19 (Off the record.)

20 CHAIRMAN KANE B:

21 Ladies and gentlemen, we're

22 11 minutes behind schedule. I see four

23 panelist -- or five. Good. I will now

24 ask general counsel to swear all of you

25 in together. Will you all please rise
and raise your right hands?

(Five witnesses sworn.)

CHAIRMAN KANEK:

This panel is entitled,

Confidentiality and Reporting: Medical
Ethics, Victim Safety, and Facility
Security.

Victims of sexual assault
need a safe and confidential way to
seek medical and mental health
services. Are there times when
reporting obligation and institutional
security considerations can -- or
should -- come before individual
victim's needs? Panelists will discuss
the tensions between preserving
patient/provider confidentiality and
trust, and ensuring safe and secure
functioning of correctional facility;
and option to address these tensions.

We have five panelists.

Mike Puisis, D.O., Consultant, former
Medical Director at the New Mexico
Department of Corrections, Cook
County -- and the Cook County Jail;
editor of Clinical Practice in Correctional Medicine."

Art Beeler, the warden of Federal Correctional Complex (Butner, North Carolina).

Wendy Still, Associate Director of Female Offender Program and Services, California Department of Corrections and Rehabilitation, Sacramento.

Lynn Sander, M.D., NCCHC Representative and Medical Director of Denver Sheriff's Department Medical Program, Immediate Past-President, Society of Correctional Physicians, Denver.

And Carrie Hill, Attorney, Corrections Law and Criminal Justice Consultant; Editor of Corrections Manager's Report (Maple Grove, Minnesota).

Thank you all. The format we use is each expert witness presents his testimony, which can either be the whole statement you presented or if --
it's all up to you -- it may be a
shorten version thereof. And we will
go to, hopefully, an interactive
process, and questions will be posed to
you and -- by various members of the
Commission.

So Mr. Puisis, would you --
am I pronouncing it correctly?

MR. PUISIS:

Close.

CHAIRMAN KANE:

Okay. Well, actually,
that's -- I'll settle for that.

MR. PUISIS:

Thank you, Commissioner. I
appreciate the opportunity to speak to
the Commission and to help you develop
your recommendations to Congress. I
come from 23 years of experience in
correctional medicine. I've both taken
care of people, including patients who
have been raped, had managed
correctional facilities, and had
monitored facilities in a variety of
settings.
We've created, in the United States, a large jail and prison system with over 2.2 million people, the largest per capita in the world. The system is largely subterranean. No reporters and cameras are allowed into facilities to record what's going on as would occur in a community setting.

The system is managed by thousands of wardens, each of whom has a unique style of management. And security is the dominant function. It's the purpose of a prison is to securely hold people. There's no mandatory oversight system over security functions, except those that occur under the auspices of the United States Department of Justice or the U.S. Federal Courts. And the U.S. Federal Court system of oversight has been significantly curtailed under PLRA.

Within the system, physicians and other health professionals have to see patients, and
we are used to privacy and confidentiality. But this conflicts with the control mentality of security. And security typically wins that -- that battle, because the Supreme Court even has affirmed that a warden has the responsibility to manage, in a secure fashion, the facility. And that includes obtaining reports of medical records if the warden sees fit to manage the facility.

Accrediting agencies for medical care in prison, such as the National Commission Correctional Healthcare ACA, American Public Health Association, have standards on privacy. But, for example, the Commission standard of privacy is a -- is a standard that's important and not essential. And in general, all accrediting and correctional facilities is voluntary and not mandatory. As a result, these standards do not impact practice as much as one would expect.

In relation to rape, there's
a large gap between the reports of inmates, advocates, and the statistical data that we have that demonstrate what the prevalence of rape is. There's also a gap between the NSO's reports and what medical providers say they report to their superiors. So even at the level of the physicians and other health professionals working in correctional settings, those individuals are not seeing rape at the rates that even I believe are occurring.

And the question is, is why is this happening? Privacy and confidentiality issues are rarely, I believe, the reason why this gap exist. Inmates are really in a position to have to make choices. And the choice they have to make is, if they report rape, is their condition going to improve. And I think lacking that assurance, the reporting of rape will not improve, regardless of confidentiality matters.
And what I would like to do is just close with some recommendations that I would suggest that the Commission consider as it reports to Congress.

Number one, I would strongly recommend a reduction in the prison population, particularly for those portions of the prison population that are vulnerable or who's placement -- a prison is not the placement or -- or should not be the placement of choice, specifically the mentally ill. Many of the mentally ill belong in mental health institutions, not in prison. And we -- we heard earlier a psychologist from the Georgia Department of Corrections describe the prevalence of rape in the mentally ill. You can reduce rape by removing that population into a setting that's more appropriate for them. Other populations could include the homeless populations in jail settings, and people who are so ill they don't really
even know that they're in prison any
longer.

Number two recommendation.

There should be some form of external
monitoring that is mandatory.
Currently, there is no -- no oversight.
And any agency that I can think of that
has any importance is monitored in some
aspect. There's the FDA that -- Jayco
for hospitals, there's a nuclear
regulatory agency. But prisoners have
no -- not advocates, but no one looking
over the shop. And so the decisions
that are made by these individual
wardens are -- can be unique, but are
the final say. And Federal laws have
diminished to the extent that very few
cases now are being filed in federal
court as class actions.

Regarding rape,
specifically, all inmates who are
suspected of rape should be presented
for medical evaluation when it's known.
The evaluation should be private to the
extent it can be. And I think unless
you've work in a correctional setting,
you may not know what can occur in many
of these facilities.
I have recently monitored a
facility in a state where the officer
who is guarding the inmate is sitting
next to the examination table as the
inmate is being examined. You can
believe that or not, but that's --
that's what occurs.
Medical professionals should
be required to report rape. Rape, to
me, is the equivalent of the laws in
most states that require the reporting
of child abuse. And it should be a
reportable issue. In my opinion,
medical ethics and patient safety are
the reasons that reporting rape should
be a professional obligation.
Hopefully, the reporting of rape will
result in the safety of the patient.
Medical treatment should be
consistent with community standards
regarding the management. Custody
policy and procedure should be
standardized so that the reporting and the confidentiality are established in policy and procedure, rather than invented on the spot. Policy and procedure should require automatic transfer to a safe location that would, hopefully, encourage people to report. There should be confidentiality so that only those who need to know that someone has been raped know, and it should not be something that is discussed. And that should be in policy.

Correctional staff are used to a military style mentality in control and policy and procedure in post-orders. And I think to the extent that those post-orders are standardized and absolutely clear, I think they will adhere to them.

The inmate patient should be informed about how the rape would be reported and to whom it will be reported, in addition to being offered counseling services. Officers who
interview inmates who have been raped
should receive training as to how to
conduct such interviews and how to
maintain confidentiality.
I hope these suggestions are
useful, and good luck on your work.

CHAIRMAN KANEH:
Thank you. Many of the
recommendations that you put before us,
as you might have -- might know, have
been placed before us. And we are
considering many of them very seriously
as we formulate standards and -- and
write our report.

But again, speaking for
myself, the very first thing you said
after your opening remark, are really
the dilemma of the prisoner who has
been the victim of sexual violence. By
violence, the way we define it, coerced
sex is violent sex. You put it so
well. And then the answer you pose to
your own question was, basically, no.
And that's very disturbing.

The question is, should I
report this rape? And one way or
another I then ask myself the question,
will I be better off if I report it?
And your answer to that question is,
most of the time, no.
Is that what I heard?
MR. PUISIS:
Not entirely. In principle,
I believe that all rape should be
reported. There's no question about
that. However, we work in abnormal
settings where some jurisdictions do
not function well. And if you reported
a rape, it would not be taken
seriously.
So under all considerations,
from my point of view as a physician, a
physician should take responsibility to
make sure that the patient is safely
cared for in the best manner that you
can do under the circumstances. In
some settings that may not include
reporting. If it is known that if you
report a rape, the patient will be
humiliated. Why would you do that?
However, under ideal settings, all rape should be reported. And because it's -- and typically it's the only way that a -- an inmate can be transferred to safe housing, is working through custody.

So I think in answer to your question, yes, all rape should be reported. There will be circumstances where I can understand why a clinician would not do so.

CHAIRMAN KANEK:

If transportation or removal to the safe housing situation is a requirement of -- of your feeling that it is best place to report the rape, isn't there a question many times as to whether or not reporting that rape will result in the victim being put into safe housing?

MR. PUISIS:

Well, that's a dilemma of incarceration, isn't it? I mean, we all understand that -- if you think of a woman who is in a marriage where she
is abused and raped, or a child who's beaten by a parent, you would want to remove them from that situation. And more often in so many settings you could do that than you can in correctional settings. And unfortunately, that is our dilemma. And that's why I believe your Commission is -- has a -- a momentous task. Because I believe it's the conditions of incarceration, and that's why I recommend external monitoring, to try to improve those conditions.

Remember, the wardens and the secretaries of corrections also have what they have. They have the funding that they have to run the -- this vast system of incarceration, and often it's not enough. It just isn't. And what are they to do? So I think external monitoring points out those deficiencies, and at least brings them to the legislators and others so that remedies can be taken. But it is a dilemma.
CHAIRMAN KANEB:

Thank you.

Questions from other commissioners?

Commissioner Smith.

COMMISSIONER SMITH:

Okay. Since this seems to kind of be the area that I seem to be spending a bit of time today -- hypothetical. You've recommended -- one of the things that you've said is that, hopefully, the reporting of the rape will result safety for the inmate. And as I hear it, one of the things that you're recommending, which I think is an excellent recommendation, is some degree of informed consent for the offender, when you're counseling the offender as a clinician. So if you were doing an informed consent interaction with the offender, what would it sound like, given the discussion that you and Commissioner Kaneb had?

MR. PUISIS:
Well, I would tell the person that it's my responsibility to report this, and that I would be reporting it. The purpose of that is to try to get you into a housing situation that is safe for you. I would ask them their opinion. I would ask them what are the issues surrounding housing changes that -- that affect their safety. Because inmates know, often better than we do, where different gangs and affiliations within a prison lie, and what risk they're entering into.

I would allow a degree of flexibility in talking with them. But I think that the -- THE inmate needs to be treated as a person, and they need to be treated with respect as if they were a civilian, in that situation. And that's hard to do in custody.

COMMISSIONER SMITH:
And so under that set of circumstances, if the inmate said to you under an informed consent model
that, based on what you've told me, and based on what I know about the likelihood about being transferred or that reporting will result in my safety, I don't think that I want to report this. What would be your response?

MR. PUISIS:

Well, my response is that -- to the patient you're saying, or to you?

COMMISSIONER SMITH:

To the patient.

MR. PUISIS:

I would still maintain to the patient that the only way to break the cycle within the prison is to make sure that we bring this forward. And I think in some states there may be a legal responsibility to do so. If there is, in those states, I would acknowledge that. And -- but I would discuss it. I would, frankly, discuss it. And I know where you're coming from.
I guess if I worked -- and I won't name the prison. But if I worked in certain prisons, I might not do that. But places where I've worked, I have always been able to have a relationship with someone in the organization of custody that would allow for a safe transfer of the inmate.

CHAIRMAN KANEB:

Thank you.

Other -- Commissioner Nolan.

COMMISSIONER NOLAN:

We had a hearing in South Bend at Notre Dame, and there was an inmate there who had been in two different institutions.

At one institution, he was being attacked and he went to the lieutenant and said, I'd like to transfer. The lieutenant understood what was going on and said, is there a place you'd like to go? And he told him -- he moved him.

In the other institution, he
went and the lieutenant said, why are you being beaten or raped? And Steve said, no. And the reason he lied was because there was a death sentence, if you were a rat. And so the lieutenant said, well, if you're not being beaten or raped, you know, if you're not going to report it, there's nothing I can do. And Steve says, well, I just want to transfer housing. The lieutenant, knowing what was going on, said, well, you don't get to choose where you house. Get back in your cell. So he condemned him to be beaten and raped.

Given that circumstance -- and in that the medical personnel generally doesn't control the housing. How -- how can we help in a situation like that so that the lieutenants give -- understands the situation, and if Steve doesn't want to report it, still put him in a safer place?

MR. PUISIS:

If there were national standards that were externally
enforced, you could have a standard
that require that medical personnel
could -- could order a transfer of an
inmate to a certain housing unit, based
on a recommendation.

Typically, if you do that
now, you would be asked for a
rationale, and you would have to give
specifics. But if you were allowed to
do that -- now that -- you would have a
lot of people saying that that will
violate security rules. And I could
see where they would -- where they
would be coming from. But that could
be one way you could overcome that.

COMMISSIONER NOLAN:

Thank you.

MR. PUISIS:

You would have to give a
carte blanche ability.

COMMISSIONER FELLNER:

Could I just -- for
followup?

You had said in your -- that
one of the main reasons to require
medical personnel was to ensure safe housing, so I was going to ask that very question. Well, if medical personnel themselves can ensure safe housing, then the remaining reasons to report wouldn't be safe housing, but would be to enable the facility to identify perpetrators, to take action against the perpetrator, or to otherwise enforce security.

If medical personnel were given the authority to order housing -- so that's no longer the issue, the safe housing -- how would you, as a medical clinician, weigh the inmate's desire to have a control of what's reported or not in his or her assessment of what's safe versus the facility's desire to be able to prosecute, investigate, or take other steps to ensure the safety and security of the facility, but no longer the specific individual's safety and security? Did I phrase that --

MR. PUISIS:

No, I think I understand.
There's an assumption that safe housing can be provided, which is, I think, a question of assumption.

COMMISSIONER FELLNER:

Yes.

MR. PUISIS:

But I think in answer to your question, at that point, it wouldn't matter because, if you could provide safe housing, I think that inmates would not be reluctant to report. And I think that the reason they don't report is -- is twofold. One, a lack of safe housing. But, two, the fear and humiliation of acknowledgment. It's a personal acknowledgment that they have been raped. Something they do not want to do. But in addition, there's a safe housing issue.

But if you can create safe housing and you allow it, I think that -- why would anyone not think that that's a good thing to do? I think the inmates would think it's a good thing
to do. I'm just speaking from
experience, but. I don't see why they
wouldn't think it's a good thing to do.
I have never in my 22 years offered
something that was good for an inmate
that they didn't accept. I just don't
see it. There are ordinary people like
you and I, and if you offer a good deal
to them, they'll take it. If you offer
them safety and protection, they'll
take it. I think the fact that we
can't offer it is why we have this
discussion about reporting and -- and
hiding and -- it's a subterranean
world.

CHAIRMAN KANEB:
Thank you.
Are there any other
questions?
Well, thank you.
We'll now move on to Art
Beeler, please.

MR. BEELER:
Thank you, sir.

Mr. Chairman and other
members of the Commission, let me

preface my remarks by saying that my --

I was asked to talk about absolute

confidentiality. That was the limit of

what I was asked to speak of today.

It's a very narrow topic, and I'm going
to try to restrain my testimony to that

very, very narrow topic. Because it is

a narrow topic against a whole -- of

issues that you guys are dealing with

in a most effective way.

By way of background, I've

been a warden for six federal

institutions, to include transportation
center, a federal jail, two medical
centers, and the largest federal prison

in the country. I've been a warden for

over 20 years. And I would like to say

that I haven't dealt with this subject,

but I have dealt with this subject.

Your task is critically

important to every prison administrator

in this country, and that's is how to

manage and protect offenders who have

been sexually abused or allegedly
sexually abused. And I want to regress 
for a second and talk about what is 
allegedly sexual abuse. 

In the prison environment, 
it doesn't matter if it's sexually 
abusive or allegedly sexually abusive. 
Because if the word gets out, it's just 
as if it happened in the world of the 
prison environment. 

I doubt that you'll find one 
prison administrator who will even say 
one case of abuse by other inmates with 
staff is acceptable. And we must deal 
with, even the one case, in the most 
expeditious manner we can, up and 
including prosecution whenever 
possible. 

This discussion of today's 
discussion comes from balancing the 
needs of confidentiality in a prison 
environment whether or not treatment 
staff should be allowed or required to 
maintain absolute confidentiality when 
discussing the sexual abuse of an 
offender. And I'm talking about
confidentiality you get here, and not a legal concept of privilege. This absolute confidentiality would allow for treatment to be provided to the offender who's been abused by qualified staff or, in some cases, by contractors or volunteers, without prison staff becoming knowledgeable of the abuse or involved in the process.

The ethical dilemma of whom to share information with in a prison environment is probably as old as prisons are themselves. On the one side, it is the desired that the information not be shared with those who do not have the sensitivity to handle the information in a professional manner. On the other side, is the need to keep staff and inmate safe and the institution secure. Both of those are dynamic tensions, as you have mentioned already.

And discussions with professional and advocates the suggestion was that nothing would be
told to prison staff. How about
information relating to a crime? As
law enforcement officials, we have a
duty, obligation to report a crime. In
fact, when I reviewed the monograph --
the recent review of the monograph,
Breaking the Code of Silence, the
correctional officers handbook for
identifying and address sexual
misconduct. It says that, misconduct
with offenders affects correctional
staff by jeopardizing staff safety,
threatening agency and facility safety,
creating the risk of legal action,
creating health risk, harming family
relationships, creating negative public
views, diminishing trust and morale,
and weakening the respect for in
authority of correctional staff among
offenders.

While this monograph was
written primarily looking at sexual
abuse of staff against inmates, I'm
here to tell you that it doesn't
matter, in my view, if staff or inmates
are perpetrating the sexual abuse. I would argue that many of the same factors facing correctional administrators are both with staff and inmates. If we do not attempt to enforce the law and regulations, because we know -- because we're not told of the behavior. And quite frankly, and this isn't my written testimony, but if we do know and don't do something, that's a crime. But if we don't know about something of a behavior, then how do you attempt to deter the behavior?

In our system, when someone comes forward with a statement that they've been sexually abused, three entities become immediately involved. First, medical staff to determine if there's any physical harm to the offender. Also, if a crime has occurred, it is either this medical staff or community medical staff that must act to preserve the evidence, along with trained investigators.
Second, mental healthcare, to ensure that someone is discussing the trauma of the abuse with the offender as well as the resources available to the offender. And finally, the investigative arm of the agency to determine if there's a crime or rule violation. And if action needs to be taken -- and I say that on purpose with a comma -- and if action is to be taken, because sometimes those are outside the hands of correctional administrators, who like to action.

It is hoped this is accomplished with professional sensitivity. But each of the component and parts is important to maintain the safety and security of the offender and the safety and security of the institution.

California -- or the University of California just published a monograph called, Violence in Correctional -- Correctional Facilities and Empirical Examination of Sexual
In this monograph, there's a significant dialog going on regarding housing assignment compatibility. Any unit manager or correctional officer, for that matter of fact, or correctional administrator, knows that this compatibility is essential in maintaining safety inside your institution. But again, if there's absolute confidentiality regarding the incident of sexual abuse, whether it's real or perceived, administrators will not know this information. Without it, a correctional officer or unit staff member may house the offender with the perpetrator's best buddy. Or worse yet, with the perpetrator themselves. This is especially relevant when you look at the issue against broad spectrum of inmates cliques, ethnic grouping and the like. And that's a nice way of saying gangs. If this information was not available to correctional personnel, your decision
in housing an offender may be, in fact, a death sentence.

Finally, much has been said about the victim having to suffer when information becomes noted about him or her, and induced by either staff or inmates.

The realities of prison life are that these issues are very difficult. And sometimes the victim does end up in administrative segregation until alternative arrangements are made. I want to underscore the word, alternative arrangements are made.

However, as I once told a mother on the phone, I would rather your son come home alive in one piece, even if that means I keep him locked down, than come home in a coffin, because I did not take steps to ensure his safety.

Absolute confidentiality is a nice idea. And in an ideal world, I would concur wholeheartedly. However,
prison life and the practicality of the correctional administrator maintaining safe and secure confinement does not allow for this in its totality.

I'll be happy to try to answer any questions any of you may have.

CHAIRMAN KANEK:

Commissioners?

COMMISSIONER PURYEAR:

I just have a quick question. Take it just a step beyond the confidentiality context but along with the lines when we were talking about, if an inmate -- I'm talking about from Notre Dame. If an inmate comes up and says, I want to transfer, and won't give reason. Does the BOP have a policy about what to do there, or is it left to the discretion of the warden? And what would be your response in either event?

MR. BEELER:

Well, generally, we're going
to try to -- to -- first of all, we're not going to put the inmate on the hot seat, meaning we're not going to make a big deal out of it right then and there. Are we going to try to find out what's going on? The answer is yes. If it's an unverified protection case, meaning we've done -- the inmate says, I want to a transfer. And if it's an unverified protection case, meaning that we cannot verify a reason for protection, then we're going to treat that as an unverified protection case, and after a period of time, try to work the person back into the general population.

If it's a verified protection case, then we're going to move the offender.

COMMISSIONER PURYEAR:

I guess this gets a little bit to the point that the first witness was raising about medical staff being involved in these decisions. Is there any risk to that? And then secondly,
could you -- could the whole problem be
solved if inmates were allowed to make
a request for a transfer knowing that
request will be honored but not having
any idea where they might have be
transferred to? In other words, it
might get them out of the immediate
zone of danger where there's a stigma
against reporting what's happening, and
a great risk potentially.

MR. BEELER:
I could see that used very
quickly as a manipulative device by
inmates wanting to transfer to another
location, so I would give that as a
caution. And -- but I would also say
that I think medical staff should be
involved, and we do involve medical
staff in issues regarding these
situations, to include both mental
health and medical staff because they
are often two different entities
looking at two different aspects of the
problem. So I -- I encourage that --
that issue.
The one thing that the doctor said that I wanted just to make a comment upon, is sometimes medical staff don't know what's going on inside the cell blocks either. And you've got to be careful there. That dynamic development of tension going on has to be -- that's why I -- I'm very reticent to say that you can have the absolute confidentiality.

I would love to tell you that I would sit here and say that that could be a possibility. But my job as a prison administrator is to keep people alive in my institution. My job as a prison administrator is to keep people safe inside my institution. My job as a prison administrator is to stop assaults inside my institution. I take that very seriously. Whatever I can do to make that happen, I'm going to try to make it happen. But at the same time, I've got to have the information to make that happen.

CHAIRMAN KANE-B:
Thank you.

Other questions?

COMMISSIONER AIKEN:

Just one question, sir.

And please correct me if I'm wrong. In relationship to protective custody, in that universe, you've got all types of population going into a protective custody setting. You've got the ex-gang member that turned against his gang and gave some valuable information; however, that individual still has traits of random as well as systemic violence against other inmates. The sexual predator that's now tagged the wrong person and half the institution is after him, and he's on protective custody. And then on the other end, you have a very vulnerable population in protective custody.

What are some of the protocols, some of the approaches, and some of the criteria that you may use in order to protect the people that are in protective custody from each other?
MR. BEELER:

That's a very good question, Commissioner. Many times you have to protect them from each other, as you say. And oftentimes, that means three-men holds on staff having to take them out, especially if the candidates that you just mentioned that -- we haven't talked about at all, but you just mentioned it. The sexual predator who then becomes a victim because of the situation -- because of the situation, whatever that situation might be.

And I think the Commission should remember that, as the correctional administrator, I have to provide care and custody to both of these parties, not just the victim. I have to provide care and custody for the predator also in this situation.

The child pornographer, the child molester. When the information becomes known inside of an institution. I'm fortunate that we've been able to
work most of those things out at my
facility, and we can work most of them
into the population. But I run a large
medical facility, as you know,
Commissioner. And I run a large mental
health facility, as you know. I'm not
sure that I could do the same things in
the penitentiary. In fact, I have run
a penitentiary and know that I can't --
not necessarily to do the same things
for the penitentiary.

So it's -- each case you
have to look at an individual. And you
have to take those safeguards that you
have to take against each case, each
individual inmate, to make sure that
you did the best you can to keep them
safe.

COMMISSIONER AIKEN:
So basically what you're
possibly implying is that each case has
to be, quote, unquote, custom case?

MR. BEELER:
Yes, sir.

COMMISSIONER AIKEN:
You've got to look at the medical issue, the security issue, the gang issue, of who he can get along with, the mental health issue. All those issues have to take a weight and a value before a final decision is made; is that correct?

MR. BEELER:

That is correct, sir.

COMMISSIONER AIKEN:

Thank you.

CHAIRMAN KANE:

Commissioner Smith.

COMMISSIONER SMITH:

Thank you.

Warden Beeler, thank you --

MR. BEELER:

It's good to see you again.

COMMISSIONER SMITH:

You too. Thanks so much for your testimony. And it's good to see that some of the materials that we've been working on is useful.

What I hear you saying, and I think you responded to it in
Commissioner Aiken's, is that one of the reasons that you're able to talk with such certainty about this, is your particular context being in a medical and mental health facility. And I think we have lots to learn from how to do things at Butner. But you've also been pretty explicit about, if you were doing this in a penitentiary -- in a penitentiary it wouldn't work.

And so going back to this whole thing that you've been asked to testify about, which is absolute confidentiality. What I hear you saying, or at least what I'm taking from your testimony, is that you feel like absolute -- absolute confidentiality is not helpful in terms of safety and security. But the reality is, is that we end up having absolute confidentiality anyway, because inmates make an assessment about that, and they create their own sense -- they create that environment by not report it.
Is that a fair assessment?

MR. BEELER:

Partially but not totally.

COMMISSIONER SMITH:

Okay.

MR. BEELER:

We often find out about sexual assault or alleged sexual assault without the inmates coming forward.

COMMISSIONER SMITH:

Exactly. From a third party of some kind.

MR. BEELER:

Through a drop note --

COMMISSIONER SMITH:

Right.

MR. BEELER:

-- through a 1-800 line. Those kinds of avenues. And when we find out those information, it's not -- it's us going forward to deal with that situation. So sometimes the inmates create their own situation around themselves, and I'm not going to
dismiss that. But oftentimes, it -- it ends up coming to us anyway.

Prisoners typically want to live in a pretty peaceful existence inside institutions. And many times, if there's something going on that we need to know about, we find out about it, and it's not necessarily from the inmates themselves coming forth and telling us. Many times it's from a third party telling us. And then we have to deal with that situation. And then we have to protect not only the victim, we have to protect the third party who's come forth and told us, if that knowledge is public. Thankfully, most of the time that, and large majority of the time, that information doesn't become public.

COMMISSIONER SMITH:

And just one last comment. I know that the Bureau has been struggling and really doing some reassessment in the aftermath of incidents at Tallahassee. Because I
think that that was a real situation
where there was an impact, not only on
inmates, where information wasn't
coming up, but it also ultimately
resulted in a death of an OIG agent, I
believe. Is that correct?

MR. BEELER:

Yes, ma'am. And one of the
most tragic days of the Bureau's
history is when the OIG agent was
killed by a staff member who was under
investigation at Tallahassee. And
large parts of that are still in
litigation. Many of those people have
pled guilty already, but I don't know
if everybody has pled guilty. But it's
certainly a tragedy.

CHAIRMAN KANE:

Any other questions?

COMMISSIONER SMITH:

John, one last question.
I guess -- not wanting to
take up a quick -- but what are the
lessons that the Bureau has learned or
is taking from that? And I think it
relates directly to issues around where information comes from and how it circulates up, because it creates kind of a really explosive environment.

MR. BEELER:

You know -- and I don't mean to speak for the director --

COMMISSIONER SMITH:

Right. I understand that.

MR. BEELER:

-- right now. But in being a prison administrator and being a warden for 22 years, I found Tallahassee to be one of the blackest mark in our history, because I'm not going to sit here and tell you that I don't think somebody didn't know about it. There are very few secrets in prison. And -- when I talk about totality of secrets. And I am still sitting here today saying that somebody knew what was going on. Can I prove that? The answer is no. My gut is telling me somebody knew the information was going on. What are we
doing about it? Well, we're doing a
number of things about it.

One of the thing is that we
are continually harping on training.
Not that that hadn't happened before,
but we've got to continue the training.
We've got to continue the training.
We've got to get people to understand
their responsibilities.

The other thing is swift
action against people, and I mean staff
in those situations. We've got to take
swift action against staff, and certain
action against staff up to prosecution.

One thing that has not been
asked of me, and I -- I will just
simply say this since, it is the
prosecution of these cases, whether
they're staff or inmates. Now, in the
inmate situation it's often not
prosecution because in many places it's
not a law. It's a regulation. But for
staff, sometimes it's very difficult to
move forward with the prosecution
because the -- there are prosecutional
issues, whether it be -- people say, hey, this is a prison case. You guys handle this.

And I will tell you most prison administrators -- and I'm not going to speak for all prison administrators. Most prison administrators want to take these cases forward. We need no stop these behaviors, and that's one of the ways to stop the behavior.

We could have a long discussion on this, Brenda.

COMMISSIONER SMITH:

We surely could.

CHAIRMAN KANE:

Thank you.

I think we'll now move on to Ms. Still, please.

MS. STILL:

Thank you. My name Wendy Still, and I serve as the associate director for the California Department of Corrections and Rehabilitation.

On behalf of Governor
Schwarzenegger and Secretary Tilton,
I'd like to thank the Commission for
inviting the speakers at CDCR to
testify today.

The CDCR is one of the
largest state corrections department in
the nation with over 173,000 offenders.

In 2005, the legislature put
rehabilitation back into the core
mission of the California Department of
Corrections to indicate and reflect its
strong commitment for CDCR to become a
place where offenders make positive
strides towards becoming productive
citizens of our state and nation. PREA
in the work of this Commission fits
clearly within that mission.

The State of California also
qualified its support of PREA and the
principles described therein when it
passed the Sexual Abuse and Detention
Elimination Act in 2005. I believe we
were the first state in the nation to
pass a state version of PREA. State
legislation requires, among other
things, that the CDCR works in collaboration with the communities partners to end sexual violence in its prisons, and ensures that prisoners who have been victims of abuse have access to basic services. Regarding confidentiality and reporting, the CDCR policies and law require disclosure of the information by all staff, including healthcare, when the safety and security of an inmate is at risk. And we have formal reporting protocols that must be followed. However, one critical strategy that we've employed, from the beginning of our work on PREA, is to collaborate without fine organization that have expertise in sexual violence for victim services. This collaboration has allowed us to incorporate fresh ideas and to expand the limits of what we are able to accomplish. One such example is the pilot project called, Path to Recovery,
through which we are collaborating with Stop Prison Rape, a national human rights organization based in Los Angeles, and two of California's community rape crisis centers, Path to Recovery, which brings independent rape crisis counselors into CDCR facilities to provide confidential counseling to survivors of sexual abuse. The counselors work with inmates who have been sexually assaulted, at any time of their lives, not only those who are victimized while incarcerated.

Drawing on the success of this program, I'd like to address today the issue of confidentiality in mental healthcare and correctional facilities, particularly for inmates who have been sexually assaulted.

Prior to Path to Recovery, there was no mechanisms for CDCR inmates who have been sexually assaulted to obtain counseling without, in essence, making an official report. We know that sexual assault is one of
the most under-reported crimes in
society and in prison. It only serves
to reason then that many inmates will
not ask for help if it means making a
report.

Focusing on the well-being
of inmates, who have endured sexual
abuse, we at CDCR decided to take this
full step forward and launch the Path
to Recovery at 200 institutions. One
men's facility housing nearly 6,000
inmates at all security levels, and a
women's facility with 2400 inmates at
secure levels one through three.

During the pilot stage,
staff members at each of the pilot
institutions expressed hesitation about
the project, citing security concerns.
Investigators were particularly
resistant stating that creating a venue
for inmates to discuss an assault that
have conceivably occurred within the
institution without initiating a
formalized report, would undermine
their roles and the ability to ensure
institutional safety.

While this concern certainly has merit, we believe that this effort, in fact, ultimately would lead to more, not fewer, formal reports of sexual abuse. If survivors of sexual assault know that confidential support services are available, if they see the institution providing for their emotional as well as medical needs, they will be more likely to access the services and to create an environment where offenders feel safe enough to file these formal complaints so that proper action may be taken against the perpetrator.

Initially, staff also raised concern about the potential for departmental liability. How can someone such as a community rape crisis counselor know about a crime that has been committed or planned in a state institution and did nothing with that information? Rape crisis counselors operate under ethical and legal
obligations to protect their clients' confidentiality, except in those cases where confidentiality is legally limited, such as where the inmate poses a danger to him or herself or others. In other words, because the Path to Recovery counselors provide services under that auspices of the community rape crisis program by which they're certified, they're bound not to tell CDCR officials about the content of their counseling session.

I am pleased to report that far from being a security risk, the access to confidential counseling has, in fact, improved security at the two pilot prisons. The investigation -- investigators in both of the pilot institutions have created, in no uncertain terms, that both the relationship with the services and the services offered by the community organizations are useful tools in carrying out the CDC's mission of maintaining safe, orderly facilities
and keeping, basically, the offender safe. The project has progressed to where the CDCR mental staff members also view it as an important tool.

One of the Path to Recovery counselor recently reported she's now receiving referrals from the CDCR Mental Health Department at the prison.

I want to acknowledge that inviting counselors from community groups to come into the institution and maintain the same confidentiality that they had in the community to careful planning and a leap of faith on the CDCR's part. We have to have build a positive, mutually respectful relationship with community groups or investigators, and carefully review safety, security, and legal concerns. Path to Recovery has also increased our awareness in situations in which many inmates may be at risk for sexual abuse, but not reporting.

At one of the pilot sites, the counselors were providing services
to an inmate who had been sexually abused as a child and never received any counseling or support, and indeed, he had never told anyone. During the course of the counseling, the inmate also revealed being pressured by other inmates to perform sexual acts. The inmate stated that under no circumstances was reporting it an option. He feared retaliation from the inmates, from feeling a great deal of shame relating to the acknowledgment that he is gay. However, he committed Path to Recovery counselor to discuss the safety concerns with the correctional counselor without disclosing the details of the threat. And as a result, correctional counselor took the appropriate steps and was able to decrease inmates' risk by moving to new housing. Not only does this avert more serious problems, but it also helps to develop a more positive working relationship between the inmate and his correctional counselor. And
that word certainly gets out within the population.

In terms of prevention, the impact of a respectful and caring response to sexual assault cannot be underestimated. A good example can be seen in the case of an inmate who reported a sexual assault by another inmate. While interviewing the inmate, the investigator informed him that he could have access to a confidential rape crisis counseling. And the inmate, prior to that, was unwilling to provide the investigator with any information regarding the nature of the potential risk for assault. But just by virtue of the investigator offering that option, the inmate provided full details to the investigator, and appropriate steps were taken.

This is just one example, but it's clearly indicative of progress we've made through this program. And I can tell you this is not the only example.
At both institutions, the rape crisis counselors and investigators have developed cooperative professional relationships that are apparent to any inmate with whom they interact.

The counselors trust in the investigator's ability to handle cases sensitively and respectfully, carries over to the inmate with whom the team works. Perhaps, most importantly with respect to prevention is the change in culture that my last example illustrated.

We all know that information and rumor spread quickly in detention settings. If the survivor had not felt supported, he would be telling not to report sexual abuse, as it is of inmates who have been targeted for sexual assault. And potential perpetrators will see that the prison is a place where survivors are believed and supported and sexual assault allegations are taken very seriously.
The Path to Recovery program is part of an overall shift in how we respond to sexual assault by providing confidentiality. And counseling relationship is a vital component of the shift. The collaboration will stop prison rape and local crisis -- excuse me, rape crisis centers have shifted our institutional culture in other ways as well.

Prison, by default, can be a dehumanizing environment. Programs, such as Path to Recovery exert humanity influence by changing expectation, increase in available support, and bringing in the influence of people who are not in the detention environment every day. In short, it challenges us to think more expansively about what is possible.

The more safe avenues we can create for offenders to report, the more reports that will be made. Another one of our goals is that individuals who might never file a
report would still be able to receive services. An inmate who has been sexually assaulted is likely to experience a variety of emotional and behavioral problems, particularly if he or she believes there is no option but to stay silent. So we believe, therefore, that an increase in the number of survivors of sexual assault receiving counseling services will have a positive overall impact on institutional stability, safety and community safety, also. We also expect that for those that have had the opportunity to participate in the program, we will see a decrease in reentry difficulties.

We see Path to Recovery Project is one of the ways in which the CDCR is putting the intent of PREA into practice. We also have accomplished some myth by staying around the idea that providing confidential counseling for inmates who have been sexually assaulted is inconsistent with sound
correctional management.

In some, the in-house of operating confidential counseling with a trained crisis -- rape crisis counselor has been an increased awareness and understanding of sexual violence among staff and inmates, an increased capacity to fulfill a rehabilitative mission and create an environment that is more conducive to reporting incidents of sexual abuse, a positive shift in corrections culture, inmate culture, and the perception of inmates and officer by service organizations in the surrounding communities.

In addition, the project's team approach means that the pilot institutions are accountable to the community and vice versa. Ultimately, we believe that Path to Recovery will result in an overall decrease in sexual assault in our institution.

It's been an honor to speak before the Commission on this
groundbreaking effort. I appreciate that opportunity, and welcome any further questions or comments that you have.

CHAIRMAN KANE:

Thank you, Ms. Still.

So these counselors are not under any legal obligation to report. They've been told by somebody who sought their advice was sexually assaulted?

MS. STILL:

That is correct. They do not work for us. They work for the Rape Crisis Center and, therefore, their mandatory reporting requirements are much different than the department's or any employee of the department.

CHAIRMAN KANE:

And presumably, inmates are seeking them out even though -- I would assume the fact that if I were an inmate and I sought an appointment with one of these counselors, it would
become known that I had sought such an appointment?

MS. STILL:

That is correct. However, they are offered in terms of the way they conduct it and the way that they can request the appointment. It also -- just the way that they request the appointment is treated in a very confidential manner also.

CHAIRMAN KANEK:

Thank you. Are there -- Commissioners, questions?

COMMISSIONER SMITH:

Ms. Still, I wonder -- I mean, in reading your testimony, does the -- do the rape counselors also offer -- following up on Commissioner Kaneb's question. Do they also offer sort of general education to inmates regardless of whether it's related to report? That was the impression that I got. It was more general education for
anybody so that it was sort of institutionalized, and the system is sort of mass whether it might be involving any individual incident.

MS. STILL:

That is correct. We have a very formalized PREA program. We have policies. We have training. We have videos. And so PREA awareness and safety, we have the whole program. We've created a partnership with Stop Prisoner Rape to come in as one component of our program so that education, that interaction, getting used to see the counselors and knowing that they'll maintain that confidentiality, is all part of having a program that the offenders really think that you take it seriously. And they trust that you're going to do the right thing.

COMMISSIONER SMITH:

And so to some extent, having that comprehensive program also provide some cover so that it doesn't
seem as if, okay, the Pathway to
Recover people aren't showing up, so
somebody must have been raped?

MS. STILL:
That is correct. Because
you could also be receiving counseling
about any type of abuse in their prior
history, not necessarily about
something that's happened right now.

CHAIRMAN KANEB:
Any type of sexual abuse or
any type of abuse at all?

MS. STILL:
Sexual abuse.

CHAIRMAN KANEB:
Thank you.

MS. STILL:
And I also just want to
point out, we also have our -- you
know, our mental health program, a
mental health reporting. And we will
follow the normal protocols that you
hear in the other system. This just an
added component.

CHAIRMAN KANEB:
Yes, Commissioner Fellner.

COMMISSIONER FELLNER:
The Path to Recovery is both
at the men's facility and at a women's
facility?

MS. STILL:
That's correct.

COMMISSIONER FELLNER:
And I know you're a director
of Female Offender Program, but I
wonder can you -- has -- what have you
learned in terms of -- are there
differences in how it's worked at a
men's facility versus the women? Are
there certain problems or obstacles?
Can you shed any light on -- is there a
gender difference here?

MS. STILL:
Sure. I worked and managed
and provided oversight to both male and
female prison. I just happen to be,
right now, over the female prison. In
addition to that, I also chair the PREA
Commission. So we -- our program
focuses on both the male and female
population.

But what I can say is there may be logistical challenges, of course, because an institution that has 6,000 versus an institution that has 2,400 offenders, whether it be male or female, that in and of itself are going to create logistical issues.

But in terms of -- I'd say both have real reluctance in terms of our investigators about the liability of this type of program. Probably the male prison more so, although our female also have concerns within the institution. But the first investigative team that came forward and say, this is really working, was our male facility. And then subsequently right behind that, we had some really great experiences in our women's facility. So we've been very happy, as had the wardens of those facilities been. They rave about the program.

COMMISSIONER FELLNER:
And how do you respond in your statement, both what you said in writing and speaking, about how you respond to some of the investigators' concerns? How do you respond to the questions that were -- how do you handle housing? I mean, if somebody is -- if a man is being threatened by someone and you can't -- it's not reported, it's not known, so he may remain being double celled or -- with the person who is victimizing him? What's -- how are you handling that?

MS. STILL:

Well, I think look at the purpose of the counseling in and of itself. An offender may want to have someone to talk to. If they're having a housing concern, they are either going to deal with it or not, irregardless if that crisis counseling is taking place. If they are serious about wanting a housing move, they will come forward, or they will try through other ways -- I have to somewhat use
the word "manipulative" -- to try and
achieve that housing move.

If an incident is reported
to our mental health or healthcare
staff, they will work very closely with
our custody. The question came up
earlier about if you're a healthcare
staff, if something was reported, could
they facilitate a move.

We pay close attention. We
don't -- sometimes we need as much
detail, of course, as possible to
protect the inmate so that we don't
move them back in. But that inmate is
not telling that rape crisis counselor
because he or she wants a cell move.
They're wanting to download the
emotionalism and all -- all the
feelings that go along with that. They
don't tell them because of the safety
concerns. But what those counselors
will try and do is, even though they
belong to the Rape Crisis and outside
the department, try to convince them to
at least allow them to go forward with
enough information, as the example I
gave, so that a housing move could be
facilitated, or the safety could be
protected.

So there still is that
cooperation that goes between the
counselors. I just think it creates
more credibility to the program. And
again, the more that we can break down
the environment or the culture to where
the offenders really believe it's going
to be taken seriously, the more
effective we are going to be in terms
of maintaining their -- or protecting
their safety.

COMMISSIONER FELLNER:
Could I ask one follow-up to
that?

CHAIRMAN KANEH:
Yes.

COMMISSIONER FELLNER:
Could you do the same thing
and have the same impact and trust or
whatnot if the counseling was being
done by department staff? Does it have
to be an outside agency?

MS. STILL:

I think right now where our system is at, and I think where many systems are at, is it's about trust. And so -- and I think that that's what that outside crisis counseling represents to them, objective, independent. They're not CDCR. I do believe as more programs like that are rolled out and the cultures are broken down and the inmate see a change, I think it will become more viable for our staff to provide also that type of an alternative. And our mental health staff can and do now provide it when asked for. But a lot of times the inmates won't want to necessarily talk to our mental health staff. And so this is just another avenue for them.

COMMISSIONER FELLNER:

Because your mental health staff would have to report it?

MS. STILL:
Exactly. Because of the mandatory reporting.

CHAIRMAN KANE-B:

Ms. Still, is this program in compliance with your own PREA Act, or is it something you're undertaking just because you think it's a good thing to do?

MS. STILL:

Well, it's really in compliance with our own state PREA law, which requires us to develop partnerships and work with outside entities, you know, to all of our programs. We also have a PREA commission that I chair, and the Stop Prison Rape since this. It's a part of our PREA commission. As you see, Irvine was mentioned earlier. We've done a lot of research in our system. We're getting ready to do more research.

CHAIRMAN KANE-B:

So you're saying your Act requires CDCR to cooperate with outside
entities to prevent -- to deal with prison rape?

MS. STILL:

It requires us to work in collaboration with community partners to end prison rape.

CHAIRMAN KANEB:

Commissioner Puryear wants to ask a question, but one last -- and I assume, whether it's MOU or others, they are being paid for the service?

MS. STILL:

They are. And how they're being paid for their service in terms of $500 grants to the crisis center, it's really nominal. They do that as part of their charter.

CHAIRMAN KANEB:

Okay. So in order to work, this program requires, at least from a budgetary point of view, a low cost availability of fairly skilled people to make -- to make it function. I guess I'm asking that as a question.

MS. STILL:
That is correct. And depending upon the use of the services, right now, I believe with our MOU provides is the $500 grant toward the crisis center for their cost and services for really establishing the program and a little bit of travel.

CHAIRMAN KANEB:

This is very interesting.

Excuse me. commissioner Puryear has questions for you.

COMMISSIONER PURYEAR:

Just one quick question. Have you determined whether there's been any impact on the prosecution for sexual assaults, either of staff, other inmates, in result of paths to recovery?

MS. STILL:

No. We've seen no impact quite -- in terms of the prosecutions. The few -- the examples that I've given to the two institutions, the investigators are very pleased because they're getting more information.
They're getting information that they wouldn't have gotten before. And one of the cases led directly to a prosecution. So it's -- it's opening up more information coming to the investigators.

CHAIRMAN KANE:

Other questions of Ms. Still?

COMMISSIONER SMITH:

I just have one -- one question.

Ms. Still, one of the thing is that -- you know, and I raised this question earlier. In California's scheme, can rape crisis counselors provide services to people in custody to defendants? Because I know that that's -- that in some jurisdictions they're not able to provide those services. So I'm wondering how you guys are managing that, or sort of getting around that barrier, if there is one.

MS. STILL:
Well, that's why the $500 grant to them, because there is a barrier. Some of -- some of the crisis centers will do that, and they have the money to operate. But in reality, they can't use any of their funds that they get from the feds, as I understand it, for that purpose we're talking about.

CHAIRMAN KANEK:

Well, thank you very much.

This has been an enlightening presentation.

COMMISSIONER FELLNER:

Has our staff asked you or gotten -- is it possible for us to get your research results? You've done research; the monograph was mentioned. Have we got -- has the Commission's staff contacted you to get copies of it?

CHAIRMAN KANEK:

Yes. We have -- we have-- Professor Cooksberry (phonetic) is raising his hands and putting his thumb up to your --
COMMISSIONER FELLNER:
Okay. Thank you.

MS. STILL:
We have a subsequent research project getting ready to start. We will be happy to provide that when it's finished.

CHAIRMAN KANEB:
Thank you again.

Ms. Sander.

MS. SANDER:
Hi, I'm Lynn Sander, and I'm also going to be talking about confidentiality reporting. I listened in this morning, and I heard many things and it brought stuff to my mind. And so I'm not going to be reading from my thing. I'm trying to -- some things that came to mind --

CHAIRMAN KANEB:
Thank you.

MS. SANDER:
-- and I tried to rearrange, but I did not have a computer where I can cut and paste and put things in
that order. Hopefully, I will be able
to follow my arrows on my piece of
paper.

One thing that I wanted to
mention that I've heard over and over
again that people are talking about,
who are we talking about, and who are
we talking about. And we hear a lot
about male on male prisoner rape. I
have not heard any talk about female on
female prisoner rape, and that happens
as well. Obviously, there's not
necessarily a penetration, but there
can be a lot of sexual coercion amongst
female population, and I have females
report that to me. We also talked
about inmate and officer rape, and that
can go both direction. It can be
either heterosexual or homosexual. And
I just wanted these things stated.

CHAIRMAN KANEB:
Thank you.

MS. SANDER:
The other issue is the issue
of the victim who becomes a
perpetrator, or the perpetrator who
becomes a victim. And I think again,
we talked about -- touched on that a
little bit. And I think, again, that
we need -- all these things need to be
addressed.

I come from mostly a jail
background. And I think I am probably
half a little -- because I come from a
very progressive administration, and
the inmates in that facility trust most
medical -- most of the medical staff
and most of the custody staff and felt
very comfortable in reporting. As a
matter of fact, most cases brought to
my attention were brought by the
officers. The inmates report it to the
officers, and they brought the person
to medical to then get them evaluated.
So it's a very different situation.

I'm also here representing
NCCH, which is the National Commission
of Correctional Healthcare, has asked
me to come and talk a little bit about
their standards. And I am the
immediate past-president of the Society of Correctional Physicians, and I'm on their board. And both of those organizations, I'm sure, would be happy to work with you in developing standards. They have their own standards and they also have policy, and we'll be happy to work with you.

I think when you're talking about confidentiality, the most important thing confidentiality gives you is trust. And without trust, you're not going to get reporting. If they don't trust that you're going to use that information in a way that's helpful to them and will not bring harm to them, then they're not going to report, and you're going to defeat your purposes. The other thing that -- and if you didn't get reporting to either medical or security, you don't get treatment.

We heard someone say just this morning that most of these people go back to the community. If you don't
get treatment, you're harming the
community in an additional way because
you're bringing it back to the
community, if there's no prophylactic
treatment. So we need to consider all
these factors.

And now I'm going to go in
the NCCH standards. There is a
standard on the procedural for sexual
assault. Their primary thing they
said -- the first recommendation is
that you send patients to a facility
that's equipped to do the proper
evaluation of the patient, both from
the medical and forensic point of view.
I personally think that there are a lot
of real benefits to that.

In-house -- the medical
staff has to take care both the victim
and the perpetrator as their primary
care physician and nursing staff. And
if you are taking sides in that case,
that really prevents you from doing
your mission of what you're really
there in a correctional institution to
If you send them out to a hospital or facility, first of all, they're going to have people there with the training to do that properly. Most correctional institutions, especially small jails, are not going to have people with the experience and the training. They're not going to have the mental health staff and the proper rape counselors there to follow-up with those patients. So I think it's really -- I take that as one ideal way to do it.

The other thing that it does is, in every state has a law, have -- have various reporting laws. Most of them rape is a crime. Sexual assault is a crime. And therefore, there is mandatory reporting just as with child abuse. If you bring them to a hospital ER setting to manage them, they are required to report that, and they will call the police on it. The police will start the investigation, but then the
police will report back to the

correctional institute. It really
takes your staff at the institution out
of the loop, which I think is very
helpful.

If you're in an institution
where you really have all this, you
have the rape kits, you have medical
staff who have gone through proper
training, then at the very least they
should be brought for medical
evaluation. They should get sexually
transmitted disease testing. They
should get mental health counseling.
And you should ensure the safe -- now
there's been a lot of talk. How do you
ensure safety? And what do you tell
the officers when you, as a medical
person, make a recommendation to move
them? Well, you can say, I'm concerned
for this person's safety. He has some
medical conditions that, probably if it
got out to the other inmates, would put
him in harm's way. And I think you
should put him in some kind of
protective custody.

In the institution I work with, that would be enough. That may not be true in all institutions, and there's a lot of concern for prosecution. And ideally, we all want every perpetrator of every crime prosecuted, investigated, and punished.

But the reality is, in the outside world, if a woman is raped they can report it but she doesn't have to say, I want to prosecute for male sexual assault. So why should an inmate be treated differently? I mean, if you look at the constitutional standards, there's community standards. A person has a choice whether they want that perpetrator prosecuted. So even though, you know -- especially in the correctional environment, you really want -- you know, your mentality is more towards that. We need to remember that they're under the same laws in that regard as anybody else.

Now, whether the institution
then feels, well, we have our own internal procedures that we want to go through. That's fine. But a true criminal prosecution really can't take place without the victims' willingness for that to take place, unless there's a law, such as domestic violence, where you can prosecute the partner without the victim.

CHAIRMAN KANE: Excuse me, Ms. Sander. Unfortunately, I have mismanaged the clock here.

MS. SANDER: Okay.

CHAIRMAN KANE: So I need to ask you to -- if you'll -- and I thank you for not reading your statement. -- wrap up, and we will have questions.

MS. SANDER: Yeah. I think I really pretty much said it all, so you came at a perfect timing.

CHAIRMAN KANE:
Well, thank you. I will now take even greater advantage of my mismanagement. Would I just be able to ask you this.

What if the answer to your question about why a victim should not have to have his or her victimization reported is that sex in prison is illegal, and it's not a matter of you not wanting your rape to be reported. It's a matter that sex took place, and that it's a crime. Is that an answer to your -- would that suggestion be optional on the part of the victim?

MS. SANDER:

Yes. But what I'm saying is, for any crime, a victim has the opportunity to say, I don't wish to press charges. That's what I'm saying. It's not that it's not a crime. It's not that they don't acknowledge it as a crime, 'cause they don't want to press charges.

CHAIRMAN KANE:

I'm out of my element. I'm
not a lawyer. Are there other
questions of Ms. Sanders?

All right. Thank you.

And, Ms. Hill, I give you
what time you -- you need here. I
apologize.

MS. HILL:

Should I talk really fast
then? Well, good afternoon. It is a
privilege for me to present to you on
PREA, specifically on issues of
confidentiality reporting from a legal
and corrections perspective.

Undoubtedly, this whole process of
eliminating rapes is an allottable one,
and it is heinous. And it is one we
should all unite in this amazing effort
to do that.

The United States Supreme
Court has recognized that such offenses
are not part of the penalty that
prisoners are sentenced to suffer. In
my 20 years in corrections field as a
former general counsel to the Utah
Department of Corrections and in my
training to the jails in -- nationally,
we teach them that it's not only the
inmates having Eighth Amendment rights
to be free from cruel and unusual
punishment, but we in corrections have
a duty, and it's a strong duty, to
protect these inmates from harm.

Exactly how corrections goes
about protecting their inmates,
especially from rape, is not so simple
as has been mentioned. Decisions
regarding prisoners require delicate
balancing between the prisoners' rights
and corrections' obligation to maintain
a safe and secure environment. But
also as the Supreme Court has
recognized, there is a need to defer to
corrections and how best to operate
their facilities on a day-to-day basis.

And as the Commission
mandates -- mandates on the issues of
confidentiality and reporting, I
respectfully request that you recommend
broad policies, which allow the
administrators in the trenches to best
determine how procedurally to implement
the mandate, recognizing that the
resources of a very small jail are
vastly different than that of a huge
prison. They are unique.

In addition, I also would
like to encourage the Commission to
consider the appropriation of monies
for much needed mental healthcare, and
also for training to make PREA a
reality. As progressions go with --
mandatory reporting goes, one critical
issue is to whom such report should be
made. We've heard so much about this.
There is no specific legal requirement
as to how an institution gathered --
gathered its information regarding
protecting its prisoners. What is key,
and as everyone has mentioned, is that
the prisoner reports, and then that
information somehow gets to security.

I speak generally that how
the prisoner -- or prisoners are more
likely to report when they feel
comfortable in telling; that has been
said. Requiring prisoners, however, to report to one specific person or a type of person may be too restrictive, depending on resources available to that particular institution. Again, deference to correctional administrators on how and to whom the individuals should report, remembering that very small jails have very limited resources from community. At a minimum though, corrections should make reporting mechanisms part of every prisoner's orientation. Second, mandatory reporting should be required of all staff, vendors, and visitors who know of or suspect that a prisoner may be a victim so that correctional staff can respond.

Knowledge is essential in our correctional system. Unlawful conduct, such as rape, must be reported to security staff so that they can fulfill the objective of maintaining a safe and secure environment. Protecting the victim, once identified,
securing the crime scene, providing
necessary mental health treatment,
protecting other criminal -- or other
prisoners from possible future harm
from the alleged perpetrator,
reclassifying the prisoner, if
necessary, and disciplining both
administrative and criminally are
obligations that security, in fact,
has.

There has been mention of
housing, and I would like to touch on
that just real briefly. One of the
recommendations we do when we're
training is to encourage corrections to
triage with medical on all issues --
all cases involving inmates so that
housing decisions can be made together.
Maybe even without getting in all the
specifics, but clearly, corrections has
to be involved in that.

Decisions regarding
confidentiality require, again, that
balancing act between the victims'
desire to confidentiality and the
corrections' constitutional need to protect not only the victims but all of the other prisoners. The general practice in corrections is that security has access to all confidential files, including medical on a need to know basis for legitimate penological purposes, specifically housing decisions, classification decisions, decisions as well as vulnerability and protection issues, specifically on the issue of rape.

The reporting of a rape, including the identity of the alleged perpetrator, cannot be kept confidential from corrections, and must be reported to security staff so that they could take immediate action against -- to protect the victim for classification decisions, for disciplinary issues, et cetera.

In addition, medical staff should be required to report, and I would ask that they be exempt from any statutory liability for doing so. The
doctors who we work with and we talk
with, all want to protect that
particular inmate, and are all feeling
this tear between their privilege and
this confidential information and the
need to also share it with corrections.
So if this were to — and how this
happens, I encourage you to look at
some statutory exemptions for them.
I applaud the Commission for
its goal. Eliminating rape in our
jails and prisons is one shared by
every correctional professional that I
work with. But I also encourage us to
look at broad policies in making these
mandates with specific procedurals
going to the individual institution,
again, recognizing that a very small
jail has very different resources and
allocation as that of a super max-type
of prison.
I thank you very much, and
I'm opened to your questions.

CHAIRMAN KANE: Thank you, Ms. Hill. So I
understand what you're asking in
respect to leaving the medical
professionals' liability, would you
please restate that again?

MS. HILL:

Some type of exemption. If
a doctor works within a facility --

CHAIRMAN KANE:

A doctor or a nurse?

MS. HILL:

Correct. Let's call it
medical. The question is whether or
not there is a privilege between the
doctor and the inmate, and it's a
questionable one. The doctor will tell
you -- and everyone will recognize that
there's a doctor-patient privilege.
The question then becomes, if there is
a legitimate governmental interest,
does medical have -- or does security
have access to that information? And
the practice is, that they do.

They need to have access to
that medical information in making
determinations regarding
classification, regarding housing for protection purposes, whatever it might be. So many doctors, medical profession, may feel conflicted mandatory reporting. They have a privilege that they see, and yet security staff needs this information for making decisions, again, on housing classification, et cetera.

So I guess if they do report, what I'm asking is that there would be an exemption on them from liability.

CHAIRMAN KANE: Against by a claim by the victim that they had breached a confidential patient-doctor relationship?

MS. HILL: Correct.

CHAIRMAN KANE: Do you think that medical staff now feel they are exposed to such liability?

MS. HILL:
I have several doctors who have expressed the concern and asked whether or not you would at least consider it, depending upon how the language and how reporting comes down.

CHAIRMAN KANE:
Okay. Well, we are a federal commission, and we are, basically, going to develop standards that are going to be meant for the federal system. And their degree of -- of jurisdiction in non-federal systems is --

MS. HILL:
I understand.

CHAIRMAN KANE:
-- to be silenced, so. But thank you.

Commissioner Fellner.

COMMISSIONER FELLNER:
I have a question from your written statement about Broward County, Florida.

MS. HILL:
Yes.
COMMISSIONER FELLNER:

You say that it requires all staff, contractor, vendors, and visitors who know or suspect that a prisoner may be a victim must report.

By visitors, do you mean family, friends are also under the obligation to report, or do you mean official -- what is the scope of the mandatory reporting here?

MS. HILL:

And you're asking me a very good question, and I can't specifically answer 'cause it's general. It's not defined. But the general policy is, as I understand it, is that anyone -- anyone who has access to an inmate is required to report any indication of sexual abuse, whatever that might be, and whether it be to any staff member that they come into contact with.

COMMISSIONER FELLNER:

Do you think that it is meant to extend to family, friends, not officials, that that's a good idea?
MS. HILL:
And I don't think that's generally who they were referring to.
I'm assuming they might have been referring to people who are visiting.
And I don't have a specific definition on that. And it's one that I'll be absolutely more than willing to followup with you.

The purpose, I think, behind it is, is that all staff, vendors, everyone tells -- anyone who comes in contact with the visitor should be required to report so that we can immediately protect the victim and, again, start looking whether there's a crime scene and whether or not we have to look at classification, investigation, etc. But the idea is mandatory reporting for anyone coming into contact with an inmate for sexual abuse.

CHAIRMAN KANE:
That's certainly -- thank you.
Are there other questions?
Yes, Commissioner Struckman-Johnson.

COMMISSIONER STRUCKMAN-JOHNSON:
Mr. Beeler and Mr. Puisis, would you respond to Ms. Still's idea of recovering -- Pathway to Recovery? If you could have a conversation about what you think about that. I'll ask either one of you. Does that sound good?

MR. PUISIS:
I'm sorry. I didn't understand your question.

COMMISSIONER STRUCKMAN-JOHNSON:
What do you think about the Pathway to Recovery program? Does it sound like a solution to either one of you? Technically, you can have -- you can have treatment without reporting, so

DR. PUISIS:
Well, I -- I think the strong part of it is that it's an outside entity, so it removes the
problem outside of the prison where there's likely to be more pressure on staff to be seen as part of the correctional machinery. And so by getting -- it's very similar to -- I agree very much with the recommendation, that if someone's raped to take them outside the prison for medical evaluation. I think that's a very sound principle.

In the same sense, I think what that stands for is removing the counseling piece to an outside entity. And I think that's allottable. But obviously, you cannot sustain a system like that if it's a pro bono system. And I think the Chair mentioned that -- he was talking about that, that there has been mechanisms that can sustain. But I think it's a good system. It ensures counseling. It ensures an inmate an avenue to talk to someone who they feel is -- may not be compromised, regardless of physicians who work in corrections field
themselves relative to patients.
Inmates may not see it that way. I think it's, overall, a good thing.

CHAIRMAN KANE:

Mr. Beeler, did you have something you want to say on this subject?

MR. BEELER:

Certainly, sir. Thank you.

It boils down to a matter of trust.

And where is the trust laid? If the trust is laid in an outside resource, the only caveat I would put there -- and she made -- Ms. Still made this caveat. Is there a danger to somebody else, to themselves, or others? The only question I raise to that is, how do they know where the danger lies?

And that's my only concern there, because they're not going to know all the time where the danger lies. And that's my biggest issue, making sure that the safety of that individual is -- I mean, it's a dynamic mentioned with this all along. It's the safety
of that individual. It's not just all
about the prosecution of the
offender -- of the perpetrator. It's
about the safety of the individual too
and the safety of that institution and
the safety of other people who may be
victimized.

CHAIRMAN KANEB:

Thank you.

Commissioner Smith.

COMMISSIONER SMITH:

I thank the entire panel.

And I think one of the reason that we
wanted to do this panel is because all
of the issues around privilege,
reporting, HIPAA, other ethical -- I
mean, you guys have done a great job in
trying to make it clear. But I have to
still say that it's clear as mud to me.

Because I think -- Ms. Hill,

when you -- it sounds like in your
testimony you suggest that there's sort
of be a broader standard that would
kind of help deal with these privilege
issues. But as you also recognize,
privilege stuff is very much state
based, and it goes across clergy -- and
often these matters are reported to
clergy. -- physicians, drug counselors,
so on and so forth. So I think that
this is really something that the
Commission is going to have to struggle
with. But I think that you've added
tremendously, and also you as well as,
Ms. Sander, have added tremendously in
terms of identifying some resources
that are all in one place that we did
not know were available. So I
really -- I appreciate it, and will go
back and try to wade through. So thank
you.

CHAIRMAN KANEK:
Let me just finish by saying
the matter of reporting, the
effectiveness of reporting, the
availability of reporting, the trust in
reporting, we know is absolutely
essential to constructing a safe house
here for potential victims. This has
been helpful. We're putting a lot of
work in it.

I hope you know that we're consulting with lots of different people, you know, in several days a week outside of the hearing process. I know professionals in the industry would know that, but. We are gathering a lot of information and taking it very seriously. So thank you so much.

Thank you. And now we're going to have a brief recess. And we'll come back at 2:30.

(Off the record.)

CHAIRMAN KANE:

Ladies and gentlemen, we're resuming. Our next panel is seated, and I would ask that the other people also seat themselves at this time.

At this point we swear in our panelist. Unfortunately, my general counsel and officer does that is not here at the moment. Actually, I might even do it myself.

COMMISSIONER FELLNER:

Go for it.