inviting me.

CHAIRMAN WALTON: And I should place you under oath too.

You have written testimony you've submitted.

DR. KUPERS: I can talk to begin with, but I'm perfectly responsive for the questions.

CHAIRMAN WALTON: But you had a written statement?

DR. KUPERS: Yes.

CHAIRMAN WALTON: Without objection, would you have any problem with our admitting that into the record?

DR. KUPERS: Not at all.

(Dr. Kupers was duly sworn.)

CHAIRMAN WALTON: Thank you. You may proceed with a statement, and then we'll follow up with some questions.

STATEMENT OF TERRY KUPERS, M.D., M.S.P.

DR. KUPERS: All right. I'm very happy to be here, honored to be able to share some time with the Commission in your very important work.

I'm a psychiatrist, and the way that I get involved mainly with correctional issues is as an expert witness in litigation involving prison conditions, sexual assault in prison, mental-health care in prison, and so that's where my background comes from. I actually practice in the community. I don't practice inside Corrections.

As you all know, mental illness is a very big problem in our prisons for very structural reasons which are beyond this Commission's basic concerns but, I think, very relevant on the issue of

sexual assault and rape inside the prisons.

The number of prisoners has multiplied by about ten times since the early 1970s, when I started doing this work, probably when you-all got involved in it. And as the number of prisoners has skyrocketed, the proportion of prisoners with serious mental illness has also risen. So the growth of the population of very seriously mentally-ill people inside our jails and prisons has just skyrocketed.

And needless to say, the resources for treatment and the level of treatment inside the institutions has not grown at the same pace. So what we have is an awful lot of people with very serious mental illness who once, in a previous time, would have been in state mental hospitals or VA hospitals, are now in jails and prisons, and they're just loose. There's not enough mental-health resources.

When it's stated in the press that the prison budget has not been cut, because there are cuts in every public sector except prisons, it's not -- that's not actually accurate. What's happened is that the security salaries and the construction of prisons has risen. And if the budget is kept constant, what happens is there's a reduction in resources for mental-health programs, rehabilitation, education and so forth, and medical care.

So the mental-health programs have actually been deteriorating in the last couple of decades inside the prisons on average. This leaves the

prisoners with mental illness to shift for themselves, and they're not very good at that. Part of the reason a lot of them are in prison is they didn't have mental-health services and support out in the community.

On average -- and I don't want to stereotype people with mental illness -- but on average they have less savvy than others. We heard testimony this morning from survivors. And I was thinking, as I was listening to that very poignant testimony, what would I do if I were in their situation? How would I navigate? Really what needs to be navigated is two sets of rules. There are the institutional rules; that is, if an inmate tells a staff person I've been sexually assaulted, that staff person is required to say by who, tell me who, and often -- this they're not required to do, but often it's also stated and if you don't tell me who, I can't help you. And that, by the way, needs to be corrected. But that's the institutional level of the rules.

Then there are the informal rules; for instance, the requirement that you don't snitch, which is part of the male prison code.

People with serious mental illness don't know how to navigate. They don't know how to navigate out of their community, and that often has to do with why they get arrested. They get left literally holding the bag. In prison, the same thing

happens. So they can be basically manipulated into one situation or another.

In my written comments I mentioned the choice of victim for a sexual predator. You really don't want to choose as a victim someone who has a lot of social savvy and friends. You don't want to choose a gang member. You don't want to choose someone who gets along with other prisoners because their friends will then retaliate against you if you attack them.

So people with mental illness, besides not knowing how to conduct themselves, just get singled out and attacked more often than others. That creates a real problem.

Now, I'm talking so far about people with serious mental illness, the categories we know about: Schizophrenia, bipolar disorder, that kind of thing.

The other mental illness to consider is posttraumatic stress disorder. A huge proportion of prisoners come into prison with histories of massive and repeated traumas through their lifetime. And I think the Commission has been paired with evidence about this, but a national study showed that 57 percent of women entering prison have been sexually or physically assaulted as children or as adults. A huge number of people from low-income communities -- and that's who leads our prisons -- have either witnessed or been the victim of sexual or physical violence from very early in their life.

There's a lot of posttraumatic stress disorder.

One of the points I want to share with the Commission is that it often goes unrecognized that someone is suffering from a mental illness. And the reason is because, to put it very simply, schizophrenia trumps posttraumatic stress disorder. If someone with schizophrenia is raped, they probably will not present the classic signs of posttraumatic stress disorder, of flashbacks, nightmares, that kind of thing, reliving. Instead, they're going to have a heightening of their hallucinations and their social disorganization. Their anxiety level is going to rise, and what we're going to say is they have an exacerbation of their schizophrenia, but they well might have been raped in the meantime.

And the same thing is true of depression, with despair, with self-castigation, with suicidal inclinations. Someone might show those signs and symptoms and not the classic signs of posttraumatic stress disorder. So in a sense the problem of prison rape and sexual assault gets lost in the mental illness.

One of the things we've found out about posttraumatic stress disorder -- I'm going to skip around, because I don't want to take too long to present. In the treatment of posttraumatic stress disorder -- and this is the work of Judy Herman at Harvard, "Trauma and Recovery" was her book in

1994 -- the work of helping someone heal from posttraumatic stress disorder requires first establishing safety; that is, someone who has been raped needs to know that their rapist is not there to do it again. They need to know that they've actually got physical safety. They need to know they have emotional safety, that they can control their emotional reactions, that they're okay to be with people.

I mention that because, as you can imagine, in prison that's not a very safe situation. Someone who has been raped is probably in more danger after the rape, on average, than before the rape, because the rapist and others are going to be watching them very closely to see what they document; for instance, if they report it, their life could be in danger.

So the safety is extremely hard to establish in prison. There are protocols. The National Institute of Corrections has published protocols. The Human Rights Watch has published recommendations on how staff should handle this.

The biggest problem is retaliation, and the biggest staff effort has to be on preventing retaliation, making retaliation impossible inside the institutions. The reason is that no one will report it if they fear of retaliation. That's the reason, as the Commission has heard from all of the witnesses, the reporting is very low, because most rapes, most sexual assaults are not reported. That's

especially true, again, for people with mental illness, because they don't know how to negotiate the entire problem of retaliation.

I want to mention something which is what I call staff collusion. I personally -- and I've testified in a lot of cases around the country, both criminal and civil, about sexual assault and rape inside jails and prisons. I don't believe it can happen in an institution where the administration truly has a zero-tolerance policy. And let me say that another way: Bad management leads to more sexual assaults.

And I have been to institutions and investigated cases where, actually, if you talk to the correctional staff, they will say we have a hands-off policy about, for instance, male prisoners raping each other. In fact, they will say the only way we can maintain order in the community is to turn our backs on it and let them have their victims and that way we maintain order.

I call that staff collusion. That staff member is not doing their job, and the prison administration is not doing their job.

I've heard worse. And you probably have too. I've heard of staff laughing at prisoners, telling them they have to get themselves -- in men's prisons, they have to get themselves a man. I have seen, in women's prisons, where the main problem is

custodial misconduct, the male staffs stick with each other. The blue code is kind of tantamount, and so the staff will either be silent or they'll actually -- I've seen situations where male security staff will keep an eye out while another male security staff member sexually assaults a woman prisoner.

It's a massive problem, and we've discussed it -- the Commission has discussed it even this morning -- in terms of prosecutions, in terms of what happens to offending custody staff or other staff who break the law and commit sexual assault or rape.

There's a bigger problem. That problem is when the event is reported and someone is actually investigated and possibly prosecuted. The bigger problem is when no notice ever comes of the collusion and the collusion is massive, and that needs to be attended to.

The bottom line, I think, is this: Rape and sexual assault happen in a culture of disrespect. In women's facilities, where male staff are doing the sexual assault, it has to do with misogyny. It permeates the culture. It has to do with grown women being called girls or worse. It has to do with men on the staff not taking seriously offensive jokes that come out about the women under their control.

And they have the responsibility to take care of those women. Those women have done a crime, they have time to serve. Rape is not part of their

sentence. And when there is an acceptance of misogynist jokes, of misogynist little slaps on the bottom or something like that, when the management does not stop that and does not want to hear about it, that is where sexual assault occurs.

The more general phenomenon in men's and women's facilities is what I call culture of disrespect; that is, you have officers yelling at the prisoners, demeaning them. Racist slurs are happening. Sexist homophobic slurs are happening. And that's the culture. That's an everyday activity.

It's within that culture, then, that someone who actually says -- comes forward, which takes a huge amount of bravery on the part of the inmate, comes forward and says I have been inappropriately touched by this officer or I've been raped or whatever it is, they're not listened to.

And then we get to the situation where the investigation, the internal affairs or whoever is investigating, comes up with, well, there are no witnesses except for the two alleged partners in a sexual act. She says it happened, he says it didn't happen.

A prisoner's word is not listened to, generally, and particularly within the prisons themselves, in terms of the disciplinary process. That has to be reversed; that is, we have to take the kind of stance towards the person accusing, alleging

a sexual assault, that we take in the community.  
When someone in the community alleges that someone else sexually assaulted them, it's not necessarily true, but we give them the respect and the honor of listening to what they think happened and then we investigate and we do a certain set of procedures in order to determine the guilt or innocence.

I think we need to do that in a prison.  
It's the disrespect that causes us to dismiss and discount what the prisoner is telling us happened.  
And I think we have to reverse that if we're going to do anything about the problem.

Thank you very much.

QUESTIONS FROM THE COMMISSION OF THE  
"AT RISK: THE MENTALLY ILL POPULATION" PANEL

CHAIRMAN WALTON: Thank you very much, Doctor.

Commissioner Kaneb?

COMMISSIONER KANEB: Dr. Kupers, thank you. You observed that retaliation or fear of retaliation is a major impediment to discovery, which is a major impediment, obviously, to prevention.

Do you have any particular suggestions to us as to how we could impose standards, which is part of our mandate, to try to reduce or prevent retaliation and the fear thereof?

DR. KUPERS: Yes, I do. And I think many have been proposed.

First, I think that safety needs to be provided. When someone alleges sexual assault by another prisoner or by a staff member, that needs to be taken seriously and that person needs the benefit of the doubt.

Now, it's true -- and if you talk to a correctional staff they will tell you -- we can't listen to everybody's allegations or we wouldn't be able to have any staff here because everybody would have accusations.

But what's also true is that certain staff

members have a lot of allegations and certain prisoners are known to be predators. I think it has to be -- the benefit of the doubt has to be with the prisoner alleging the abuse, and they have to be provided safety until a full investigation happens so that they will be separated, for instance, from the alleged perpetrator. And the safety will be made possible while the case is being investigated.

The other thing, I think, that has to happen is -- there are many parts to the response to retaliation. I'm not going to get into all of them, but the other thing that has to happen is independent; that is, a person alleging particularly custodial misbehavior cannot allege that to the custodial staff who are allegedly the perpetrators. So there has to be some independent process of grievance, complaint, of reporting. It has to go in a separate track, not up through the security command in order to be investigated.

And someone has to be able to step in, an independent someone -- in some institutions that's an ombudsman, in some it's an internal affairs department -- whatever it is, there needs to be some separation from the line staff and that people in charge of that investigation have to be able to institute safety; that is, they have to be able to require an institutional move or protection of some kind.

By the way, protection is not such a good --

protection -- for reasons that were explained this morning, classification in protection is far from perfect, and people who choose to go into protection have certain negative consequences attached to protection; for instance, they have a reputation, probably, as a snitch from that time on in a men's institution.

Asking for protection is a huge step and does not necessarily provide safety, because inside protection there's not a good classification system, usually, on average, in the institutions, and people in protection, as was mentioned this morning, are often put in solitary confinement, which has no rationale at all. People in protection should be able to take part in all the activities that they're generally permitted because of their security level. If they ask for protection, they often get put into the isolation unit, like a SHU in California or supermax, where the predators are.

So protection is really not an answer. But as I mentioned, I think giving the inmate the benefit of the doubt, or the one that's alleging the assault, until some kind of resolution occurs and having an entirely independent mechanism for investigating and taking action I think are two of the prerequisites, but not at all the entire picture.

COMMISSIONER KANEB: Just one follow-up: You talk about staff collusion, active or passive. One

of the conundrums that I think our Commission is going to face is dealing with matters like what about condoms in prison? I understand that is an issue in the State right now.

And I think -- I think there are potentially two, maybe three, but at least two views among my fellow commissioners. One of them is it would be helpful in preventing disease, danger, et cetera, et cetera, if condoms were available.

Another view, let's say at the other end, is if the authority itself is providing condoms, it is, in fact, openly condoning sexual activity in the institution, which in the first case, I believe, is in most states or jurisdictions prohibited.

Secondly, those opposing distribution of condoms might say, well, that is certainly going to help those, whether they're deemed the correctional systems or the systems of the various jurisdictions or not, that say that a lot of this problem that you people see, the forced sex, particularly among males -- male inmates is really consensual, it isn't nearly the problem that some people portray it to be, in terms of violent or forced sex. It's really mostly consensual and some of the I think people who are opposing or would oppose condom distribution would say that that process would, in fact, abet the argument that this is a pretty consensual thing and we just put up with it.

Would you comment on any of that.

DR. KUPERS: I'd be happy to.

My job is a lot easier than yours on the issue of distributing condoms, and that is because I'm a physician. In general, physicians concerned about public health are in favor of distributing condoms in prison and in other such places. And the reason is because with the huge problem of HIV and AIDS today, it's an emergency public-health issue. So the distribution of condoms is not controversial in the field of medicine.

Whether distributing condoms then means that the state is approving of sexual activity, we have to look at a few facts. One fact is that sex occurs. There have been studies. The question that -- is if you distribute condoms, would sex occur more? And the answer is no. It's the same research -- and this research was done in Canada, but it's the same kind of research that was done about distributing clean needles to drug addicts. Would more people be drug addicts if they were given clean needles. And the answer is no from all the research that I've reviewed.

Now, on the issue of coerced sex or voluntary sex in prison, I think we don't know. I have an unusual research position, and that is I interview thousands of prisoners on court order. I go into prisons for some kind of pending litigation, and I will talk to hundreds of prisoners at a time.

I will spend 20 or 30 minutes with one prisoner and move on to the next. I'll go to various institutions. So I have a large number of interviews with prisoners, and I hear about their sex life.

It is simply not the case that all sexual assault is reported. Dr. Struckman-Johnson has done some of the key research in this area. In fact, it's very much the case that most coerced, unwanted sexual activity is not reported. It's the minority we hear about. It's the tip of the iceberg.

Most of the coercion does not occur because of physical force. It occurs because of the threat of physical force; that is, someone who cannot really defend themselves against a larger person in a prison setting is told, look, you either have sex with me -- and it will be said even more explicitly than that, you either do this act or that act with me -- or I am going to beat you up or all these other people here are going to beat you up. And that is so universal in the prisons that there's absolutely no doubt about that in the research.

So what we know is that the reported incidents of sexual assault and rape in prison is very much lower than the actual incidents. What we don't know is precisely what it is, because that would require an open and honest exchange of information, which we're not in a situation to have.

COMMISSIONER KANEB: I'm not sure you've answered my question.

Would, in your opinion, the distribution of condoms by those in control of the prisons abet the argument that the primary, if not overwhelming, basis for sex in prison is consensual?

DR. KUPERS: Is?

COMMISSIONER KANEB: Consensual.

Would it not abet that argument?

DR. KUPERS: Well, I still don't -- the primary reason for sex is?

COMMISSIONER KANEB: It's consensual behavior rather than forced if the authority running the prison is distributing condoms.

DR. KUPERS: Right. Well --

COMMISSIONER KANEB: And I'm not going to press it. We have other things to go on. I'm not sure --

DR. KUPERS: I'm not sure how to answer that more clearly, because it's partly consensual. Consensual sex occurs in prison, and nonconsensual, coerced sex occurs in prison.

What we know is that nonconsensual, coerced sex occurs a lot, and therefore all the figures we have on reported sexual activity and whether it's consensual is wrong and it's wrong in the direction of being underreported.

COMMISSIONER KANEB: I understand that.

DR. KUPERS: Numbers I can't give you.

COMMISSIONER KANEB: I'm not asking.

DR. KUPERS: But it is true that both consensual

and nonconsensual sex occur in prison.

Now, I think what we get into is a moral public discussion, and I think it has to do with devaluing and discounting prisoners; that is, people think prisoners -- just like it was said this morning, people think that gay men like to be raped, which is just absolutely not true. And I've interviewed many people in that situation, and it's just absolute nonsense. It's also not true that all prisoners have sex or that all prisoners who have sex like having sex and agree to it.

What's probably the larger phenomenon is that prisoners have sex with the implied coercion that if they don't they will --

COMMISSIONER KANEB: I think I understand. Thank you.

CHAIRMAN WALTON: Commissioner Nolan.

COMMISSIONER NOLAN: Dr. Kupers, are there any corrections systems that you think, or institutions, even, within systems, that you have found do a better job of handling sexual abuse? And if so, what are the hallmarks, what do they do differently within those systems?

DR. KUPERS: Yes. One I can mention, and it happens to be timely to do so is the San Francisco City and County Jail, because I understand Sheriff Hennessey is going to address you this afternoon. I believe they have an outstanding plan to address the issue.

Like Secretary Hickman said this morning, classification is a key part of the prevention of sexual assault in prison, and it's -- classification in an overcrowded correctional system is less than perfect. And the reason is because not enough time is spent to accurately classify people.

In my written comments, I reported a case I was involved in where a inmate in a county jail was in protection and was raped very terribly by two gang members who were also in protection. The young man who was the victim of the rape was in protection because he couldn't handle himself in jail. The gang members were in protection because their gang was out to get them. So there was just no classification within protection, and the predators attacked the victim. And anybody could have predicted that that was going to happen.

So one of the key things is classification, and Sheriff Hennessey has some very sophisticated ideas about classification, about past record, about that kind of thing.

Another thing is staffing. We haven't gotten into this yet, but, for instance, in women's facilities, having male staff do cross-gender searches, controlling the inmate housing areas, that's problematic. Sheriff Hennessey has policies that prevent men, male staff, from being in a position to do things to female staff without -- with

female inmates without female staff being involved and halting it.

So there are many steps that can be taken, and I think this jail is an example of how it can be done well.

I just want to mention one other thing: I think respect is a big part of it. I think the demeaning of prisoners in every regard is the grounds on which sexual assault occurs.

At the Shelton supermax unit in Washington state, they had an outbreak of violence that seemed out of control. For months on end they had -- I'm not sure if you're familiar with the term "cell extraction," but it's where a group of officers barge in on a prisoner and take him out of his cell and often usually involves violence. They had many cell extractions a day, and the prison was just totally out of control.

The State of Washington changed the administration of that unit, and the new superintendent, which is what they call wardens there, issued an ultimatum, and the ultimatum was this: I want all staff to call all prisoners Mister, no more swear words, no more first names. Everybody calls everybody Mister. And I want all prisoners to call all officers Officer Jones. Prisoners readily agreed to that and started doing that.

That accompanied some other changes; however, what I'm saying is it was an actual

administrative institution of respect. And the incidence of violence went way down. The cell extractions went from several a day to one a month, and it was a totally successful intervention.

It has relevance in terms of sexual assault. I think less sexual assault occurs in a situation where there's a culture of respect.

COMMISSIONER NOLAN: I really appreciate that, because we can get very clinical. It really gets down to human dignity, is this person a fellow human being or do we treat them as an object.

DR. KUPERS: Yes.

COMMISSIONER NOLAN: And the more we dehumanize them, the easier it is to do it. So thank you.

CHAIRMAN WALTON: Let me just ask -- I don't mean to impugn the integrity of individuals who have mental illnesses, but is there anything about the malady of mental illness or in particular maybe certain types of mental illnesses that makes someone with that malady more inclined to fabricate an allegation of sexual assault?

DR. KUPERS: That's a very good question, and it's very much in the air today.

There is an article in this month's issue of the "Archives of General Psychiatry," which takes on the issue whether people with mental illness are more prone to violence than other people on average. And there's been a lot of research about this, and

generally my understanding of all the research today is this: People with mental illness are no more prone to violence than anyone else; however, people with mental illness who are currently under the influence of substances, alcohol or illicit drugs, and are not complying with their mental-health treatment are more prone to violence than the average person.

Now, the same is true when it comes to the issue of credibility. My experience in my clinical practice is that people with mental illness have the same range of credibility as everybody else. They're not particularly prone to distorting the truth. There are some people who exaggerate symptoms. Often, when someone exaggerates a symptom and I call them on it, they will say, "Yes, I did exaggerate, I'm not that suicidal. I'm having suicidal thoughts, but I didn't think you would talk to me if didn't tell you that I was really suicidal."

And I say, "Okay, here we are. We're talking. So you're not really suicidal. What is the problem?" And then they proceed to tell me what the problem is.

That kind of exchange goes on all the time.

But the answer is no. In my experience, people with mental illness are no more prone to distorting the truth than anyone else, and of course that includes the provision that some of them are.

COMMISSIONER KANEB: Commissioner

Struckman-Johnson.

COMMISSIONER STRUCKMAN-JOHNSON: Well, I'll take advantage of your expertise and move to treatment. What would you recommend as a minimum treatment for, let's say, a 23-year-old male victim who comes to you reporting reports of gang rape and you are now -- now he comes to you, luckily? What would you recommend be done?

DR. KUPERS: Well, as I mentioned -- and this is explicit in Judith Herman's work -- there is some structural considerations. The first thing I would do is the Hippocratic oath, and that is to do no harm. I would have to look at the context within the reporting -- within which the reporting and seeking treatment is occurring, and I would have to think about whether this person is putting themselves, for instance, in more danger by talking to me or -- and I'll give you an example of that -- or whether, emotionally, it's going to be bad for them to work on this right now.

An so what I would do is emphasize the issue of establishing safety, both emotional safety, in terms of can this person really work on this issue right now or do they, for instance, need a tranquilizer or antidepressant medication and need a safe place and some time to pass before they actually work on this very severe trauma.

Now, at the same time, the context in the

institution is very important if we're talking about a correctional setting. Many correctional institutions have a rule that if any staff member, including mental health, hears about an illegal activity on the part of another prisoner or staff, they have to report it.

Now, I understand that as a security precaution. That makes some sense from simply security grounds. However, it creates a problem for someone who has been raped, a prisoner, for instance, who has been raped. Let's take the example first of a woman prisoner who has been raped by a male staff member. She wants to talk to somebody about it. If she talks to the psychologist, if she goes in to see the psychologist because she's having massive and disabling symptoms and tells the psychologist and the psychologist then has to go tell the warden that the rape occurred, which is going to trigger an investigation and, one hopes, prosecution, that woman has now reported the rape officially. And all she wanted to do was talk to a psychologist.

So the first principle is that at all points in time the treating clinician needs to make clear to the patient exactly what the terms of this discussion are. If the psychologist has a rule they have to report to the security administration, they should tell the patient that up front. Then the discussion goes something like this -- and I do this in my office; for instance, when someone is on parole or

probation and they want to tell me something, I say have you considered the fact that your parole officer calls me and asks me if you've come to therapy. And they said, "No, I didn't know that. Thank you for telling me that." And then they then have the choice of whether to proceed with what they want to talk about or not.

Well, the equivalent principle holds in prison, and that is that the clinician has the responsibility to tell this victim of a traumatic assault here is the situation: Anything you tell me that has to do with misconduct on the part of another prisoner or staff member, I have to tell the warden. Do you want to continue this discussion?

Now, the person might say I don't know. I'm totally confused. I don't know what to do. Then the clinician's job is to say let's look at your options. If you're going to talk to me, given these rules, it's going to be reported. If you're not ready to report it, you can't talk to me about that. But I don't want to leave you with no one to talk to. And then it seems to me the clinician has an obligation to arrange something.

Now, some of the best ideas I've heard for this is to arrange an independent outside clinician to come in and see this person so that they're outside this rule that the clinician has to report.

Do you see the problem?

COMMISSIONER STRUCKMAN-JOHNSON: Yeah.

DR. KUPERS: I don't have the answer to this problem. I just want to point out that it's part of the treatment consideration.

For someone who's been traumatized, it's not always clear that they should talk about the trauma, nor that they should talk about the trauma with a clinician.

So these questions need to be looked at first, and we need to come up with protocol. The National Institute of Corrections has a protocol. It's a very good one. Andie Moss is here, and she had something to do with writing it, I believe. It's a very good protocol.

It doesn't get into this issue that I'm raising now. So what I think we need to do is go through that protocol in great detail and get some clinicians who have worked with trauma -- and I'm such a person, I've done that, but others have too -- and see if we can't refine that protocol and make it both safe and therapeutic for the prisoner.

COMMISSIONER STRUCKMAN-JOHNSON: Just a question on that: Would you say that perhaps one solution would be to give the clinician a release of that reporting dilemma?

DR. KUPERS: That is the option I favor.

COMMISSIONER STRUCKMAN-JOHNSON: Would it be not better for treatment?

DR. KUPERS: It would be better for treatment.

My feeling is that there are some things that are better in the interest of treatment and some things that are better in the interest of security, and those two things are often at odds.

My concern is that in a correctional setting, the mental-health staff and the clinicians bow too much to security. What needs to happen is we need to have a debate, a struggle in the correctional setting; that is, the mental-health person says I don't think this is a good rule. And the correctional people say, well, we need that rule in order to enforce order in the institution. Then we have a problem-solving session, where we come up with a better rule that serves both interests.

Today, in corrections across the board -- and I go to many states -- it's generally the case that the mental-health people become silent at that point and corrections makes the rules.

COMMISSIONER STRUCKMAN-JOHNSON: Thank you.

CHAIRMAN WALTON: Commissioner Smith, any questions?

COMMISSIONER SMITH: Actually, just I feel like all my questions have been answered or had been asked, and I think that's one of the benefits of coming at the end.

But I think that the most, from my perspective, important contribution you've made today is to let us know that it's a lot more complicated

and complex than we had been thinking and that we do need to have that sort of nuance and sophisticated conversation.

You had mentioned the NIC protocol a couple of different times. Are there other standards or protocols that you would suggest that we look at specifically around looking at treatment and sort of reporting?

DR. KUPERS: Yes. I would suggest you cover those NIC standards and the Human Rights Watch recommendations. It's at the end of their report on sexual assault in women's institutions. And take those two lists -- they're almost congruent -- and go through them and fill in the gaps.

I think there needs to be -- that, first of all, there's investigation. I think that safety needs to be provided during investigation; that is, it's not okay to be investigating an officer for sexual assault on a woman prisoner while -- and that woman is being interviewed by internal affairs while that officer is still in charge of that woman because he's on the shift in that facility. I think something needs to be done, I mean common sense, in order to separate the two and take that officer off duty where it's affecting women prisoners and do a thorough investigation.

There are steps to the investigation, and I think they all need to be followed. My finding in a lot of the states -- and I'm not a security expert.

I'm the clinician who comes in and gives an opinion about the psychiatric problem. But in my -- it's my impression that the NIC protocol is not followed in most states, even states that say they're following it. The investigation does not have the thoroughness required by the NIC standards. The prisoner is not provided safety while the investigation is going on. There isn't an independent route for a prisoner to complain.

There needs to be an independent route; that is, the complaint needs to go through people who are not involved in the day-to-day working of that prison unit. You can't give to the coworker of an allegedly offending officer the complaint that he's offended. That just leads to retaliation and, really, a disaster story. So that has to be pursued.

There is a protocol about mental-health treatment; that is, there needs to be a mental-health assessments. I believe that has to follow the rules that I just laid out, which is respect for confidentiality, respect for boundaries; that is, the person doing the assessment -- and it has to be an immediate assessment -- says, you know, "I'm being asked to see you because the protocol for allegations of sexual assault are that you have a mental-health examination. Do you want to talk to me?"

Nobody should be forced to talk to a mental-health professional. There are exceptions in

court-ordered evaluations and such, but, generally, if we're offering someone mental-health assessment because they've been traumatized, they should be willing. And if the woman says no, I don't want to talk to you, then that mental-health clinician has a responsibility to explain the situation to the woman and say that's perfectly your right not to talk to me. I would like to explain a few things to you first before I leave, and that is: Here are the rules in a prison. Here's how you would access mental-health care. I would even go so far as to say in an educational sense, what I call psycho-education, here's what often happens after someone has been traumatized. These are the kinds of things we generally expect to happen.

And often people don't feel they want to talk about it, but then when they do talk about it they feel better. I would say something like that of an educational sort, and then I would explain the confidentiality rules. Because it should be -- the prisoner's next question should be, well, if I talk to you, who is going to hear about it? And if that clinician can answer honestly nobody, it's confidential, that will lead to one course.

And if the mental-health professional has to say, by mandate of the institutional rules, well, nothing is confidential here. If there's any allegation of misbehavior, misconduct, I have to report it, then that woman is on notice that she has

to have another kind of conversation with this person.

CHAIRMAN WALTON: We are off schedule, but Mr. Aiken, if you have any pressing questions.

COMMISSIONER AIKEN: Just one quick question, sir. Good afternoon.

Can you share a little bit about the retarded offender in relationship to sexual-predator activities within a corrections environment.

DR. KUPERS: What was the first term? What kind of predator?

COMMISSIONER AIKEN: Retarded inmates.

DR. KUPERS: As victims or as predators?

COMMISSIONER AIKEN: Victims.

DR. KUPERS: Okay. I think special care needs -- it's the same considerations I mentioned for mental illness. It has to do with this: Again, I'll repeat when I was listening this morning to the survivors talk, I had a hard time figuring out what I would do in each incident where they were describing; in other words, you've got hard choices. If you talk, if you tell another prisoner about it, if you admit to having been hurt, et cetera, you suffer certain consequences. For instance, you might be seen as a weakling, you might be seen as a snitch, whatever.

If you go for mental-health services in a situation where it's known by others that you're going to get mental-health treatment, you might be

seen as a weakling and then be victimized anew.

Generally, people with mental illness and people with mental retardation are not very aware of the subtleties of these social queues and social protocols, and so what happens is they inappropriately, given a prison setting, will cry openly, which is very likely to subject them to some kind of attack, because they're seen as a weakling. Or they'll say something to someone that they should keep to themselves for their own safety's sake. Or they'll talk to staff in a --

People with mental retardation, they don't do a lot of second guessing about -- they don't have a whole self. They don't figure out what's going to happen if I act such and such a way. Rather, on average -- and I don't want to stereotype anybody -- but on average they will sort of impulsively or spontaneously say what they feel.

Well, in prison, that can be very dangerous. And that's the rationale for separating people with mental retardation within prisons, and that is providing them some kind of safety. Implied in everything I said about mental-health care, which is, on average, deficient in our jails and prisons -- although a lot of mental-health professionals are trying to do their best to do good care, but what's missing is relatively safe treatment environments, what I call step-down units. Not a hospital. I mean most systems have a hospital, and when you're acutely

psychotic or acutely suicidal you go to the hospital. When you get over being that acutely disturbed or acutely in danger, then you're returned to the general-population prison or to solitary confinement, which can be worse.

What's needed is the equivalent to what we have in the community in supportive housing, of halfway houses, where there's relatively little expense. It's nothing like the expense of running a hospital, but the person is in a slightly protected and slightly more intensive treatment-oriented setting. And those are called intermediate-care programs. They're called step-down units, residential treatment inside prisons. We need places like that for people with mental illness. We also need places like that for people with mental retardation. And the best prison systems have that and don't mix people with mental retardation with the general population.

COMMISSIONER AIKEN: Thank you.

CHAIRMAN WALTON: Thank you, Doctor. Your education that you've provided to us I'm sure will be very helpful as we proceed with our mission. So thank you very much for your presence and your contribution.

DR. KUPERS: Thank you. And I appreciate your attention to these issues. They're really urgent, and I wish you luck in your work.

CHAIRMAN WALTON: Thank you.