

21 (Five witnesses sworn in.)

22 CHAIRMAN KANEB:

23 This panel is Response and

24 Treatment. Response in treatment,

25 obviously, for victims of sexual abuse

1 in prison. Panelists will discuss
2 adequate, appropriate care of victims
3 of sexual violence, psychological,
4 physical, spiritual in the
5 consequences. They are Robert B.
6 Greifinger, MD, HealthCare Policy and
7 Quality Management Consultant, who are
8 focusing on designing quality
9 improvement and utilization to manage
10 correctional health -- healthcare
11 systems.

12 Jim DeGroot, Ph.D., is
13 mental health director. Dr. DeGroot
14 will lay a foundation for providing
15 psychological services in correctional
16 setting.

17 Jennifer Pierce-Weeks is
18 President-Elect, International
19 Association of Forensic Nurses and
20 Forensic Nurse Examiner, Memorial
21 Hospital. Ms. Weeks has 21 years in
22 the nursing experience and is an
23 educator and expert in the areas of
24 child development and adult sexual
25 assault.

1 Lannette Linthicum, MD,
2 Medical Director of the Texas
3 Department of Criminal Justice. Dr.
4 Linthicum made her first rounds in the
5 Texas prison system in 1986. She
6 founded the healthcare policy delivery
7 system. She found their healthcare
8 policy to be inadequate. A years
9 earlier, a federal judge presiding over
10 the prison reform lawsuit found nearly
11 the entire medical program inadequate.
12 And Dr. Linthicum is here to provide
13 valuable information on the current
14 state of healthcare delivery.

15 And lastly, Ben Raimer, MD,
16 vice president and CEO of Community
17 Health Services, University of Texas
18 Medical Branch.

19 The number of advisors on
20 the panel are of various government
21 agencies and professional
22 organizations.

23 Thank you all.

24 Starting from my left,
25 Dr. Greifinger.

1 DR. GREIFINGER:
2 Good morning, Commissioners.
3 Thank you very much for asking me to
4 testify today. I'd like to speak to
5 two issues. The first is to give you a
6 broad scope of view of the status of
7 correctional healthcare in the United
8 States today. And the second is to
9 talk about some of the challenges that
10 I see to the implementation of
11 standards in the areas of medical care
12 and mental healthcare behind bars in
13 this country.

14 During the past 31 years,
15 since the Supreme Court case Estelle v.
16 Gamble, correctional healthcare has
17 come a long way. There are now written
18 standards of care. There are fairly
19 clear expectations for policies and
20 procedures about access to care and the
21 timeliness of care. And we have seen
22 increasing quality of correctional
23 health professionals and, thereby,
24 improved sense of professionalism,
25 which has raised self-esteem and worked

1 toward recruitment and retention of
2 even better qualified staff.

3 It's widely understood that
4 timely access to care, both medical
5 care and mental healthcare, underpins
6 the standard of care in the United
7 States. Now, in reality, the
8 implementation of those policies and
9 procedures varies considerably. We
10 have some very fine correctional
11 healthcare systems and others that
12 far -- really fall far below the
13 standard. In large part because of, in
14 my opinion, the failure of many
15 jurisdictions to be able to specify
16 what they want for their medical care,
17 whether that be a contracted medical
18 care or care provided by their own
19 agencies, and for agencies' inability
20 to provide oversight.

21 There are substantial
22 challenges that lie ahead in the area
23 of correctional healthcare. First of
24 all, correctional health professionals
25 are disconnected from mainstream

1 medicine. They've got healthcare for
2 the rich, healthcare for the poor, and
3 healthcare for folks behind bars. And
4 there's a tremendous discontinuity.

5 Behind bars, for the most
6 part, we still use what's called a
7 sick-call model. It's a model of
8 episodic care that would -- is not even
9 recognized in the community. We have
10 primary care model in the community --
11 folks have been talking about that for
12 decades -- but we still use this
13 so-called sick-call model, which does
14 not provide for continuity in
15 coordination of care.

16 Generally, there's very poor
17 integration of care for patients with
18 co-existing illness, for example,
19 mental illness and drug addictions. We
20 have performance measurement and
21 quality management systems that are
22 cruel compared to those in the
23 community, and they're typically not
24 constructive.

25 There's very poor transfer

1 of medical information from the
2 community to the prison and from the
3 prison back to the community, in large
4 part, because of our medical
5 recordkeeping techniques. And there's
6 often very poor communication between
7 agencies, leadership, and correctional
8 healthcare practitioners. In large
9 part, because of the different styles
10 that we train them.

11 Prison and jails, typically,
12 are command control environments where
13 uncertainty is unacceptable. In
14 medicine and in nursing and psychology,
15 we -- we thrive on uncertainty. We
16 train to live within uncertainty. So
17 there's often conflicting style and
18 personality between well-trained
19 doctors and nurses and well-trained
20 correctional leaders.

21 So we have some challenges
22 ahead, generally, in correctional
23 healthcare and then challenges,
24 specific, in my opinion, to the
25 implementation of -- of standards.

1 First of all, the majority of
2 correctional agencies are accreditation
3 naive. They're not comfortable with
4 quantitative performance measurement in
5 they loath to be self-critical,
6 especially if they have to write it
7 down. If they have to write down what
8 may have gone wrong so we can learn
9 from that and make things better in the
10 future. Behind bars, there's a vast
11 cultural and bureaucratic resistance to
12 oversight, especially oversight by
13 outsiders. Preparation for
14 certification or to meet any standards
15 takes resources, resources like time,
16 training, and recordkeeping, which are
17 often not made available by legislative
18 bodies.

19 And there are also some very
20 legitimate concerns by health
21 professionals, regarding the
22 consequences of reporting episodes of
23 sexual violence. First of all, there
24 are these tensions between the command
25 control environment where sex is not

1 allow. So the risk of disclosing that
2 sex has occurred, particularly
3 nonviolent, coercive sexual
4 victimization. There's a risk, A, the
5 custody staff may want to minimize
6 these episodes of sexual behavior and
7 victimization. But also, there's the
8 risk that disclosure will lead to
9 punishment. Because if a sexual victim
10 has been involved -- has been a victim
11 over a period of time, where it may
12 have the appearance of being
13 consensual, even though there is no
14 such thing as consensual sex behind
15 bars, that victim could be punished for
16 having participated in sexual activity
17 without reporting it.

18 Another tension that we're
19 going to have -- if we have standards
20 that require intake assessments to be
21 done asking for histories of sexual
22 violence, we can take -- assessments
23 are often done by custody staff, by
24 uniformed staff and not by healthcare
25 staff, so there's a real risk there.

1 It's a challenge for victims to
2 disclose that kind of information. And
3 there's a potential ethical dilemma to
4 maintain the confidentiality of medical
5 information, such as recent sexual
6 encounters, and the public safety duty
7 to report that to prevent harm to that
8 individual patient or to prevent harm
9 to other patients, if there's a sexual
10 predator in the midst.

11 CHAIRMAN KANEB:

12 I think I will follow the
13 practice of letting questions be asked
14 after each group of panelist at this
15 point, otherwise, we're going to have a
16 blurred situation in the Commissioners'
17 minds, right though they may be. So I
18 will simply ask, does anybody have a
19 question of this witness?

20 COMMISSIONER SMITH:

21 So, Chairman, we're going to
22 ask questions now?

23 CHAIRMAN KANEB:

24 Please do.

25 COMMISSIONER SMITH:

1 Okay. Just one question for
2 Dr. Greifinger. In terms of -- you
3 know, we've actually heard lots of
4 information about ethical, legal
5 obligations around maintaining
6 confidentiality and sort of the tension
7 with custody and control.

8 How do those obligations
9 work in a correctional environment
10 when, I believe, that all staff,
11 including medical staff, are required
12 to report things that affects safety
13 and security of the institution? I
14 mean, how do medical professionals deal
15 with that?

16 MR. GREIFINGER:

17 With difficulty. It's one
18 of the big differences between the
19 practice of medicine in the community
20 and the practice of medicine behind
21 bars. Most physicians will tell you
22 that their first obligation, their
23 first duty, is to do no harm to their
24 patient. And that's been an ethical
25 tenant for thousands of years in

1 medicine. So it's very difficult to
2 violate patient confidentiality,
3 particularly if that violation might
4 cause real harm, like punishment, to
5 the person who shares the information.
6 So it's a -- it's a very big challenge
7 situation.

8 COMMISSIONER SMITH:

9 Do you have any sense about
10 what people do? I guess that's what
11 I'm really asking you.

12 DR. GREIFINGER:

13 My sense is that they --
14 they -- correctional doctors are very
15 reluctant to report. Very, very
16 reluctant to report. It's very hard
17 for them to see the other side of the
18 story, and that is their responsibility
19 for -- for public safety, and should
20 try to prevent this harm from -- from
21 coming to others.

22 COMMISSIONER SMITH:

23 And so they may not report?

24 DR. GREIFINGER:

25 Yes.

1 COMMISSIONER PURYEAR:

2 I just have one quick
3 question. I hear what you're saying
4 about the disconnect between
5 correctional medicine and medicine in
6 the general community. Isn't there
7 another problem, too, that the sites
8 where many facilities are located in
9 the mental health area, in particular
10 finding a well-trained psychiatrist or
11 psychologist in those areas to help
12 treat the inmates is difficult for any
13 correctional system. And -- is that
14 your observations, and do you have any
15 suggestions about ways, like
16 telemedicine or things that could be
17 used to help improve on the situation?

18 DR. GREIFINGER:

19 Well, geography is certainly
20 a problem. We have competing interest,
21 typically -- let's say for state
22 prisons. State prisons are built where
23 there's a strong lobby to help develop
24 the economy of the communities. It
25 brings jobs and brings money. But

1 those tend to be communities that don't
2 have much medical care so it becomes
3 very difficult.

4 Telemedicine has been
5 helpful, particularly for psychiatry,
6 across the country. It's not been so
7 successful in other areas. There's
8 some spots where it works really well.
9 I still think there's hope for it.

10 But what we have to really
11 be making decisions about is why we're
12 locking up so many people, why we're
13 locking up so many people who
14 disproportionately have mental illness
15 and who disproportionately, those with
16 mental illness get involved in sexual
17 victimization on one side or the other.
18 I think we have to think about those
19 broad policy issues first. But
20 certainly not skirt the realities of
21 the allocation of healthcare researches
22 in the communities.

23 I find that the quality of
24 leadership in a facility has the most
25 to do with the recruitment and the

1 retention of good staff. And that's
2 whether it be in the big county jails
3 with 10,000 inmates or in -- or in the
4 suburban counties and small prisons in
5 rural areas.

6 CHAIRMAN KANEB:

7 Do you -- do you have a
8 thought that, in developing our
9 standards, the Commission should pay
10 some special attention to a problem to
11 which you allude to about reluctance to
12 report, reluctance by staff who have
13 knowledge, particularly in a case of --
14 where somebody may be mentally
15 challenged, emotionally challenged, as
16 well as being victimized? Is there
17 some way a -- would you -- I can't
18 think of it right now. But if you have
19 some thoughts about helping us with
20 standards to develop, which pertains to
21 right now --

22 DR. GREIFINGER:

23 I think it's one of the most
24 important things you can do, and I
25 would certainly be happy to help work

1 with you on that. It's a terrible
2 dilemma. You can just imagine if you
3 have a relationship with a therapist
4 and your therapist says be open, and
5 you say, okay. I'll be open but,
6 please, you've got to keep this between
7 us.

8 CHAIRMAN KANEB:

9 We do. We're -- we're right
10 into that sort of thing now. And so I
11 would ask the staff that's here
12 maybe -- Dr. Greifinger before he
13 exits.

14 Dr. DeGroot.

15 MR. DeGROOT:

16 Good morning, Commissioner.
17 Thank you. It's an honor to be here
18 today sharing with your experiences,
19 challenges, and lessons learned from
20 the Georgia Department of Corrections,
21 which I'm going to refer to is GDC, in
22 our attempt to eliminate prison rape.

23 My testimony is based on my
24 oversight of the mental health program
25 that's treating 8200 mentally ill

1 prisoners, and on my history with a
2 1992 amended civil rights complaint,
3 namely Cason v. Seckinger, which was
4 filed by a certified class of female
5 prisoners alleging rape, sexual
6 assault, coerced sexual activity,
7 involuntary abortions, retaliation for
8 not participated in sexual activity,
9 and inadequate medical and mental
10 healthcare.

11 The complaint never went to
12 trial, however, GDC revised a number of
13 its past practices and standard
14 operating procedures, to include
15 medical and mental health standard
16 operating procedures. We learned a lot
17 of lessons from Cason v. Seckinger.
18 I'd like organize my testimony around
19 one of those lessons. That lesson
20 arose from our analyses of our mental
21 health database, which was created
22 during Cason.

23 The lesson is that mentally
24 ill prisoners are disproportionately
25 represented among sexual perpetrators

1 and victims. For example, as recently
2 as calendar year '06, we had 15 percent
3 of the general population receiving
4 mental health services. We also had 70
5 percent of the investigated sexual
6 assault victims and 62 percent of the
7 perpetrators receiving mental health
8 services when the assaults took place.

9 Another database reveal
10 that, among those currently in GDC who
11 have ever received a sexual assault
12 disciplinary report, 58 percent were
13 receiving mental health services when
14 they committed the assault. These
15 findings are compelling, and they're
16 being further analyzed before we make
17 problematic changes. However, one
18 lesson that is clear, even before doing
19 further analyses, is that we need
20 quality mental health delivery systems.

21 The following eight program
22 elements, if present -- if present,
23 helped us provide quality services to
24 assault victims and conversely, if
25 absent, hampered service delivery.

1 Number one, an executive
2 management team that conveys the
3 importance of the sexual assault
4 elimination program to middle
5 management and line staff. Number two,
6 a sexual assault investigation team
7 that's independent from a local
8 grievance investigation. Three, mental
9 health SOP's that are clearly written
10 and aligned with both medical and
11 investigation SOP's. Four, adequate
12 staffing patterns. Five, training
13 programs for prisoners and for staff.
14 Six, a mechanism that identifies
15 prisoners who have a history of sexual
16 victimization and/or gradation. Seven,
17 oversight procedures that review SOP
18 compliance and quality of care. And
19 eight, mental health database on sexual
20 allegations that identifies the number
21 of critical barrier bolts.

22 Challenges -- or barriers of
23 adequate mental health delivery system
24 can be categorized into three areas,
25 resource barriers, prisoner barriers,

1 and institutional barriers.

2 Resource barriers include
3 not having enough clinicians or not
4 having enough experienced clinicians.
5 when staff are short, the squeaky wheel
6 gets the grease, namely the mental
7 health emergencies. SOP corners are
8 cut by reducing non-emergent
9 programming and training and oversight,
10 such as continuous quality improvement.
11 Likewise, when inexperienced staff
12 evaluate and treat psychologically
13 complex prisoners, they often make a
14 bad situation worse, despite their best
15 efforts and good intentions.

16 Prisoner barriers include
17 stigma, fear of retaliation, staff
18 distrust, and dread of protective
19 custody. Stigma, especially with male
20 prisoners, is a gigantic barrier for
21 sexual assault victims who are seeking
22 help. The reason this is such a
23 gigantic barrier is because, if there's
24 one place males don't want to appear
25 emotionally and physically weak, it's

1 in prison. Unfortunately, if and when
2 assault victims overcome the barrier of
3 stigma, they're confronted with three
4 more barriers, namely fear of
5 retaliation, distrust of staff, and
6 dread of protective custody.

7 Institutional barriers
8 include staff bias, such as confusing
9 sexual orientation with consent and
10 attributing allegation to deception and
11 manipulation. And number two, a sense
12 of futility among some mental health
13 staff. Feeling as if prisoners are
14 hopeless sense, quote, they have a
15 personality disorder which their
16 parents, teachers, counselors, and
17 preachers were unable to fix.

18 The strategy is to overcome
19 these barriers include, one, using
20 multiple oversight mechanisms, and,
21 two, adopting a public health model.

22 Oversight mechanisms consist
23 of internal and external audits, peer
24 reviews, CQI, and utilization review.
25 A public health approach consists of,

1 A, promoting health through education,
2 and, B, preventing sexual assaults by
3 identifying and tracking perpetrators
4 and victims, and, C, treating mental
5 illness with qualified providers and
6 best practices.

7 Thanks for your
8 attention. On behalf of GDC, I'd like
9 to express appreciation for the work
10 you're doing. I'd also like to say
11 that we look forward to continuing to
12 support the Commission in any way we
13 can.

14 CHAIRMAN KANEB:

15 One question to clarify
16 something for me, Dr. DeGroot. 8200
17 inmates are -- is the population of,
18 what?

19 MR. DeGROOT:

20 Right now we have
21 approximately 54', 55,000 inmates in
22 Georgia Department of Corrections.
23 Of that population, 16 percent, or
24 8,200, are receiving mental health
25 services, have been diagnosed with a

1 mental illness.

2 CHAIRMAN KANEB:

3 And is there a central -- I
4 don't know if I'd call it
5 administration -- management of
6 healthcare for those 8200 identified
7 people with mental health problems for
8 the whole system?

9 MR. DeGROOT:

10 I'm not --

11 CHAIRMAN KANEB:

12 Or is it done entirely on a
13 local facility basis?

14 MR. DeGROOT:

15 No, sir. It's centralized.
16 We have a set of standard operating
17 procedures that the whole system uses
18 in the delivery of mental health
19 services to these -- to these inmates.
20 We have mental health programs in 31
21 facilities, sir.

22 CHAIRMAN KANEB:

23 And are these folks in the
24 field reporting to the central -- your
25 administration, or are they reporting

1 through the line officers and the line
2 staff and the warden of the facility?

3 MR. DeGROOT:

4 The direct line of reporting
5 is to the warden of the facility. We
6 provide, in central office, oversight
7 and technical support.

8 CHAIRMAN KANEB:

9 If someone were to ask you
10 whether you thought having a direct
11 line of reporting to your office with
12 information to -- rather than line
13 reporting to line staff at the
14 facility, what would you say to that?

15 MR. DeGROOT:

16 Yes, sir. I've been in central
17 office for 13 years now, and during all
18 13 years we've been discussing this
19 issue. I can see merits both ways. If
20 they reported directly to me, I'd need
21 a lot larger staff than I have right
22 now, sir.

23 CHAIRMAN KANEB:

24 Thank you. I understand. I
25 think we'll -- it's something I think

1 we will want to think about, in terms
2 of our standards of -- it's the whole
3 matter of quality control in a
4 manufacturer facility. If you want to
5 take it into business, is it a quality
6 control group at the factory report to
7 the head of the plant or does he or she
8 report to a central quality control
9 function for the corporation?

10 MR. DeGROOT:

11 Right. The -- the way we
12 get around that is mental health is
13 part of the Department of Health
14 Services, which reports to the
15 commissioner. So we are free from
16 reporting to custody in central office.
17 And we conduct an annual audits -- now,
18 these are compliance audits and quality
19 of care audits -- at all 31 facilities.
20 And we expect them to also do
21 self-audits. Self- audits are done
22 three months before our central office
23 audit. We want to make sure they can
24 oversee themselves. And then we
25 contract for external audits also,

1 annually.

2 CHAIRMAN KANEB:

3 Okay. So, I mean, it is
4 good that your office reports to, let's
5 say, a non-inhouse. But the people in
6 the field report through the in-house
7 staff. Thank you.

8 MR. DeGROOT:

9 Yes, sir.

10 CHAIRMAN KANEB:

11 Are there any -- are there
12 other Commissioners with questions for
13 Dr. DeGroot?

14 Yes, Pat.

15 COMMISSIONER NOLAN:

16 Dr. DeGroot, the statistics,
17 I think, will be very helpful to us in
18 talking about this and the impact of
19 incarceration of the mentally ill. And
20 so I just want to get them straight.
21 Sixteen percent have a diagnosis mental
22 health condition?

23 MR. DeGROOT:

24 Yes, sir.

25 COMMISSIONER NOLAN:

1 And 70 percent of the
2 victims sexual abuse have -- are
3 diagnosed?

4 MR. DeGROOT:

5 70 percent of the cases that
6 were investigated for sexual abuse.

7 COMMISSIONER NOLAN:

8 And then 58 percent of the
9 perpetrators are --

10 MR. DeGROOT:

11 62 percent --

12 COMMISSIONER NOLAN:

13 Yeah, thank you.

14 MR. DeGROOT:

15 -- were perpetrators.

16 COMMISSIONER NOLAN:

17 Thank you.

18 COMMISSIONER FELLNER:

19 Can I just followup on that?

20 We've heard a lot about
21 victims of sexual abuse. And there's
22 actually been very little research, and
23 we've heard very little testimony,
24 actually, about perpetrators. And I
25 assume here we're talking about inmate

1 perpetrators not staff perpetrators.
2 And I wonder if your -- if you have
3 anything you want to add, or maybe our
4 staff can talk to you about what you
5 have learned and what services you
6 provide to inmates who have been
7 perpetrators. You say there are --
8 there's a very high percentage of them
9 who are in the mental health caseload.
10 Can you provide any other information
11 to us about who and why the inmates are
12 who perpetrate?

13 MR. DeGROOT:

14 One of the things I also
15 mentioned was that this population is
16 very complex. It's a complicated
17 population to work with. And when you
18 start taking their histories, you
19 discover a lot of them have been
20 victims of physical and/or sexual
21 abuse.

22 COMMISSIONER FELLNER:

23 The perpetrators?

24 MR. DeGROOT:

25 To -- not just the -- all

1 mental health inmates. All prisoners
2 receiving mental health services.

3 We did a study back in the
4 late 90s, males and females, and we
5 discovered that, at Metro State Prison
6 in Atlanta, one of our larger female
7 facilities, 87 percent of the women
8 receiving mental health services
9 reported a positive history of physical
10 and/or sexual abuse. And likewise,
11 with males, we discovered 56 percent of
12 the males reported a positive history
13 of physical and/or sexual abuse.

14 Now, we discovered that as
15 the severity of the mental illness goes
16 up, so does the -- the reporting of
17 physical and sexual abuse. So what we
18 have are perpetrators who are both
19 victims and perpetrators. We run
20 groups for perpetrators. We run groups
21 for -- for victims. And one of the
22 things we do with identification is,
23 obviously, try to -- try to keep them
24 separate.

25 CHAIRMAN KANEB:

1 Jimmy?

2 COMMISSIONER AIKEN:

3 Yes. Just one quick
4 question, sir.

5 And my understanding is that
6 you are part of a state correctional
7 system; is that correct?

8 MR. DeGROOT:

9 Yes, sir.

10 COMMISSIONER AIKEN:

11 And most of the people --
12 this is an assumption and you can
13 validate it if -- if it is appropriate.
14 That most of the people that you have
15 that's entering your system has been or
16 have been confined for a period of time
17 prior to adjudication; is that correct?

18 MR. DeGROOT:

19 Yes, sir.

20 COMMISSIONER AIKEN:

21 Now, what type of
22 relationship or what type of
23 information that you have available to
24 to you, with this new population coming
25 in, in relationship to their mental

1 health status, treatment plan,
2 medication, things of this nature?
3 What kind of shape are these people in
4 once they have been received by -- by
5 your agency?

6 MR. DeGROOT:

7 At intake, they receive a
8 mental health screen given to them by a
9 master degree mental health counselor
10 within 24 hours of entering the system.
11 If there's a history of receiving
12 mental health services, we ask them to
13 sign a release of information, so we
14 can obtain records from wherever they
15 received those services.

16 This is a good question.
17 We're struggling with this right now,
18 because there are a lot of disconnects
19 in the public mental health system.
20 The governor has convened a mental
21 health commission about four months
22 ago. The commissioner of corrections
23 sits on that commission, and I
24 accompany him to most meetings. And
25 one of the things we're trying to do is

1 increase connection or communication
2 between community mental health
3 services, state hospital, jails, and
4 the prison system. There's a big
5 disconnect between the jails and the
6 prison.

7 Right now in Georgia we have
8 159 counties, 157 jails. The sheriffs
9 are struggling trying to provide
10 medication and treatment for the
11 mentally ill coming into their jails.
12 One of the things we're looking at with
13 this mental health commission is
14 establishing one mental health
15 authority, a cabinet position that
16 would have budgetary authority and
17 authority over procedures for public
18 mental health in -- in these states.
19 So that would be over the state
20 hospitals, over community mental
21 health, mental health services in the
22 jails and in the prison systems.

23 COMMISSIONER AIKEN:

24 Thank you, sir.

25 Thank you, sir, Mr.

1 Chairman.

2 CHAIRMAN KANEB:

3 Commissioner Puryear.

4 COMMISSIONER PURYEAR:

5 I just want to followup on
6 John's line of questioning from a few
7 moments ago.

8 One of the things that -- I
9 don't mean to get us down into too much
10 of the details. But you talk about the
11 audit process that you go through as
12 providing some assurance about the
13 quality of the operations. I take it,
14 if a self-audit is done three months
15 prior that the facility knows when
16 you're coming to audit them, in every
17 evident?

18 MR. DeGROOT:

19 This is like an open-book
20 test. The -- every facility has a copy
21 of the audit, and the audit schedule is
22 published a year in advance, along with
23 the self-audits.

24 COMMISSIONER PURYEAR:

25 Have you ever been concerned

1 that someone could be penciled in the
2 files into shape right before you get
3 there, and kind of spruce up the place
4 a bit?

5 MR. DeGROOT:

6 That's always a concern. We
7 take a whole team -- a large team to do
8 this audit. We spend three, sometimes,
9 four days. We interview prisoners and
10 staff, medical and mental health staff,
11 and we expect a corrective action plan
12 to be done, and we go and followup
13 after we receive -- after they -- after
14 we receive the corrective action plan.
15 About three months after we receive it,
16 we followup and see the implementation,
17 and we will continue following up if we
18 have any suspicions.

19 We are in the field quite a
20 bit, so we're -- we're on top, pretty
21 much, of which programs have what kind
22 of problems.

23 COMMISSIONER PURYEAR:

24 Last question for you.

25 If -- if the mental health

1 professionals report to the warden, how
2 would you assess the average warden's
3 capabilities as a manager of mental
4 health delivery services?

5 MR. DeGROOT:

6 Some of them are very good,
7 and some of them, there's a lot of room
8 for improvement. I've been asked to
9 speak at the warden meetings quarterly,
10 and I'd like to think we're making
11 ground.

12 CHAIRMAN KANEB:

13 Thank you, Dr. DeGroot.

14 Are there -- yes. Yes,
15 Commissioner Smith.

16 COMMISSIONER SMITH:

17 This is actually not a -- a
18 question, but really just a thanks to
19 the Georgia Department of Corrections
20 for its leadership in this area around
21 mental health and also around medical
22 issues as well. I think that the
23 Commission noted and was very gratified
24 by the Georgia Department of
25 Corrections' participation in the study

1 around HIV sterile conversion in
2 institutional settings. And I believe
3 that that has been very helpful in
4 forming our work.

5 MR. DeGROOT:

6 I appreciate the feedback,
7 Commissioner.

8 CHAIRMAN KANEB:

9 Thanks. If there are no
10 other questions -- yes, Pat.

11 COMMISSIONER NOLAN:

12 You mentioned that intake,
13 that the inmates are interviewed by a
14 mental health professional. Is that
15 every inmate coming into the system?

16 MR. DeGROOT:

17 Yes, sir. Within 24 hours,
18 they are screened eye-to-eye by a
19 mental health counselor with a master's
20 degree.

21 COMMISSIONER AIKEN:

22 Just one quick question,
23 sir.

24 And that's more of a --
25 self-report, in relationship to a

1 criminal -- I mean, a professional
2 person that's trained to look at those
3 particular behavior patterns, et
4 cetera; is that correct?

5 MR. DeGROOT:

6 yes, sir. That's
7 correct.

8 COMMISSIONER AIKEN:

9 Okay. Is there anything in
10 your auditing process that you look at,
11 critical events, you look at what went
12 wrong, and is there a mechanism to
13 address that and incorporate it in
14 policy changing as well as training of
15 staff, et cetera?

16 MR. DeGROOT:

17 One of the big lessons we
18 learned from Cason v. Seckinger is to
19 provide a lot of oversight, so we do
20 that during audits. We also have a
21 continuous quality improvement program
22 where we follow NCCHC guidelines
23 mandating a quarterly report, for
24 example, use of seclusion, use of
25 restraint, use of involuntary

1 medication. We have logs sent to
2 central office, along with CQI reports.
3 And then we collect a lot of data.

4 Data is sent to me, to
5 central office, monthly. And we use
6 this data to identify outliers in the
7 system. Once we identify outliers, we
8 will go and work with the facility
9 to -- to explore the reasons for it,
10 and then bring about any corrections.

11 In terms of changing policy,
12 all policies are reviewed annually,
13 which means we're constantly reviewing
14 policies and updating them manually.

15 COMMISSIONER AIKEN:

16 Thank you, sir.

17 CHAIRMAN KANEB:

18 Thank you, Doctor. One
19 more.

20 Commissioner Smith.

21 COMMISSIONER SMITH:

22 You know, just a very -- a
23 very obvious question. Are you still
24 under supervision under Cason versus
25 Seckinger?

1 MR. DeGROOT:

2 The mental health portion of
3 Cason v. Seckinger was closed in '98,
4 Commissioner.

5 COMMISSIONER SMITH:

6 But I guess -- it sounds
7 like, based on it -- even though it
8 might have been a very, I guess,
9 negative event, it sounds like you guys
10 have made sort of lemonade out of
11 lemons; is that fair to say?

12 MR. DeGROOT:

13 Yes, Commissioner. We tried
14 to -- and we continue to struggle. The
15 problem is, once you get out from under
16 oversight --

17 COMMISSIONER SMITH:

18 Right.

19 MR. DeGROOT:

20 -- a lot of times budget
21 starts to be cut. So it's a constant
22 struggle to maintain the policies and
23 procedures at -- at the level you
24 initially wrote them at. And we've
25 been able to do that, to include

1 keeping our audit instrument, but --
2 but it's been a struggle.

3 In fact, yesterday we were
4 in front of the House Appropriations
5 Committee pleading our case, and it
6 looked -- it looks positive for this
7 year, although it's been lean the past
8 few years.

9 COMMISSIONER FELLNER:

10 Dr. DeGroot, I just wanted
11 to add that I know that we have a very
12 short question time here. And as with
13 Dr. Greifinger, your prepared comments
14 are dense and rich of information for
15 us. And I'm hoping and know that our
16 staff will be in touch with you further
17 to mind, and hope you don't feel
18 frustrated by the gravity that's forced
19 by the time here.

20 MR. DeGROOT:

21 No. Thank you,
22 Commissioner.

23 CHAIRMAN KANEB:

24 Thank you, Dr. DeGroot.

25 Ms. Pierce-Weeks.

1 MS. PIERCE-WEEKS:

2 Good morning. I thank you
3 very much for the honor of being able
4 to speak to you today and give you some
5 opinions as the International
6 Association of Forensic Nurse. I've
7 been a practicing sexual assault
8 nursing examiner myself.

9 Just as way of introduction,
10 although I suspect that ya'll know this
11 at this point, SANE, sexual assault
12 nurse examiners and sexual assault
13 forensic examiners make up the majority
14 of our membership. We have 3,000 nurse
15 members internationally, and they are
16 registered nurses who are specially
17 trained in the comprehensive care of
18 sexual assault patients.

19 The IFN has designed
20 education guidelines associated with
21 what needs to happen in order to be
22 trained as a sexual assault nurse
23 examiner in both for the adult as well
24 as the pediatric population. And
25 really, the practice of SANE, nursing

1 was created from the recognition by
2 nursing that the impact of sexual
3 violence on the human person has
4 enormous psychological, physical,
5 spiritual, and social effects as,
6 obviously, evidenced by everyone's
7 testimony here today.

8 The health and well-being of
9 our patients, their families, and
10 communities is both acutely and
11 chronically impacted by their sexual
12 victimization. And by the same token,
13 as SANE nurses, receiving compassionate
14 care at the time of the assault by an
15 appropriately trained examiner, can
16 assist all victims in their short and
17 long-term healing process.

18 With that in mind, the
19 organization representing the largest
20 group of nurses caring for victims of
21 sexual assault would make the following
22 suggestions to -- to the Commission.

23 One, that any -- and this is
24 regarding protocols involving provision
25 of care to sexual assault victims,

1 inmates, whether or not the perpetrator
2 is another inmate or a staff person.
3 One, that safety of the same should be
4 a priority in any -- any examiner, who
5 may be requested to respond to a
6 correctional facility, should receive
7 specialized education about the unique
8 issues that may impact the safety and
9 well-being of the nurse or any other
10 examiner who provide care to the
11 special population.

12 It's obvious to us, in this
13 practice, that most nurses, even as
14 SANE nurses are not necessarily trained
15 in the specialty of the correctional
16 facility and what those patients
17 require in boundary issues, et cetera,
18 so.

19 Two, safety of the
20 community. The healthcare providers
21 and the patient should be a priority
22 when any patient is brought to an
23 outside facility for sexual assault,
24 which is often the case, in many
25 communities. Certainly, in my own

1 community.

2 Correctional institutions
3 should use appropriately trained sexual
4 assault forensic examiners whether or
5 not they're nurses to provide care to
6 the victims in a manner that
7 efficiently uses institutional and
8 community resources and provides timely
9 care and evidence collection to the
10 patient as time is of the essence, if
11 prosecution is one of your goals.

12 Protocols for care must be
13 consistent with the scope of practice
14 defined by the Nurse Practice Act, if
15 nurses are the ones providing the care
16 in the state where the nurse is
17 licensed. And in any protocol for
18 response for victims of sexual assault
19 should incorporate the standards
20 described in the National Protocol for
21 Sexual Assault Medical Forensic
22 Examination when appropriate. Because
23 there is a national standard for care
24 for these patient populations.

25 So just keeping it brief and

1 knowing your time, I would entertain
2 any questions and say that the
3 International Association is very much
4 invested in working with the Commission
5 in any way we can to assist you in your
6 mission. Thank you very much.

7 CHAIRMAN KANEB:

8 Questions?

9 Yes, Commissioner Smith.

10 COMMISSIONER SMITH:

11 One of the things -- thank
12 you for your -- for your testimony.

13 One of the things we have
14 heard consistently is that having a
15 SANE nurse perform the examination is
16 really the goal standard, right? And I
17 guess what I'd be interested in is, in
18 those situations where a SANE nurse is
19 not available, what suggestions or what
20 would you offer, particularly in rural
21 facilities or other facilities where
22 it's just not there? You know, what
23 would you offer or what could you offer
24 in terms of what agencies should do?

25 MS. PIERCE-WEEKS:

1 That's a great question and
2 very appropriate, because there are
3 certainly communities throughout the
4 country that do not have a capacity to
5 have trained SANE nurses. But that --
6 that should not preclude, whoever your
7 examiner is, whether it's a nurse,
8 physician, PA, PO, whatever the title,
9 from getting additional education in
10 the medical forensic aspect of care.
11 That doesn't mean it has to be a
12 week-long training in the comprehensive
13 care. But certainly, training that can
14 hit the highlights for those
15 communities that aren't going to be
16 able to really realistically employ
17 SANE nurses.

18 COMMISSIONER SMITH:

19 And how would they get that
20 training? Would they get that
21 nationally through your organization,
22 or are there local resources where they
23 could do that? And has your
24 organization developed anything that
25 sort of talks about, if you're not

1 going to be a SANE, what are other core
2 kind of training you would need to
3 have?

4 MS. PIERCE-WEEKS:

5 Actually, there are both
6 resources through our organization
7 nationally and probably local
8 resources, depending on the community.

9 Many communities have
10 established SANE programs or safe
11 programs where a part of their program
12 is providing community education, both
13 to the lay community but also to the
14 professional community, such as your
15 correctional facilities as well as any
16 other members of the multidisciplinary
17 team that works with sexual assault
18 victims. So you could certainly get
19 information from us, and we would
20 absolutely be prepared to assist you
21 with that as an organization.
22 But I suspect we can also direct local
23 communities to their own local
24 resources and nurses available to them,
25 who would be happy to help out.

1 CHAIRMAN KANEB:

2 Other questions of
3 Ms. Pierce-Weeks?

4 Commissioner Nolan, yes.

5 COMMISSIONER NOLAN:

6 How are recruitment
7 conditions for SANE nurses, is it --
8 especially, you know, for a prison
9 setting? Is it difficult? Are there
10 barriers? Are there things that we
11 could do to help? 'Cause they do seem
12 so critically important to the victims.

13 MS. PIERCE-WEEKS:

14 There are recruitment issues
15 regarding sexual assault nurse
16 examiners nationally, whether or not
17 the setting is at a correctional
18 facility, in truth. Just because this
19 is not a patient population that,
20 generally speaking, the medical
21 community is thrilled to take care of
22 for a variety of reasons. So, yeah,
23 there's a challenge. Absolutely.

24 With the second part of your
25 question was --

1 COMMISSIONER NOLAN:

2 Can you tell me what some of
3 those barriers are? It would not be
4 just in the correction setting. But if
5 there are any, in particular, in a
6 correction setting, that would be
7 helpful to us.

8 MS. PIERCE-WEEKS:

9 Well, one of the things that
10 we -- because, obviously, we went to
11 our membership and chatted with them
12 about this very day and what challenges
13 they face in some of the correctional
14 settings that exist now that do have
15 nurses employed.

16 One of the challenges that
17 was voiced is the perceived -- and I
18 would strongly -- that really is the
19 keyword, the perceived conflict of
20 interest caring for an inmate sexual
21 assault victim while being employed by
22 the Department of Corrections or, you
23 know, the agency. And truly from a
24 nursing perspective, not being able to
25 speak for the other medical

1 professions, that is a perceived
2 conflict of interest. It is not a true
3 one, because when I practice on my
4 license, as any other registered nurse
5 in any state in this country, my
6 true -- I am truly there as a person to
7 provide care for the patient, the
8 community, and the families that we
9 serve. And while the Department of
10 Corrections, or in my case the hospital
11 employs me and they pay me, my
12 obligation is to my license and,
13 therefore, to that patient. So the
14 perception of conflict of interest, I
15 think is something that should
16 seriously be looked at, and really some
17 resource toward educating those --
18 those nurses about the fact that there
19 really is no conflict of interest,
20 though there may be system problems for
21 them bringing forward issues of
22 victimization within the correctional
23 setting. Does that make sense?

24 COMMISSIONER NOLAN:

25 Yes.

1 MS. PIERCE-WEEKS:
2 That's probably the largest
3 thing we've heard for barriers.
4 COMMISSIONER NOLAN:
5 Thank you.
6 CHAIRMAN KANEB:
7 Commissioner
8 Struckman-Johnson.
9 COMMISSIONER STRUCKMAN-JOHNSON:
10 You aroused my curiosity.
11 Why are sexual assault victims not
12 welcomed by the medical community?
13 MS. PIERCE-WEEKS:
14 well, several different
15 reasons. One is many times the patient
16 population who are victimized tend to
17 be vulnerable populations in the first
18 place. The correctional facility,
19 being one of the greatest examples of
20 this, the mental health issues that
21 have been discussed today. Many
22 victims come to the table having
23 already been victimized, having already
24 established their alcohol and drug
25 problems, their clinical depression,

1 their -- the list goes on and on.
2 And so they can be challenging to take
3 care of. But I think one of the other
4 difficulties for the medical community
5 is, when you take care of a sexual
6 assault victim, you assume from the
7 get-go you may end up in court
8 testifying. That is not a place of
9 comfort for the medical community,
10 because they're much more trained in
11 malpractice in court than they are
12 testifying, in truth, than they are
13 testifying to the care the patient was
14 given.

15 COMMISSIONER STRUCKMAN-JOHNSON:

16 Any issue of prejudice of
17 male patients with male assault
18 perpetrators? Is that the idea of
19 dealing with the male on male sexual
20 assault problem attitude-wise or --

21 MS. PIERCE-WEEKS:

22 From the nurse examiner's
23 perspective?

24 COMMISSIONER STRUCKMAN-JOHNSON:

25 Yeah. Through that, are

1 you --

2 MS. PIERCE-WEEKS:

3 Absolutely. We are prepared
4 for the male victim and they're
5 definitely a part of the training. Of
6 course, I would say the biggest issue
7 for us in that regard is getting them
8 to come forward and tell us.

9 COMMISSIONER STRUCKMAN-JOHNSON:

10 All right. Thank you.

11 CHAIRMAN KANEB:

12 If there are no other
13 questions for Ms. Pierce-Weeks, we will
14 move on to Dr. Linthicum.

15 MS. LINTHICUM:

16 Good morning. My name is
17 Dr. Lannette Linthicum. I'm the
18 medical director of the Texas
19 Department of Criminal Justice, which I
20 will refer to as TDCJ. I'm here to
21 give testimony to the Commission on the
22 Texas Department of Criminal Justice
23 Peer Educational Program, and the
24 impact of release in treating victims
25 of sexual assault.

1 I would like to begin with
2 the Ruiz case. In June of 1972, a
3 Texas offender by the name of David
4 Ruiz filed a handwritten petition with
5 William Wayne Justice, a United States
6 district judge out of the eastern
7 district of Texas, claiming that
8 conditions in the Texas prison system
9 violated his constitutional rights. In
10 April of 1974, the court consolidated
11 eight such offender petitions into a
12 class action lawsuit styled, Ruiz
13 versus Estelle.

14 After our FBI investigation,
15 the United States Justice Department
16 intervened and -- intervened in the
17 lawsuit on behalf of the plaintiffs.
18 Approximately, two years later, in
19 November of 1976, another Texas case
20 was decided at the United States
21 Supreme Court, Estelle versus Gamble.
22 This case was the landmark case that
23 set the national standard for
24 correctional medicine. The court
25 decided that deliberate indifference to

1 a serious medical need constituted the
2 want of infliction of cruel and unusual
3 punishment under the Eighth Amendment
4 of the United States Constitution.

5 Estelle versus Gamble
6 established three basic rights for
7 offenders. The first right is the
8 right to access care. The second right
9 is the right to a professional medical
10 judgment. And the third right is the
11 right to receive the medical care that
12 was ordered.

13 The Ruiz case went to trial
14 in October of 1978. In April of 1981,
15 a final decree was issued in a
16 timetable for implementing the changes
17 required by the decree. A special
18 master was assigned, Attorney Vince
19 Nathan of Toledo, Ohio.

20 Over the next ten years, a
21 series of reforms occurred in the Texas
22 prison system. In March of 1990, the
23 Office of the Special Masters submitted
24 a final report, and the office was
25 dissolved ending active court

1 supervision. In January of 1991, the
2 Texas Attorney General petitioned the
3 court to terminate the federal court's
4 jurisdiction of Ruiz. In December of
5 1992, Judge Justice signed the final
6 judgment in Ruiz.

7 With regard to healthcare,
8 the final judgment imposed a series of
9 additional reporting requirements which
10 were, number one, to maintain
11 accreditation of all units and regional
12 healthcare facilities. Number two, to
13 ensure that no prisoner is assigned to
14 work that was medically
15 contraindicated. Number three, to
16 ensure full access to healthcare for
17 all prisoners. And number four, to
18 ensure that non-medical staff do not
19 countermand medical orders. And number
20 five, to maintain adequate staffing
21 across all disciplines.

22 In April of 1996, Congress
23 enacted the Prison Litigation Reform
24 Act. In September of 1996, the Texas
25 Attorney General filed a motion to

1 terminate the Ruiz final consent decree
2 pursuant to the Prison Litigation
3 Reform Act. On January 21st, 1999, the
4 hearing begins and lasted until
5 February 12th of 1999. On June 18th,
6 2001, the federal court ordered the
7 following areas of the Ruiz final
8 judgment were free from court
9 oversight. And those areas were:
10 visitation, crowding, internal
11 monitoring and enforcement, health
12 services, and death row.

13 The reform of the Ruiz
14 litigation transformed the Texas
15 Department of Criminal Justice into a
16 premiere criminal justice agency. All
17 of the internal and external monitoring
18 that Texas went through in the Ruiz
19 years, equipped our system to
20 aggressively embrace the challenges of
21 the Prison Rape Elimination Act. We in
22 Texas are highly committed and
23 especially tenacious in operating a
24 constitutional criminal justice agency.
25 In fact, the health services division

1 of TDCJ is statutorily required through
2 the provisions of Texas Government Code
3 501.150 to ensure access to care,
4 conduct periodic operational review
5 audits, which are compliance audits,
6 investigate medical grievances, and
7 monitor quality of care and request
8 corrective action.

9 In the area of sexual
10 assault, the TDCJ healthcare program
11 has established a statewide policy.
12 The policy is a part of your handout
13 materials. TDCJ has a sexual assault
14 nurse examiner who is already involved
15 with compliance and quality monitoring.
16 There is also a handout dated
17 11-19-2005 in your handout materials
18 that summarize her activities.

19 Our SANE nurse, with each
20 reported allegation of sexual assault,
21 reviews the medical records and audits
22 it for completeness of the sexual
23 assault evidence collection. She
24 audits to make sure there are referrals
25 to mental health services. She reviews

1 it for appropriateness of labs,
2 laboratory and her other tasks, and
3 also to ensure that prophylactic
4 medications were offered. If a
5 deficiency is noted, a letter is faxed
6 to the unit health administrator and/or
7 the unit medical director requesting
8 corrective action.

9 I would like to use my final
10 minutes in telling you a little bit
11 about our peer education program. In
12 1998, a collaborative partnership
13 between TDCJ, the University of Texas
14 Medical Branch of Galveston, Texas Tech
15 University Health Science Center, and
16 the AIDS Foundation of Houston,
17 Incorporated was established to conduct
18 a pilot program for HIV/AIDS peer
19 education at five TDCJ institutions.

20 Peer education is a teaching
21 model utilizing offenders to instruct
22 other offenders. It has a high degree
23 of success, due to the powerful
24 influence of the peer group dynamics.
25 Researchers have found that prisoners

1 are more likely to have a greater
2 degree of trust among each other than
3 they would with correctional staff.
4 After six months, SANE Associates of
5 Houston, Texas evaluated the program.
6 The evaluation results showed a greater
7 knowledge of HIV and AIDS in offenders
8 who have undergone the peer education
9 training. The pilot, needless to say,
10 was a tremendous success and resulted
11 in establishment of the peer education
12 coordinator position in the Health
13 Services Division. This peer education
14 program is supported by our agencies,
15 executive director, and the director of
16 the Correctional Institution Division.
17 TDCJ has 95 peer education programs as
18 of October 31st, 2007. Seven-hundred
19 sixteen offenders peer educators have
20 educated 35,249 offenders. The peer
21 education curriculum includes HIV,
22 tuberculosis, viral hepatitis, and a
23 safe prison module. The classroom
24 education has increased from four hours
25 of instructions, between six and eight

1 hours. The individual units designed
2 the program to meet their needs in
3 building schedules. The Wyndham School
4 District, which is the formal educator
5 for TDCJ, is collaborating with health
6 services. The offender educators can
7 go to the classrooms and teach the
8 students enrolled in school. Wyndham
9 educates, approximately, 72,000
10 offenders a year. This represent a
11 great opportunity to implement
12 preventive healthcare education and the
13 safe prisons module to a much more
14 broader audiences. Classification has
15 created a full-time job position for
16 peer educators. TDCJ has an annual
17 conference for peer educators. For the
18 safe prisons module -- peer educators
19 receive, as part of their annual
20 update, information on preventing all
21 forms of sexual abuse and
22 victimization.

23 In your handout materials is
24 a white booklet entitled, Safe Prisons
25 Peer Education Training Manual.

1 Typically, for the conferences, food is
2 served. There is also guest speakers,
3 and the peer educators look forward to
4 this all year. TDCJ completed the 6th
5 annual conference this past October and
6 November. There were five conferences
7 this year held at the Big Oak Justice
8 Reed Smith's Gainesville Unit.

9 The conferences are a huge
10 collaborative effort between Health
11 Services, Correctional Managed
12 Healthcare, the Correctional
13 Institutions Division, and AIDS
14 Foundation, Houston, and the
15 pharmaceuticals industry.

16 Thank you for your time.
17 And I will take any questions.

18 CHAIRMAN KANEB:

19 Thank you, Dr. Linthicum.

20 Are there questions?

21 Commissioner Puryear and
22 Commissioner Smith.

23 COMMISSIONER PURYEAR:

24 Quick question for you along
25 the lines of what Dr. DeGroot was asked

1 about. After the provisions of Ruiz
2 were terminated, what has been your
3 observations about the level of funding
4 and the level of importance attached to
5 the mental health area?

6 MS. LINTHICUM:

7 As you may know, Texas, we
8 are the second largest state prison
9 system in the country. We have 2,000
10 inpatient mental health beds at four
11 inpatient psychiatric facility. And we
12 have, approximately, 21,000 on our
13 mental health caseloads. We have a big
14 challenge.

15 Primarily, my story is the
16 same as that in Georgia. There's been
17 a breakdown in community mental health,
18 in terms of the disorders that they
19 treat, and so correctional institutions
20 or prisons have become the safety net
21 for the mentally ill.

22 In 1993, the Texas State
23 Legislature implemented a correctional
24 managed healthcare program. All of our
25 healthcare services are contracted to

1 two of the state's university medical
2 schools. My colleague, who's sitting
3 here, Dr. Ben Raimer, will be telling
4 you a little bit more about that. But
5 the University of Texas Medical Branch
6 provides healthcare to, approximately,
7 120,000 -- 122,000 offenders. And then
8 Texas Tech University Health Science
9 Center of West Texas provides the
10 means -- the remaining healthcare
11 services. And this includes all
12 healthcare services, including
13 specialty care, hospitalization, and
14 the care at the unit level.

15 The mental healthcare is provided by
16 UTMB and Texas Tech healthcare staff.

17 My role as the TDCJ medical
18 director, is one of a contract monitor.
19 And we recently, through this past
20 legislative session, has been tasked in
21 working with the quality of care issues
22 as well. We have a comprehensive
23 quality improvement/quality management
24 program. The program is organized in
25 two different types of structures.

1 We have a system leadership council.
2 That council is composed of all of the
3 three partner agencies, UTMB, TDCJ, and
4 Texas Tech. The discipline directors,
5 the director of nurses, director of
6 mental health, the medical directors,
7 the pharmacy directors, the medical
8 records personnel, we all meet, and we
9 look at indicators related to access to
10 care, including mental health. We have
11 nine access to care indicators that we
12 study as a system, on a statewide
13 basis. All of the units are required
14 to report in monthly, those data. And
15 I have quality improvement nurse
16 facilitators that then verify that
17 their access to care is correct through
18 the methodology that we've taught to
19 the units. And then we are fortunate
20 to have an electronic medical record.
21 And we can go into the electronic
22 medical record and do a random
23 verification as well.

24 CHAIRMAN KANEB:

25 Doctor, in summary response

1 to Commissioner Puryear's question,
2 which, I think, he could rephrase.
3 Maybe I will take a shot at it.

4 Notwithstanding the -- I
5 don't know the correct legal term --
6 the vacating of the right to medical
7 care that was in Ruiz, and that whole
8 system you established to comply with
9 that aspect of Ruiz, notwithstanding
10 that litigation format -- I'm using the
11 word "vacate" as a layman -- are you
12 saying that Texas has -- has carried on
13 just as it was before and --

14 MS. LINTHICUM:

15 Yes. That's what I'm
16 saying.

17 CHAIRMAN KANEB:

18 Is that the gist of --

19 MS. LINTHICUM:

20 We have -- we have a whole
21 office of operational review, which is
22 compliance monitoring, yes.

23 CHAIRMAN KANEB:

24 But I think he was getting
25 to, whether or not, that the format

1 effect has had an affect in Texas
2 delivery of medical care to inmates,
3 and, I think, you're saying no; is that
4 correct?

5 MS. LINTHICUM:

6 We have not changed our
7 day-to-day business.

8 CHAIRMAN KANEB:

9 Is there something -- okay.
10 Commissioner Smith.

11 COMMISSIONER SMITH:

12 Yes. Dr. Linthicum, one of
13 the challenges that I think we -- I
14 think that Ms. Pierce-Weeks talked
15 about it, was working with male
16 survivors of sexual violence. And I
17 wondered -- you know, you've got a -- I
18 was looking at the curriculum here, and
19 I wondered whether you guys have
20 evaluated, you know, sort of what's the
21 process of evaluating the curriculum.
22 And then I guess the second piece is
23 around the services that are available
24 in Texas for male survivors of sexual
25 violence. 'Cause, I know, in many

1 parts of the country, many places don't
2 provide, you know, services for male
3 survivors.

4 MS. LINTHICUM:

5 Well, as part of our sexual
6 assault policy that we have in health
7 services, any person who is a victim of
8 sexual assault are referred
9 automatically to our mental health
10 services. In there, they primarily
11 receive therapy designed to
12 posttraumatic stress and individual
13 counseling, et cetera. That's
14 determined by the mental healthcare
15 providers.

16 With respect to the
17 curriculum on the safe prison peer
18 education, we are awarded from Sage
19 Associates of Houston. They will be
20 doing an evaluation phase, like they
21 did with the HIV/AIDS module, for us.
22 And that should be coming.

23 COMMISSIONER SMITH:

24 And the other -- again, the
25 question I was asking was really more

1 about resources in the community. Sort
2 of the whole continuity of care piece,
3 which is, I'm sure, the people that --
4 that prisoners to the extent that they
5 report and are identified can get
6 services inside, internally. But what
7 has been your experience about after
8 they transition out to the community?

9 MS. LINTHICUM:

10 I have very little
11 experience with respect to services
12 that are available outside. I will
13 tell you in Texas, the legislature,
14 years ago, funded an office called, the
15 Texas Correctional Office on Offenders
16 with Medical and Mental Impairment.
17 That office is funded for continuity of
18 care. They've established a number of
19 MOU's with various state agencies and
20 community-based organizations. And
21 they actually -- we actually have
22 Health and Human Services case workers
23 that come into our prison and do
24 discharge planning and continuity of
25 care services for offenders who are --

1 who are near parole.

2 COMMISSIONER SMITH:

3 And the reason that -- John,
4 I just want to say one thing.

5 And the reason that I ask
6 this is 'cause one of the sort of
7 consistent themes that's going through
8 are, the witnesses that we've heard, is
9 sort of the impact of this in the
10 community, you know, the failure to
11 report, internally and then externally.
12 And so that's something that, I think,
13 we as a commission are going to
14 struggle with.

15 CHAIRMAN KANEB:

16 Thank you.

17 MS. LINTHICUM:

18 Can I just say that is not a
19 problem in the Texas system. We view
20 sexual assault as a crime. And just as
21 Ms. Pierce-Weeks said, we're governed
22 by professional ethics and licensing
23 board. And if I, as a physician,
24 worked in an emergency room and a
25 person came in as a victim of sexual

1 assault,
2 I'm -- I'm duty bound to report that.

3 In Texas, we have an Office
4 of Inspector General. This Office of
5 Inspector General is certified peace
6 officers. They investigate criminal
7 activities and abuse within the prison
8 system. All allegations of sexual
9 assault are investigated, medical
10 staff, witnesses. We provide witness'
11 statements. We participate in our safe
12 prisons council, myself and my mental
13 health director. We are actively
14 engaged in running a safe prison in
15 Texas.

16 COMMISSIONER SMITH:

17 And I'm saying something
18 different though, okay?

19 MS. LINTHICUM:

20 Okay.

21 CHAIRMAN KANEB:

22 Dr. Raimer, please.

23 MR. RAIMER:

24 Thank you, Chairman and
25 Commissioners. I thank you for the

1 opportunity to speak to you this
2 morning.

3 MY name is Ben Raimer. I'm
4 the vice president and CEO of the
5 University of Texas Medical Branch as
6 the correctional managed healthcare
7 programs.

8 I've been asked to give
9 testimony to this commission on
10 correctional healthcare protocols on
11 our ethical responsibility as
12 practitioners working in corrections,
13 and also on some federal funding
14 opportunities.

15 Offender Healthcare Services
16 at the Texas Department of Criminal
17 Justice, or TDCJ as we commonly call
18 it, is contracted to two of our state's
19 universities, as Dr. Linthicum has
20 pointed out. That's defined in our
21 Texas Government Code, 501.132.

22 The mission of that
23 organization has been to develop a
24 statewide healthcare network that
25 provides offenders with timely access

1 to constitutional level of care, while
2 at the same time, hopefully,
3 controlling those costs.

4 UTMB has been able to
5 participate in that endeavor as the
6 state's first medical school, founded
7 in 1891. We have historically provided
8 care to vulnerable populations, the
9 poor, the undeserved, as well as the
10 state's offenders. We are the only
11 University Medical Center in the United
12 States, that I know about, that has a
13 full service prison hospital located in
14 the very central part of its campus,
15 that is first and foremost a prison.
16 But it is a hospital of 240 beds also
17 for that population. We provide
18 medical, dental, mental health, and
19 other related services to 126,000
20 offenders. And our colleagues at Texas
21 Tech University in Lubbock provides
22 healthcare to the other 32,000
23 offenders.

24 Together, and taking care
25 of over 160,000 offenders, we have put

1 together a network of systems that
2 tries to focus less on sick call
3 management and more on the management
4 of chronic disease, primary care
5 access, management of crowded
6 conditions coming into the prison
7 systems, classifying those illnesses
8 using the federal acuity rating system,
9 as well as a network of medical records
10 that are electronic, and telemedicine
11 that permits us to do over 50,000
12 visits per year in that system.

13 The unit based medical staff
14 work in a hand-to-hand fashion with the
15 office of the inspector general that my
16 colleague has mentioned. That OIG, our
17 office of inspector general, addresses
18 allegations of sexual assault that are
19 brought to their attention from a
20 number of sources. When a sexual
21 assault occurs, the offender is
22 immediately taken to the medical
23 department for an evaluation and
24 examination.

25 The Commission has been

1 provided a copy of the correctional
2 management healthcare policy, G-57.1,
3 entitled, Sexual Assault. The salient
4 highlights of that policy are as
5 follows: A brief history is obtained
6 by the medical staff. The facility
7 physician, are a mid-level
8 practitioner, conducts a physical
9 examination on the offender. If
10 requested by the TDCJ office of
11 inspector general, and if the
12 offender/victim consents to a sexual
13 assault examination, a chain of custody
14 examination, that is a forensic exam,
15 is conducted.

16 In Texas, the law allows the
17 offender to have an approved
18 representative present during the
19 forensic examination. The
20 representative must be approved by the
21 warden and must be, either a
22 psychologist, sociologist, social
23 worker, or case manager. In our
24 system, psychologist and social workers
25 are always health service employees.

1 All offender/victims of sexual assault
2 are then referred to mental health
3 services for required additional
4 services. We do that through our
5 comprehensive evaluation in counseling
6 services.

7 As my colleague, Dr.
8 Linthicum, said, sexual assault is a
9 crime. In Texas, healthcare staff are
10 obligated to report it as a crime.
11 Healthcare staff report any and all
12 offender allegations of sexual assault
13 to the warden and/or the office of the
14 inspector general, generally, in
15 accordance with executive directive
16 03.03, safe prisons program.

17 In TDCJ, the office of
18 inspector general reports directly to
19 the Board of Criminal Justice. It does
20 not report to our executive director or
21 any other agency head. We feel that
22 that arrangement best serves the office
23 of the inspector general and our
24 system. OIG investigators are all
25 certified peace officers, and their

1 office investigates allegations of
2 criminal activity and must -- that must
3 be reported.

4 Correctional healthcare
5 providers are obligated to put their
6 offenders/patient's health and their
7 safety first. Moreover, they are
8 obligated to follow the ethical
9 guidelines of their respective
10 professional licensing boards as well
11 as in providing that care to patients.

12 Finally, I would like to
13 close by, hopefully, offering some
14 suggestions for federal support of
15 correctional health, sexual assault
16 initiatives. My colleagues and I have
17 identified the following areas that
18 certainly could benefit from federal
19 funding.

20 Funding is needed for
21 medical and mental health staff
22 training. As you have heard today,
23 there are some confusion in the field
24 about what constitutes sexual assault.
25 There's a need for a universal

1 definition of sexual assault, and to
2 also be sure that that definition is
3 common from jurisdiction to
4 jurisdiction.

5 Correctional medical staff
6 need more training in sexual assaults
7 of evidence collection and in
8 performing forensic exams. Funding for
9 multiple sexual assault nurse examiner
10 positions would certainly be of
11 assistance to our state and, I would
12 think, to other states.

13 Medical health -- mental
14 healthcare staff requires specialized
15 training, as you could imagine, to stay
16 abreast of new developments in both the
17 evaluation and the treatment of victims
18 of sexual assault. But certainly, that
19 area could benefit for the additional
20 training support.

21 Funding is also needed to
22 develop a national peer reviewed and
23 evidence based journal for correctional
24 medicine that is dedicated to research
25 regarding prevention and management of

1 sexual assault. As you have heard
2 today, we -- we highly suspect that
3 much more of this occurs within the
4 system than is reported. And the more
5 we understand and can make this area a
6 top priority the better our prisons
7 will be.

8 Funding is needed to
9 redevelop, reproduce, and distribute
10 educational and informational
11 brochures. Funding is also needed to
12 support offender/peer education
13 conferences and educational activities.

14 I appreciate the opportunity
15 to provide this testimony to you today.
16 Thank you.

17 CHAIRMAN KANEB:

18 Thank you, Dr. Raimer. You
19 note that there is a need for a clear
20 definition of sexual assault in prison.
21 May I ask, what is the definition by
22 which the State of Texas goes in
23 determining what is a sexual assault?

24 MR. RAIMER:

25 It's actually recorded in

1 the act I -- I quoted to you. And
2 there are -- I'll read -- well, I think
3 probably better than read this G-57.1,
4 it goes through multiple stages.

5 CHAIRMAN KANEB:

6 May I shorten the need of a
7 lengthy answer by better -- or more --
8 certainly delineating my question.

9 Does sexual assault include
10 a nonviolent achievement of the
11 assaulter's objective?

12 MR. RAIMER:

13 I would have to go back on
14 some of my training. I am, by
15 training, a pediatrician. And for the
16 first 20 years of my career, I was a
17 specific individual in our area of our
18 state doing examinations on children
19 who were victims of sexual assault.
20 And so I think we all recognize that
21 not always is violence used in
22 perpetrating criminal acts of sexual
23 assault. In fact, among children and
24 in people who are mainly handicapped,
25 it is often a non-traumatic event for

1 them. So I think when no one is
2 harmed, quote, unquote, however you
3 define harmed, then we are less likely
4 to consider that a -- an event worth
5 reporting. That is not the case.

6 Sexual assault, as your
7 literature certainly defines, is all to
8 do with power, is all to do with
9 authority over another. Those abuses
10 can occur at the hands of parents, they
11 can occur within our prison system, it
12 can occur with people out in society.

13 CHAIRMAN KANEB:

14 Excuse me. So you are
15 saying that the definition that the
16 Commission uses, which is coerced sex,
17 is sexual assault is what the State of
18 Texas uses in deciding whether
19 something is sexual assault or not?

20 MR. RAIMER:

21 Yes, sir.

22 CHAIRMAN KANEB:

23 Good. Good. Thank you.

24 Which -- just one last thing
25 and other -- in an incident or an

1 allegation of assault, the TDCJ goes to
2 the warden and/or OIG, according to
3 your statement?

4 MR. RAIMER:

5 Yes.

6 CHAIRMAN KANEB:

7 So at least by that
8 language, it might not go to the OIG.
9 It might just go to the warden?

10 MR. RAIMER:

11 That could be, but they --
12 OIG looks at all incidents that occur
13 within our system. And so if it comes
14 into our medical area, a report is
15 filed, OIG is -- is, in all likelihood,
16 going to review that. Also,
17 Dr. Linthicum's office will review all
18 of those in the form of audit.

19 CHAIRMAN KANEB:

20 I did ask the question of
21 Dr. DeGroot, so. At the facility
22 level, does a complaint go to the
23 healthcare overseer -- from the
24 healthcare overseer to the warden and
25 then on to Dr. Linthicum's office, or

1 goes directly to her office?

2 Yes, ma'am.

3 MS. LINTHICUM:

4 Can I answer that question?

5 CHAIRMAN KANEB:

6 Yes.

7 MS. LINTHICUM:

8 At the facility, most of our
9 facilities have OIG investigators
10 assigned there. So if a sexual assault
11 occurs, really, sort of simultaneously
12 the OIG becomes involved as well as the
13 warden is notified.

14 CHAIRMAN KANEB:

15 By most the our facilities,
16 I assume you mean state operated
17 facilities. You're not speaking of the
18 panel or municipal --

19 MS. LINTHICUM:

20 The TDCJ facilities.

21 CHAIRMAN KANEB:

22 Thank you.

23 Other commissioners? Yes,

24 Commissioner Fellner.

25 COMMISSIONER FELLNER:

1 This is actually a question
2 for both Dr. Linthicum and Dr. DeGroot
3 and actually Dr. Greifinger, too.

4 All of you have extensive
5 experience in different capacities with
6 court supervision in the role of the
7 courts. In Dr. DeGroot's testimony,
8 and, Dr. Linthicum, you made it very
9 clear, that it was the intervention of
10 Federal courts which catalyzes and
11 oversaw a huge professionalization and
12 improvement in the quality of the
13 services you provide. And I don't
14 think -- it's just the question was
15 really fully answered as to whether
16 absent court supervision, then the
17 legislature, in their efforts, steps
18 back on how willing they are to fund.

19 But leaving that aside, I
20 wonder if you still believe that -- or
21 would like to address whether courts
22 remain an important avenue for inmates
23 to -- from whom to seek help when, for
24 whatever reasons, agencies are unable,
25 maybe for funding reasons or unwilling

1 for reasons of philosophy or whatever,
2 to indicate and protect inmates'
3 rights.

4 We're talking later on today
5 different oversight mechanisms.
6 Dr. DeGroot says that they have
7 external audits as part of the way to
8 maintain quality control. I don't
9 think you have external, independent
10 audits in the same way. But I'm
11 wondering if you would like to say
12 something about the role of courts as
13 the sort of ultimate guarantors for
14 inmates. And I'd be interested in both
15 the Georgia and the Texas perspective
16 on this, and your general perspective.

17 MR. GREIFINGER:

18 I think, in general, court
19 intervention have the most constructive
20 change in correctional healthcare more
21 than anything else. But litigation is
22 a very slow, very expensive, and it has
23 a tail on it, particularly with the
24 litigation -- Prison Litigation Reform
25 Act, so I think that should be our last

1 resort. Once court supervision ends,
2 in my experience, the legislators are
3 very quick to start to grab up what
4 they consider the extra expense
5 incurred by the litigation.

6 MR. DeGROOT:

7 With PLRA, the complaints
8 definitely slowed down, but we still
9 continue to have complaints filed
10 against us. Even when we were on top
11 of our game, we had complaints filed
12 against us. And the complaints were
13 taken seriously.

14 In fact, there was one
15 complaint in 2002 filed at Phillips
16 State Prison, a prison located a little
17 north of Atlanta, saying mental
18 healthcare was inadequate and -- and a
19 few other complaints. And that
20 definitely stimulated the system to --
21 to look at it very closely and look at
22 the system very closely. Within a
23 year-and-a-half, the complaint was
24 dropped. But whenever there are
25 complaints made, it motivates the

1 system to -- to stand up and -- and
2 take action, to look at itself and do
3 what needs to be done.

4 COMMISSIONER FELLNER:

5 But in the case the
6 complaint was dropped was, in part,
7 because there has been major changes
8 made at Phillips, if I remember
9 correctly.

10 MR. DeGROOT:

11 Yeah. In fact, that's
12 correct.

13 COMMISSIONER FELLNER:

14 Yeah.

15 MR. DeGROOT:

16 In fact, when the complaint
17 was filed -- and this, I think, is why
18 we have an audit process in place. We
19 have identified the complaints -- or
20 the deficiencies before the complaint
21 was filed through the audit process.
22 So we were well aware. And the
23 commissioner had been informed before
24 we knew a complaint was coming. And
25 we're in the process of putting

1 together a corrective action plan to
2 correct those complaints. And once the
3 complaint was filed, it just
4 accelerated the implementation of that
5 corrective action plan.

6 I think the courts still
7 exert a powerful influence over -- over
8 the implementation of -- of these
9 policies and procedures.

10 CHAIRMAN KANEB:

11 Thank you.

12 COMMISSIONER FELLNER:

13 No. Dr. Linthicum was going
14 to say something.

15 CHAIRMAN KANEB:

16 Sorry.

17 MS. LINTHICUM:

18 I think after 30 years of
19 litigation -- and I'm going into my
20 22nd year. I was there most of my
21 career under court orders and
22 litigation. -- I would hope that we
23 learned our lesson. I think that, you
24 know, offenders continue to file
25 lawsuits with the PLRA -- it's more

1 difficult for them, but they still are
2 able to file lawsuits. And I think
3 that's -- that's always good. We
4 always need checks and balances.

5 Much of the internal and
6 external monitoring -- we do have an
7 external monitoring through the
8 American Correctional Association
9 through our accreditation process, that
10 come in and audit the entire facility.
11 Much of that, as I stated before, is
12 still in place, and we continue to
13 strive to make sure we're running a
14 constitutional system.

15 CHAIRMAN KANEB:

16 Thank you, Dr. Linthicum.

17 Yes, Commissioner

18 Struckman-Johnson.

19 COMMISSIONER STRUCKMAN-JOHNSON:

20 This question is to Doctors
21 Linthicum and Raimer.

22 Is there any feedback from
23 the inmates who go through -- receive
24 the sexual assault counseling and
25 treatment that suggest that it's

1 working? That -- everything, it sounds
2 very good and it sounds like possibly a
3 model for best practices, but is there
4 an evaluation in place? What are the
5 inmates saying after they go through
6 it? Is this something that works?

7 MR. RAIMER:

8 Thank you for that question.
9 We actually did pre- and post-testing
10 on offenders. And what we found is
11 tremendous satisfaction with the
12 program. The information was looked at
13 as very, very valuable. Offenders
14 actually wrote to families about their
15 experience, shared information.

16 One remarkable thing that we
17 noted in our unit culture, was that
18 these individuals became similar to
19 community health workers commotores
20 (phonetic) within the units. People
21 came to them with other medical
22 questions. We have used this model and
23 beginning to roll out a peer education
24 program for diabetes treatment and
25 management. We manage almost 8,000

1 diabetics in the prison system in
2 Texas. Also for cardiovascular
3 disease, we have over 21,000
4 hypertensives on medications. And
5 we've just completed a bilingual
6 education program that we will be
7 piloting this year for education in
8 that area.

9 In short, I think it's a
10 very, very successful educational
11 program. It's been extremely well
12 accepted by offenders within their --
13 their culture and the units themselves.

14 COMMISSIONER STRUCKMAN-JOHNSON:

15 I guess the big question is
16 the program mitigating long-term
17 effects of sexual abuse, and you don't
18 know that?

19 MS. LINTHICUM:

20 We really don't have an
21 answer for that. We do have also, in
22 terms of the perpetrators, part of our
23 policy is to do a review of their
24 medical records as well. We have a
25 program called, The Program for the

1 Aggressive Mentally Ill Offender that's
2 out in Amarillo, Texas, at our unit out
3 there. And so that is another referral
4 group that we use for the perpetrators
5 if we find comorbidities of mental
6 illness.

7 We are also participating
8 with the Bureau of Justice statistics.
9 We're going to be starting a research
10 study looking at clinical indicators of
11 sexual violence in correctional
12 facilities. Texas is one of six state
13 prisons, and then there's six large
14 county jails that will be participating
15 in this study. And that's planning to
16 get started this month.

17 CHAIRMAN KANEB:

18 Thank you, Doctor. We, I
19 believe, are two minutes away from --
20 it will be a short lunch break. Are
21 there any other questions?

22 Yes, Commissioner Smith.

23 COMMISSIONER SMITH:

24 I just -- Dr. Raimer, one of
25 the things that I just wanted to point

1 out or ask is that, in your testimony
2 you indicated that healthcare staff are
3 obligated to report sexual assault as a
4 crime. But then later on in the same
5 paragraph, you talked about health
6 providers being obligated to put their
7 offenders -- the offenders/patient's --
8 the offender/patient's health and
9 safety first in following the ethical
10 guidelines for your respective
11 professional licensing board.

12 So I guess, just in
13 presenting a scenario, if I come to you
14 as an offender and I want treatment,
15 and I'd been sexually assaulted. But
16 in terms of my own sense of my own
17 personal safety, I want to get
18 treatment, but I don't want you to
19 report it. Based on your testimony,
20 what would you do as a medical
21 provider?

22 MR. RAIMER:

23 Based on my testimony, Ms.
24 Smith, what I would do is report it.
25 And at the same time try to provide

1 that individual with a safe place
2 immediately.

3 And in our system, we have a
4 very good communication system, through
5 Dr. Linthicum's office, to do just
6 that. I think it would be egregious
7 for a physician to knowingly know that
8 a violent crime had been committed
9 and -- and not provide a safe
10 environment for other offenders and --
11 and by treating that individual. Now,
12 those are my personal ethics,
13 Ms. Smith. And I think, most of our
14 physicians practice that in our system.

15 COMMISSIONER SMITH:

16 Even if the offender told
17 that you they did not want to report
18 it?

19 MR. RAIMER:

20 I treat that very much like
21 I treat an adolescent who tells me they
22 are going to commit suicide. Because
23 for that individual to stay in that
24 abusive situation, I may subject that
25 person to further violence. And we all

1 know that if that person is evaluated
2 medical, that information will go back
3 the other way very quickly. And so I
4 think I have to do all I could to
5 provide that person a safe place. In
6 our system, at least, I could do that
7 with confidence.

8 CHAIRMAN KANEB:

9 Well, that question and that
10 answer provided an excellent ending for
11 this fine panel because at 12:30, we're
12 convening a panel entitled, which is,
13 Confidentiality and Reporting. So stay
14 tuned.

15 Thank you all. Thank you
16 very much. And if you have time,
17 please stay. So we'll adjourn until
18 12:30.