

**National Prison Rape Elimination Commission Public Hearing  
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**Provision of Mental Health Services to Sexual Assault Victims in Prison: Programs and  
Procedures that Help/Hamper Care**

**Testimony of:  
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I've been asked to testify on the provision of mental health services to sexual assault victims in correctional facilities, discussing programs and procedures that help and/or hamper the functioning of these systems of care.

I am a psychologist, currently employed by the Georgia Department of Corrections (GDC). I've worked as a psychologist at Georgia's maximum-security prison (Georgia State Prison, GSP) from 1987 to 1994, as GDC's Clinical Director from 1994 to 1996 and as GDC's Mental Health Director from 1996 to the present. Additionally, I provide expert testimony in jail civil rights litigation, consult with Georgia's Department of Juvenile Justice, perform social security evaluations and sit on Georgia State University's Institutional Review Board.

My testimony begins with a discussion of the evolution of GDC's mental health service delivery system, specifically focusing on how civil rights litigation impacted the development of mental health services for victims of sexual assault. The second section examines specific medical and mental health policies and procedures that address the delivery of services to these alleged victims of sexual assault. The third section identifies barriers/challenges to the delivery of these mental health services and the fourth section proposes some strategies to eliminate these barriers. My testimony ends with a summary of the lessons learned from and after *Cason v. Seckinger*.

### **Historical Context**

The formal delivery of mental health services in our nation's prisons is a relatively recent phenomenon following the court's "hands off" policy from the '60s. During this time, prisons were isolated from and invisible to society. The abysmal conditions of our prisons were exposed in the '70s and '80s with help from the National Alliance for the Mentally Ill, the John Howard Association, and a number of professional organizations (i.e., American Correctional Association, American Medical Association and the National Commission of Correctional Health Care). Conditions began to change with civil rights litigation filed by the National Prison Project, Advocacy Groups and the Department of Justice's Special Litigation Section. In 1976 *Estelle v. Gamble* from the 4<sup>th</sup> Circuit established that inmates have a constitutional right to health care. In 1977 *Bowing v. Godwin* from the 4<sup>th</sup> Circuit established that inmate's constitutional right to health care includes mental health care. In 1980, *Ruiz v. Estelle* from the 4<sup>th</sup> Circuit established that mental health care consists of more than just medicating inmates. This case began identifying elements of an adequate mental health program such as mental health screens, evaluations and confidentiality.

The development of a mental health service delivery system in Georgia's prisons was the result of a civil rights complaint (*Guthrie v. Evans*) filed in the 11<sup>th</sup> Circuit by Arthur S. Guthrie, Joseph Coggins II and fifty other African American prisoners from Georgia's maximum security prison in September 1972. In 1985, Judge Anthony Alaimo concluded a thirteen-year involvement in *Guthrie* with a final injunctive order and in 1998 the case was closed. This complaint led to the most detailed and comprehensive set of remedial decrees ever imposed on a single prison. One of these decrees was a mandate to develop a mental health service delivery system. Consequently, in 1980, a number of mental health procedures were developed specifically for GSP. Approximately 250 miles north of GSP, the provision of mental health services was also initiated at Metro Correctional Institution in 1980. During the next three years,

seven more facilities began to provide mental health services. In 1984, GDC created a formal mental health program with a State Mental Health Director, statewide policies and procedures, and a budget.

The creation of this statewide mental health program coincided with the filing of another civil rights complaint (Cason v. **Seckinger**), which challenged conditions in a number of prisons in Central Georgia. With the final injunctive order on Guthrie in 1985, little attention was given to this new complaint and the newly developed mental health service delivery system until 1992. At that time, Cason v. **Seckinger** was amended to include a certified class of female prisoners alleging rape, sexual assault and coerced sexual activity, involuntary abortions, retaliation or threats of retaliation for not participating in sexual activity and inadequate medical and mental health care. This amended complaint received a lot of attention to include media attention. For example, in July 1993 Day One on ABC televised the results of their own 4-month investigation into these allegations. The complaint never went to full trial but there were a number of hearings and federal court orders between 1992 and 1998 requiring GDC to rectify many of its past practices. There were also a number of personnel changes during this time to include GDC Commissioner **Whitworth's** reassignment to the Board of Pardons and Parole in 1993, Allen Ault's tenure as GDC Commissioner from 1993 to 1995, and Wayne Garner's tenure as GDC Commissioner from 1996 to 1999. In 1994, I was promoted from a staff psychologist at GSP to State Clinical Director. From 1994 to 1996, I coordinated the revision of GDC's mental health policies and procedures. In 1996, I was promoted to GDC Mental Health Director and charged with the implementation of these policies and procedures. For the next two years, the implementation process was audited quarterly by plaintiff and defendant experts, Dr. Jeffery Metzner and Dr. Dennis **Koson**, respectively. In 1998, the mental health portion of Cason v. **Seckinger** was closed.

A number of lessons were learned during the revision and implementation of our mental health policies and procedures during and after Cason v. **Seckinger**. Our ability to practice what we've learned is often challenged by changing Agency policies, revised professional standards, fiscal constraints and the political will of the electorate. Some of the lessons learned and challenges confronting the provision of mental health services to sexual assault victims will be discussed below. The focus of this discussion is not on the symptoms caused by the trauma of sexual assault nor on the merits of specific interventions with survivors of such trauma. Instead of discussing significant research results on specific populations, I am going to discuss operational procedures and both barriers to accessing services and strategies to eliminate these barriers in the delivery of mental health services to victims of sexual assault in prison.

### **Policies and Procedures**

Agency policies and procedures provide the infrastructure and mechanism used by internal investigations and by both medical and mental health to provide services to the alleged victims of sexual assault. Coordinating custody's procedures is crucial to each Division's ability to perform their mission. Duties, boundaries and linkages have to be clearly defined. If duties are vague, boundaries unclear and linkages fragmented then Divisions will under cut each other. To minimize the odds of system malfunction, the highest-ranking facility official (usually the Warden) is named as the point person responsible for notification, documentation and coordination of procedures. For example, facility operations SOP II A 21-0001 states that after

reviewing incident reports and supporting documents, the highest ranking facility official notifies the Sexual Assault Response Team (SART), the Field Operations Manager and Internal Investigations. In turn, SART notifies both medical and mental health of the sexual allegation.

Physical health SOP VH 81-0001 states that if the alleged incident occurred within the last 72 hours, medical staff will counsel the alleged victim regarding the need for a medical evaluation to determine the extent of the injuries, to test and treat for sexually transmitted disease and to rule out pregnancy. If the alleged victim refuses the examination, the medical staff counsels him/her regarding the medical and legal implications of forgoing the examinations. Refusals are thoroughly documented in the medical record, both in a progress note and on a Refusal of Treatment Form. If the alleged victim consents to the examination, he/she is transported to an outside medical facility, accompanied by a medical staff person for support. Under no circumstances are alleged victims transported by staff who are suspected of abuse. A release of information, a consultation sheet and a rape kit also accompany the alleged victim. The consultation sheet is completed by the examining physician who asks the alleged victim to sign the release of information permitting the outside medical facility to share information with medical staff at the correctional facility. The rape kit is used to collect evidence, which is taken by security who maintains a chain of custody. Upon returning to the correctional facility, the alleged victim is placed into protective custody, given a 72-hour follow-up appointment to assess both his/her physical and emotional states and scheduled to be evaluated my mental health.

After receiving the notification from SART and/or medical, mental health SOP VG55-0001 states that the Mental Health Unit Manager immediately makes arrangements for the prisoner's emotional and psychological state to be evaluated by a "specially trained counselor." The notification information is documented in the Mental Health Sexual Allegation Notification and Evaluation Log. The specially trained counselor performs a structured 3-page psychological evaluation within one workday. The purpose of this evaluation is to determine if the prisoner is likely to need further evaluation or mental health treatment. It's a clinical evaluation not an investigation to determine guilt or innocence, truth or falsehood. Prior to this evaluation, the specially trained counselor will discuss the limits of confidentiality regarding mental health information and ask the prisoner to sign an informed consent to be evaluated. If the prisoner refuses the evaluation, the specially trained counselor documents the refusal in a progress note along with observations of the prisoner's mental status. Within one week, the specially trained counselor meets with the prisoner again in order to perform the mental health evaluation. If the prisoner refuses again, the counselor informs the prisoner that mental health services are available when he/she wants them. If the prisoner consents to the mental health evaluation, the specially trained counselor meets with the prisoner in a safe and private setting and provides the prisoner with an opportunity to talk freely about the experience and any feelings that have arisen. The evaluator must review relevant correctional, health and mental health history, and be especially aware of any prior victimization that could increase the prisoner's psychological vulnerability and then increase the likelihood that the alleged victim will develop serious sequelae as a result of the trauma. The evaluator should set a low threshold for referral to further evaluation or treatment. That is, the evaluator will error on the side of caution to avoid denying treatment where it may be needed, even if some referrals turn out to be unnecessary.

Following the mental health evaluation, the counselor immediately notifies internal investigations stating whether or not the prisoner is willing to be interviewed and whether or not the prisoner is requesting the presence of the counselor during the investigative interview. For accountability, the counselor documents the date, time and person notified on the Mental Health Sexual Allegation Notification and Evaluation Log.

When the specially trained counselor is not professionally licensed, the results of the evaluation will be discussed with the counselor's clinical supervisor or a doctoral licensed clinician who signs and dates the evaluation within two working days.

When both the specially trained counselor and the prisoner see no need for any type of counseling or mental health treatment after the evaluation, then the prisoner is informed that future mental health services will be available per his/her request.

When the specially trained counselor sees no need for follow-up sessions after the evaluation, but the prisoner requests treatment, then the counselor refers him/her to the Mental Health Clinical Director for a second opinion.

When mental health treatment is recommended and the prisoner approves, then the Mental Health Unit Manager and the treatment team promptly review the case and refer to the most appropriate treatment provider and modality, with treatment to begin as soon as clinically indicated.

When the allegations are found to be false or not sustained, treatment will continue as clinically indicated on the basis of clinical needs independent of internal investigation's findings.

### **Barriers to Identification and Service Delivery**

No amount of policies and procedures by themselves will ensure coordination between custody, medical and mental health care to alleged victims of sexual assault/misconduct. To ensure Division coordination and quality care, Department of Corrections (DOCs) need to be able to first identify barriers that compromise coordination and lower the quality of care and second, develop strategies to eliminate those barriers. Below, I'll discuss nine barriers that challenge most DOCs and then propose a couple strategies that can help eliminate those barriers. The nine barriers are 1) not having enough staff to treat such an unhealthy population; 2) having relatively inexperienced mental health staff treat such a complex mental health population; 3) evaluating and treating a diagnostically complex population; 4) using dualistic thinking to simplify diagnostic complexity; 5) ascribing stigma to males who appear physically and emotionally weak; 6) being frightened of the inherent threat of retaliation for "snitching"; 7) struggling with both victims and providers distrusting each other because of communication problems; 8) minimizing the allegations of alleged sexual assault; and 9) minimizing the efficacy of mental health services.

#### **Barriers 1 and 2**

The demand of quality correctional officers, medical staff and mental health staff is high with HIV and AIDS being six times more prevalent in prison than in the community, positive TB skin tests being fourteen times greater, Hepatitis C being twelve times greater, female STDs being

fourteen times higher, substance abuse being seven times greater and mental illness being two and a half times greater. Due to oppressive and dangerous working conditions and relatively low salaries in most states, staff tend to use corrections as a spring board to obtain experience and then move to better paying jobs with better working conditions. Consequently, staff turnover and vacancies remain high for correctional officers, nurses, mental health counselors and psychiatrists.

### Barriers 2 and 3

The mental health service delivery system is especially challenged by high staff turnover, which often results in hiring inexperienced staff and compromising continuity of care. This is a big problem because of the prisoners' diagnostic complexity, making it difficult to accurately assess and effectively treat them. Along with exacerbated symptoms secondary to the alleged sexual assault, many prisoners have a long history of substance abuse, a learning disability and personality traits/disorders (i.e., Antisocial, Narcissistic and/or Paranoid). Therefore, not only are many prisoners struggling with a mental illness but they're also struggling with their interpersonal relationships. Over time, many inexperienced clinicians get "burnt" by the complex ways in which prisoners defend themselves and interact with others. Consequently, many of these clinicians begin to focus on the prisoner's onerous personality losing sight of the mental illness and concluding that most prisoners are just manipulating to get medication, or to be transferred, or to obtain contraband, or to punish staff, or to **ad infinitum**. The list of secondary gains goes on and on.

### Barriers 3 and 4

To help work with these complex patients who are often both victims and perpetrators of abuse, many clinicians adopt a dualistic perspective. In other words, they begin to focus on prisoners as either victims who are struggling with distress secondary to trauma or as perpetrators who are manipulating and **ruining** them. Those who focus on prisoners as victims become known as "do-gooders" who are hypersensitive to any distress and blind to any manipulation, excusing it as an adaptive response to a stressful situation. Prisoners perceive these clinicians as patronizing and easy pawns to be manipulated. Those who focus on prisoners as perpetrators become known as "law-n-order cynics" who are hypersensitive to any manipulation and blind to real distress, dismissing it as a manipulative play for secondary gain. Prisoners perceive these clinicians as hostile and indifferent to their distress. Both perspectives compromise a clinician's ability to establish a therapeutic relationship and thus perform valid evaluations and provide effective treatment. Prisoners, especially the most vulnerable, perceive this no-win situation and try to avoid it.

### Barriers 5 and 6

Two barriers preventing prisoners from accessing medical and mental health care are stigma and fear. Stigma, especially with male inmates is a gigantic barrier to victims of sexual assault. It's one of the largest barriers preventing many victims from reporting assaults and seeking help for their mental health problems (i.e., shame, guilt, intrusive distressing thoughts, recurrent distressing dreams, flashbacks, anhedonia, tearfulness, impulsivity, hallucinations, sleep problems, appetite problems, and suicidal ideation). Needless to say, it's a much bigger problem in prison than in the community because the last place a male wants to appear weak and sentimental is in prison. Admitting mental health problems and accessing mental health services

even without having been sexually assaulted is rare for most male inmates because it implies emotional weakness. This phenomenon is best illustrated by comparing the annual incidence of male depression in the community to the incidence in Georgia's prisons. The National Co-Morbidity Study revealed that the annual incidence of community male depression is 7.1% while in Georgia's prisons it's 3.6%, even though incarcerated males have significantly more risk factors and fewer protective factors. To make a bad situation worse, the strength of this barrier is enhanced by fear that the perpetrator and/or his friends will retaliate for "snitching."

#### Barrier 7

Another barrier hindering males from accessing help is their distrust of the staff and conversely the staff's distrust of the prisoners. By definition, prisoners and prison staff are in an adversarial relationship since the former are being detained by the latter against their will. Many prisoners perceive staff to include mental health staff as part of the system that's treating them unfairly. Likewise, many staff perceive inmates as being deceptive and manipulative. These attitudes are often complicated by gender and race. For example, 93% of Georgia's prisoners are male while only 30% of the mental health staff are male. Likewise, approximately 67% of the prisoners are nonwhite while only 39% of the mental health staff are nonwhite. Finally, 59% of the total prison population is African American male while only 5% of the mental health staff is African American male. Consequently, there's a high probability that many prisoners and staff have problems truly communicating with each other.

#### Barrier 8

Many books that discuss the criminal mind, antisocial/psychopathic personalities and games criminals play emphasize deception and manipulation at a cost to prisoner's credibility resulting in an underlying and pervasive staff bias. Consequently, when prisoners make a sexual allegation many staff dismiss it as deception or manipulation until it's proven that the prisoner wasn't retaliating against staff/prisoners or merely seeking attention. Allegations against other prisoners are also often dismissed as the result of a lover's spat after having consensual sex. These attitudes which are found in staff who work in security, medical and mental health, discourage legitimate allegations from being made.

#### Barrier 9

Along with dismissing the credibility of most sexual allegations, staff often minimize the potential benefits of mental health counseling. It's reflected in counselor's salaries and in attitudes that "any nurse or counselor can provide mental health services." It's also reflected in an attitude that prisoners are hopeless since their parents, teachers, counselors and preachers were unable to help them. Consequently, **staff to include many mental health staff** don't expect much from their counseling sessions with prisoners. Treatment failures are usually blamed on the prisoners who "have a personality disorder that can't be changed."

#### **Strategies to Eliminate Barriers**

Strategies used in GDC to begin to eliminate these barriers include the implementation of a public health model and an intensive oversight program.

## Public Health Model

The threat of sexual assault and the barriers to accessing and receiving adequate mental health by alleged victims is a public health problem placing the general prisoner population at risk for physical and psychological trauma. A review of GDC's surveillance data revealed that in calendar year 2006, there were 654 sexual allegations out of a total population of approximately 54,000 prisoners. A comparison of investigated sexual assault victims and perpetrators who were receiving mental health services to those who weren't receiving mental services revealed that 70% of the alleged victims and 62% of the alleged perpetrators were receiving mental health services. These findings are significant in that the mental health population, which is 16% of the total prison population, is disproportionately represented in the alleged victim and perpetrator groups. Obviously, a lot more surveillance data needs to be collected to determine if this is an artifact of our method of data collection or analysis. Regardless of its accuracy, the point is that surveillance data identifies the variables that create, increase and maintain public health risks. This data is essential in the selection of targeted interventions: that promote physical and mental health; that prevent both physical and mental illness; and that treat both physically and mentally ill prisoners.

Current efforts at health promotion include: 1) training the Agency's policies and procedures to prisoners, staff, and visitors; 2) training mental health counselors how to evaluate and treat victims of sexual assault and 3) training all mental health staff how to increase their empathy.

The Prisoner Handbook notifies prisoners that sexual activity is strictly prohibited per Agency policy, subject to disciplinary action and may be subject to criminal prosecution. Prisoners also receive a written notice and training on: 1) how to avoid being a target for unwanted sexual advances; 2) the various methods available for reporting: a.) when they have been asked by someone to engage in sexual activity; b.) when another has forced them to engage in sexual activity; or c.) when they have witnessed sexual activity involving another prisoner; and 3) what to do if they believe they have been a victim of sexual assault/misconduct including how to preserve evidence lost when showering or washing hands, clothing or bedding. Staff and visitors who may come into contact with a prisoner and who have not had prior training will read and sign the PREA policy acknowledging that they understand it before coming into a prison. Staff will also receive training that includes instruction on the law, how to recognize warning signs that assault of a prisoner may have occurred or may occur and what to do when they suspect, witness or receive a report of sexual assault /misconduct.

Current efforts at health promotion also include training mental health counselors how people react to trauma, issues of confidentiality in prison, elements of a good evaluation and commonly used interventions. Successful completion of these classes is a minimum requirement before a counselor's clinical supervisor allows the counselor to evaluate and/or treat a prisoner who has been sexually assaulted.

In addition to training mental health counselors how to assess and treat victims of sexual assault, they also receive training on relevant developmental issues to facilitate empathy, (the ability to experience the world from another's perspective). They're reminded of most prisoner's

developmental history; namely, growing up in poverty and in a chaotic and often abusive family. Most prisoners' childhoods are characterized by drugs and alcohol, violence, emotional invalidation, and school failure. At a relatively young age, these children begin to perceive the world as a dangerous place that is at best indifferent to their needs. Males tend to protect themselves from emotional pain by seeking thrills and staying hyper-aroused. Females tend to protect themselves by reducing stimulus input and dissociating. It's as if these boys and girls put on a protective suit of armor. It heaviness forces them to grow into grotesque shapes and drains them of their energy. Worse yet, after years of wearing it, their growing bodies become so distorted that the armor can no longer be taken off even though the dangers against which it once protected them has passed. It's as if the armor has become part of their skin and it keeps away not only archaic danger but also needed and longed for human contact. Unfortunately, this maladaptive protection results in a number of developmental deficits such as an inability to delay gratification, modulate affect, control impulses, comfort themselves, tolerate frustration and trust others. Without these abilities/resources, these individuals will have a life-long problem with interpersonal relationships/intimacy.

Current efforts at preventing sexual assault include: 1) classifying prisoners as potential sexual victims or predators when they enter the system; 2) classifying prisoners as potential victims or predators when they're placed in segregation; 3) identifying prisoners who are at risk of being assaulted; 4) implementing a system-wide referral policy; and 5) facilitating a sex offender psycho-educational program.

When prisoners enter the prison system, they're administered a number of inventories and screens to determine their educational, vocational, medical and mental health needs and both their vulnerabilities and security risks. One of the inventories determines whether or not an inmate is a sexual victim or predator, potential sexual victim or predator, sexual victim and predator, or potential sexual victim and predator. The results of this inventory will be used by classification to place the prisoner in an appropriate facilities.

Prisoners who are receiving mental health services are also classified as being potential victims or predators when they're going to be placed on protective custody status or administrative segregation status because they can be placed with other prisoners in protective custody or administrative segregation. Prisoners receiving mental health services in the general population can be placed with other prisoners receiving mental health services while living in general population. In contrast to these prisoners, those receiving mental health services in a level III or IV supportive living unit can only be placed in a single cell. Within twenty-four hours of placement, mental health staff reviews the Lockdown Placement Clearance Form and notifies security of any modifications to the housing assignment. Three exceptions to these housing assignments are: a.) all mental health prisoners charged with assault will be "housed" alone; b.) all mental health prisoners who are alleged victims of sexual abuse will be "housed" alone; and c.) all mental health prisoners with a physical/sexual assault history will be "housed" alone. These exceptions are guidelines for placement. The demands of specific situations might result in placement contrary to these guidelines. It's the responsibility of the mental health duty officer to ensure that the exceptions are being considered in determining placement and to relay this information to the appropriate institutional duty officer.

Mental health screens, evaluations and treatment plans address prisoner's history of sexual abuse and determine if it's salient in the prisoner's current treatment and housing placement. The prisoner's primary mental health clinician works with the interdisciplinary treatment team to ensure appropriate treatment and housing.

To ensure identification of potential victims, especially those who are afraid to report threats of actual assault, staff to include correctional officers and medical staff are trained how to identify the signs and symptoms of potential victims and how to refer these prisoners to mental health for an urgent or routine evaluation. Referral forms are present in all dorms and medical clinics.

Another program to prevent sexual assault is our Sexual Offender Psycho-educational Program. All sex offenders are mandated to successfully complete this program in order to be considered for parole.

Current efforts at providing mental health treatment for sexual assault victims include: 1.) an annual review of each clinician's request for clinical privileges by facility Clinical Directors; 2.) clinical supervision of unlicensed master degree clinicians; and 3.) semi-annual treatment plan reviews and utilization reviews.

All mental health programs have credentialing files on their clinical staff and clinical privileging files. All clinicians must request clinical privileges annually. Their requests are reviewed and approved/denied by each program's Clinical Director. Two clinical functions on the request form are "evaluating alleged victims of sexual assault" and "treating these assault victims." Clinical Directors are responsible for ensuring that the applicant's credentials are appropriate and current and that his/her clinical supervisor doesn't have any reservations about approving the request.

All unlicensed master degree clinicians receive one hour of weekly clinical supervision from a licensed psychologist, licensed clinical social worker or licensed professional counselor. Supervision is documented and maintained in the supervisor's office. Staff also attend bi-monthly case conferences to discuss complex assessment and treatment cases.

All prisoners receiving mental health services have a treatment plan which is reviewed semi-annually by an interdisciplinary treatment team that includes counselors, psychologists, psychiatrists, nurses, activity therapists and a mental health trained correctional officers. This review includes a determination of whether or not the prisoner is receiving the appropriate type and level of care, which has to be justified on the utilization review form.

#### Oversight Procedures

To ensure both compliance with policies and procedures and delivery of quality mental health services, audits are performed annually, peer review is performed annually, continuous quality improvement is performed quarterly, mortality review has been performed monthly and surveillance reports are reviewed monthly.

All thirty-one mental health programs are audited annually. Each facility audits itself three months prior to central office's audit. The intent of these double audits is to ensure that each program can identify and correct its own deficiencies. The audit tool takes a comprehensive look at both SOP compliance and the quality of services (i.e., different types of evaluations, treatment plans, progress notes, prescription practices). The audit team consists of a psychologist, mental health nurse and mental health counselors. Records are reviewed and both staff and inmates are interviewed. The results are quantified and a report is written. Within thirty days of receiving the report, a Corrective Action Plan is written by the facility and reviewed by central office within three months.

The Agency also pays for an annual external audit of both medical and mental health. Dr. Ronald **Shansky** audits medical and Dr. Jeffrey Metzner audits mental health. Each audit includes site visits and a review of central office operations.

Psychiatry and psychology peer reviews are performed annually. Staff psychiatrists and psychologists are scheduled to review each other, write a report and send it to the State Psychiatric Director and Clinical Director.

The facility medical and mental health continuous quality improvement (CQI) committees meet quarterly. They present the findings of their CQI studies and send a copy of their reports to central office which oversees the status of each program's studies.

Mortality review is performed monthly by the State Medical Director and her designees. The State Mental Health Director and Psychiatric and/or Clinical Director participate when there's a suicide, homicide or unusual death.

Surveillance data is compiled and sent to central office monthly. This data includes information on critical incidents to include sexual assaults. Some program logs are also sent to central office (i.e., Crisis Stabilization Logs, Self-Injurious Logs and Sexual Allegation Notification and Evaluation Logs). This information is used to track trends and identify outliers.

### **Summary of Lessons Learned**

Fifteen years ago, a civil rights complaint which had been filed in '85 contesting conditions of confinement was amended to include a certified class of female prisoners alleging rape, sexual assault and coerced sexual activity, involuntary abortions, retaliation or threats of retaliation for not participating in sexual activity, and inadequate medical and mental health care. The complaint never went to full trial but there were a number of federal court orders requiring GDC to rectify past practices and revise standard operating procedures (SOPs), (i.e., procedures on investigating sexual allegations and both medical and mental health's procedures on examining, evaluating and treating alleged victims of sexual assault). During the next fifteen years, the Agency adapted a zero-tolerance policy for sexual assault and misconduct. The Office of Special Investigations was created within the office of Internal Affairs. Its only task was to investigate sexual allegations. Prisoners were instructed on their rights and the mechanism of reporting sexual allegations. Employees were also instructed on the Agency's revised procedures and intentions to prosecute those who sexually assaulted prisoners. Employees and volunteers who worked at female facilities had to attend a two-hour block of instruction on the

revised procedures and had to pass a test before being permitted to work in these facilities. To the Agency's surprise, the number of allegations increased with time. Closer examination revealed that the rise in allegations was primarily due to Close and Maximum Security prisoners alleging sexual contact during "pat-downs" and "strip searches". Consequently, in spite of the number of allegations increasing, the investigation decreased along with the number of substantiated allegations. Do these results mean that the procedures put in place as a result of *Cason v Seckinger* are working?

Clearly, *Cason* put the spotlight on sexual misconduct between staff & prisoners and between prisoners. Over the last fifteen years, this spotlight has not been turned off. Unfortunately, it has not eliminated the problem of sexual misconduct but it has made it more difficult for staff and prisoners who behave inappropriately to go undetected.

Major issues which came to light as a result of *Cason v Seckinger* were the need to: 1.) separate sexual allegations from grievances; 2.) write and integrate procedures for reporting and investigating allegations and for medically and psychologically examining and treating these alleged victims; 3.) maintain adequate staffing patterns; 4.) reduce the stigma of reporting a sexual allegation; 5.) stop staff and prisoner retaliation; 6.) identify and separate potential victims and predators; 7.) educate prisoners and staff; 8.) identify victims who are afraid to report their abuse; 9.) inform alleged victims of the limits of confidentiality; 10.) regularly monitor staff's compliance with policies and procedures and the quality of their work; 11.) monitor and address staff's cynicism; 12.) have leadership show interest in the implementation of these procedures; and 13.) conduct timely investigations. Due to changing policies, standards, funds, staff and inmates we continue to grapple with these issues.

Over time we have learned a number of lessons. First, we learned that separating investigations of sexual allegations from investigations of grievances eliminated potential conflicts by removing the facility from the investigation process and giving it to an independent investigator. Second, after a number of minor SOP revisions, our policies and procedures appear to be sound, withstanding the test of time. Third, we discussed that staffing patterns cannot fall below a certain level or officers are unable to adequately observe prisoners, investigators are unable to investigate allegations in a timely manner, and clinicians are unable to provide comprehensive care. Fourth, education and communication begin to reduce stigma, resulting in increased allegations. Fifth, anonymous reporting begins to reduce retaliation. Sixth, inventories administered during the diagnostic intake process help classification identify and separate potential victims from predators. Seventh, prisoners become empowered by being informed of their rights and how to report a violation of their rights. Likewise, staff become enlightened by being informed of what constitutes appropriate behavior and the consequences of inappropriate behavior. Eighth, educating correctional staff on signs and symptoms of sexual assault victims helps increase appropriate referrals to medical and mental health. However the silent victim is a gigantic problem. Currently GDC and the Center for Disease Control are developing a research protocol to investigate ways to identify the silent victims. Ninth, when alleged victims confide in mental health staff, the victim is immediately informed on the limits of confidentiality. Tenth, audits, continuous quality improvement and peer review increase SOP compliance and improve the quality of care. Eleventh, staff's cynicism about prisoners lying, manipulating and engaging in consensual sex is a deeply engrained problem that gets fueled by frivolous allegations. Trying

to change these attitudes is extremely difficult. Management's attitude and education on the psychology of coercion appear to soften these attitudes. Twelfth, leadership needs to be committed to implementing and overseeing these policies. Lastly, when prisoners remain locked down in protective custody for months waiting on their allegations to be investigated, the incidence of reporting decreases.

In closing, on behalf of Commissioner James Donald and Georgia Department of Correction, it's an honor to testify in front of this Commission, sharing the lessons learned since Cason v Seckinger. We look forward to continuing to help the Commission gather information and develop guidelines that will help eliminate prison rape.

***"I DECLARE UNDER PENALTY OF PERJURY THAT THE FOREGOING IS TRUE AND CORRECT. EXECUTED ON THIS 26 DAY OF NOVEMBER, 2007."***

James F. DeGroot, Ph.D.