(Five witnesses sworn in.)

CHAIRMAN KANEK:

This panel is Response and Treatment. Response in treatment, obviously, for victims of sexual abuse
in prison. Panelists will discuss adequate, appropriate care of victims of sexual violence, psychological, physical, spiritual in the consequences. They are Robert B. Greifinger, MD, HealthCare Policy and Quality Management Consultant, who are focusing on designing quality improvement and utilization to manage correctional health -- healthcare systems.

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

Jennifer Pierce-Weeks is President-Elect, International Association of Forensic Nurses and Forensic Nurse Examiner, Memorial Hospital. Ms. Weeks has 21 years in the nursing experience and is an educator and expert in the areas of child development and adult sexual assault.
Lannette Linthicum, MD, Medical Director of the Texas Department of Criminal Justice. Dr. Linthicum made her first rounds in the Texas prison system in 1986. She founded the healthcare policy delivery system. She found their healthcare policy to be inadequate. A year earlier, a federal judge presiding over the prison reform lawsuit found nearly the entire medical program inadequate. And Dr. Linthicum is here to provide valuable information on the current state of healthcare delivery.

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

The number of advisors on the panel are of various government agencies and professional organizations.

Thank you all.

Starting from my left,

Dr. Greifinger.
DR. GREIFINGER:

Good morning, Commissioners.

Thank you very much for asking me to testify today. I'd like to speak to two issues. The first is to give you a broad scope of view of the status of correctional healthcare in the United States today. And the second is to talk about some of the challenges that I see to the implementation of standards in the areas of medical care and mental healthcare behind bars in this country.

During the past 31 years, since the Supreme Court case Estelle v. Gamble, correctional healthcare has come a long way. There are now written standards of care. There are fairly clear expectations for policies and procedures about access to care and the timeliness of care. And we have seen increasing quality of correctional health professionals and, thereby, improved sense of professionalism, which has raised self-esteem and worked
toward recruitment and retention of
even better qualified staff.

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

There are substantial
challenges that lie ahead in the area
of correctional healthcare. First of
all, correctional health professionals
are disconnected from mainstream
medicine. They've got healthcare for the rich, healthcare for the poor, and healthcare for folks behind bars. And there's a tremendous discontinuity.

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

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

There's very poor transfer
of medical information from the
community to the prison and from the
prison back to the community, in large
part, because of our medical
recordkeeping techniques. And there's
often very poor communication between
agencies, leadership, and correctional
healthcare practitioners. In large
part, because of the different styles
that we train them.

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

So we have some challenges
ahead, generally, in correctional
healthcare and then challenges,
specific, in my opinion, to the
implementation of -- of standards.
First of all, the majority of correctional agencies are accreditation naive. They're not comfortable with quantitative performance measurement in they loath to be self-critical, especially if they have to write it down. If they have to write down what may have gone wrong so we can learn from that and make things better in the future. Behind bars, there's a vast cultural and bureaucratic resistance to oversight, especially oversight by outsiders. Preparation for certification or to meet any standards takes resources, resources like time, training, and recordkeeping, which are often not made available by legislative bodies.

And there are also some very legitimate concerns by health professionals, regarding the consequences of reporting episodes of sexual violence. First of all, there are these tensions between the command control environment where sex is not
allow. So the risk of disclosing that sex has occurred, particularly nonviolent, coercive sexual victimization. There's a risk, A, the custody staff may want to minimize these episodes of sexual behavior and victimization. But also, there's the risk that disclosure will lead to punishment. Because if a sexual victim has been involved -- has been a victim over a period of time, where it may have the appearance of being consensual, even though there is no such thing as consensual sex behind bars, that victim could be punished for having participated in sexual activity without reporting it.

Another tension that we're going to have -- if we have standards that require intake assessments to be done asking for histories of sexual violence, we can take -- assessments are often done by custody staff, by uniformed staff and not by healthcare staff, so there's a real risk there.
It's a challenge for victims to disclose that kind of information. And there's a potential ethical dilemma to maintain the confidentiality of medical information, such as recent sexual encounters, and the public safety duty to report that to prevent harm to that individual patient or to prevent harm to other patients, if there's a sexual predator in the midst.

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

COMMISSIONER SMITH:
So, Chairman, we're going to ask questions now?

CHAIRMAN KANEK:
Please do.

COMMISSIONER SMITH:
Okay. Just one question for Dr. Greifinger. In terms of -- you know, we've actually heard lots of information about ethical, legal obligations around maintaining confidentiality and sort of the tension with custody and control.

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

MR. GREIFINGER:

With difficulty. It's one of the big differences between the practice of medicine in the community and the practice of medicine behind bars. Most physicians will tell you that their first obligation, their first duty, is to do no harm to their patient. And that's been an ethical tenant for thousands of years in
medicine. So it's very difficult to violate patient confidentiality, particularly if that violation might cause real harm, like punishment, to the person who shares the information. So it's a -- it's a very big challenge situation.

COMMISSIONER SMITH:

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

DR. GREIFINGER:

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

COMMISSIONER SMITH:

And so they may not report?

DR. GREIFINGER:

Yes.
COMMISSIONER PURYEAR:

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

DR. GREIFINGER:

Well, geography is certainly a problem. We have competing interest, typically -- let's say for state prisons. State prisons are built where there's a strong lobby to help develop the economy of the communities. It brings jobs and brings money. But
those tend to be communities that don't have much medical care so it becomes very difficult.

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

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

I find that the quality of leadership in a facility has the most to do with the recruitment and the
retention of good staff. And that's whether it be in the big county jails with 10,000 inmates or in -- or in the suburban counties and small prisons in rural areas.

CHAIRMAN KANEH:

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

DR. GREIFINGER:

I think it's one of the most important things you can do, and I would certainly be happy to help work
with you on that. It's a terrible
dilemma. You can just imagine if you
have a relationship with a therapist
and your therapist says be open, and
you say, okay. I'll be open but,
please, you've got to keep this between
us.

CHAIRMAN KANEB:

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

Dr. DeGroot.

MR. DeGROOT:

Good morning, Commissioner.

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

My testimony is based on my
oversight of the mental health program
that's treating 8200 mentally ill
prisoners, and on my history with a
1992 amended civil rights complaint,

namely Cason v. Seckinger, which was
filed by a certified class of female
prisoners alleging rape, sexual
assault, coerced sexual activity,
involuntary abortions, retaliation for
not participated in sexual activity,
and inadequate medical and mental
healthcare.

The complaint never went to
trial, however, GDC revised a number of
its past practices and standard
operating procedures, to include
medical and mental health standard
operating procedures. We learned a lot
of lessons from Cason v. Seckinger.

I'd like organize my testimony around
one of those lessons. That lesson
arose from our analyses of our mental
health database, which was created
during Cason.

The lesson is that mentally
ill prisoners are disproportionately
represented among sexual perpetrators
and victims. For example, as recently as calendar year '06, we had 15 percent of the general population receiving mental health services. We also had 70 percent of the investigated sexual assault victims and 62 percent of the perpetrators receiving mental health services when the assaults took place.

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

The following eight program elements, if present -- if present, helped us provide quality services to assault victims and conversely, if absent, hampered service delivery.
Number one, an executive management team that conveys the importance of the sexual assault elimination program to middle management and line staff. Number two, a sexual assault investigation team that's independent from a local grievance investigation. Three, mental health SOP's that are clearly written and aligned with both medical and investigation SOP's. Four, adequate staffing patterns. Five, training programs for prisoners and for staff. Six, a mechanism that identifies prisoners who have a history of sexual victimization and/or gradation. Seven, oversight procedures that review SOP compliance and quality of care. And eight, mental health database on sexual allegations that identifies the number of critical barrier bolts.

Challenges -- or barriers of adequate mental health delivery system can be categorized into three areas, resource barriers, prisoner barriers,
and institutional barriers.

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

Prisoner barriers include stigma, fear of retaliation, staff distrust, and dread of protective custody. Stigma, especially with male prisoners, is a gigantic barrier for sexual assault victims who are seeking help. The reason this is such a gigantic barrier is because, if there's one place males don't want to appear emotionally and physically weak, it's
in prison. Unfortunately, if and when assault victims overcome the barrier of stigma, they're confronted with three more barriers, namely fear of retaliation, distrust of staff, and dread of protective custody.

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

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

Oversight mechanisms consist of internal and external audits, peer reviews, CQI, and utilization review.

A public health approach consists of,
A, promoting health through education, and, B, preventing sexual assaults by identifying and tracking perpetrators and victims, and, C, treating mental illness with qualified providers and best practices.

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

CHAIRMAN KANEB:

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

MR. DeGROOT:

Right now we have approximately 54', 55,000 inmates in Georgia Department of Corrections. Of that population, 16 percent, or 8,200, are receiving mental health services, have been diagnosed with a
CHAIRMAN KANE:

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

MR. DeGROOT:

I'm not --

CHAIRMAN KANE:

Or is it done entirely on a local facility basis?

MR. DeGROOT:

No, sir. It's centralized.

We have a set of standard operating procedures that the whole system uses in the delivery of mental health services to these -- to these inmates.

We have mental health programs in 31 facilities, sir.

CHAIRMAN KANE:

And are these folks in the field reporting to the central -- your administration, or are they reporting
through the line officers and the line
staff and the warden of the facility?

MR. DeGROOT:

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

CHAIRMAN KANE:

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

MR. DeGROOT:

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

CHAIRMAN KANE:

Thank you. I understand. I
think we'll -- it's something I think
we will want to think about, in terms of our standards of -- it's the whole matter of quality control in a manufacturer facility. If you want to take it into business, is it a quality control group at the factory report to the head of the plant or does he or she report to a central quality control function for the corporation?

MR. DeGROOT:

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

CHAIRMAN KANEB:

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

MR. DeGROOT:

Yes, sir.

CHAIRMAN KANEB:

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

Yes, Pat.

COMMISSIONER NOLAN:

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

MR. DeGROOT:

Yes, sir.

COMMISSIONER NOLAN:
And 70 percent of the victims sexual abuse have -- are diagnosed?

MR. DeGROOT:

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

COMMISSIONER NOLAN:

And then 58 percent of the perpetrators are --

MR. DeGROOT:

62 percent --

COMMISSIONER NOLAN:

Yeah, thank you.

MR. DeGROOT:

-- were perpetrators.

COMMISSIONER NOLAN:

Thank you.

COMMISSIONER FELLNER:

Can I just follow up on that? We've heard a lot about victims of sexual abuse. And there's actually been very little research, and we've heard very little testimony, actually, about perpetrators. And I assume here we're talking about inmate
perpetrators not staff perpetrators.
And I wonder if your -- if you have
anything you want to add, or maybe our
staff can talk to you about what you
have learned and what services you
provide to inmates who have been
perpetrators. You say there are --
there's a very high percentage of them
who are in the mental health caseload.
Can you provide any other information
to us about who and why the inmates are
who perpetrate?

MR. DeGROOT:

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

COMMISSIONER FELLNER:
The perpetrators?

MR. DeGROOT:

To -- not just the -- all
mental health inmates. All prisoners receiving mental health services.

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

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

CHAIRMAN KANEK:
COMMISSIONER AIKEN:

Yes. Just one quick question, sir.

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

MR. DeGROOT:

Yes, sir.

COMMISSIONER AIKEN:

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

MR. DeGROOT:

Yes, sir.

COMMISSIONER AIKEN:

Now, what type of relationship or what type of information that you have available to you, with this new population coming in, in relationship to their mental
health status, treatment plan,
medication, things of this nature?
What kind of shape are these people in
once they have been received by -- by
your agency?

MR. DeGROOT:

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

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

115
increase connection or communication between community mental health services, state hospital, jails, and the prison system. There's a big disconnect between the jails and the prison.

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

COMMISSIONER AIKEN:

Thank you, sir.

Thank you, sir, Mr.
Chairman.

CHAIRMAN KANE:

Commissioner Puryear.

COMMISSIONER PURYEAR:

I just want to follow up on John's line of questioning from a few moments ago.

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

MR. DeGROOT:

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

COMMISSIONER PURYEAR:

Have you ever been concerned
that someone could be penciled in the
files into shape right before you get
there, and kind of spruce up the place
a bit?

MR. DeGROOT:

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

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

COMMISSIONER PURYEAR:

Last question for you.

If -- if the mental health
professionals report to the warden, how
would you assess the average warden's
capabilities as a manager of mental
health delivery services?

MR. DeGROOT:

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

CHAIRMAN KANE:

Thank you, Dr. DeGroot.

Are there -- yes. Yes,

Commissioner Smith.

COMMISSIONER SMITH:

This is actually not a -- a
question, but really just a thanks to
the Georgia Department of Corrections
for its leadership in this area around
mental health and also around medical
issues as well. I think that the
Commission noted and was very gratified
by the Georgia Department of
Corrections' participation in the study
around HIV sterile conversion in institutional settings. And I believe that that has been very helpful in forming our work.

MR. DeGROOT:

I appreciate the feedback, Commissioner.

CHAIRMAN KANE:

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

COMMISSIONER NOLAN:

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

MR. DeGROOT:

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

COMMISSIONER AIKEN:

Just one quick question, sir.

And that's more of a -- self-report, in relationship to a
criminal -- I mean, a professional person that's trained to look at those particular behavior patterns, et cetera; is that correct?

MR. DeGROOT:

yes, sir. That's correct.

COMMISSIONER AIKEN:

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

MR. DeGROOT:

One of the big lessons we learned from Cason v. Seckinger is to provide a lot of oversight, so we do that during audits. We also have a continuous quality improvement program where we follow NCCHC guidelines mandating a quarterly report, for example, use of seclusion, use of restraint, use of involuntary
medication. We have logs sent to central office, along with CQI reports. And then we collect a lot of data. Data is sent to me, to central office, monthly. And we use this data to identify outliers in the system. Once we identify outliers, we will go and work with the facility to -- to explore the reasons for it, and then bring about any corrections.

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

COMMISSIONER AIKEN:
Thank you, sir.

CHAIRMAN KANE:
Thank you, Doctor. One more.

COMMISSIONER SMITH:
You know, just a very -- a very obvious question. Are you still under supervision under Cason versus Seckinger?
MR. DeGROOT:

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

COMMISSIONER SMITH:

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

MR. DeGROOT:

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

COMMISSIONER SMITH:

Right.

MR. DeGROOT:

-- a lot of times budget starts to be cut. So it's a constant struggle to maintain the policies and procedures at -- at the level you initially wrote them at. And we've been able to do that, to include
keeping our audit instrument, but --
but it's been a struggle.
In fact, yesterday we were
in front of the House Appropriations
Committee pleading our case, and it
looked -- it looks positive for this
year, although it's been lean the past
few years.

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

MR. DeGROOT:
No. Thank you,
Commissioner.

CHAIRMAN KANEK:
Thank you, Dr. DeGroot.

Ms. Pierce-Weeks.
Good morning. I thank you very much for the honor of being able to speak to you today and give you some opinions as the International Association of Forensic Nurse. I've been a practicing sexual assault nursing examiner myself.

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

The IFN has designed education guidelines associated with what needs to happen in order to be trained as a sexual assault nurse examiner in both for the adult as well as the pediatric population. And really, the practice of SANE, nursing
was created from the recognition by nursing that the impact of sexual violence on the human person has enormous psychological, physical, spiritual, and social effects as, obviously, evidenced by everyone's testimony here today.

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

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

One, that any -- and this is regarding protocols involving provision of care to sexual assault victims,
inmates, whether or not the perpetrator
is another inmate or a staff person.

One, that safety of the same should be
a priority in any -- any examiner, who
may be requested to respond to a
correctional facility, should receive
specialized education about the unique
issues that may impact the safety and
well-being of the nurse or any other
examiner who provide care to the
special population.

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

Two, safety of the
community. The healthcare providers
and the patient should be a priority
when any patient is brought to an
outside facility for sexual assault,
which is often the case, in many
communities. Certainly, in my own
Correctional institutions should use appropriately trained sexual assault forensic examiners whether or not they're nurses to provide care to the victims in a manner that efficiently uses institutional and community resources and provides timely care and evidence collection to the patient as time is of the essence, if prosecution is one of your goals.

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

So just keeping it brief and
knowing your time, I would entertain
any questions and say that the
International Association is very much
invested in working with the Commission
in any way we can to assist you in your
mission. Thank you very much.

CHAIRMAN KANE:

Questions?

Yes, Commissioner Smith.

COMMISSIONER SMITH:

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

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

MS. PIERCE-WEEKS:
That's a great question and very appropriate, because there are certainly communities throughout the country that do not have a capacity to have trained SANE nurses. But that -- that should not preclude, whoever your examiner is, whether it's a nurse, physician, PA, PO, whatever the title, from getting additional education in the medical forensic aspect of care. That doesn't mean it has to be a week-long training in the comprehensive care. But certainly, training that can hit the highlights for those communities that aren't going to be able to really realistically employ SANE nurses.

COMMISSIONER SMITH:

And how would they get that training? Would they get that nationally through your organization, or are there local resources where they could do that? And has your organization developed anything that sort of talks about, if you're not
going to be a SANE, what are other core
kind of training you would need to
have?

MS. PIERCE-WEEKS:
Actually, there are both
resources through our organization
nationally and probably local
resources, depending on the community.
Many communities have
established SANE programs or safe
programs where a part of their program
is providing community education, both
to the lay community but also to the
professional community, such as your
correctional facilities as well as any
other members of the multidisciplinary
team that works with sexual assault
victims. So you could certainly get
information from us, and we would
absolutely be prepared to assist you
with that as an organization.
But I suspect we can also direct local
communities to their own local
resources and nurses available to them,
who would be happy to help out.
CHAIRMAN KANEK:

Other questions of Ms. Pierce-Weeks?

Commissioner Nolan, yes.

COMMISSIONER NOLAN:

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

MS. PIERCE-WEEKS:

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

With the second part of your question was --
COMMISSIONER NOLAN:
Can you tell me what some of those barriers are? It would not be just in the correction setting. But if there are any, in particular, in a correction setting, that would be helpful to us.

MS. PIERCE-WEEKS:
Well, one of the things that we -- because, obviously, we went to our membership and chatted with them about this very day and what challenges they face in some of the correctional settings that exist now that do have nurses employed.

One of the challenges that was voiced is the perceived -- and I would strongly -- that really is the keyword, the perceived conflict of interest caring for an inmate sexual assault victim while being employed by the Department of Corrections or, you know, the agency. And truly from a nursing perspective, not being able to speak for the other medical
professions, that is a perceived
conflict of interest. It is not a true
one, because when I practice on my
license, as any other registered nurse
in any state in this country, my
ture -- I am truly there as a person to
provide care for the patient, the
community, and the families that we
serve. And while the Department of
Corrections, or in my case the hospital
employs me and they pay me, my
obligation is to my license and,
therefore, to that patient. So the
perception of conflict of interest, I
think is something that should
seriously be looked at, and really some
resource toward educating those --
those nurses about the fact that there
really is no conflict of interest,
though there may be system problems for
them bringing forward issues of
victimization within the correctional
setting. Does that make sense?

COMMISSIONER NOLAN:

Yes.
MS. PIERCE-WEEKS:
That's probably the largest thing we've heard for barriers.

COMMISSIONER NOLAN:
Thank you.

CHAIRMAN KANE:
Commissioner Struckman-Johnson.

COMMISSIONER STRUCKMAN-JOHNSON:
You aroused my curiosity. Why are sexual assault victims not welcomed by the medical community?

MS. PIERCE-WEEKS:
well, several different reasons. One is many times the patient population who are victimized tend to be vulnerable populations in the first place. The correctional facility, being one of the greatest examples of this, the mental health issues that have been discussed today. Many victims come to the table having already been victimized, having already established their alcohol and drug problems, their clinical depression,
their -- the list goes on and on. And so they can be challenging to take care of. But I think one of the other difficulties for the medical community is, when you take care of a sexual assault victim, you assume from the get-go you may end up in court testifying. That is not a place of comfort for the medical community, because they're much more trained in malpractice in court than they are testifying, in truth, than they are testifying to the care the patient was given.

COMMISSIONER STRUCKMAN-JOHNSON: Any issue of prejudice of male patients with male assault perpetrators? Is that the idea of dealing with the male on male sexual assault problem attitude-wise or --

MS. PIERCE-WEEKS: From the nurse examiner's perspective?

COMMISSIONER STRUCKMAN-JOHNSON: Yeah. Through that, are
you --

MS. PIERCE-WEEKS:

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

COMMISSIONER STRUCKMAN-JOHNSON:

All right. Thank you.

CHAIRMAN KANEB:

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

MS. LINTHICUM:

Good morning. My name is Dr. Lannette Linthicum. I'm the medical director of the Texas Department of Criminal Justice, which I will refer to as TDCJ. I'm here to give testimony to the Commission on the Texas Department of Criminal Justice Peer Educational Program, and the impact of release in treating victims of sexual assault.
I would like to begin with the Ruiz case. In June of 1972, a Texas offender by the name of David Ruiz filed a handwritten petition with William Wayne Justice, a United States district judge out of the eastern district of Texas, claiming that conditions in the Texas prison system violated his constitutional rights. In April of 1974, the court consolidated eight such offender petitions into a class action lawsuit styled, Ruiz versus Estelle.

After our FBI investigation, the United States Justice Department intervened and -- intervened in the lawsuit on behalf of the plaintiffs. Approximately, two years later, in November of 1976, another Texas case was decided at the United States Supreme Court, Estelle versus Gamble. This case was the landmark case that set the national standard for correctional medicine. The court decided that deliberate indifference to
a serious medical need constituted the want of infliction of cruel and unusual punishment under the Eighth Amendment of the United States Constitution. Estelle versus Gamble established three basic rights for offenders. The first right is the right to access care. The second right is the right to a professional medical judgment. And the third right is the right to receive the medical care that was ordered.

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

Over the next ten years, a series of reforms occurred in the Texas prison system. In March of 1990, the Office of the Special Masters submitted a final report, and the office was dissolved ending active court
supervision. In January of 1991, the Texas Attorney General petitioned the court to terminate the federal court's jurisdiction of Ruiz. In December of 1992, Judge Justice signed the final judgment in Ruiz.

With regard to healthcare, the final judgment imposed a series of additional reporting requirements which were, number one, to maintain accreditation of all units and regional healthcare facilities. Number two, to ensure that no prisoner is assigned to work that was medically contraindicated. Number three, to ensure full access to healthcare for all prisoners. And number four, to ensure that non-medical staff do not countermand medical orders. And number five, to maintain adequate staffing across all disciplines.

In April of 1996, Congress enacted the Prison Litigation Reform Act. In September of 1996, the Texas Attorney General filed a motion to
terminate the Ruiz final consent decree pursuant to the Prison Litigation Reform Act. On January 21st, 1999, the hearing begins and lasted until February 12th of 1999. On June 18th, 2001, the federal court ordered the following areas of the Ruiz final judgment were free from court oversight. And those areas were: visitation, crowding, internal monitoring and enforcement, health services, and death row.

The reform of the Ruiz litigation transformed the Texas Department of Criminal Justice into a premiere criminal justice agency. All of the internal and external monitoring that Texas went through in the Ruiz years, equipped our system to aggressively embrace the challenges of the Prison Rape Elimination Act. We in Texas are highly committed and especially tenacious in operating a constitutional criminal justice agency. In fact, the health services division
of TDCJ is statutorily required through
the provisions of Texas Government Code
501.150 to ensure access to care,
conduct periodic operational review
audits, which are compliance audits,
investigate medical grievances, and
monitor quality of care and request
corrective action.

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

Our SANE nurse, with each
reported allegation of sexual assault,
reviews the medical records and audits
it for completeness of the sexual
assault evidence collection. She
audits to make sure there are referrals
to mental health services. She reviews
it for appropriateness of labs, laboratory and her other tasks, and also to ensure that prophylactic medications were offered. If a deficiency is noted, a letter is faxed to the unit health administrator and/or the unit medical director requesting corrective action.

I would like to use my final minutes in telling you a little bit about our peer education program. In 1998, a collaborative partnership between TDCJ, the University of Texas Medical Branch of Galveston, Texas Tech University Health Science Center, and the AIDS Foundation of Houston, Incorporated was established to conduct a pilot program for HIV/AIDS peer education at five TDCJ institutions. Peer education is a teaching model utilizing offenders to instruct other offenders. It has a high degree of success, due to the powerful influence of the peer group dynamics. Researchers have found that prisoners
are more likely to have a greater degree of trust among each other than they would with correctional staff. After six months, SANE Associates of Houston, Texas evaluated the program. The evaluation results showed a greater knowledge of HIV and AIDS in offenders who have undergone the peer education training. The pilot, needless to say, was a tremendous success and resulted in establishment of the peer education coordinator position in the Health Services Division. This peer education program is supported by our agencies, executive director, and the director of the Correctional Institution Division. TDCJ has 95 peer education programs as of October 31st, 2007. Seven-hundred sixteen offenders peer educators have educated 35,249 offenders. The peer education curriculum includes HIV, tuberculosis, viral hepatitis, and a safe prison module. The classroom education has increased from four hours of instructions, between six and eight
hours. The individual units designed
the program to meet their needs in
building schedules. The Wyndham School
District, which is the formal educator
for TDCJ, is collaborating with health
services. The offender educators can
go to the classrooms and teach the
students enrolled in school. Wyndham
educates, approximately, 72,000
offenders a year. This represent a
great opportunity to implement
preventive healthcare education and the
safe prisons module to a much more
broader audiences. Classification has
created a full-time job position for
peer educators. TDCJ has an annual
conference for peer educators. For the
safe prisons module -- peer educators
receive, as part of their annual
update, information on preventing all
forms of sexual abuse and
victimization.

In your handout materials is
a white booklet entitled, Safe Prisons
Peer Education Training Manual.
Typically, for the conferences, food is served. There is also guest speakers, and the peer educators look forward to this all year. TDCJ completed the 6th annual conference this past October and November. There were five conferences this year held at the Big Oak Justice Reed Smith's Gainesville Unit.

The conferences are a huge collaborative effort between Health Services, Correctional Managed Healthcare, the Correctional Institutions Division, and AIDS Foundation, Houston, and the pharmaceuticals industry.

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

CHAIRMAN KANE:

Thank you, Dr. Linthicum. Are there questions? Commissioner Puryear and Commissioner Smith.

COMMISSIONER PURYEAR:

Quick question for you along the lines of what Dr. DeGroot was asked
about. After the provisions of Ruiz were terminated, what has been your observations about the level of funding and the level of importance attached to the mental health area?

MS. LINTHICUM:

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

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

In 1993, the Texas State Legislature implemented a correctional managed healthcare program. All of our healthcare services are contracted to
two of the state's university medical schools. My colleague, who's sitting here, Dr. Ben Raimer, will be telling you a little bit more about that. But the University of Texas Medical Branch provides healthcare to, approximately, 120,000 -- 122,000 offenders. And then Texas Tech University Health Science Center of West Texas provides the means -- the remaining healthcare services. And this includes all healthcare services, including specialty care, hospitalization, and the care at the unit level. The mental healthcare is provided by UTMB and Texas Tech healthcare staff. My role as the TDCJ medical director, is one of a contract monitor. And we recently, through this past legislative session, has been tasked in working with the quality of care issues as well. We have a comprehensive quality improvement/quality management program. The program is organized in two different types of structures.
We have a system leadership council. That council is composed of all of the three partner agencies, UTMB, TDCJ, and Texas Tech. The discipline directors, the director of nurses, director of mental health, the medical directors, the pharmacy directors, the medical records personnel, we all meet, and we look at indicators related to access to care, including mental health. We have nine access to care indicators that we study as a system, on a statewide basis. All of the units are required to report in monthly, those data. And I have quality improvement nurse facilitators that then verify that their access to care is correct through the methodology that we've taught to the units. And then we are fortunate to have an electronic medical record. And we can go into the electronic medical record and do a random verification as well.

CHAIRMAN KANEB:

Doctor, in summary response
to Commissioner Puryear's question, which, I think, he could rephrase. Maybe I will take a shot at it.

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

MS. LINTHICUM:

Yes. That's what I'm saying.

CHAIRMAN KANE:

Is that the gist of --

MS. LINTHICUM:

We have -- we have a whole office of operational review, which is compliance monitoring, yes. CHAIRMAN KANE:

But I think he was getting to, whether or not, that the format
effect has had an affect in Texas
delivery of medical care to inmates,
and, I think, you're saying no; is that
correct?

MS. LINTHICUM:
We have not changed our
day-to-day business.

CHAIRMAN KANE:
Is there something -- okay.

Commissioner Smith.

COMMISSIONER SMITH:
Yes. Dr. Linthicum, one of
the challenges that I think we -- I
think that Ms. Pierce-Weeks talked
about it, was working with male
survivors of sexual violence. And I
wondered -- you know, you've got a -- I
was looking at the curriculum here, and
I wondered whether you guys have
evaluated, you know, sort of what's the
process of evaluating the curriculum.
And then I guess the second piece is
around the services that are available
in Texas for male survivors of sexual
violence. 'Cause, I know, in many
parts of the country, many places don't
provide, you know, services for male
survivors.

MS. LINTHICUM:

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

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

COMMISSIONER SMITH:

    And the other -- again, the
question I was asking was really more
about resources in the community. Sort
of the whole continuity of care piece,
which is, I'm sure, the people that --
that prisoners to the extent that they
report and are identified can get
services inside, internally. But what
has been your experience about after
they transition out to the community?

MS. LINTHICUM:

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

COMMISSIONER SMITH:

And the reason that -- John,

I just want to say one thing.

And the reason that I ask

this is 'cause one of the sort of
consistent themes that's going through
are, the witnesses that we've heard, is
sort of the impact of this in the
community, you know, the failure to
report, internally and then externally.
And so that's something that, I think,
we as a commission are going to
struggle with.

CHAIRMAN KANE:

Thank you.

MS. LINTHICUM:

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

I'm -- I'm duty bound to report that.

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

COMMISSIONER SMITH:

And I'm saying something different though, okay?

MS. LINTHICUM:

Okay.

CHAIRMAN KANE:

Dr. Raimer, please.

MR. RAIMER:

Thank you, Chairman and Commissioners. I thank you for the
opportunity to speak to you this morning.

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

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

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

The mission of that organization has been to develop a statewide healthcare network that provides offenders with timely access
to constitutional level of care, while
at the same time, hopefully,
controlling those costs.

UTMB has been able to
participate in that endeavor as the
state's first medical school, founded
in 1891. We have historically provided
care to vulnerable populations, the
poor, the undeserved, as well as the
state's offenders. We are the only
University Medical Center in the United
States, that I know about, that has a
full service prison hospital located in
the very central part of its campus,
that is first and foremost a prison.

But it is a hospital of 240 beds also
for that population. We provide
medical, dental, mental health, and
other related services to 126,000
offenders. And our colleagues at Texas
Tech University in Lubbock provides
healthcare to the other 32,000
offenders.

Together, and taking care
of over 160,000 offenders, we have put
together a network of systems that
tries to focus less on sick call
management and more on the management
of chronic disease, primary care
access, management of crowded
conditions coming into the prison
systems, classifying those illnesses
using the federal acuity rating system,
as well as a network of medical records
that are electronic, and telemedicine
that permits us to do over 50,000
visits per year in that system.

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

The Commission has been
provided a copy of the correctional management healthcare policy, G-57.1, entitled, Sexual Assault. The salient highlights of that policy are as follows: A brief history is obtained by the medical staff. The facility physician, are a mid-level practitioner, conducts a physical examination on the offender. If requested by the TDCJ office of inspector general, and if the offender/victim consents to a sexual assault examination, a chain of custody examination, that is a forensic exam, is conducted.

In Texas, the law allows the offender to have an approved representative present during the forensic examination. The representative must be approved by the warden and must be, either a psychologist, sociologist, social worker, or case manager. In our system, psychologist and social workers are always health service employees.
All offender/victims of sexual assault are then referred to mental health services for required additional services. We do that through our comprehensive evaluation in counseling services.

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

In TDCJ, the office of inspector general reports directly to the Board of Criminal Justice. It does not report to our executive director or any other agency head. We feel that that arrangement best serves the office of the inspector general and our system. OIG investigators are all certified peace officers, and their
Correctional healthcare providers are obligated to put their offenders/patient's health and their safety first. Moreover, they are obligated to follow the ethical guidelines of their respective professional licensing boards as well as in providing that care to patients.

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

Funding is needed for medical and mental health staff training. As you have heard today, there are some confusion in the field about what constitutes sexual assault.
definition of sexual assault, and to also be sure that that definition is common from jurisdiction to jurisdiction.

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

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

Funding is also needed to develop a national peer reviewed and evidence based journal for correctional medicine that is dedicated to research regarding prevention and management of
sexual assault. As you have heard today, we -- we highly suspect that much more of this occurs within the system than is reported. And the more we understand and can make this area a top priority the better our prisons will be.

Funding is needed to redevelop, reproduce, and distribute educational and informational brochures. Funding is also needed to support offender/peer education conferences and educational activities.

I appreciate the opportunity to provide this testimony to you today.

Thank you.

CHAIRMAN KANEB:

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

MR. RAIMER:

It's actually recorded in
the act I -- I quoted to you. And
there are -- I'll read -- well, I think
probably better than read this G-57.1,
it goes through multiple stages.

CHAIRMAN KANEB:

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

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

MR. RAIMER:

I would have to go back on
some of my training. I am, by
training, a pediatrician. And for the
first 20 years of my career, I was a
specific individual in our area of our
state doing examinations on children
who were victims of sexual assault.
And so I think we all recognize that
not always is violence used in
perpetrating criminal acts of sexual
assault. In fact, among children and
in people who are mainly handicapped,
it is often a non-traumatic event for
them. So I think when no one is
harmed, quote, unquote, however you
define harmed, then we are less likely
to consider that an event worth
reporting. That is not the case.

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

CHAIRMAN KANE B:

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

MR. RA M E R:

Yes, sir.

CHAIRMAN KANE B:

Good. Good. Thank you.

Which -- just one last thing
and other -- in an incident or an
allegation of assault, the TDCJ goes to
the warden and/or OIG, according to
your statement?

MR. RAIMER:

Yes.

CHAIRMAN KANE:

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

MR. RAIMER:

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

CHAIRMAN KANE:

I did ask the question of
Dr. DeGroot, so. At the facility
level, does a complaint go to the
healthcare overseer -- from the
healthcare overseer to the warden and
then on to Dr. Linthicum's office, or
goes directly to her office?

Yes, ma'am.

MS. LINTHICUM:

Can I answer that question?

CHAIRMAN KANE:

Yes.

MS. LINTHICUM:

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

CHAIRMAN KANE:

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

MS. LINTHICUM:

The TDCJ facilities.

CHAIRMAN KANE:

Thank you.

Other commissioners? Yes,

Commissioner Fellner.

COMMISSIONER FELLNER:
This is actually a question for both Dr. Linthicum and Dr. DeGroot and actually Dr. Greifinger, too.

All of you have extensive experience in different capacities with court supervision in the role of the courts. In Dr. DeGroot's testimony, and, Dr. Linthicum, you made it very clear, that it was the intervention of Federal courts which catalyzes and oversaw a huge professionalization and improvement in the quality of the services you provide. And I don't think -- it's just the question was really fully answered as to whether absent court supervision, then the legislature, in their efforts, steps back on how willing they are to fund. But leaving that aside, I wonder if you still believe that -- or would like to address whether courts remain an important avenue for inmates to -- from whom to seek help when, for whatever reasons, agencies are unable, maybe for funding reasons or unwilling
for reasons of philosophy or whatever,
to indicate and protect inmates' rights.

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

MR. GREIFINGER:
I think, in general, court intervention have the most constructive change in correctional healthcare more than anything else. But litigation is a very slow, very expensive, and it has a tail on it, particularly with the litigation -- Prison Litigation Reform Act, so I think that should be our last
resort. Once court supervision ends, in my experience, the legislators are very quick to start to grab up what they consider the extra expense incurred by the litigation.

MR. DeGROOT:

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

In fact, there was one complaint in 2002 filed at Phillips State Prison, a prison located a little north of Atlanta, saying mental healthcare was inadequate and -- and a few other complaints. And that definitely stimulated the system to -- to look at it very closely and look at the system very closely. Within a year-and-a-half, the complaint was dropped. But whenever there are complaints made, it motivates the
system to -- to stand up and -- and
take action, to look at itself and do
what needs to be done.

COMMISSIONER FELLNER:

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

MR. DeGROOT:

Yeah. In fact, that's
correct.

COMMISSIONER FELLNER:

Yeah.

MR. DeGROOT:

In fact, when the complaint
was filed -- and this, I think, is why
we have an audit process in place. We
have identified the complaints -- or
the deficiencies before the complaint
was filed through the audit process.
So we were well aware. And the
commissioner had been informed before
we knew a complaint was coming. And
we're in the process of putting
together a corrective action plan to correct those complaints. And once the complaint was filed, it just accelerated the implementation of that corrective action plan.

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

CHAIRMAN KANE:

Thank you.

COMMISSIONER FELLNER:

No. Dr. Linthicum was going to say something.

CHAIRMAN KANE:

Sorry.

MS. LINTHICUM:

I think after 30 years of litigation -- and I'm going into my 22nd year. I was there most of my career under court orders and litigation. -- I would hope that we learned our lesson. I think that, you know, offenders continue to file lawsuits with the PLRA -- it's more
difficult for them, but they still are able to file lawsuits. And I think that's -- that's always good. We always need checks and balances.

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

CHAIRMAN KANEB:

Thank you, Dr. Linthicum.
Yes, Commissioner Struckman-Johnson.

COMMISSIONER STRUCKMAN-JOHNSON:

This question is to Doctors Linthicum and Raimer.

Is there any feedback from the inmates who go through -- receive the sexual assault counseling and treatment that suggest that it's
Are you working? That -- everything, it sounds very good and it sounds like possibly a model for best practices, but is there an evaluation in place? What are the inmates saying after they go through it? Is this something that works?

MR. RAIMER:

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

One remarkable thing that we noted in our unit culture, was that these individuals became similar to community health workers commo tores (phonetic) within the units. People came to them with other medical questions. We have used this model and beginning to roll out a peer education program for diabetes treatment and management. We manage almost 8,000
diabetics in the prison system in Texas. Also for cardiovascular disease, we have over 21,000 hypertensives on medications. And we've just completed a bilingual education program that we will be piloting this year for education in that area.

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

COMMISSIONER STRUCKMAN-JOHNSON:

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

MS. LINTHICUM:

We really don't have an answer for that. We do have also, in terms of the perpetrators, part of our policy is to do a review of their medical records as well. We have a program called, The Program for the
Aggressive Mentally Ill Offender that's out in Amarillo, Texas, at our unit out there. And so that is another referral group that we use for the perpetrators if we find comorbidities of mental illness.

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

CHAIRMAN KANEB:

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

Yes, Commissioner Smith.

COMMISSIONER SMITH:

I just -- Dr. Raimer, one of the things that I just wanted to point
out or ask is that, in your testimony
you indicated that healthcare staff are
obligated to report sexual assault as a
crime. But then later on in the same
paragraph, you talked about health
providers being obligated to put their
offenders -- the offenders/patient's --
the offender/patient's health and
safety first in following the ethical
guidelines for your respective
professional licensing board.

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

MR. RAIMER:

Based on my testimony, Ms.
Smith, what I would do is report it.
And at the same time try to provide
that individual with a safe place
immediately.

And in our system, we have a
to do just
that. I think it would be egregious
knowingly know that
and -- and not provide a safe
environment for other offenders and --
and by treating that individual. Now,
those are my personal ethics,
Ms. Smith. And I think, most of our
physicians practice that in our system.

COMMISSIONER SMITH:

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

MR. RAIMER:

I treat that very much like
I treat an adolescent who tells me they
are going to commit suicide. Because
for that individual to stay in that
abusive situation, I may subject that
person to further violence. And we all
know that if that person is evaluated medical, that information will go back the other way very quickly. And so I think I have to do all I could to provide that person a safe place. In our system, at least, I could do that with confidence.

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

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