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Protecting Youth in the PREA National Standards

Public comments from youth advocates on proposed standards for the implementation of the National Prison Rape Elimination Act

April 4, 2011

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Dear Attorney General Holder,

Thank you for the opportunity to comment on the Department's Prison Rape Elimination Act (PREA) draft regulations. The Department's draft regulations have the potential to improve the safety of children involved in the justice system. They reflect pragmatic approaches to a complicated problem, but we believe that the standards still need improvement in order to reflect the nature of juvenile facilities and to protect youth from harm. Because young people have the capacity for change and growth, these regulations must take into account the goals of the juvenile justice system to support their rehabilitation in a safe environment. Further, the regulations must also respond to youths' unique vulnerability in correctional settings.

Although we strongly support many of the draft regulations, we recommend several revisions that are necessary to fulfill PREA's mandate and protect youth in secure custody. Among our recommendations are the following key issues:

- **PREA Coordinators:** The draft regulations only require that agencies and facilities appoint a full-time PREA coordinator if the resident population is greater than 1000. According to the Department's Initial Regulatory Impact Assessment, this means only 11 state juvenile systems will fall under this requirement. As 12% of adjudicated youth in juvenile facilities reported experiencing sexual abuse in 2009, a PREA coordinator is needed in every facility to implement the PREA standards fully. The final regulation should require that all agencies and facilities designate a PREA coordinator with sufficient staff time to ensure the standards are implemented properly.

- **Staffing:** The draft regulation fails to require safe staffing of juvenile facilities. By requiring that agencies develop staffing plans as well as plans for what to do if they fail to comply with their initial staffing goals, the draft regulation permits agencies to provide unsafe supervision levels. We propose requiring compliance with the agency's staffing analysis and eliminating the provision requiring agencies to plan for sub-optimal staffing. The regulation also does not establish staffing ratios necessary to keep youth and staff safe. In questions four through seven, the Department asks whether the PREA standards should establish minimum staffing ratios in juvenile facilities. We propose establishing a minimum 1:6 ratio for supervision during awake hours and a 1:12 ratio during sleeping hours, recognizing the value of continuous, direct supervision in preventing sexual misconduct.

- **Employee training:** While we commend the Department's recognition of the importance of training all employees working with youth, the draft regulations provide insufficient guidance for training employees regarding unique considerations pertaining

to juveniles. The regulation should additionally include the need for staff of juvenile facilities to receive training on: (1) age of consent laws to ensure proper understanding of the limited circumstances under which voluntary sexual contact between juvenile residents constitutes abuse; (2) adolescent development to ensure better understanding of the characteristics, limitations, and behaviors of juvenile residents; (3) behavioral manifestations of trauma in youth and appropriate responses by adults; and (4) effective and professional ways to communicate with juvenile residents who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as those with limited reading skills, learning disabilities or cognitive or emotional limitations.

- **Definition of "sexual abuse":** As written, the definition of "sexual abuse" requires proving the subjective intent of the perpetrator with respect to incidents involving intentional touching. Adding an intent element to the definition would exclude conduct that is sexual abuse from coverage under these regulations and would make it much more difficult to prove sexual abuse, requiring agencies to investigate and make findings about the perpetrator's state of mind. If the Department has concerns regarding situations in which staff members intentionally make contact with residents in accordance with an agency's policies and procedures, such as during use of an approved restraint technique or body cavity search, they should adopt The National Prison Rape Elimination Commission's ("the Commission's") definition of staff-on-resident abuse which excluded touching related to official duties. However, the Department should strike the language related to the intent of the perpetrator.

- **Searches of transgender and intersex residents:** We are concerned that § 115.314 does not adequately protect transgender and intersex residents from unnecessary, abusive, and traumatic searches. Even when conducted by medical professionals, touching a transgender or intersex resident's genitals or requiring a resident to undress so the professionals can determine their genital status is unnecessary and inherently traumatic. We strongly urge the Department to prohibit facilities from engaging in such searches. In the very limited circumstances where this information is needed by a facility, it can be determined by asking the resident, reviewing the resident's medical records or other files, or during routine intake medical examinations. We also strongly urge the Department to include specific guidance on how facilities should apply the restrictions on cross-gender searches to transgender and intersex residents. The gender of the staff member to search a particular transgender or intersex resident should be determined on a case-by-case basis. As individual transgender and intersex residents may have different privacy and safety concerns, facility staff should ask such residents to indicate the gender of staff they feel most safe being searched by and facilities should accommodate these requests, regardless of whether the unit the youth is housed in is for males or females.

- **Housing decisions for transgender and intersex residents:** The draft regulation does not provide sufficient guidance to agencies on making determinations for housing transgender or intersex residents and fails to include consideration of the resident's views of his or her own safety. Many facilities struggle with appropriate housing options for these residents and will solely look to the resident's genital status. Transgender and intersex residents are very vulnerable to sexual abuse if their safety needs are not considered in housing determinations. We strongly encourage the Department to include specific guidance for facilities on what to consider when assigning a transgender or intersex resident to a facility or unit for male or female residents.

- **Limits on cross-gender viewing:** The Department's authorization of cross-gender viewing of residents in states of undress "incidental to routine cell checks" diminishes the scope and effectiveness of the Department's intended limitation of cross-gender viewing. In many facilities, residents change clothes, use the toilet, and sometimes wash in their cell areas. The practice of officers viewing residents of the opposite sex at these times should be prohibited in non-emergency situations.

- **Victimization of LGBTI and gender nonconforming youth:** We are pleased that the regulations now prohibit agencies from placing lesbian, gay, bisexual, transgender, or intersex (LGBTI) residents in segregated housing or isolation on the basis of such identification or status, as doing so deprives them of access to rehabilitative programming and essentially punishes them for who they are. While studies indicate that LGBTI residents are at high risk of sexual abuse, we are concerned that the draft regulations fail to acknowledge other studies demonstrating that LGBTI youth are not more likely to be abusive. Without such a statement, facilities may wrongly treat LGBTI status as an indication of potential sexual abusiveness based on bias or misconceptions. In addition, the regulations fail to include gender nonconforming appearance as a factor agencies must take into account when determining housing, bed, program, education, and work assignments for residents, even though gender nonconforming youth are often victimized because of their appearance. Accordingly, gender nonconforming appearance should be added to the regulations.

- **Sexual harassment:** Various provisions of the draft regulations exclusively address sexual abuse, but should also address sexual harassment. Under the definition of sexual harassment included in the Department's draft regulations, some behavior that most states would consider to be child abuse is termed sexual harassment. Sexual harassment is left out of most provisions of the Department's draft regulations, even though it prevents obvious harms to children. We recommend including sexual harassment in the regulations regarding: reporting duties and training of staff,

guidelines for investigations, timelines for filing grievances, confidentiality requirements, protection against retaliation, agency data collection, and several others in order to clarify the responsibilities of the various stakeholders and better protect the safety of youth.

- **Isolation:** Under the draft regulations, facilities may isolate youth in their efforts to eliminate sexual abuse and violence. Even short periods of isolation can have negative consequences for youth, including raising the risk of suicide, exacerbating emotional and mental health needs, and depriving youth of programming, such as educational services. The final regulation should limit isolation to no more than 72 hours and ensure that youth enjoy the same privileges as other residents if they are isolated for safety reasons. Similarly, the draft regulations do not place any restrictions on the use of isolation as a disciplinary sanction for youth who have engaged in the sexual abuse of another resident or non-consenting staff member. The Department should explicitly limit the use of isolation to no more than 72 hours and ensure that youth receive daily visits from mental health or medical professionals.

- **Discipline:** The draft regulation addressing disciplinary sanctions for juvenile residents is problematic in that it (1) fails to provide guidance on responding appropriately to resident-on-resident voluntary sexual contact that is not legally consensual; and (2) permits facilities to deprive youth of programming if they refuse to participate in certain treatment. The Department's definition of sexual abuse requires juvenile facilities to treat some voluntary sexual activity between residents as sexual abuse if one or both residents could not legally consent under state law. The Department should provide further guidance to prevent facilities from using the standards to target LGBTI youth who engaged in voluntary sexual activity for harsh sanctions or prosecution based on disapproval of same-sex activity or related bias. Additionally, we recommend removing the provision that permits facilities to condition a resident's access to programming on participation in certain treatment. Withholding programming from juvenile residents for refusing treatment is unduly punitive and contrary to the purpose of the juvenile justice system.

- **Accommodations for youth with limited English proficiency:** The current standard does not require agencies to provide limited English proficient (LEP) youth and youth with disabilities with accommodations throughout the entire investigation and response process. However, federal law and the Justice Department's own regulations and guidance require that agencies make these accommodations. We encourage the Department to ensure that LEP youth and youth with disabilities receive the same protections under the standards as other youth throughout the entire investigative and response process.

- **Exhaustion of administrative remedies:** The draft regulations impose a short grievance timeline that ignores important developmental differences between adults and youth that may contribute to a child's hesitancy to report abuse. The short timeline not only prevents young victims from being protected through the administrative process, it also unreasonably restricts their ability to bring valid legal claims. We propose incorporating the recommendations of the Commission , which would impose no time limit for young victims to report abuse and would consider administrative remedies exhausted 90 days after making a report. In the alternative, we propose extending the time for youth to file grievances to 180 days, and requiring the agency to consult with the youth and medical and mental health practitioners to determine if filing a grievance in the normal timeline would have been impractical.

- **Audits:** Audits conducted by independent, qualified professionals are necessary to provide a credible, objective assessment of a facility's safety. The Department's definition of "independent" – which allows the audits to be conducted by an entity that reports to the agency head or the agency's governing board – is too broad and compromises the integrity of the auditing process. The audit provision should require the auditing team to be completely separate from the agency being audited and have expertise in juvenile corrections and sexual violence against youth. Furthermore, the Department's draft regulations leave unresolved critical details about oversight. The outside auditor should visit every facility during each triennial audit period. If that is not possible, then a combination of "for cause" and random audits – all determined by the auditor – should be conducted at some facilities, along with review of policies, data, and other documents at all facilities. Finally, the standards should require that auditors consider a facility's staffing plans under PREA, an assessment of staffing ratios, and an assessment of the use of a PREA coordinator.

- **Youth in adult facilities:** Adult facilities housing youth face a dangerous dilemma, forced to choose between housing them in the general adult population where they face substantial risk of sexual abuse, or in segregated settings that can exacerbate mental health problems. The Department should prohibit placing youth in adult jails and prisons to reduce the sexual abuse of youth without subjecting them to harmful segregation or isolation. At a minimum, the regulations should require a presumption that all youth will be housed in juvenile facilities, and ensure access to programs and services for youth who remain in adult facilities in protective custody.

Our comments below follow the order of the draft regulations, highlighting any concerns we have regarding the current language, detailing specific revisions we believe are appropriate, and answering any related questions posed by the Department on which we felt we could offer our

expertise. After a brief discussion of our rationale for each recommended change, we suggest textual changes to the draft regulations, with deletions of text ~~struck through~~ and additions of text in **bold**.

We urge you to consider and accept our proposed revisions, and we urge you, in all decisions you make while crafting the final regulations, to take extra care to recognize the unique needs and characteristics of youth that make them different from adult inmates.

Thank you for your consideration.

Sincerely,

Dana Shoenberg, Center for Children's Law and Policy
Jason Szanyi, Center for Children's Law and Policy
Neelum Arya, Campaign for Youth Justice
Jody Marksamer, The Equity Project
Joshua Delgado, The Equity Project
Terry Schuster, Juvenile Law Center
Jessica Feierman, Juvenile Law Center
Sarah Bergen, National Juvenile Defender Center
Morna Murray, First Focus
Sue Burrell, Youth Law Center
Catherine Beane, Children's Defense Fund

Organization Descriptions and Contact Information

Our organizations are committed to policy reforms that remove youth from adult facilities, improve the conditions of confinement for youth held in juvenile facilities, and ensure that youth under community supervision are kept safe. Many of our organizations have extensive experience working to improve the conditions of confinement for youth held in juvenile and adult facilities. Please feel free to contact us if you have questions about our recommendations or other concerns regarding children and youth.

- The **Campaign for Youth Justice** (CFYJ) is dedicated to ending the practice of prosecuting, sentencing, and incarcerating youth under the age of 18 in the adult criminal justice system. CFYJ advocates for reforms to the justice system by serving as a clearinghouse of information on youth prosecuted as adults; conducting original research; providing support to federal, state, and local elected officials, policymakers, and advocates; coordinating outreach to parents, youth, and families; and leading national coalition efforts to reauthorize the Juvenile Justice and Delinquency Prevention Act.
  Staff Contact: Neelum Arya, Research and Policy Director, (202) 558-3580, narya@cfyj.org.

- The **Center for Children's Law and Policy** (CCLP) is a public interest law and policy organization focused on reform of juvenile justice and other systems that affect troubled and at-risk children, and protection of the rights of children in those systems. The Center's work covers a range of activities including research, writing, public education, media advocacy, training, technical assistance, administrative and legislative advocacy, and litigation. CCLP has a central role in major foundation-funded juvenile justice initiatives in the United States including the John D. and Catherine T. MacArthur Foundation's Models for Change initiative and the Annie E. Casey Foundation's Juvenile Detention Alternatives Initiative (JDAI). CCLP staff provide training and technical assistance nationwide on assessing conditions of confinement in juvenile facilities, investigate potentially abusive conditions for youth in locked juvenile and adult facilities, and advocate for needed changes to the Prison Litigation Reform Act.
  Staff Contact: Dana Shoenberg, Deputy Director, (202) 637-0377 ext. 107, dshoenberg@cclp.org.

- **The Equity Project** is an initiative to ensure that lesbian, gay, bisexual, transgender and intersex (LGBTI) youth in juvenile delinquency courts are treated with dignity, respect, and fairness. The Equity Project examines issues that impact LGBTI youth during the entire delinquency process, ranging from arrest through post-disposition. Core activities of The Equity Project include: gathering information from stakeholders about LGBTI

youth in juvenile delinquency courts, identifying obstacles to fair treatment, reporting findings, and crafting recommendations for juvenile justice professionals. Partners of The Equity Project include Legal Services for Children, National Center for Lesbian Rights, and the National Juvenile Defender Center.
Staff Contact: Jody Marksamer, Staff Attorney, (415) 365-1308, jmarksamer@nclrights.org.

- The **National Juvenile Defender Center (NJDC)** was created in 1999 to respond to the critical need to build the capacity of the juvenile defense bar and to improve access to counsel and quality of representation for children in the justice system. In 2005, NJDC separated from the American Bar Association to become an independent organization. NJDC's mission is to ensure excellence in juvenile defense and promote justice for all children. NJDC gives juvenile defense attorneys a more permanent capacity to address practice issues, improve advocacy skills, build partnerships, exchange information, and participate in the national debate over juvenile crime. NJDC provides support to public defenders, appointed counsel, law school clinical programs and non-profit law centers to ensure quality representation in urban, suburban, rural and tribal areas. NJDC offers a wide range of integrated services to juvenile defenders, including training, technical assistance, advocacy, networking, collaboration, capacity building and coordination.
Staff Contact: Sarah Bergen, Staff Attorney, (202) 452-0010, SBergen@njdc.info.

- **Juvenile Law Center** (JLC) is one of the oldest multi-issue public interest law firms for children in the United States. JLC maintains a national litigation practice that includes appellate and amicus work. JLC promotes juvenile justice and child welfare reform in Pennsylvania and nationwide through policy initiatives and public education forums. JLC uses the law to protect and promote children's rights and interests in the child welfare and juvenile justice systems, with a particular emphasis on ensuring that public systems do not harm children and youth in their care. JLC works to ensure that the juvenile justice and child welfare systems, which were created to help vulnerable children and youth, provide them with access to education, housing, physical and behavioral health care, employment opportunities and other services that will enable them to become productive adults.
Staff Contact: Jessica Feierman, Supervising Attorney, (215) 625-0551, jfeierman@jlc.org.

- The **Children's Defense Fund** (CDF) is a non-profit child advocacy organization that has worked relentlessly for more than 35 years to ensure a level playing field for all children, with special attention to the needs of poor and minority children and those with disabilities. CDF champions policies and programs that lift children out of poverty, protect them from abuse and neglect, and ensure their access to quality health and

mental health care and early childhood and education experiences. CDF's *Cradle to Prison Pipeline*® Crusade seeks to achieve a fundamental paradigm shift in policy and practice away from punishment and incarceration and toward prevention and early intervention and sustained child investment.
Staff Contact: Catherine V. Beane, Director of Policy, (202) 662- 3615, cbeane@childrensdefense.org.

- **First Focus** is a bipartisan advocacy organization that is committed to making children and families a priority in federal policy and budget decisions. First Focus brings both traditional and non-traditional leaders together to advocate for federal policies that will improve the lives of America's children. Child health, education, family economics, child welfare, and child safety are the core issue areas in which First Focus promotes bipartisan policy solutions. With respect to child safety, First Focus works to ensure that our children grow up in a setting that is safe from physical and environmental hazards that can have far-reaching effects on a child's well-being. First Focus works to protect children from hazardous consumer products and other substandard physical, chemical, and environmental living conditions. In addition, First Focus works to increase investments in criminal prevention and intervention efforts for at-risk youth, such as those in the juvenile justice system.
  Staff Contact: Morna A. Murray, Vice President and Counsel, Children's Policy and Strategy, (202) 657-0670, mornam@firstfocus.net.

- The **Youth Law Center** (YLC) is a public interest law firm that works to protect children in the nation's foster care and juvenile justice systems from abuse and neglect, and to ensure that they receive the necessary support and services to become healthy and productive adults. Since 1978, its lawyers have worked across the United States to reduce the use of out-of-home care and incarceration, to ensure safe and humane conditions in out-of home placements, to keep children out of adult jails, and to secure equitable treatment for children in both systems. Its efforts have focused on strengthening families and on advocating for education, medical and mental health, legal support, and transition services needed to assure children's success in care and in the community. YLC advocates for increased accountability of the juvenile justice and child welfare systems, and champions professional and public education.
  Staff Contact: Sue Burrell, Staff Attorney, (415) 543-3379 ext. 3911, sburrell@ylc.org.

Commentary on the Draft Regulations

§ 115.5 – General definitions

ISSUE 1: The regulations should recognize that all youth have heightened vulnerability for sexual abuse in correctional settings. The definition of *juvenile* should be modified to include all youth under the age of 18, regardless of whether they are prosecuted in the adult criminal justice system or the juvenile justice system. The definition should also explicitly cover persons over the age of 18 in the custody of the juvenile justice system, since the juvenile facility regulations should apply to all youth housed in juvenile facilities,

The current definition removes some youth under the age of 18 from the definition of juvenile by the inclusion of the phrase "unless otherwise defined by state law." This phrase is vague and will cause unnecessary confusion. There is not a consistent definition of adulthood used by state laws, so a child may be considered an adult for some purposes but not others. For example, parental consent laws for medical treatment may differ from the age of majority established for a state's juvenile justice system. We believe the phrase was intended to reflect that some states allow youth to be prosecuted in the adult criminal justice system, and these youth are deemed "legal adults." However, we believe defining juvenile in this way is inappropriate for the purposes of PREA. Laws allowing youth to be prosecuted as adults have no bearing on whether a youth is at risk of sexual assault. The definition of "juvenile" is important because it governs which set of regulations apply to a particular facility. The regulations define a "juvenile facility" as a facility primarily used for the confinement of juveniles. Whether youth are in the adult or juvenile systems, if they are confined in a facility primarily confining youth under 18, they should be protected by the juvenile facility regulations. Accordingly, the definition of juvenile should be modified to include all youth under the age of 18, regardless of whether they are considered "legal adults" and prosecuted in the adult criminal justice system.

We also propose a second modification: the definition of juvenile should include persons over the age of 18 who are currently in the custody of the juvenile justice system. Many state juvenile justice systems hold persons until the age of 21 or 25. Without this modification, it would not be clear that state juvenile facilities should follow the juvenile facilities regulations for all of their juvenile justice facilities.

ISSUE 2: The regulations should protect unaccompanied minors from sexual abuse in facilities run by the Office of Refugee Resettlement (ORR). The definitions and legislative history of PREA include civil detention, and Congress clearly intended for these highly vulnerable children to be protected from sexual abuse. The definitions for *prison* and *juvenile facility* should be amended to include immigration detention.

The Department's decision to exclude immigration detention from the draft regulations threatens the safety of the thousands of unaccompanied children in the custody of the Border Patrol and the Office of Refugee Resettlement. Unaccompanied minors, like other youth in custody, are at grave risk for sexual abuse. Histories of abuse in their home countries and/or during their journeys to the U.S. make unaccompanied minors especially vulnerable; many are victims of human trafficking, brought to the U.S. for sexual exploitation or forced labor.[1] Once apprehended, some unaccompanied minors are initially placed in Border Patrol holding facilities, in close proximity to adults. Language and cultural barriers, fear of their circumstances and of the adults in charge, and the impact of their previous trauma add to the isolation of and danger to these youth. Unaccompanied minors have no right to an attorney and are unlikely to know their rights to be free from sexual abuse or to report abuse after it occurs.

Excluding facilities run by the Department of Homeland Security and contracted by the Department of Health and Human Services from the regulations is also inconsistent with the intent of PREA and the Administration's efforts at detention reform. PREA's legislative history clearly reflects Congress' intent for the law's application to both criminal and civil detention, particularly in the immigration context.[2] Consistent with the law's intent, federal entities charged with implementing PREA included immigration detention in their mandate. The Commission held a public hearing that focused on immigration detention, convened an expert working group on immigration detention, included a section on immigration detention in its final report, and developed an immigration detention supplement in its recommended standards. Representatives from the Department of Homeland Security and the Office of Refugee Resettlement participated in the Commission's hearing on immigration detention and the immigration expert working group.

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[1] National Prison Rape Elimination Commission, Report 178 (2009) (quoting Sergio Medina, Field Coordinator with Lutheran Immigration and Refugee Service).

[2] U.S. House Committee on the Judiciary, *Report on the Prison Rape Reduction Act of 2003*, 108th Cong., 1st sess., H. Rept. 108-219, 14, 115 (2003) *available at* http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=108_cong_reports&docid=f:hr219.108.pdf. Senator Kennedy, a lead cosponsor of PREA, noted his intent for the law to protect immigration detainees in his remarks at the first hearing of the National Prison Rape Elimination Commission. *See The Cost of Victimization: Why Our Nation Must*

[2] U.S. House Committee on the Judiciary, *Report on the Prison Rape Reduction Act of 2003*, 108th Cong., 1st sess., H. Rept. 108-219, 14, 115 (2003) *available at* http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=108_cong_reports&docid=f:hr219.108.pdf. Senator Kennedy, a lead cosponsor of PREA, noted his intent for the law to protect immigration detainees in his remarks at the first hearing of the National Prison Rape Elimination Commission. *See The Cost of Victimization: Why Our Nation Must Confront Prison Rape, Hearing Before the National Prison Rape Elimination Commission* (June 14, 2005), *available at* http://www.cybercemetery.unt.edu/archive/nprec/20090820160727/http://nprec.us/docs/SenatorEdwardKennedyRemarks_Vol_1.pdf.

Notably, when PREA was first drafted in 2001, there was no Department of Homeland Security (DHS); the then-Immigration and Naturalization Service was a division of the Department of Justice and therefore was within the scope Congress intended to cover in requiring that Justice Department agencies be bound by the regulations. While DHS was established by the time PREA passed, the transition of authority and scope of power were still being defined. Even if Congress had foreseen this issue, the law's drafters would not realistically have been able to amend the statutory language in time.

The Department's narrow focus undermines the Administration's own efforts to reform the immigration detention system.[3] Moreover, the exclusion of immigration facilities from the regulations would also lead to anomalous and unjustifiable results: an unaccompanied minor held on a criminal charge would be protected by PREA but would lose that protection if transferred to an ORR facility. It is inconceivable that Congress intended PREA protections for youth to depend on the facility that confines them. We suggest adding immigration detention to the prison definition and Office of Refugee Resettlement facilities to the juvenile detention definition.

ISSUE 3: The regulations fail to define the terms *transgender* and *intersex,* although these terms are used throughout the regulations. As many facility staff may be unfamiliar with these terms, the regulations should include appropriate definitions. As we are recommending that the Department refer to *gender nonconforming* residents in the final regulations, the regulations should also include an appropriate definition for *gender nonconforming*.

ISSUE 4: The definitions of *community confinement facility* and *juvenile facility* currently overlap, leaving unclear whether the juvenile regulations or the community confinement regulations apply to juvenile community confinement facilities. We suggest clarifying that all facilities serving individuals under the jurisdiction of the juvenile justice system should follow the juvenile facility regulations.

Proposed Revisions:

[3] *See, e.g.,* Dora Schriro, ICE, DHS, *Immigration Detention Overview and Recommendations* 22 (2009), *available at* http://www.ice.gov/doclib/about/offices/odpp/pdf/ice-detention-rpt.pdf ("The system must make better use of sound practices such as … practices that comply with the Prisoner Rape Elimination Act."); Nina Bernstein, U.S. to Reform Policy on Detention for Immigrants, N.Y. Times, Aug. 5, 2009 (quoting Assistant Secretary for ICE John Morton as seeking to work toward a "truly civil detention system" that would demonstrate greater respect for the dignity of individuals held in the agency's custody).

Gender nonconforming **means a person whose gender expression does not conform to traditional societal gender-role expectations.**

. . .

Intersex **means a person who has sexual or reproductive anatomy and/or a chromosomal pattern that does not fit typical male or female anatomy or chromosomal patterns.** ***Intersex*** **medical conditions may also be called** ***Disorders of Sex Development*** **("DSD").**

. . .

Juvenile means any person under the age of 18~~, unless otherwise defined by state law.~~ **or a person who is under the jurisdiction of the juvenile justice system.**

Juvenile facility is a facility primarily used for the confinement of juveniles**, including secure, non-secure, community confinement facilities, and Office of Refugee Resettlement facilities**.

. . .

Prison means an institution under Federal or State jurisdiction whose primary use is for the confinement of individuals convicted of a serious crime, usually in excess of one year in length or a felony**, or whose primary use is for the detention of individuals on immigration charges**.

. . .

Transgender **means a person whose gender identity (internal, deeply felt sense of being male or female) is different from his or her assigned sex at birth.**

. . . .

§ 115.6 – Definitions related to sexual abuse

ISSUE 1: As written, the definition of sexual abuse requires considering the subjective intent of the perpetrator with respect to incidents involving intentional touching. Adding an intent element to the definition would exclude conduct that should be considered sexual abuse from coverage under these regulations and would make it much more difficult to prove sexual abuse, requiring agencies to investigate the perpetrator's state of mind. Our proposed changes to the definition will exclude conduct that would not be considered sexual abuse without overly narrowing the definition and without requiring facilities to look into intent.

The Department's definition of sexual abuse includes two unnecessary and unworkable distinctions. As written, the definition requires considering the subjective intent of residents and staff who engage in intentional touching. For resident-on-resident sexual abuse, the draft regulation excludes "incidents in which the intent of the sexual contact is solely to harm or debilitate rather than to sexually exploit." For abuse by staff, contractors, or volunteers, the draft regulation requires those individuals to have "the intent to abuse, arouse or gratify sexual desire."

The perpetrator's intent should not matter, particularly given that this language will require agencies to engage in a complicated time- and labor-intensive inquiry into the intent of the perpetrator. The draft regulations do not include any guidelines that would clarify how to approach these difficult inquiries.

With respect to resident-on-resident abuse, the distinction is not only unnecessary, but also potentially harmful. Sexually abusive touching should not be judged based on whether a resident intended the conduct "solely to harm or debilitate." From a victim's standpoint, unwanted sexual touching is unwanted sexual touching, regardless of the perpetrator's motive. The draft regulations would deprive a victim of protections under the standards, even if an incident were particularly traumatic for the victim, so long as the perpetrator did not intend to sexually exploit the resident. The definition of sexual abuse already properly excludes consensual resident-on-resident contact. The Department should not exclude from the definition unwanted sexual touching where the perpetrator's intent was not "solely to harm or debilitate," which is why we propose striking the language below. We suggest language to ensure that kicks to the groin or other conduct incidental to a fight with no sexual overtones would not be part of the definition.

With respect to staff-on-resident abuse, the distinction is also potentially harmful. As stated above, the act of victimization is what matters in this situation, not why the perpetrator chose to engage in the conduct. The Department may have concerns regarding situations in which

staff members intentionally make contact with residents in accordance with an agency's policies and procedures, such as during a restraint technique or body cavity search. The National Prison Rape Elimination Commission's definition of staff-on-resident abuse addressed this situation by excluding touching that was related to official duties.[4] If the Department shares this concern, it can include the proposed language below as a limitation. However, the Department should strike the language related to the intent of the perpetrator.

ISSUE 2: As written, the definition of *voyeurism* excludes situations when staff take pictures of nude residents or residents performing bodily functions, so long as staff do not distribute or publish those images. This overly narrow definition excludes conduct that is clearly sexual abuse. Our proposed edits correct that oversight.

The draft regulations define staff sexual abuse as including "[v]oyeurism by a staff member, contractor or volunteer." The definition of *voyeurism* includes situations in which staff take pictures of nude residents or residents performing bodily functions, but only if staff are involved in "distributing or publishing" those images. Whether or not a staff member distributes or publishes those images is immaterial; taking such images has no legitimate purpose and clearly constitutes sexual abuse. Accordingly, our proposed edit strikes the distribution and publication language.

Proposed Revisions:

. . .

Sexual abuse by another inmate, detainee, or resident includes any of the following acts, if the victim does not consent, is coerced into such act by overt or implied threats of violence, or is unable to consent or refuse:

. . .

(4) Any other intentional touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or the buttocks of any person**, excluding contact incidental to horseplay or a physical altercation such as a kick in the groin or touching someone's breasts while pushing her away**.~~, excluding incidents in which the~~

[4]National Prison Rape Elimination Commission, Standards for the Prevention, Detection, Response, and Monitoring of Sexual Abuse in Juvenile Facilities 6 (2009) (defining sexually abusive conduct as "[n]on-penetrative touching (either directly or through the clothing) of the genitalia, anus, groin, breast, inner thigh, or buttocks by a staff member of a resident that is unrelated to official duties'').

~~intent of the sexual contact is solely to harm or debilitate rather than to sexually exploit~~.

. . .

Sexual touching by a staff member, contractor, or volunteer includes any of the following acts, with or without consent:

. . .

(4) Any other intentional touching **not required by official duties**, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or the buttocks of any person~~, with the intent to abuse, arouse or gratify sexual desire~~.

. . .

Voyeurism by a staff member, contractor, or volunteer means an invasion of an inmate's privacy by staff for reasons unrelated to official duties, such as peering at an inmate who is using a toilet in his or her cell to perform bodily functions; requiring an inmate to expose his or her buttocks, genitals or breasts; or taking images of all or part of an inmate's naked body or of an inmate performing bodily functions~~, and distributing or publishing them~~.

§ 115.311 – Zero tolerance of sexual abuse and sexual harassment; PREA coordinator.

ISSUE: The restriction of a full-time PREA coordinator to facilities or agencies with a resident population greater than 1000 fails to protect youth adequately in the majority of the nation's facilities. The regulation should be modified to require that all agencies and facilities designate a PREA coordinator and allocate sufficient time to ensure the standards are implemented properly.

According to the Initial Regulatory Impact Analysis, only 11 state juvenile systems would be required to designate a full-time staff member to coordinate PREA activities and comply with the draft regulations.[5] In light of the recent Bureau of Justice Statistics (BJS) report's estimate that 12 percent of adjudicated youth in juvenile facilities experienced sexual abuse in 2008 and 2009, with over 10 percent attributed to incidents between staff and youth,[6] the level of staffing required under the draft regulations would fall far below what is needed to implement the PREA standards fully and protect juvenile residents from abuse. We believe the regulation should be modified to ensure that each PREA coordinator spends adequate staff time making sexual misconduct prevention a priority in juvenile facilities, with flexibility for variations in facility size and characteristics (see Table 1).

Table 1. Residential Placements for Youth, by Size[7]

Facility size	Number of facilities	Percentage of facilities	Percentage of residents
Total facilities	2658	100%	100%
1-10 Residents	843	32	5
11-20	584	22	8
21-50	667	25	21
51-100	327	12	20
101-200	163	6	23
201+	74	3	24

Larger agencies and facilities will find that a full-time coordinator is needed to implement the regulations. Smaller facilities may find a part-time employee is sufficient. Our proposed

[5] U.S. Department of Justice, *Initial Regulatory Impact Analysis for Notice of Proposed Rulemaking, Proposed National Standards to Prevent, Detect, and Respond to Prison Rape Under the Prison Rape Elimination Act (PREA)* 36 (2011), *available at* http://www.ojp.usdoj.gov/programs/pdfs/prea_nprm_iria.pdf.

[6] Allen J. Beck et al., Bureau of Justice Statistics, Victimization in Juvenile Facilities Reported by Youth (2010), *available at* http://bjs.ojp.usdoj.gov/content/pub/pdf/svjfry09.pdf.

[7] U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention, *Juvenile Offenders and Victims: National Report Series, Bulletin* 5 (2009), *available at* http://www.ncjrs.gov/pdffiles1/ojjdp/228128.pdf.

revisions would ensure that regardless of facility size, all agencies and facilities designate a PREA coordinator with sufficient staff time to ensure the regulations are implemented appropriately and that the prevention of sexual abuse of youth receives the attention it deserves.

Proposed Revisions:

. . .

(b) An agency shall employ or designate an upper-level agency-wide PREA coordinator to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities.

~~(c) The PREA coordinator shall be a full-time position in all agencies that operate facilities whose total rated capacity exceeds 1000 residents, but may be designated as a part-time position in agencies whose total rated capacity does not exceed 1000 residents.~~

~~(d) An agency whose facilities have a total rated capacity exceeding 1000 residents shall also designate a PREA coordinator for each facility, who may be full-time or part-time.~~

(c) Each facility shall employ or designate a PREA coordinator in the upper ranks of the facility management to develop, implement, and oversee facility compliance with the PREA standards.

(d) The PREA coordinator may be a full-time or part-time employee. If part-time, the employee shall devote an adequate number of hours sufficient to implement the PREA standards.

Question 2: Should the Department modify the full-time coordinator requirement to allow additional flexibility, such as by requiring only that PREA be the coordinator's primary responsibility, or by allowing the coordinator also to work on other related issues, such as inmate safety more generally?

We have proposed changes to § 115.311 above that would modify the requirement of a full-time PREA Coordinator. We believe that PREA coordinators must be in high enough ranks of management to be able to implement necessary changes, but must not have so many other duties that they cannot dedicate sufficient time to coordinating PREA implementation. They must have sufficient breadth of experience to understand the many systems within the facility or agency that must be adjusted and monitored in order to keep youth safe from sexual victimization and ensure an appropriate response if it does occur. The PREA coordinator should not be so far removed from the day-to-day operations at the facility or facilities that he or she cannot monitor and assess implementation. Under our proposed revision, agencies and facilities

would need to allocate staff time sufficient to ensure the PREA regulations are implemented properly. The coordinator could appropriately have other broader responsibilities for institutional safety or security, provided that the responsibilities do not keep the person from having enough time to devote to implementation of the regulations.

§ 115.312 – Contracting with other entities for the confinement of residents

ISSUE: The draft regulation provides virtually no oversight of private facilities, even though these institutions are less scrutinized and just as dangerous as public facilities. Private facilities should be monitored for compliance with the regulations to the same extent as public facilities, in accordance with § 115.393.

Question 3: Should the final rule provide greater guidance as to how agencies should conduct such monitoring [of contract facilities]? If so, what guidance should be provided?

Youth confined in out-of-home placements need the full protections of the PREA regulations, whether they are housed in public or privately-run facilities. Private companies that operate juvenile facilities may conceal or minimize incidents or risk factors that could subject them to contractual penalties, result in the cancellation or non-renewal of contracts, or have an adverse impact on their stock performance or other contract opportunities. Many private facilities that house juveniles are small operations that receive few visitors and little scrutiny when compared with larger detention centers and training schools.

While states and counties generally monitor contracts with private agencies, the scope and expertise involved in this monitoring is dramatically different from the audits required by § 115.393 for state and county facilities. Such monitoring is not conducted by an independent entity that is qualified to assess sexual abuse prevention and response and provide relevant recommendations. It also may not include private communications with residents or staff, nor result in any publicly available report or recommendations. These forms of review and transparency are as needed in contracted facilities as in facilities run by the agency.

In addition, the draft regulations do not explicitly require any enforcement provision in § 115.12 or related paragraphs concerning PREA compliance by private contractors. That is, should private companies that operate detention facilities fail to comply with PREA, there is no way to ensure compliance. We recommend that private facilities be subject to the same auditing requirements as public facilities in accordance with § 115.393, and that agencies enforce PREA compliance by the private companies with which they contract.

Proposed revisions:

(a) A public agency that contracts for the confinement of its residents with private agencies or other entities, including government agencies, shall include in any new contracts or contract renewals the entity's obligation to adopt and comply with the PREA standards.
(b) Any new contracts or contract renewals shall provide for agency contract monitoring to ensure that the contractor is complying with PREA standards.
(c) Private agencies or other entities responsible for confinement of youth shall be audited by qualified and independent monitoring entities, in accordance with the criteria in § 115.393 and related criteria established by the Department of Justice. The reports and action plans arising from these audits shall be made publicly available.
(d) Any new contracts or contract renewals with private agencies or other entities for the confinement of juveniles shall include enforcement provisions to ensure that the private agencies or entities are in compliance with PREA standards. Such enforcement provisions shall include but not be limited to financial sanctions for non-compliance with the PREA standards, as determined by the contracting public agency.

§ 115.313 – Prevention Planning: Supervision and monitoring

SUPPORT FOR CHANGES TO THIS REGULATION: The Department's decision to combine the concepts of supervision and technology into one standard, § 115.313, is a sensible decision, as the level of staffing and the extent of technology needed and utilized are clearly interrelated. Likewise, the additional standard requiring agencies to consider the effects of facility design and technology updates on the ability to protect residents (§ 115.317) should increase agencies' attention to the relationship between facility design, staff deployment, and technology. However, the draft regulation would significantly benefit from several modifications.

ISSUE 1: The draft regulation fails to require safe staffing of facilities. By requiring that agencies develop staffing plans without ever requiring that agencies safely staff their facilities, then requiring agencies to plan for what to do if they fail to comply with their initial staffing goals, the draft regulation permits agencies to provide unsafe supervision levels. We propose requiring compliance with the agency's staffing analysis and eliminating the provision requiring agencies to plan for sub-optimal staffing.

The draft regulation lacks any teeth to ensure that facilities are staffed adequately to provide safe supervision levels. By suggesting that agencies develop plans and then determine what will happen if they fail to comply with their initial staffing goals, the draft regulation permits agencies to provide unsafe supervision levels. The draft regulation never requires that agencies safely staff their facilities. Therefore, we suggest that agencies be required to follow minimum staffing ratios for awake and sleeping hours and also engage in staffing analysis to determine where staffing needs may be more intensive than that minimum ratio (*e.g.*, in mental health or special handling units).

We disagree with the approach offered in paragraph (b) of the draft regulation, which asks agencies to plan how to conduct staffing and surveillance when they are not able to achieve safe staffing patterns. As written, the draft regulation permits facilities to operate at sub-optimal staffing levels without any showing as to why it is necessary, and the standard lacks time limits on the use of those lower staffing levels. Furthermore, the draft regulation permits less than safe staffing simply when the goals of the staffing plan developed in paragraph (a) "are not attained." This language allows agencies and facilities to evade the intent of Congress and the requirements of the Constitution by failing to ensure that agencies and facilities identify appropriate staffing patterns and follow those patterns to ensure the safety of youth and staff. To be sure, all facilities should have contingency plans for when they face occasional unanticipated staffing shortages. However, the final regulations should not offer blanket escapes from facilities' responsibilities to employ sufficient personnel to keep residents safe from harm. Accordingly, we recommend striking paragraph (b) altogether.

ISSUE 2: The draft regulation fails to state that direct supervision is the preferred method for supervising youth, ahead of video surveillance. Our proposed revision clarifies that agencies should utilize their expertise in determining whether surveillance technology should supplement, but not substitute for, direct supervision. This approach strikes an appropriate balance between the benefits of direct supervision and the potential contributions of video surveillance.

The final regulation should clarify that video technology should be used as a supplement to direct supervision, not as a substitute. In any facility in which youth are held, youth need supervision from adults who are engaged and interacting with them, and tuned in to residents' interactions and conflicts with other youth. Continuous, direct, and engaged supervision provides one of the best forms of protection, as staff can identify signs of developing problems among youth through regular interactions with them.

Video surveillance cannot create the rehabilitative environment and personal relationships between youth and staff envisioned by the juvenile justice system. To achieve that goal, facilities must deploy trained staff to work directly with youth. The Department recognized this in its notice of final rulemaking, stating that "[a]dministrators of juvenile facilities . . . are typically more reluctant to rely heavily on video monitoring given the staff-intensive needs of their residents." Additionally, video surveillance systems rarely capture live audio. This severely diminishes the quality and effectiveness of video as a surveillance tool. Staff who directly supervise youth rely on what they hear, as well as what they see, to help prevent dangerous situations from developing, taking cues from residents' conversations and changes in tone or inflection. Because video surveillance systems lack this feature, facilities are compromised in anticipating and responding to events.

For these reasons, agencies must be careful not to become dependent on technology that separates youth from staff. The final supervision and monitoring regulation should make clear that video technology is mainly valuable for its ability to create a record of events and as a deterrent to abuse, rather than as an effective supervision tool. Our proposed revision to paragraph (a) below clarifies that agencies should utilize their expertise in determining whether surveillance technology should supplement direct supervision. This approach strikes an appropriate balance between the benefits of direct supervision and the potential contributions of video surveillance.

ISSUE 3: The draft regulation fails to provide sufficient guidance with respect to staffing analyses. Agencies would benefit from a more detailed description of what they must consider when conducting the staffing and technology analyses that PREA requires. By requiring agencies to consider the most common conditions known to contribute to the levels of sexual abuse, the regulations will provide needed guidance in addressing the challenges of observing and monitoring youth most effectively using limited resources.

The regulation should provide clearer guidance to help agencies engage in their staffing analyses and make design and technology choices that will help them keep residents safe. Specifically, agencies would benefit from a more detailed description of what they must consider when conducting staffing and technology analyses under paragraphs (a) and (c). Requiring consideration of the most common conditions known to contribute to the levels of sexual abuse, such as insufficient staff training, will provide agencies with needed guidance to address the challenges of observing and monitoring youth most effectively using limited resources. Auditors should review the feasibility and sufficiency of these plans as part of their compliance review in § 115.393(f).

ISSUE 4: The draft regulation does not establish staffing ratios necessary to keep youth and staff safe. The Department asks whether the PREA standards should establish minimum staffing ratios in juvenile facilities. Our proposed revisions establish a minimum 1:6 ratio for supervision during awake hours and a 1:12 ratio during sleeping hours, recognizing the value of continuous, direct supervision in preventing sexual misconduct.

The regulations should mandate minimum staff-to-resident ratios for awake and sleeping hours. Continuous, direct supervision of youth is the best way to keep residents and staff safe. Pennsylvania has already adopted a minimum staffing ratio of one direct care staff to every six youth during awake hours and one direct care staff to every twelve youth during sleeping hours.[8] Washington, D.C.'s secure juvenile justice facilities operate under a court-ordered staffing plan that works out to a ratio of one staff member to every 5.5 youth directly supervising the housing units during the day and evening, and one to eleven during sleeping hours.[9] These minimum ratios ensure that facilities maintain a baseline level of supervision, while recognizing that there are many circumstances that require higher staffing ratios to keep some youth safe, such as in mental health and special handling units. By establishing minimum ratios, the Department will ensure a level of staffing that will go a long way toward PREA's goal of eliminating sexual abuse in juvenile facilities.

[8] *See* 55 Pa. Code § 3800.274(5), (6) (2011).
[9] Department of Youth Rehabilitation Services, Post Analysis, March 19, 2007.

ISSUE 5: Various provisions of the draft regulations, including § 115.313, only address sexual abuse when they should also address sexual harassment. Under the definition of *sexual harassment* included in these regulations, some forms of sexual harassment would be considered child abuse, and should therefore be treated seriously alongside sexual abuse in many parts of these regulations. We recommend including sexual harassment in the final regulations regarding reporting duties and training of staff, guidelines for investigations, timelines for filing grievances, confidentiality requirements, protection against retaliation, agency data collection, and several others. Here and throughout our comments, we propose including language about sexual harassment where we believe it is necessary to clarify the responsibilities of various stakeholders and better protect the safety of residents.

Proposed Revisions:

(a) For each facility, the agency shall **develop and adhere to a plan to ensure that facilities establish staffing patterns and levels that** ~~determine the adequate levels of staffing, and, where applicable, video monitoring, to~~ protect residents against sexual abuse **and sexual harassment**. **To supplement direct supervision, provide deterrence, and establish evidence of sexual abuse or harassment, agencies may also consider the use of video monitoring as part of that plan, where applicable.** In **developing the plan** ~~calculating such levels~~, agencies shall take into **consideration:**

(1) the physical layout of each facility**;**

(2) the composition of the resident population**;**

(3) any blind spots within the facility, including spaces not designated for residents, such as closets, rooms, and hallways;

(4) the need to ensure adequate staffing and supervision in high traffic areas within the facility;

(5) the ease with which individual staff members can be alone with individual residents in a given location;

(6) the potential value of establishing and retaining video and other evidence of sexual misconduct;

(7) the need to provide enhanced protection to residents who have abused or victimized other youth;

(8) the need to ensure that vulnerable residents receive additional protections without being subjected to extended isolation or deprived of programming;

(9) previous serious incidents and the staffing and other circumstances that existed during those incidents;

(10) the need for increased or improved staff training;

(11) the number and placement of supervisory staff;

(12) the number of special needs or vulnerable youth;

(10) grievances from residents, staff, visitors, family members, or others;

(11) compliance with any applicable laws and regulations related to staffing requirements; and

(12) ~~and~~ any other relevant factors.

(b) ~~The facility shall also establish a plan for how to conduct staffing and, where applicable, video monitoring, in circumstances where the levels established in paragraph (a) of this section are not attained.~~ **When determining appropriate staffing patterns and levels under paragraph (a) of this section, facilities shall adhere to the following minimum standards:**

(1) Maintain at least a 1:6 ratio of direct care staff to youth during the hours that residents are awake. When calculating ratios, direct care staff are those staff who are physically present with residents in a part of the facility and who are engaging in ongoing visual and auditory contact.

(2) Maintain at least a 1:12 ratio of direct care staff to youth during the hours that residents are asleep. When calculating ratios, direct care staff are those staff who are physically present with residents in a part of the facility and who are engaging in ongoing visual and auditory contact.

(c) Each year, the facility shall assess, and determine whether adjustments are needed to **the plan outlined in paragraph (a), based on an analysis of the criteria listed above.**~~:~~

~~(1) The staffing levels established pursuant to paragraph (a) of this section;~~

~~(2) Prevailing staffing patterns; and~~

~~(3) The agency's deployment of video monitoring systems and other technologies.~~

(d) Each secure facility shall implement a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment. Such policy and practice shall be implemented for night shifts as well as day shifts.

Question 4: Should the standard require that facilities actually provide a certain level of staffing, whether determined qualitatively, such as by reference to "adequacy," or quantitatively, by setting forth more concrete requirements? If so, how?

The regulation should require that agencies provide staffing levels that are sufficient to protect youth from risk of harm. We offer in our proposed revisions above a more detailed list of factors that agencies and auditors should take into account when determining what constitutes

safe staffing levels. However, we also propose adding minimum staffing ratios for awake and sleeping hours in order to ensure a baseline level of supervision.

Question 5: If a level such as "adequacy" were mandated, how would compliance be measured?

In the approach we propose above, the agency would consider the enumerated factors, and the auditor would review whether the agency had sufficiently considered the factors, created a plan that addressed the factors, and complied with the plan. The auditor would also ensure that the facility's plan met the minimum staffing ratios for awake and sleeping hours.

Question 7: Some States mandate specific staff-to-resident ratios for certain types of juvenile facilities. Should the standard mandate specific ratios for juvenile facilities?

The regulations should mandate minimum staff-to-resident ratios of 1:6 for awake hours and 1:12 for sleeping hours. Continuous, direct supervision of youth is the best way to keep residents safe. Jurisdictions such as Pennsylvania and Washington, D.C. have already adopted minimum staffing ratio requirements, such as one direct care staff to every six youth during awake hours and one direct care staff to every twelve youth during sleeping hours.[10] These minimum ratios ensure that facilities maintain a baseline level of supervision while recognizing that there are many circumstances that require higher staffing ratios to keep some youth safe, such as residents in mental health and special handling units. By establishing minimum ratios, the Department will ensure a level of staffing that will go a long way toward PREA's goal of eliminating sexual misconduct in juvenile facilities.

Some commenters may argue that specific ratios are inappropriate, given the range of facility design, resident needs and risk levels, and program design. We believe that the criteria listed in paragraph (a) gives facilities the flexibility to adopt staffing patterns that will meet the needs of their individual physical plants and operations within the boundaries of the minimum staffing ratios outlined above. Pennsylvania and many other jurisdictions operate a wide range of secure juvenile facilities with varying facility and program designs while maintaining required staffing levels.[11]

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[10] *See id*.

[11] *See, e.g., id* (mandating 1:6 ratio for awake hours and 1:12 ratio for sleeping hours); *see also* Annie E. Casey Foundation, Juvenile Detention Alternatives Initiative, Juvenile Detention Facility Standards, § V(B)(2), (3) (mandating minimum ratio of 1:8 during awake hours and 1:16 during sleeping hours); David Roush & Michael McMillen, *Construction, Operations, and Staff Training for Juvenile Confinement Facilities*, Office of Juvenile Justice and Delinquency Prevention JAIBG Bulletin (Dec. 1999) (recommending ratio of 1:8 or 1:10 "to ensure effective involvement and behavior management").

Question 8: If a level of staffing were mandated, should the standard allow agencies a longer time frame, such as a specified number of years, in order to reach that level?

Because adequate staffing to prevent risk of harm to incarcerated individuals is already required by the Constitution and reinforced through case law requiring protection from harm, we do not believe that facilities should be given any grace period to establish safe staffing levels.

Questions 9 and 10: Should the standard require the establishment of priority posts, and if so, how should such a requirement be structured and assessed? To what extent can staffing deficiencies be addressed by redistributing existing staff assignments? Should the standard include additional language to encourage such redistribution?

Facility administrators set priorities and redistribute staff daily in order to meet the many needs of programming, medical and mental health care, court transportation, and other requirements. We do not believe that setting regulations for this constant juggling that occurs, especially in facilities with inadequate staffing, will be a useful exercise.

Question 12: Should the Department mandate the use of technology to supplement sexual abuse prevention, detection and response efforts?

No, facilities can run safely without the use of technology. We do not believe that facilities should be required to invest money in cameras when those funds could be spent on serving youth.

§ 115.314 – Limits to cross-gender viewing and searches

ISSUE 1: The draft regulation allows juvenile facilities to strip search transgender residents for the sole purpose of examining their genitals. Strip searching transgender residents or physically touching their genitals in order to determine their genital status is emotionally and sexually abusive to these youth. This regulation should prohibit facilities from engaging in such searches.

Strip searching transgender and intersex residents or physically touching their genitals in order to determine their genital status is emotionally and sexually abusive to these youth. This is true even if the search is called an "examination" and is conducted in private by a medical practitioner. Permitting medical practitioners to touch a transgender resident's genitals or requiring a resident to undress in front of a medical practitioner so the practitioner can look at his or her genitals is an unnecessary and inherently traumatic experience for these youth. It also presents serious potential for abuse. The regulations should prohibit searches or medical examinations of residents for the sole purpose of determining genital status under all circumstances. In the very limited circumstances where this information is needed by a facility, it can be determined by asking the resident, reviewing the resident's medical records or other files, or learning that information through routine intake medical examinations.

ISSUE 2: The draft regulations do not provide guidance to facilities to guide who can conduct strip and pat-down searches of transgender and intersex residents. The regulations should detail the steps and procedures necessary to protect the dignity and safety of these residents during searches, such as asking residents the gender of the staff whom they prefer to administer searches.

With no formal guidance for determining who shall administer routine security and contraband-related searches of transgender and intersex residents, these residents are at risk of unnecessary sexual abuse and trauma. The need for clear requirements in this area is highlighted by the Commission's findings that searches present a heightened risk of gender-based abuse, and that transgender and intersex residents are highly vulnerable to abuse by staff. The Commission heard testimony from two experts who testified that transgender and intersex individuals are frequently targeted for unnecessary, abusive, and traumatic pat and strip searches, and that these searches can be excuses for and precursors to sexual abuse.[12] This testimony is also supported by reports from human rights organizations.[13]

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[12] *At Risk: Sexual Abuse and Vulnerable Groups Behind Bars*, *Hearing Before the National Prison Rape Elimination Commission* (August 13, 2005) (testimony of Christopher Daly & Dean Spade).

[13] See, e.g., Sylvia Rivera Law Project, "It's War in Here": A Report on the Treatment of Transgender & Intersex People in New York State Men's Prisons *29-31(2007), available at* http://srlp.org/resources/pubs/warinhere; Amnesty International USA, *Stonewalled: Police abuse and*

In order to address the safety concerns of transgender and intersex residents and protect their privacy and dignity, we strongly urge the Department to include specific guidance as to how facilities should apply the restrictions on cross-gender searches to transgender and intersex residents. Transgender and intersex residents are at high risk of sexual abuse when strip-searched. For many transgender and intersex residents, the trauma of past sexual abuse is also aggravated by staff members conducting pat-down searches. As is true for all residents, this risk and trauma can be reduced if the person conducting the search is of the same gender as the resident. But unlike for other residents, the determination of what is a prohibited cross-gender search for a transgender or intersex resident cannot simply depend on whether the resident is housed in a girls' or boys' facility. Instead, as the regulations require for making housing decisions for transgender and intersex residents, determinations of the gender of the staff member to search a particular transgender or intersex resident should also be decided on a case-by-case basis after consultation with the resident. As individual transgender and intersex residents may have different privacy and safety needs during these searches, facility staff should ask transgender and intersex residents to indicate the gender of staff by whom they feel most safe being searched. Requests by transgender and intersex individuals to be searched by either male or female staff should be accommodated whenever possible, regardless of whether the facility in which the youth is housed is for males or females. This pragmatic approach is currently used by the New York State Office of Children and Family Services in its juvenile facilities.[14]

In the alternative, if the Department would prefer to make a general presumption about who should conduct searches of transgender and intersex residents, we recommend that all searches of transgender and intersex residents be conducted by female facility staff. This is because transgender and intersex people, regardless of their gender identities, are often perceived as female and/or feminine and, in our experience, are at considerably higher risk of being targeted by male staff for sexual violence and harassment.

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misconduct against lesbian, gay, bisexual and transgender people in the US 54-58 (2005), *available at* http://www.amnestyusa.org/outfront/stonewalled/report.pdf.

[14] It is also used in other settings in the United States, such as by the District of Columbia Police Department. Police departments in several Canadian jurisdictions, including Toronto, Vancouver, and Edmonton, have adopted a similar policy following a 2006 ruling by the Ontario Human Rights Commission. This approach is also used in numerous jurisdictions in the UK, including the London Metropolitan police, and has been approved by the Association of Chiefs of Police of Scotland.

ISSUE 3: Paragraph (f) of the draft regulation states that, "the agency shall train security staff in how to conduct cross-gender pat-down searches" while paragraph (e) prohibits cross-gender pat-down searches except in the case of emergency or other unforeseen circumstances. The inclusion of this specific training requirement is confusing. Facility staff who search residents need training on how to conduct all types of searches of residents in a professional and respectful manner, not only cross-gender pat down searches. We propose that this regulation require training on conducting strip searches, visual cavity searches, and pat-down searches of residents in a professional and respectful manner, and in the least intrusive manner possible.

ISSUE 4: Staff should not be permitted to view residents of the opposite gender while showering, performing bodily functions, or changing clothing "incidental to routine cell checks." This exception eliminates any meaningful protections from cross-gender viewing of residents in states of undress. We propose removing this exception since there are commonly used methods to avoid viewing undressing youth in their rooms.

The Department's authorization of cross-gender viewing of residents in states of undress "incidental to routine cell checks" negates any practical limitation on cross-gender viewing and any incentive for agencies to limit this dangerous practice. In many facilities, residents change clothes, use the toilet, and sometimes wash in their cell areas. The practice of officers viewing residents of the opposite sex at these times should be prohibited in non-emergency situations.

Low and no-cost measures that do not require changes in staffing can provide a basic level of bodily privacy that is lacking with this all-encompassing exception. For example, officers of the opposite gender can be required to announce themselves prior to entering a unit during waking hours. In the alternative, residents can be provided with the ability to shield their bodies – with towels, privacy screens, or other measures – while performing these functions. The Department should therefore not permit cross-gender viewing of residents in states of undress incidental to routine cell checks.

Proposed Revisions:

. . .

(c) The facility shall implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in the case of emergency, **or** by accident~~**, or when such viewing is incidental to routine cell checks**~~.

(d) The facility shall not **search or physically** examine a transgender **or intersex** resident **for the sole purpose of determining** ~~to determine~~ **the resident's genital status.** ~~unless the resident's genital status is unknown. Such examination shall be conducted in private by a medical practitioner~~. **If facility staff do not know a resident's genital status, this may be determined during conversations with the resident, by reviewing medical records, or during routine intake medical examinations that all residents are required to undergo.**

(e) The agency shall not conduct cross-gender pat-down searches except in the case of emergency or other unforeseen circumstances. Any such search shall be documented and justified.

(f) **Facilities shall ask transgender and intersex residents whether they prefer to be searched by male or female staff and shall accommodate such requests except in the case of emergency or other unforeseen circumstance.**

~~(f)~~**(g)**The agency shall train security staff in how to conduct ~~cross-gender~~ **strip searches, visual cavity searches, and pat-down searches of residents, including transgender and intersex residents**, ~~and searches of transgender residents,~~ in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs.

§ 115.315 – Accommodating residents with special needs

ISSUE: The draft regulation does not require agencies to provide limited English proficient (LEP) youth and youth with disabilities with accommodations throughout the entire investigation and response process. However, federal law and existing guidance require that agencies make these accommodations. Our proposed edits ensure that LEP youth and youth with disabilities receive the same protections under the regulations as other youth.

The draft regulations do not meet Title VI's mandate and fail to comply with the Department's own guidance to recipients of federal funds. Title VI and the Department's guidance for juvenile justice systems and courts require that youth be provided with "meaningful access" to programs and services.[15] As written, the draft regulations place LEP youth and English-speaking youth on an equal footing for learning about sexual misconduct policies and reporting abuse or victimization. However, the draft regulations leave LEP youth, deaf youth, and youth with disabilities behind after the reporting phase. The draft regulations do not require agencies to ensure that LEP residents are able to communicate during investigations with staff, medical and mental health care, and the provision of other supportive services that might be necessary after a youth is victimized or becomes a witness to an abusive event. These are all essential programs and services to which LEP youth are entitled to receive meaningful access.

The PREA regulations are much more than just a reporting and data collection tool. Effective communication throughout the investigation and response stages ensures that facilities gather the information necessary to address and prevent sexual misconduct. It also allows youth to receive the services and support that will help them recover from abuse or victimization. Agencies cannot achieve these important goals without making accommodations during all phases of the investigation and response process.

The Department's 2002 guidance to courts and juvenile justice systems states that "[t]he more important the activity, information, service, or program, or the greater the possible consequences of the contact to the LEP individuals, the more likely language services are needed."[16] With respect to juvenile facilities, the Department emphasized that "[h]ealth care services are obviously extremely important."[17] Given the potentially devastating consequences of sexual abuse and victimization on youth, the agency's guidelines also support a requirement to make accommodations during the investigation and response process.

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[15] Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 67 Fed. Reg. 41455, 41455 (June 18, 2002).
[16] *Id.* at 41460.
[17] *Id.* at 41470.

Agencies can accommodate LEP youth's needs in a number of ways, including through direct communication in the youth's primary language by bilingual staff, translation by qualified interpreters, or agreements with community service providers with a language capability for languages other than English that regularly come up at a facility. Our proposed changes outline these mechanisms, but recognize the need for flexibility in making accommodations for LEP youth.

Proposed Revisions:

(a) The agency shall ensure that residents who are limited English proficient, deaf, or ~~disabled~~ **are individuals with disabilities** are able to report sexual abuse and sexual harassment to staff directly or through other established reporting mechanisms, such as abuse hotlines, without relying on resident interpreters, absent exigent circumstances.
(b) The agency shall make accommodations to convey verbally all written information about sexual abuse policies, including how to report sexual abuse and sexual harassment, to residents who have limited reading skills or who are visually impaired.
(c) The agency shall make accommodations to ensure that residents who are limited English proficient, deaf, blind or otherwise disabled can communicate with facility staff and supportive service providers throughout the investigative process, when requesting and receiving medical and mental health care, and during other supportive services that may be necessary after a resident is victimized or witnesses an abusive event. Agencies shall make such accommodations by utilizing bilingual staff, providing translation by qualified interpreters, entering into agreements with community service providers with capabilities in translation or services to residents with disabilities, or by other means.

Question 17: Should the final rule include a requirement that inmates with disabilities and LEP inmates be able to communicate with staff throughout the entire investigation and response process? If such a requirement is included, how should agencies ensure communication throughout the process?

Under federal law, the answer to the Department's question is "yes." Title VI of the Civil Rights Act of 1964 provides that

> [n]o person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be

> denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.[18]

Because the PREA regulations apply to entities that receive federal financial assistance, the Department must ensure that limited English proficient (LEP) youth receive the same protections and supports under the regulations as children who do speak English. Federal law requires agencies to make the same accommodations for individuals with disabilities.[19]

Agencies can accommodate LEP youth's needs in a number of ways, including through direct communication in the youth's primary language by bilingual staff, translation by qualified interpreters, or agreements with community service providers with a language capability for languages other than English that regularly come up at a facility. Our proposed changes above outline these mechanisms, while recognizing the need for flexibility in making accommodations for LEP youth.

[18] 42 U.S.C. § 2000(d). The U.S. Supreme Court has held that the failure to make reasonable accommodations for limited English proficient individuals violates Title VI's ban on national origin discrimination. *See, e.g.*, *Lau v. Nichols*, 414 U.S. 563 (1974) (lack of linguistically appropriate accommodations for Chinese students effectively denied students equal educational opportunities under Title VI).

[19] These laws include Section 504 of the Rehabilitation Act of 1973, the Individuals with Disabilities Education Act (IDEA), and Title II of the Americans with Disabilities Act (ADA).

§ 115.316 – Hiring and promotion decisions

ISSUE 1: Although PREA restricts hiring and promotion of staff based on past involvement with certain activities, the list of activities in the draft regulation does not include domestic violence, stalking, sexual abuse convictions, or protective orders – all of which may provide useful information regarding a staff member's history of or propensity to engage in sexual abuse. Our proposed revisions require agencies to consider this important information when making employment decisions.

The draft regulation omits any reference to domestic violence, stalking, and sexual abuse convictions, all of which may provide useful information regarding a staff member's history of or propensity to engage in sexual abuse. In the past few decades, researchers have documented a clear link between domestic violence and child abuse.[20] Some studies find that between 30 percent and 60 percent of men who batter their partners also abuse their children.[21] Additionally, batterers often display personality traits that can make them particularly dangerous in an institutional setting. The Department's 2000 survey of violence against women concluded that domestic violence "is often accompanied by emotionally abusive and controlling behavior" and that battering "is often part of a systematic pattern of dominance and control."[22] The regulation should not allow facilities to hire staff for positions with tremendous power over youth if those individuals have engaged in behavior that indicates a propensity for victimization of youth in their care.

Additionally, sexual abuse adjudications of any kind, not just those involving use of force or coercion, should serve as a clear red flag for agencies charged with ensuring the safety and wellbeing of youth. These offenses should be included in the list of prohibited prior offenses for employment and promotion. Furthermore, the draft regulation omits any reference to civil protection orders, which may provide useful information regarding a staff member's history of or propensity to engage in abuse. Our proposed changes to paragraph (a) ensure that agencies do not hire or promote staff who may be dangerous to youth in their care.

[20] *See generally* Janet E. Findlater & Susan Kelly, *Child Protective Services and Domestic Violence*, 9 Future of Children 84 (1999).
[21] *Id.*
[22] *See generally* U.S. Department of Justice, Office of Justice Programs, National Institute of Justice, *Extent, Nature, and Consequences of Intimate Partner Violence: Findings from the National Violence Against Women Survey* iv (2000).

ISSUE 2: Although the draft regulation forbids agencies from promoting staff who have engaged in certain activities, it does not require that facilities conduct background checks before promoting current staff. Without that requirement, a staff member convicted of sexual abuse could be promoted multiple times before the agency uncovered evidence of that misconduct. Our proposed revisions require agencies to conduct background checks when considering staff for promotion.

As written, the draft regulation does not equip agencies with the tools necessary to avoid promoting staff who have engaged in sexual misconduct or related behaviors. Paragraph (a) bars agencies from promoting individuals who have engaged in a list of behaviors. However, the Department's draft regulation does not require agencies to conduct criminal background checks for employees who are considered for promotion, requiring only that agencies conduct criminal background checks every five years. Accordingly, a staff member convicted of sexual abuse could be promoted multiple times before the agency uncovered evidence of that misconduct. Thus, the individuals that the regulations aim to prevent from working with youth could actually take positions of greater authority. Our proposed addition to paragraph (c) addresses this concern.

Proposed Revisions:

(a) The agency shall not hire or promote anyone who has engaged in sexual abuse **or sexual harassment** in an institutional setting; who has been convicted of engaging in sexual activity in the community facilitated by force, the threat of force, or coercion; **who has been adjudicated as having engaged in sexual abuse; who has been the subject of a civil protection order or protection from abuse order because of having engaged in such activity; who has been convicted of domestic violence or stalking;** or who has been civilly or administratively adjudicated to have engaged in such activity.

(b) Before hiring new employees, the agency shall:

(1) Perform a criminal background check; and

(2) Consistent with Federal, State, and local law, make its best effort to contact all prior institutional employers for information on substantiated allegations of sexual abuse **and sexual harassment**.

(c) **The agency shall conduct criminal background checks of all employees being considered for promotion at the time that they are being considered for advancement.** The agency shall either conduct criminal background checks of current employees at least every five years or have in place a system for otherwise capturing such information for current employees.

(d) The agency shall also ask all applicants and employees directly about previous misconduct in written applications for hiring or promotions, in interviews for hiring or promotions, and in any interviews or written self-evaluations conducted as part of reviews of current employees.

. . .

(f) Unless prohibited by law, the agency shall provide information on substantiated allegations of sexual abuse **and sexual harassment** involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work.

§ 115.321 – Evidence protocol and forensic medical exams

ISSUE 1: The draft regulation presents agencies with the option of making a minimally qualified staff member available to victims instead of a victim advocate from a community service organization. Presented as equal alternatives, the option provides little incentive to agencies to enter into agreements with outside organizations that may be more capable of providing emotional support services to victims of sexual assault. Recognizing that partnering with sexual assault crisis centers in the community may be unrealistic for certain facilities due to their location, we propose that qualified staff members be available to serve as victim advocates only as a last resort.

The Department's provision allowing a "qualified staff member" to serve in the role of a victim advocate is inconsistent with draft regulation § 115.322, which requires agencies to maintain or attempt to enter into agreements with outside organizations capable of providing residents with confidential emotional support services related to sexual abuse. If agencies are allowed to assign staff members to provide this crucial service, they will have little incentive to form agreements with community service providers, making it less likely that young sexual assault victims will have access to appropriate services.

Some facilities may be in areas where there are no available community service providers, and in those locations, having a qualified staff member available to provide support services is better than having no support person available at all. To address this concern, qualified staff members should be allowed to serve as victim advocates as a last resort.

ISSUE 2: To the extent that facilities rely on staff members in place of victim advocates, the draft regulation offers insufficient guidance on the training, screening, availability, and support that would qualify a staff member to serve in this role. We propose mandating a minimum of 40 hours of training and certification from a victim advocate or sexual assault crisis center, focusing on how to respond to the medical, legal, developmental, and mental health needs of young sexual assault victims; requiring staff serving in this role to demonstrate a nonjudgmental and supportive attitude toward sexual assault victims; ensuring that qualified staff members are available around the clock; and providing such staff members with support and opportunities to debrief with experts in the field of victim advocacy.

The draft regulation provides insufficient information about what qualifies a staff member to serve as a victim advocate. Training for a victim advocate must be more extensive than general education concerning sexual assault. It must qualify a staff member not only to identify and advocate for the medical and legal needs of residents who have been sexually assaulted, but also to recognize their mental health and developmental needs, to identify a victim's primary concerns and help develop a safety plan, to respond in a non-judgmental and supportive

manner, and to prevent treatment by investigators, medical professionals, staff, and other youth that has the potential to re-traumatize victims. Most community-based agencies require that advocates receive a minimum of forty hours of training before providing this challenging, but vital, support. To the extent that staff members rather than community service providers are taking on this role, they should also be provided with support and opportunities to debrief with experts in the field of victim advocacy.

The Department's time and cost estimate for using "qualified staff members" instead of outside victim advocates is an underestimate. The resources needed to screen staff for this role, provide adequate training, and ensure that designated staff can dedicate the amount of time needed for each response, will be substantially more than the cost of developing and providing an 8-hour training. The revisions below propose what we believe are the minimum qualifications for staff members acting as victim advocates.

ISSUE 3: The Office on Violence Against Women's *National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents*, is recognized as the definitive source for conducting forensic exams for adults and adolescents; however, it is not appropriate for young children. The regulation should require that prepubescent children who are sexually abused in juvenile facilities receive a proper pediatric exam.

The *National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents* is not intended to be used when examining prepubescent youth. As noted in the protocol, abused children require a pediatric exam, guidance for which is not provided in the protocol.[23] Moreover, the *National Protocol* does not address the legal issues regarding child sexual abuse, mandatory reporting, a child's ability to consent to medical treatment and evidence collection without parental/guardian involvement, and the scope of confidentiality afforded to minors.

Currently, there is no national protocol appropriate for use with children. We urge the Department to develop one. In the interim, several jurisdictions have protocols that appropriately address the legal and developmental issues unique to forensic examinations with children. The regulations should acknowledge the limitations of the *National Protocol*.

Proposed Revisions:

(a) To the extent the agency is responsible for investigating allegations of sexual abuse, the agency shall follow a uniform evidence protocol that maximizes the potential for

[23] *See* U.S. Dep't of Justice, Office of Violence Against Women, *A National Protocol for Sexual Assault Medical Forensic Examinations Adults/Adolescents* 1 (2004), *available at* http://www.ncjrs.gov/pdffiles1/ovw/206554.pdf.

obtaining usable physical evidence for administrative proceedings and criminal prosecutions.

(b) The protocol shall **be developmentally appropriate for all youth – providing for a pediatric examination for female victims who have not experienced the onset of menarche and for male victims who have not yet reached puberty, and a medical forensic examination in accordance with** ~~adapted from or otherwise based on~~ the 2004 U.S. Department of Justice's Office on Violence Against Women publication "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," ~~subsequent updated editions, or similarly comprehensive and authoritative protocols developed after 2010~~**for youth who have reached puberty**. **The protocol shall detail policies and procedures for mandatory reporting, consent to treatment, parental notification, and scope of confidentiality in accordance with applicable laws.**

. . .

(d) The agency shall make available to the victim a ~~qualified staff member or a~~ victim advocate from a community-based organization that provides services to sexual assault victims. **If no victim advocate can be made available, the agency shall provide the victim with a similarly qualified staff member as a last resort.**

(e) As requested by the victim, the ~~qualified staff member or~~ victim advocate **or qualified staff member** shall accompany and support the victim through the forensic medical exam process and the investigatory process**, help identify the victim's primary concerns, develop a safety plan where appropriate,** and ~~shall~~ provide emotional support, crisis intervention, information, and referrals.

. . .

(h) For the purposes of this standard, a qualified staff member shall be an individual who is employed by a facility**;** ~~and~~ has received ~~education concerning sexual assault and forensic examination issues in general~~**40 hours of training and certification from a certified victim advocate or sexual assault crisis center, focusing on how to respond to the medical, legal, developmental, and mental health needs of young sexual assault victims; is provided with support and opportunities to debrief with experts in the field of victim advocacy; and has received education concerning confidentiality rules as they apply to staff members serving in this role. Staff members who are selected or who volunteer to work with youth in this capacity shall demonstrate a nonjudgmental and supportive attitude toward sexual assault victims and strong interpersonal and communication skills, with a focus on empathy.**

(g) The agency shall ensure that qualified staff members are available to provide sufficient round-the-clock coverage.

§ 115.322 – Agreements with outside public entities and community service providers

ISSUE: This draft regulation and various others exclusively address sexual abuse, but should also address sexual harassment in order to clarify the responsibilities of all involved and better protect the safety of residents.

Proposed Revisions:

. . .

(b) The agency also shall maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with emotional support services related to sexual abuse **and sexual harassment**, including helping resident sexual abuse **and sexual harassment** victims during community re-entry, unless the agency is legally required to provide such services to all residents.

. . . .

§ 115.323 – Policies to ensure investigation of allegations

ISSUE: The draft regulation does not discuss coordinating investigations of sexual misconduct with child protective services or police entities responsible for investigating child abuse. When facilities fail to define roles and procedures in these situations, child abuse allegations may not be investigated and internal investigations may be delayed far too long pending another agency's investigation. Our proposed changes require that facilities coordinate with these entities to ensure effective collaboration and timely resolution of investigations.

The draft regulation instructs agencies to identify the entity with the legal authority to conduct criminal investigations of sexual misconduct. However, many cases of alleged sexual abuse and some conduct defined in the draft regulations as sexual harassment will also trigger child abuse investigations by a state or local entity. We find that many juvenile agencies have not fully defined lines of responsibility between law enforcement agencies responsible for criminal investigations, child protective agencies that may be responsible for child abuse investigations, and internal investigative bodies responsible to complete investigations into violations of the agency's rules and policies. The lack of clearly defined roles and procedures means that sometimes reported child abuse allegations are not investigated, sometimes internal investigations are delayed far too long awaiting the resolution of other agencies' investigations, or one group's approach to collection of evidence or statements can hinder the other's investigation.

The draft regulation as written does not clearly require an agency to establish well-defined responsibilities for the three types of bodies that may have overlapping investigative responsibilities. The regulation should require that facilities coordinate with child abuse investigative bodies and law enforcement agencies so that staff understand the actions they should take and can collaborate effectively with other agencies to ensure timely resolution of all investigations. This type of coordination is essential to ensure a full and timely investigation of alleged misconduct. The language proposed below addresses this issue.

Proposed Revisions:

(a) The agency shall have in place a policy to ensure that allegations of sexual abuse or sexual harassment are investigated by an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior, and shall publish such policy on its website.

(b) If a separate entity is responsible for conducting criminal investigations, such website publication shall describe the responsibilities of both the agency and the investigating entity.

(c) Any State entity responsible for conducting criminal or administrative investigations of sexual abuse **and/or sexual harassment** in juvenile facilities shall have in place a policy governing the conduct of such investigations.

(d) The agency shall coordinate internal investigations of alleged sexual abuse and sexual harassment with any investigations by child protective services, law enforcement, or other entity charged with investigating alleged child abuse. The agency shall work to establish an understanding between investigative bodies with overlapping responsibilities to investigate allegations of sexual abuse at the facility so that staff have a clear understanding of their roles in evidence collection, interviewing, taking statements, preserving scenes of crimes, and investigative responsibilities that require clarification.

~~(d)~~**(e)** Any Department of Justice component responsible for conducting criminal or administrative investigations of sexual abuse **and/or sexual harassment** in juvenile facilities shall have in place a policy governing the conduct of such investigations.

§ 115.331 – Employee training

SUPPORT FOR CHANGES TO THIS REGULATION: We are pleased to see that paragraph (a)(9) of this proposed regulation requires employee training to include "how to communicate effectively and professionally with residents including lesbian, gay, bisexual, transgender, or intersex residents." If staff members are unable to communicate effectively and professionally with LGBTI residents, these youth may be afraid to approach staff when they are threatened with or subjected to abuse out of fear that staff will mistreat them, blame them for the abuse, or not believe them. Moreover, without this training, staff may not be equipped to detect when LGBTI residents are at risk of sexual abuse and, thus, prevent it. As BJS studies indicate, non-heterosexual residents are at very high risk of sexual abuse in facilities, underscoring the immediate need for training focused on raising competency in this area. Unfortunately, few facilities currently train staff on this topic. Including a requirement to educate staff on effective and professional communication with LGBTI residents in these regulations will help decrease the unacceptably high levels of sexual abuse that LGBTI youth experience.

ISSUE: The draft regulation does not provide sufficient guidance on the particular vulnerabilities and needs of young people, nor does it take into account the unique considerations of specific populations of youth. The regulation should expand the issues included in employee training to include topics such as adolescent sexual development, gender specific responses to trauma, and age of consent laws. This will ensure that facility staff are well equipped to appropriately respond to and protect youth from sexual abuse.

While we commend the Department's recognition of the importance of training all employees working with youth about the threat of sexual abuse in confinement and residents' rights to be free from abuse and retaliation from reporting, the catch-all phrase in § 115.331(b) provides insufficient guidance for agencies on the unique needs of juveniles. The regulation should explicitly describe the particular vulnerabilities and needs of young people, taking into account the unique considerations of specific populations of young people, and the harms associated with sexual abuse of children. Accordingly, we encourage the Department to add the text highlighted below to the list of topics that should be covered in staff trainings in all facilities that house young people.

Proposed Revisions:

(a) The agency shall train all employees who may have contact with residents on:

(1) Its zero-tolerance policy for sexual abuse and sexual harassment;

(2) How to fulfill their responsibilities under agency sexual abuse **and sexual harassment** prevention, detection, reporting, and response policies and procedures;
(3) Residents' right to be free from sexual abuse and sexual harassment;
(4) The right of residents and employees to be free from retaliation for reporting sexual abuse **and sexual harassment**;
(5) The dynamics of sexual abuse **and sexual harassment** in juvenile facilities;
(6) The factors that make youth vulnerable to sexual abuse and sexual harassment;
(7) Adolescent development for girls and boys, including what is normative sexual behavior for adolescents, what is acceptable behavior of adolescents, how to distinguish between normative adolescent behavior and sexually aggressive and dangerous behaviors, and the ways in which sexual victimization can affect healthy development;
(8) The prevalence of trauma and abuse histories among youth in juvenile justice facilities, possible behaviors of youth with trauma and abuse histories, and appropriate gender specific ways of responding to those behaviors;
~~(6)~~**(9)** The common reactions of juvenile victims of sexual abuse **and sexual harassment**;
~~(7)~~**(10)** How to detect and respond to signs of threatened and actual sexual abuse **and sexual harassment**;
(11) How to handle disclosures of victimization by youth in a sensitive manner;
~~(8)~~**(12)** How to avoid inappropriate relationships with residents;
~~(9)~~**(13)** How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, **gender nonconforming,** or intersex residents;
(14) How to communicate effectively and professionally with residents who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as residents who have limited reading skills, learning disabilities, or cognitive or emotional limitations; and
~~(10)~~**(15)** Relevant laws related to mandatory reporting **and age of consent**.

(b) Such training shall be tailored to the unique needs and attributes of residents of juvenile facilities, **including the needs of specific populations of youth (e.g., gender, race, ethnicity, sexual orientation, gender identity, disability, or youth with limited English proficiency).**

(c) All current employees who have not received such training shall be trained within one year of the effective date of the PREA standards, and the agency shall provide

annual refresher information to all employees to ensure that they know the agency's current sexual abuse **and sexual harassment** policies and procedures.

(d) The agency shall document, via employee signature or electronic verification, that employees understand the training they have received.

§ 115.332 – Volunteer and contractor training

ISSUE: This draft regulation and various others exclusively address sexual abuse, but should also address sexual harassment in order to clarify the responsibilities of all involved and better protect the safety of residents.

Proposed revisions:

(a) The agency shall ensure that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse **and sexual harassment** prevention, detection, and response policies and procedures.

. . . .

§ 115.333 – Resident education

ISSUE 1: The draft regulation fails to acknowledge the impact that differing developmental levels among juveniles can have on a facility's delivery of comprehensive education to residents. The final regulation should require that resident education be delivered in a developmentally appropriate manner to ensure that the material is accessible and understood by youth. Additionally, instruction on what constitutes sexual abuse and harassment is a critical component of developmentally-appropriate resident education and should be explicitly included in the final regulation.

In order to ensure that educational materials are accessible and actually capable of being understood by all youth, the final regulation should recognize the diverse range of cognitive and emotional development levels of juveniles within a facility. An individual youth's level of development cannot be determined by a single trait such as age, as adolescents of the same chronological age may differ greatly in their level of cognitive, emotional, or physical development.[24] An adolescent's level of development impacts his or her ability to understand educational material and new concepts, and should dictate the appropriate method for imparting such information. We therefore encourage the Department to require that resident education be delivered in a *developmentally-appropriate* fashion instead of an *age-appropriate* fashion.

Instruction on what constitutes sexual abuse and sexual harassment is a critically important and developmentally-appropriate component of resident education that is missing from the draft regulation. Children may not understand what types of behavior are actually prohibited, often need guidance on determining whether conduct is inappropriate, and may require in-depth explanations of what qualifies as abuse or harassment. Concrete examples of inappropriate conduct, behaviors, or language should be included in resident education in order to better prepare youth in protecting themselves from potential abuse. Youth who have experienced sexual abuse or harassment in the past may be particularly in need of guidance about the type of conduct from which they are entitled to receive protection, as their frame of reference may be skewed as a result of trauma suffered previously.

[24] Jennifer Woolard, *Toward Developmentally Appropriate Practice: A Juvenile Court Training Curriculum, Module 1: Adolescent Development,* MacArthur Foundation, Models for Change (2009).

ISSUE 2: The draft regulation allows too much time to pass before juvenile residents must receive comprehensive education regarding their rights and agency sexual abuse and harassment policies and procedures. Because this education is critical in arming youth with knowledge and strategies to protect themselves from sexual abuse, residents should receive such education no later than 10 days following intake.

Allowing up to 30 days to pass before a juvenile is educated about his or her rights regarding sexual abuse and a facility's response policies and procedures fails to acknowledge the especially vulnerable position of incarcerated young people. The earlier that agencies arm youth with knowledge of their rights and the facility's sexual abuse and harassment rules and procedures, the safer juvenile residents will be. Because intake can be an overwhelming time when youth are exposed to a large amount of new information, an introductory explanation of a facility's zero-tolerance policy and reporting procedures may be all the information residents are able to process at that time. However, the information pertaining to sexual abuse and harassment should be reinforced and expanded upon with a more comprehensive presentation and exploration of resident's rights and facility's policies and procedures much sooner after intake than the draft regulation currently provides. Accordingly, we recommend that agencies be required to provide comprehensive education to juveniles no more than ten days after intake.

There are inherent limitations associated with using video as a method of delivering comprehensive education to juveniles, as it does not allow for youth to be fully engaged, interact with an instructor, or ask questions. However, if the availability of comprehensive education via video allows for more immediate delivery, then the benefits of earlier implementation could outweigh the drawbacks associated with a non-interactive presentation.

Proposed Revisions:

(a) During the intake process, staff shall inform residents in ~~an age~~ **a developmentally**-appropriate fashion of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment.

(b) ~~Within 30 days of intake~~ **No more than ten (10) days following the intake process**, **either upon initial placement or when a resident is transferred from a different facility,** the agency shall provide comprehensive ~~age~~ **developmentally**-appropriate education to residents either in person or via video regarding their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such

abuse or harassment, ~~and~~ regarding agency sexual abuse **and sexual harassment** response policies and procedures~~.~~**, and including definitions and examples of prohibited and/or illegal behaviors that are considered sexual abuse or harassment, and examples of conduct, circumstances, and "red flags" that may be precursors to sexual abuse or harassment or which suggest sexual abuse or harassment is occurring.**

(c) Current residents who have not received such education shall be educated within one year of the effective date of the PREA standards, and the agency shall provide refresher information to all residents at least annually ~~and whenever a resident is transferred to a different facility,~~ to ensure that they know the agency's current sexual abuse **and sexual harassment** policies and procedures.

(d) The agency shall provide resident education in formats accessible **and capable of being understood by** all residents, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to residents who have limited reading skills.

. . . .

§ 115.334 – Specialized training: investigations

ISSUE: This draft regulation and various others exclusively address sexual abuse, but should also address sexual harassment in order to clarify the responsibilities of all involved and better protect the safety of residents.

Proposed revisions:

(a) In addition to the general training provided to all employees pursuant to § 115.331, the agency shall ensure that, to the extent the agency itself conducts sexual abuse **and sexual harassment** investigations, its investigators have received training in conducting such investigations in confinement settings.
(b) Specialized training shall include techniques for interviewing juvenile sexual abuse **and sexual harassment** victims, proper use of *Miranda* and *Garrity* warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral.
(c) The agency shall maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse **and sexual harassment** investigations.
(d) Any State entity or Department of Justice component that investigates sexual abuse **and sexual harassment** in juvenile confinement settings shall provide such training to its agents and investigators who conduct such investigations.

§ 115.335 – Specialized training: medical and mental health care

ISSUE: This draft regulation and various others exclusively address sexual abuse, but should also address sexual harassment in order to clarify the responsibilities of all involved and better protect the safety of residents.

Proposed Revisions:

(a) The agency shall ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in:

(1) How to detect and assess signs of sexual abuse **and sexual harassment**;

(2) How to preserve physical evidence of sexual abuse;

(3) How to respond effectively and professionally to juvenile victims of sexual abuse **and sexual harassment**; and

(4) How and to whom to report allegations or suspicions of sexual abuse **and sexual harassment**.

. . . .

§ 115.341 – Obtaining Information from residents

SUPPORT FOR CHANGES TO THIS REGULATION: We are pleased to see that the Commission's recommendation that facilities encourage all residents during intake to tell staff if they fear being abused is included in the draft regulations' list of information staff are required to ascertain during the assessment. Knowing this information will help agencies to better identify vulnerable youth, develop an appropriate safety plan, and protect youth who fear for their safety – including LGBTI residents who fear for their safety but are uncomfortable identifying themselves as LGBTI to facility staff – before they are subjected to any actual abuse.

ISSUE 1: Unlike the Commission's standards, the Department's draft regulation no longer states that medical or mental health providers are the only staff who are permitted to talk with residents to gather information about sensitive issues during the screening process. The draft regulation allows intake and security staff to ask these sensitive questions, but these staff may not have the appropriate level of training to do so effectively and respectfully. We propose that the Department adopt the Commission's approach to obtaining sensitive information from residents for facilities where medical or mental health practitioners conduct assessments during intake.

In the standards drafted by the Commission, medical and mental health professionals were assigned the responsibility for asking youth about sensitive information such as their sexual orientation and history of victimization. The draft regulation does not state who should gather this sensitive information during the intake and classification process. It is important to have trained professionals asking residents such sensitive questions, in order to both increase the likelihood that residents will share this important information and decrease the likelihood that they will be traumatized in the process. We encourage the Department to adopt the Commission's approach for questioning residents in these sensitive areas in facilities that have medical or mental health practitioners conduct health assessments during the intake and classification process.

We agree with the Department's approach for handling conversations about a youth's history of engaging in victimization of others. Helping professionals such as medical and mental health staff should not be in the position of questioning youth about prior crimes. Because that information is generally available in other types of records, we do not encourage the Department to adopt the Commission's approach to questioning youth about their histories of committing abuse.

ISSUE 2: The draft regulation fails to include gender nonconforming appearance as one of the pieces of information agencies should attempt to ascertain during assessment of residents. Gender nonconforming residents are often perceived to be LGBTI and are therefore also at risk of sexual abuse. The final regulation should include this information.

Residents who are gender nonconforming are often targeted for sexual abuse and harassment based solely on the fact that other residents or staff perceive them to be LGBTI, even if these residents are not actually LGBTI. In our experience, gender nonconforming youth who are perceived as LGBTI are at just as high risk of sexual abuse as youth who are LGBTI (gender nonconforming or not). Thus, we recommend that this regulation explicitly include gathering information about gender nonconforming appearance. Without this addition, many youth who are vulnerable to sexual abuse may not be identified as such during assessment.

ISSUE 3: The draft regulation instructs agencies to attempt to ascertain information about youth during the intake process using "an objective screening instrument." The state of the research in juvenile justice today does not support creation of an "objective screening instrument." There is no research to support a tool that could predict risk of sexual victimization or sexual offending behavior in adolescents, or one that could differentiate between levels of sexual abuse or victimization risk. Perhaps the Department meant to instruct agencies to use a standardized set of questions for all youth passing through the intake process. We propose changing the term to "standardized information gathering list" to avoid any potential confusion. We also suggest that the Department engage in and support the research necessary to develop a predictive instrument in the future, as the usefulness of gathering the information without knowing its predictive value is limited and has the potential for misuse.

The draft regulation instructs agencies to attempt to ascertain a host of different information about youth during the intake process using "an objective screening instrument." Perhaps by using the term "objective," the Department simply meant to instruct agencies to use a standardized set of questions for all youth passing through the intake process. However, professionals familiar with assessment and screening impute a different meaning into the term "objective." For those individuals, "objective screening instrument" means a tool that has been validated and that determines different levels of risk of being victimized or engaging in sexual abuse.[25] We know of no validated objective screening instrument that assesses a resident's risk of engaging in sexual abuse or being victimized. Furthermore, the state of research today does not support creation of such an instrument.[26] In addition, it is unlikely that one tool would be

[25] Email from Gina Vincent to Dana Shoenberg, March 31, 2011; Email from Tom Grisso to Dana Shoenberg, March 31, 2011.
[26] *Id.*; Email from Barry Krisberg to Dana Shoenberg, March 2, 2011.

able to identify both youth at risk of victimization and risk of victimizing others. Two tools will be necessary.[27] To avoid potential confusion, we recommend that the Department reword the language in the final regulation according to the revisions below. We also encourage the Department to engage in and support the research necessary to develop such tools in the future.

Proposed Revisions:

(a) During the intake process and periodically throughout a resident's confinement, the agency shall obtain and use information about each resident's personal history and behavior to reduce the risk of sexual abuse **and sexual harassment** by or upon a resident.

(b) Such ~~assessment shall be conducted~~ **information shall be gathered** using **a standardized information gathering list,** ~~an objective screening instrument,~~ blank copies of which shall be made available to the public upon request.

(c) At a minimum, the agency shall attempt to ascertain information about:

(1) Prior sexual victimization or abusiveness;

(2) Sexual orientation, transgender, ~~or~~ intersex status, **or gender nonconforming appearance**;

. . .

(d) This information shall be ascertained through conversations with residents during the intake process and medical and mental health screenings; during classification assessments; and by reviewing court records, case files, facility behavioral records, and other relevant documentation from the residents' files. **In facilities where medical and mental health practitioners conduct medical and mental health screenings during the intake process, these practitioners, and not other facility staff, should ask residents information about their sexual orientation or gender identity, prior sexual victimization, mental health status, intersex condition, or mental or physical disabilities.**

(e) The agency shall implement appropriate controls on the dissemination of ~~responses to screening questions~~ **information gathered through this process** ~~within the facility~~ in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents.

[27] Email from Gina Vincent, *supra* note 25.

§ 115.342 – Placement of residents in housing, bed, program, education, and work assignments

SUPPORT FOR CHANGES TO THIS REGULATION: We are pleased that the Department added paragraph (d) to this regulation, prohibiting agencies from placing LGBTI residents in particular housing, bed, or other assignments solely on the basis of such identification or status. Without such a prohibition facilities could automatically place all LGBTI residents in segregated housing or in isolation, depriving them of access to rehabilitative programming.

Individualized placement determinations are particularly important for ensuring the physical and emotional safety of LGBTI residents. Unfortunately, many juvenile facilities segregate or isolate all LGBTI youth for their own protection, presumably because it is easier for the facility to keep LGBTI youth in isolation than it would be to address the sexual violence that these youth would likely face in the general population. This practice essentially punishes LGBTI youth because they may be victimized by others and denies them access to the same privileges and programs as other residents. Prohibiting facilities from making placement determinations for LGBTI residents based solely on their LGBTI identification is necessary in order to ensure that LGBTI residents are not automatically placed in segregated units, in isolation, or worse, in sex offender units as sometimes occurs.

Even when purportedly for their own protection, the involuntary segregation of LGBTI residents in special units or in administrative segregation denies these youth access to programs, services and an ability to move around the facility in ways to which they may otherwise be entitled, and thus amounts to punishment. Punishing residents for their vulnerable status is unjust and harmful, is contrary to the rehabilitative purpose of the juvenile justice system, promotes bias against LGBTI residents, and discourages honest responses to screening questions. As the Commission recognized, "housing assignments based solely on a person's sexual orientation, gender identity, or genital status… can lead to labeling that is both demoralizing and dangerous."[28] Paragraph (d) of this regulation will go a long way in helping to prevent this from happening.

ISSUE 1: While studies indicate that LGBTI residents are at high risk of sexual abuse, the draft regulation fails to clarify that being LGBTI makes a resident more vulnerable to abuse but not more likely to be abusive towards others. Without such a statement facilities may wrongly treat LGBTI status as an indication of potential sexual abusiveness based on bias or misconceptions.

[28] National Prison Rape Elimination Commission, *Report*, *supra* note 1, at 80.

Without a clear statement that LGBTI residents are at high risk of sexual abuse, the regulations will allow facilities that lack understanding of LGBTI residents to consider LGBTI status an indicator of potential abusiveness. At this time, unlike in the adult prison and jail contexts, there are no comprehensive studies identifying the characteristics of youth who are at greatest risk of being victimized in juvenile facilities. Nevertheless, the Commission has identified some characteristics, including being LGBTI, that are often associated with higher vulnerability to sexual abuse.

The 2009 BJS study of sexual victimization reported by youth, released after the publication of the Commission's standards, highlights the heightened vulnerability for LGBTI youth. The BJS survey found that more than one in five non-heterosexual youth reported sexual victimization involving another youth or facility staff.[29] Non-heterosexual youth were almost ten times as likely as heterosexual youth to have reported abuse by other residents while in custody (12.5 percent vs. 1.3 percent).[30] While the BJS survey did not ask about gender identity, the Commission found that transgender girls are particularly vulnerable to abuse, especially when housed with boys.[31] This danger is starkly illustrated by the testimony before the Commission of Cyryna Pasion, a transgender girl, who, after being transferred from the girls' unit to a boys' unit at the Hawaii Youth Correctional Facility, was sexually harassed, abused, and threatened with rape on an almost daily basis.[32]

In addition, a fall 2009 report by The Equity Project found that professionals throughout the juvenile justice system routinely stereotype LGBTI youth as sexual predators, rather than as youth who are vulnerable to sexual abuse.[33] Yet, unlike the regulation for Adult Prisons and Jails, the regulation for juvenile facilities does not state that identification as lesbian, gay, bisexual, transgender, or intersex is an indicator for risk of sexual victimization. We recommend that, as in the adult regulations, this regulation explicitly state that LGBTI identification is an indicator of heightened risk of victimization.

ISSUE 2: This draft regulation fails to include gender nonconforming appearance as one of the pieces of information agencies must take into account when determining housing, bed, program, education, and work assignments for residents.

[29] Allen J. Beck et al., *supra* note 6.
[30] *Id*. (Twelve percent of the youth in the study reported a sexual orientation other than heterosexual.)
[31] National Prison Rape Elimination Commission, Report, *supra* note 1, at 18.
[32] *Elimination of Prison Rape: Focus on Juveniles*, *Hearing Before the National Prison Rape Elimination Commission* (June 1, 2006) (testimony of Cyryna Pasion).
[33] The Equity Project, *Hidden Injustice: Lesbian, Gay, Bisexual and Transgender Youth in Juvenile Courts* 104-106 (2009), *available at*http://www.equityproject.org/pdfs/hidden_injustice.pdf.

As discussed above, residents who are gender nonconforming are often targeted for sexual abuse and harassment based solely on the fact that other residents or staff perceive them to be LGBTI, even if these residents are not actually LGBTI. We recommend that this regulation require facilities to consider information about gender nonconformity when determining housing and other assignments for residents. Without this addition, many youth who do not identify as LGBTI but who are vulnerable to sexual abuse because of others' perceptions of them may not have this vulnerability taken into account when determining housing assignments.

ISSUE 3: The draft regulation does not provide sufficient guidance to agencies to make determinations for housing transgender or intersex residents and fails to include consideration of the resident's views of his or her own safety. Many facilities struggle with appropriate housing options for these residents and will solely look to the resident's genital status. Transgender and intersex residents are vulnerable to sexual abuse if their safety needs are not considered in housing determinations. This regulation should include specific guidance for facilities on what to consider when assigning a transgender or intersex resident to a facility or unit for male or female residents.

The Commission's report "strongly urge[s] agencies to give careful thought and consideration to the placement of each transgender [individual] and not to automatically place transgender individuals in male or female housing based on their birth gender or current genital status."[34] In addition, a transgender or intersex resident's view as to where he or she will be most safe should be considered in all placement determinations for that resident. The draft regulation on this topic for Adult Prisons and Jails provides better guidance and protections for transgender and intersex individuals than do the juvenile regulations. Because inappropriate placements of transgender and intersex residents greatly increases such youth's risk of victimization, this regulation should provide additional guidance to agencies on what to consider when making an individualized determination as to whether a transgender or intersex resident will be housed in a boys' or girls' facility or living unit.

ISSUE 4: Under the draft regulations, facilities may isolate youth in their efforts to eliminate sexual abuse and violence. The final regulations should not permit jurisdictions to use extended isolation to protect youth, thus relying on one dangerous practice in an attempt to eliminate another. The final regulation should explicitly limit isolation to no more than 72 hours and ensure that youth enjoy the same privileges as other residents if they are isolated for safety reasons.

The final regulation must do more to highlight the dangers associated with isolation and clarify a facility's responsibility to keep children safe without resorting to that practice. Isolation is particularly harmful to youth for a number of reasons. Even short periods of isolation can have

[34] National Prison Rape Elimination Commission, Report, *supra* note 1, at 74.

particularly negative consequences for youth, including raising the risk of suicide[35] and exacerbating emotional and mental health needs. Isolating a youth who may have been a recent victim of sexual abuse adds these negative effects to an already traumatic experience. Additionally, isolation deprives youth of programming designed to support their rehabilitation, such as educational services.[36] Isolating residents who may be at risk of victimization has the effect of singling those youth out for punishment based solely on safety concerns.

By limiting isolation to a maximum of 72 hours, the final regulations will place a limit on the negative consequences of this practice for youth in secure facilities, providing adequate time for facilities to make other arrangements to hold youth if they cannot be kept safe without extended isolation. By requiring that victimized youth enjoy the same privileges as other residents, the final regulations will also avoid punishing youth based on their risk of victimization.

Additionally, in the draft regulations for adult prisons and jails, the Department requires agencies to follow a number of steps before and after placing an inmate in protective custody. These include:

- requiring documentation of the basis for the agency's decision to place an inmate in protective custody for safety reasons;
- requiring documentation of the reason why the agency could not utilize less restrictive alternatives; and
- periodically reviewing whether an inmate continues to require protective custody to preserve his or her safety.[37]

These documentation and review requirements are designed to ensure that facilities only resort to isolation as a last resort. Yet, the Department has only included these protections in the regulations governing adult inmates in jails and prisons. Thus, the draft adult regulations actually afford greater protections to adult inmates than youth in juvenile justice facilities, despite the serious harms that isolation imposes upon youth.

Documentation and reporting requirements should be required in the juvenile facility regulations as well. These requirements will provide agencies and the Department with

[35] Lindsay M. Hayes, National Center on Institutions and Alternatives, *Juvenile Suicide in Confinement: A National Survey*, Office of Juvenile Justice and Delinquency Prevention (2009), *available at* http://www.ncjrs.gov/pdffiles1/ojjdp/213691.pdf (describing a "strong relationship between juvenile suicide and room confinement").

[36] Michael Puisis, Ed., Clinical Practice in Correctional Medicine139 (2006) (noting that "[v]arious activities, positive relationships between staff and youth, individual attention, and accessible counseling are all aspects of the general program that help stabilize youth…").

[37] *See* § 115.43(c)-(d).

valuable data, including tracking use of protective isolation so that facilities that may be employing isolation too readily in response to the final PREA regulations may be identified. These data may also assist the Department and other organizations in providing guidance and technical assistance to jurisdictions to help them reduce the use of isolation.

Our proposed language below adapts the requirements from the adult prison and jail protective custody provision for use in the juvenile regulations.

ISSUE 5: The state of the research in juvenile justice today does not support creation of a validated "objective screening instrument" that assesses a resident's risk of engaging in sexual abuse or being victimized. The regulation should therefore not refer to an objective screening instrument.

Proposed Revisions:

(a) The agency shall use all information obtained about the resident during the intake process and subsequently to make placement decisions for each resident ~~based upon the objective screening instrument~~ with the goal of keeping all residents safe and free from sexual abuse **and sexual harassment**.

(b) When determining housing, bed, program, education and work assignments for residents, the agency must take into account:

(1) A resident's age;

(2) The nature of his or her offense;

(3) Any mental or physical disability or mental illness;

(4) Any history of sexual victimization or engaging in sexual abuse **or sexual harassment**;

(5) His or her level of emotional and cognitive development;

(6) His or her **gender nonconforming appearance or** identification as lesbian, gay, bisexual, transgender, or intersex **(LGBTI)**; ~~and~~

(7) **The increased likelihood of sexual victimization for LGBTI and gender nonconforming residents; and**

~~(7)~~**(8)**Any other information obtained about the resident pursuant to § 115.341.

(c) Residents may be isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged. **Residents may not be isolated for a continuous period of more than 72 hours.**

(1) To "isolate" a resident means to confine the resident alone in a room, cell, or area of the facility.

(2) In addition to the other protections outlined in this regulation, facilities shall ensure that residents who are isolated receive the following:

- **(i) regular access to facility staff;**
- **(ii) access to facility administrators, upon request;**
- **(iii) unimpeded access to health and mental health services;**
- **(iv) full meals and evening snacks;**
- **(v) a full complement of clean clothes and linens;**
- **(vi) access to showers, toilets, drinking water, and hygiene products;**
- **(vii) access to visits by family members and caregivers;**
- **(viii) access to attorneys;**
- **(ix) access to telephone and mail;**
- **(x) an opportunity for at least one hour of large muscle exercise outside of his or her room;**
- **(xi) educational services that are comparable to those received by other residents;**
- **(xii) an opportunity to attend religious services and/or obtain religious counseling of the youth's choice; and**
- **(xiii) an opportunity to participate in other programming at the facility, such as recreational activities.**

(3) If an agency isolates a resident according to this provision, it shall:

- **(i) Document the basis for the agency's decision;**
- **(ii) Document the reason(s) why no alternative, less restrictive measures can be arranged for that particular resident;**
- **(iii) Review whether there is a continuing need for isolation every 24 hours and document the reason for ongoing isolation; and**
- **(iv) Ensure that a mental health professional meets with the resident at least every 24 hours and document that the meetings occurred.**

(d) Lesbian, gay, bisexual, transgender, or intersex residents shall not be placed in particular housing, bed, or other assignments solely on the basis of such identification or status**, nor shall** a**gencies consider LGBTI status as an indicator of likelihood of being sexually abusive.**

(e) The agency shall make an individualized determination about whether a transgender **or intersex resident** should be housed with males or with females. **Such determination shall not be based solely on the resident's genital status or birth gender. In deciding whether to assign a transgender or intersex resident to a facility or unit for male or**

female residents, and in making other housing and programming assignments, the agency shall consider on a case-by-case basis whether the placement would ensure the resident's health and safety. Transgender and intersex residents' own views with respect to their own safety shall be given serious consideration.
(f) Placement and programming assignments for transgender and intersex residents shall be reassessed at least twice each year to review any threats to safety experienced by the resident.

§ 115.351 – Resident reporting

ISSUE: This draft regulation and various others exclusively address sexual abuse, but should also address sexual harassment in order to clarify the responsibilities of all involved and better protect the safety of residents.

Proposed Revisions:

(a) The agency shall provide multiple internal ways for residents to privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse **or sexual harassment**.

. . . .

§ 115.352 – Exhaustion of administrative remedies

Question 24: Because the Department's proposed standard addressing administrative remedies differs substantially from the Commission's draft, the Department specifically encourages comments on all aspects of this proposed standard.

ISSUE 1: By imposing identical grievance timelines for adult and juvenile facilities, the draft regulation ignores important developmental differences between adults and youth, including the unique effects of trauma, shame, and fear on young victims that contribute to a child's hesitancy to report abuse or to use a facility's grievance system. The narrow timeframe not only prevents young victims from being protected through the administrative process, it also unreasonably restricts their ability to bring valid legal claims seeking protection through the courts. We propose incorporating the Commission's recommendations, which would consider administrative remedies exhausted 90 days after reporting sexual abuse, regardless of the time that has elapsed between the abuse and the report; or 48 hours after reporting abuse in an emergency situation requiring immediate protection from imminent harm. In the alternative, we propose altering the timelines in the final regulation to take into account the myriad barriers to immediate reporting by young victims. We also propose a shorter timeline for investigation, recognizing that youth generally do not stay in secure facilities as long as adults.

By proposing identical grievance timelines for adult and juvenile facilities, the draft regulation ignores the significant differences between adult and juvenile victims of sexual abuse. It is often difficult for young people to understand their rights as entitlements that they can exercise without adverse consequences; they are more likely than adults to acquiesce to authority figures rather than assert those rights.[38] Abusers often convince young victims that if they reveal the abuse, they will get in trouble or other harm might come to them or someone they care about.

Trauma-related stress and other factors may act as barriers to immediate reporting. Child victims may feel guilt, shame, and confusion if the perpetrator is someone the victim has become close to, or if the victim experienced physical pleasure during coerced sexual activity. LGBTI youth may fear that if they report sexual abuse by another resident, staff will assume the abuse was consensual on account of their sexual orientation or gender identity, and that they will be punished for engaging in sexual activity. LGBTI youth who have not yet disclosed their sexual orientation or gender identity may also fear that reporting abuse may reveal that information to families and peers. Other youth may fear being labeled gay or lesbian if they report being victimized by someone of the same gender.

[38] Barry C. Feld, *Police Interrogation of Juveniles: An Empirical Study of Policy and Practice*, 97 J. Crim. L. & Criminology 219, 229-30 (2006).

Policies that require youth to navigate complicated grievance procedures shortly after the abuse can lead to the dismissal of victims' valid legal claims. Residents who fail to file a grievance within the short window of time provided in the draft regulation may be permanently barred from court for failing to exhaust administrative remedies under the Prison Litigation Reform Act. Providing such a narrow timeframe for young victims to report abuse not only fails to recognize the differences between adolescents and adults, it also fails to advance PREA's goals. Additionally, because youth are generally not held in juvenile facilities for extended periods of time compared with adult inmates, the timelines for the agency to investigate and issue decisions regarding allegations are too long.

The revisions below propose either instituting the recommendations of Commission on exhaustion of administrative remedies, or altering the timelines in the draft regulation to take into account the many barriers to immediate reporting by young victims as well as their shorter lengths of stay. The Commission's recommendations would consider administrative remedies exhausted 90 days after reporting sexual abuse, regardless of the time that has elapsed between the abuse and the report; or 48 hours after reporting abuse in an emergency situation requiring immediate protection from imminent harm.[39] In the alternative, we recommend altering the timeline in the final regulation to permit all youth 180 days to report abuse, and to require a facility to issue a decision on the merits of the grievance within 30 days.

ISSUE 2: The draft regulation imposes an unreasonable barrier to extending the time for filing a grievance by requiring juvenile residents to "provide[] documentation" that demonstrates that filing a grievance in the normal time period would have been impractical. Expecting youth to secure these materials is unrealistic. Moreover, all reports of sexual abuse should trigger protective responses by the agency regardless of the time that has elapsed between the abuse and the report. In the alternative, we propose incorporating the Commission's recommendations, which would impose no time limit for young victims to report abuse; or requiring the agency to determine the impracticality of filing a grievance within the normal time limit by consulting with the resident and medical and mental health practitioners.

The draft regulation requires residents to provide documentation showing the impracticality of filing a grievance within the normal timeframe in order to be granted an extension. Such a requirement is particularly harmful for two reasons. First, all reports of sexual abuse should trigger responses by the agency to investigate, treat, and protect alleged victims, regardless of the time that has elapsed between the abuse and the report. Second, expecting a traumatized youth to successfully secure these materials is unrealistic, and it creates an unreasonable barrier to seeking help through administrative and legal processes.

[39] National Prison Rape Elimination Commission, Standards, *supra* note 4, at 23-33.

Adopting the Commission's standards, which impose no time limit for young victims to report abuse, would further the goals of PREA without creating unreasonable barriers to reporting by young victims.[40] Alternatively, we propose requiring the agency to consult with the resident and medical and mental health practitioners to determine whether filing a grievance within the normal time limit was or would likely be impractical.

ISSUE 3: As written, the draft regulation permits agencies to punish youth who report sexual abuse and reasonably believe that an emergency exists if the agency ultimately disagrees with the youth's assessment. This vague language will serve as a disincentive to reporting. The final regulation should permit punishment only when two conditions are met: (1) a resident had no basis to believe that an emergency existed; and (2) the resident filed the report with the intent to deceive.

As written, the draft regulation contains vague language that may act as a disincentive to reporting abuse. Specifically, it provides that "[a]n agency may discipline a resident for intentionally filing an emergency grievance where no emergency exists." Youth may reasonably believe that an emergency exists even where the agency determines that the situation is not an emergency. Further, a youth's assessment may vary depending on mental health, exposure to trauma, and other relevant surrounding circumstances. Accordingly, the Department should amend the provision to permit disciplinary action only when two conditions are met: (1) the youth filed an emergency grievance without any basis to believe than an emergency existed; and (2) the youth filed the grievance with the intent to deceive.

Furthermore, young victims are often hesitant to report legitimate claims of abuse because they think that no one will believe them, particularly where it is their word against an adult perpetrator's word. Clarifying the vague language in the draft regulation, therefore, will reduce the likelihood that agency disciplinary rules will act as a disincentive to reporting legitimate claims of abuse.

ISSUE 4: The draft regulation requires agencies to permit parents and legal guardians to file grievances on behalf of their children. We propose expanding the list to include other family members and the youth's attorney or other legal advocates.

The draft regulations require agencies to establish procedures allowing parents and legal guardians to file grievances on behalf of residents. Because system-involved youth are frequently raised by grandparents or other family members, these family members should be added to the list of third parties who can file grievances on behalf of youth. In some instances, youth may feel uncomfortable discussing sexual abuse with family members, but may confide in

[40] *See id*.

their attorneys. Our proposed revisions require agencies to establish procedures that allow a youth's attorney or other legal advocate to file a grievance on the youth's behalf.

Proposed Revisions – Alternative 1:

~~(a)(1) The agency shall provide a resident a minimum of 20 days following the occurrence of an alleged incident of sexual abuse to file a grievance regarding such incident.~~

~~(2) The agency shall grant an extension of no less than 90 days from the deadline for filing such a grievance when the resident provides documentation, such as from a medical or mental health provider or counselor, that filing a grievance within the normal time limit was or would likely be impractical, whether due to physical or psychological trauma arising out of an incident of sexual abuse, the resident having been held for periods of time outside of the facility, or other circumstances indicating impracticality. Such an extension shall be afforded retroactively to a resident whose grievance is filed subsequent to the normal filing deadline.~~

~~(b)(1) The agency shall issue a final agency decision on the merits of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance.~~

~~(2) Computation of the 90-day time period shall not include time consumed by residents in appealing any adverse ruling.~~

~~(3) An agency may claim an extension of time to respond, of up to 70 days, if the normal time period for response is insufficient to make an appropriate decision.~~

~~(4) The agency shall notify the resident in writing of any such extension and provide a date by which a decision will be made.~~

(a) Under agency policy, a resident has exhausted his or her administrative remedies with regard to a claim of sexual abuse or sexual harassment either:

(1) when the agency makes a final decision on the merits of the report of abuse or harassment, regardless of whether the report was made by the resident, made by a third party, or forwarded from an outside official or office; or

(2) when 90 days have passed since the report was made, whichever occurs sooner.

(b) A report of sexual abuse or sexual harassment triggers the 90-day exhaustion period regardless of the length of time that has passed between the abuse and the report.

(c) A resident seeking immediate protection from imminent sexual abuse under [renumbered paragraph (e)] below will be deemed to have exhausted his or her administrative remedies 48 hours after notifying any agency staff member of his or her need for protection.

~~(c)~~**(d)**(1) Whenever an agency is notified of an allegation that a resident has been sexually abused **or sexually harassed**, other than by notification from another resident, it shall consider such notification as a grievance or request for informal resolution submitted on behalf of the alleged resident victim for purposes of initiating the agency administrative remedy process.

. . .

(4) The agency shall also establish procedures to allow the parent**,** ~~or~~ legal guardian**, family member, attorney, or other legal advocate** of a juvenile to file a grievance regarding allegations of sexual abuse **or sexual harassment**, including appeals, on behalf of such juvenile. **Parents, legal guardians, and family members shall have the opportunity to communicate with the resident through visitation, telephone, and mail; the ability to meaningfully participate in decisions made about the resident's treatment and safety; and the ability to speak with the child's victim advocate.**

~~(d)~~**(e)**(1) An agency shall establish procedures for the filing of an emergency grievance where a resident is subject to a substantial risk of imminent sexual abuse.

(2) After receiving such an emergency grievance, the agency shall immediately forward it to a level of review at which corrective action may be taken, provide an initial response within 48 hours, and a final agency decision within five calendar days.

(3) The agency may opt not to take such actions if it determines that no emergency exists, in which case it may either:

(i) Process the grievance as a normal grievance; or

(ii) Return the grievance to the resident, and require the resident to follow the agency's normal grievance procedures.

(4) The agency shall provide a written explanation of why the grievance does not qualify as an emergency.

(5) An agency may **only** discipline a resident for ~~intentionally~~ filing an emergency grievance where ~~no emergency exists~~ **the agency establishes that the youth had no basis to believe that an emergency existed and that such grievance was filed with the intent to deceive.**

Proposed Revisions – Alternative 2:

(a)(1) The agency shall provide a resident a minimum of ~~20~~ **180** days following the occurrence of an alleged incident of sexual abuse **or sexual harassment** to file a grievance regarding such incident.

(2) The agency shall grant an extension of no less than 90 days from the deadline for filing such a grievance when ~~the resident provides documentation, such as from a medical or mental health provider or counselor~~ **it determines, in consultation with the resident and medical and mental health practitioners**, that filing a grievance within the normal time limit was or would likely be impractical, whether due to physical or psychological trauma arising out of an incident of sexual abuse **or sexual harassment**, the resident having been held for periods of time outside of the facility, or other circumstances indicating impracticality. Such an extension shall be afforded retroactively to a resident whose grievance is filed subsequent to the normal filing deadline.

(b)(1) The agency shall issue a final agency decision on the merits of a grievance alleging sexual abuse **or sexual harassment** within ~~90~~ **30** days of the initial filing of the grievance.

(2) Computation of the ~~90~~ **30**-day time period shall not include time consumed by residents in appealing any adverse ruling.

(3) An agency may claim an extension of time to respond, of up to ~~70~~ **30** days, if the normal time period for response is insufficient to make an appropriate decision.

(4) The agency shall notify the resident in writing of any such extension and provide a date by which a decision will be made.

(c)(1) Whenever an agency is notified of an allegation that a resident has been sexually abused **or sexually harassed**, other than by notification from another resident, it shall consider such notification as a grievance or request for informal resolution submitted on behalf of the alleged resident victim for purposes of initiating the agency administrative remedy process.

. . .

(4) The agency shall also establish procedures to allow the parent**,** ~~or~~ legal guardian**, family member, attorney, or other legal advocate** of a juvenile to file a grievance regarding allegations of sexual abuse **or sexual harassment**, including appeals, on behalf of such juvenile.

(d)(1) An agency shall establish procedures for the filing of an emergency grievance where a resident is subject to a substantial risk of imminent sexual abuse.

(2) After receiving such an emergency grievance, the agency shall immediately forward it to a level of review at which corrective action may be taken, provide an initial response within 48 hours, and a final agency decision within five calendar days.

(3) The agency may opt not to take such actions if it determines that no emergency exists, in which case it may either:

(i) Process the grievance as a normal grievance; or

(ii) Return the grievance to the resident, and require the resident to follow the agency's normal grievance procedures.

(4) The agency shall provide a written explanation of why the grievance does not qualify as an emergency.

(5) An agency may **only** discipline a resident for ~~intentionally~~ filing an emergency grievance where ~~no emergency exists~~ **the agency establishes that the youth had no basis to believe that an emergency existed and that such grievance was filed with the intent to deceive.**

§ 115.353 – Resident access to outside support services and legal representation

SUPPORT FOR CHANGES TO THIS REGULATION: We support the Department's draft regulation requiring that juvenile facilities provide residents with access to their attorneys or other legal representation and to outside victim advocates. Because juveniles may be especially vulnerable and unaware of their rights in confinement, providing youth access to legal representation is particularly important in protecting residents from the harms associated with sexual abuse and retaliation for reporting such abuse. Allowing residents access to attorneys or other legal representation establishes an additional method of reporting, particularly in situations where youth do not feel safe reporting an incident internally. Such access may also improve youth's opportunities to seek legal relief for sexual abuse and harassment. Similarly, we applaud the Department's recognition that allowing juveniles access to outside victim advocacy organizations can have great emotional and psychological benefits for young residents who have experienced sexual abuse, but who may be reluctant to report it to facility administrators.

ISSUE 1: This draft regulation and various others exclusively address sexual assault, but should also address sexual harassment in order to clarify the responsibilities of all involved and better protect the rights of youth.

ISSUE 2: The draft regulation ensures a resident's access to his or her parent or legal guardian. However, because system-involved youth are frequently raised by grandparents or other family members, we recommend expanding the final regulation on access to outside support services to include reasonable and confidential access to family members, and to ensure meaningful opportunities for family involvement. Recognizing that a youth's family is most often his or her primary emotional resource, we also propose that agencies' procedures provide family members with the opportunity to communicate with the resident, the ability to meaningfully participate in decisions made about the youth's treatment and safety, and the ability to speak with the youth's victim advocate.

Proposed Revisions:

§115.353 – Resident access to outside support services and legal representation

(a) In addition to providing onsite mental health care services, the facility shall provide residents with access to outside victim advocates for emotional support services related to sexual abuse **and sexual harassment**, by providing, posting, or otherwise making

accessible mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations, and by enabling reasonable communication between residents and these organizations, as confidential as possible, consistent with agency security needs and with applicable law.

. . .

(c) The facility shall also provide residents with reasonable and confidential access to their attorney or other legal representation and reasonable access to parents**,** ~~or~~ legal guardians**, and other family members**. **Parents, legal guardians, and family members shall have the opportunity to communicate with the resident through visitation, telephone, and mail; the ability to meaningfully participate in decisions made about the resident's treatment and safety; and the ability to speak with the child's victim advocate.**

§ 115.354 – Third-party reporting

ISSUE 1: This draft regulation and various others exclusively address sexual abuse, but should also address sexual harassment in order to clarify the responsibilities of all involved and better protect the safety of residents.

ISSUE 2: The draft regulation requires the facility to distribute information to parents and legal guardians on how to report sexual abuse on behalf of their child. Because system-involved youth are frequently raised by grandparents or other family members, we recommend adding other family members to the list of people who will receive this information.

Proposed Revisions:

The facility shall establish a method to receive third-party reports of sexual abuse **and sexual harassment**. The facility shall distribute publicly, including to residents' attorneys and parents**,** ~~or~~ legal guardians, **and other family members** information on how to report sexual abuse **and sexual harassment** on behalf of a resident.

§ 115.361 – Staff and agency reporting duties

SUPPORT FOR CHANGES TO THIS REGULATION: We strongly support the requirement that all staff members report abuse immediately, and that they not reveal any information related to a sexual abuse report to anyone other than those who need to know. This requirement will strengthen protections for youth from abuse as well as from retaliation for reporting. In particular, we support the draft regulation's enhanced responsibilities of a facility to inform the juvenile court, the victim's parents or legal guardians, and/or the victim's caseworker. We agree that there is a need to afford facilities some flexibility in limiting the information provided to parents or legal guardians with regard to certain situations (e.g., when parental rights have been terminated or when reporting to the victim's family may place the victim's emotional or physical well-being at risk or otherwise interfere with treatment).

ISSUE 1: The draft regulation fails to include the alleged victim's attorney of record within the class of parties to be notified in the event of a sexual abuse allegation. In order to better protect youth against future abuse and provide information critical to post-dispositional representation, we propose expanding the facility's reporting requirements to include notifying the juvenile's attorney or other legal representative.

ISSUE 2: This draft regulation and various others exclusively address sexual abuse, but should also address sexual harassment in order to clarify the responsibilities of all involved and better protect the safety of residents.

Proposed Revisions:

(a) The agency shall require all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse **or sexual harassment** that occurred in an institutional setting; retaliation against residents or staff who reported abuse; and any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse**, sexual harassment,** or retaliation.
(b) The agency shall also require all staff to comply with any applicable mandatory child abuse reporting laws.
(c) Apart from reporting to designated supervisors or officials and designated State or local services agencies, staff shall be prohibited from revealing any information related to a sexual abuse **or sexual harassment** report to anyone other than those who need to

know, as specified in agency policy, to make treatment, investigation, and other security and management decisions.

(d)(1) Medical and mental health practitioners shall be required to report sexual abuse **and sexual harassment** to designated supervisors and officials pursuant to paragraph (a) of this section, as well as to the designated State or local services agency where required by mandatory reporting laws.

(2) Such practitioners shall be required to inform residents at the initiation of services of their duty to report.

(e)(1) Upon receiving any allegation of sexual abuse **or sexual harassment**, the facility head or his or her designee shall promptly report the allegation to the appropriate central office of the agency and the victim's parents or legal guardians, unless the facility has documentation **of parental termination, or has notice of other circumstances related to a youth's physical or emotional well-being which indicate that** ~~showing the~~ parents or legal guardians should not be notified.

(2) If the victim is under the guardianship of the child welfare system, the report shall be made to the victim's caseworker instead of the victim's parents or legal guardians.

(3) If a juvenile court retains jurisdiction over **an alleged victim,** ~~a juvenile,~~ the facility head or designee shall also report the allegation to:

(i) such court within 14 days of receiving the allegation, unless additional time is needed to comply with applicable rules governing ex parte communications~~.~~**; and**

(ii) the juvenile's attorney or other legal representation of record within 14 days of receiving the allegation.

(f) The facility shall report all allegations of sexual abuse **and sexual harassment**, including third-party and anonymous reports, to the facility's designated investigators.

Various provisions – Addressing sexual harassment

ISSUE: The draft regulations below and various others mentioned above exclusively address sexual abuse, but should also address sexual harassment in order to clarify the responsibilities of all involved and better protect the safety of residents. We propose here, for example, requiring facilities to report sexual harassment allegations made by youth about incidents in previous placements, requiring agencies to monitor the conduct and treatment of those who have reported sexual harassment for possible retaliation, requiring prompt investigations of sexual harassment allegations, and imposing the same evidentiary standard for sexual harassment as that required to substantiate claims of sexual abuse.

§ 115.362 – Reporting to other confinement facilities

Proposed Revisions:

(a) Within 14 days of receiving an allegation that a resident was sexually abused **or sexually harassed** while confined at another facility, the head of the facility that received the allegation shall notify in writing the head of the facility or appropriate central office of the agency where the alleged abuse **or harassment** occurred and shall also notify the appropriate investigative agency.

. . . .

§ 115.365 – Agency protection against retaliation

Proposed Revisions:

. . .

(c) The agency shall monitor the conduct or treatment of residents or staff who have reported sexual abuse **or sexual harassment** or cooperated with investigations, including any resident disciplinary reports, housing, or program changes, for at least 90 days following their report or cooperation, to see if there are changes that may suggest possible retaliation by residents or staff, and shall act promptly to remedy any such retaliation. The agency shall continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need.

(d) The agency shall not enter into or renew any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff abusers **and harassers** from contact with residents pending an investigation.

§ 115.371 – Criminal and administrative agency investigations

Proposed Revisions:

(a) When the agency conducts its own investigations into allegations of sexual abuse **or sexual harassment**, it shall do so promptly, thoroughly, and objectively, using investigators who have received special training in sexual abuse **and sexual harassment** investigations involving juvenile victims pursuant to § 115.334, and shall investigate all allegations of sexual abuse **and sexual harassment**, including third-party and anonymous reports.
(b) Investigators shall gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; shall interview alleged victims, suspected perpetrators, and witnesses; and shall review prior complaints and reports of sexual abuse **and sexual harassment** involving the suspected perpetrator.
. . .
(i) The agency shall retain such investigative records for as long as the alleged abuser **or harasser** is incarcerated or employed by the agency, plus five years.
(j) The departure of the alleged abuser**/harasser** or victim from the employment or control of the facility or agency shall not provide a basis for terminating an investigation.
(k) Any State entity or Department of Justice component that conducts such investigations shall do so pursuant to the above requirements.
(*l*) When outside agencies investigate sexual abuse **or sexual harassment**, the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation.

§ 115.372 – Evidentiary standard for administrative investigations

Proposed Revisions:

The agency shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse **or sexual harassment** are substantiated.

§ 115.373 – Reporting to residents

Proposed Revisions:

(a) Following an investigation into a resident's allegation of sexual abuse **or sexual harassment** suffered in an agency facility, the agency shall inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded.

. . .

(c) Following a resident's allegation that a staff member has committed sexual abuse **or sexual harassment**, the agency shall subsequently inform the resident whenever:

(1) The staff member is no longer posted within the resident's unit;

(2) The staff member is no longer employed at the facility;

(3) The agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or

(4) The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility.

§ 115.377 – Disciplinary sanctions for residents

SUPPORT FOR THIS REGULATION: The Department included an explicit statement in the draft regulation that consensual sexual activity between residents does not constitute sexual abuse. This distinction prevents facilities from using their limited resources to investigate and file reports of abuse for consensual sexual activity that would not be considered sexual abuse in any other setting.

We are pleased that the Department included paragraph (g) in this regulation, which explicitly states that any prohibition of resident-on-resident sexual activity shall not consider consensual sexual activity to constitute sexual abuse. This necessary clarification distinguishes between the serious harms and trauma of sexual abuse that PREA intends to prevent and a facility's interest in preventing sexual activity between residents. It also ensures that facilities do not further penalize and pathologize consensual same-sex sexual activity. This distinction prevents facilities from having to use their limited resources investigating and filing reports for sexual activity that would not be considered sexual abuse in any other setting. In addition, the change in this regulation prevents the lasting emotional harm that a youth would experience if inappropriately treated as a sexual abuser for engaging in consensual same-sex sexual activity with another youth.

ISSUE 1: This draft regulation fails to provide guidance as to how staff should handle discipline in situations where residents engage in voluntary sexual conduct with other residents, but where the regulations classify the conduct as "sexual abuse" because one or both residents could not legally consent under state law. Without such guidance, facilities may not consider the voluntary nature of this conduct and may harshly discipline these residents based on disapproval of same-sex sexual activity or bias.

The inclusion of the words "who is unable to consent or refuse" in the definition of sexual abuse requires juvenile facilities to treat some voluntary sexual activity between residents as sexual abuse because state law criminalizes such behavior based on the age or relative ages of the youth involved. The draft regulations do not provide any guidance regarding the effect of age of consent laws on the way facilities should handle incidents of voluntary sexual contact between residents in these situations.[41] Without this guidance, we are concerned that facilities will use the regulations to target LGBTI youth for harsh sanctions and even prosecution. When sexual contact between similarly aged youth is voluntary but legally non-consensual due to a state's

[41] The inclusion of the words "who is unable to consent or refuse" in the definition of resident-on-resident sexually abusive contact would require juvenile facilities to treat some voluntary sexual activity between residents as sexual abuse solely because of the age or relative ages of the youth involved. We strongly disagree with the treatment of voluntary, non-coercive sexual conduct between similarly aged youth as sexual abuse. However, because it is state law that makes this conduct illegal in certain states, we recognize that this is not the forum in which to express our disagreement.

age of consent laws, the voluntary nature of the contact should nevertheless be taken into account in any disciplinary process.

Unfortunately, many facilities have failed to make this distinction. According to a BJS report, 35 percent of all substantiated incidents of sexual abuse between residents in juvenile facilities from 2005 to 2006 were voluntary sexual contacts.[42] The findings of this report indicate that youth designated as initiators of these *voluntary* sexual contacts often received harsher sanctions than those found to be perpetrators of *abusive* sexual contacts. For example, initiators of *voluntary* sexual contact were more than twice as likely to be placed in solitary confinement (25 percent) or be referred for prosecution (27 percent), compared to perpetrators of *abusive* sexual contact (12 percent and 13 percent, respectively).[43] Facilities need additional guidance to prevent them from misapplying the regulations in cases of voluntary sexual contact between similarly aged youth. This regulation should discourage the use of harsh sanctions to punish youth who engage in voluntary, but legally non-consensual, sexual contact. Specifically, facilities should not treat these youth as sexually aggressive, violent, or deviant, or attempt to change their sexual orientation. In addition, interventions for "victims" and "perpetrators" of voluntary sexual contact should not be more punitive than those for sexual contact that is forced, aggressive, or violent. Instead, the voluntary nature of the sexual contact should be recognized as a mitigating factor in disciplinary interventions.

ISSUE 2: The Department's proposed regulation allows for the discipline of a resident for sexual contact with staff if there is a finding that the staff member did not consent to such contact. This language is too broad, permitting abusive staff members to use the threat of discipline as a deterrent to resident reporting. To avoid this problem, the final regulation should require a finding of force or threat of force, in addition to lack of consent.

The draft regulation allows agencies to discipline a resident for sexual contact with staff based upon a finding that the staff member did not consent to such conduct. Sexual assaults against staff members by residents should always be taken seriously. However, as written, the draft regulation creates the opportunity for a staff member to leverage the threat of discipline in order to continue abusing a youth or prevent reporting. For example, a staff member who was sexually abusing a resident might tell the resident that if the resident were to disclose the abuse, the staff member would say that he or she did not consent to the contact so that the resident would be disciplined. Because these regulations do not govern investigations related to sexual abuse allegations made by a staff member against a resident, facilities may not have sufficient procedures in place to adequately investigate such allegations. The addition of a finding of force

[42] Allen J. Beck et al., Bureau of Justice Statistics, *Sexual Violence Reported by Juvenile Correctional Authorities, 2005-06* (2008), *available at* http://bjs.ojp.usdoj.gov/content/pub/pdf/svrjca0506.pdf.
[43] *Id*. at 11.

or threat of force used against a staff member will help prevent facilities from disciplining residents in situations where the resident is actually the victim. And it will make it more difficult for an abusive staff member to threaten a resident with discipline if he or she discloses sexual abuse.

ISSUE 3: The draft regulations do not place any restrictions on the use of isolation as a disciplinary sanction for youth who have engaged in the sexual abuse of another resident or non-consenting staff member. The final regulation should explicitly limit the use of isolation to no more than 72 hours and ensure that youth receive daily visits from mental health or health professionals.

The final regulation must do more to highlight the dangers associated with isolation as a disciplinary sanction. As the American Psychiatric Association has stated, "[c]hildren should not be subjected to isolation, which is a form of punishment that is likely to produce lasting psychiatric symptoms."[44] Even short periods of isolation can have particularly negative consequences for youth, including raising the risk of suicide[45] and exacerbating emotional and mental health needs.

Limiting the use of isolation as a disciplinary sanction is also consistent with the clear consensus of national correctional standards, juvenile justice experts, social scientists, and reinforced by practitioners from leading jurisdictions.[46] The most detailed best practice standards currently available in the juvenile justice field are from the Annie E. Casey Foundation's Juvenile Detention Alternatives Initiative (JDAI). The relevant JDAI standards are:

1. Prior to any imposition of room confinement, staff provide the components of due process [explained elsewhere in the JDAI standards]. Room confinement is defined in this instrument as a disciplinary sanction requiring youth to remain in a room after a youth has violated a rule. Room confinement should not be confused with isolation, which is defined in this instrument as placing a youth in a room because of his or her current acting-out behavior.

[44] Press Release, American Psychiatric Association, Incarcerated Juveniles Belong in Juvenile Facilities (Feb. 27, 2009), *available at* http://www.psych.org/MainMenu/Newsroom/NewsReleases/2009NewsReleases/IncarceratedJuveniles.aspx.

[45] Lindsay M. Hayes, National Center on Institutions and Alternatives, *Juvenile Suicide in Confinement: A National Survey*, Office of Juvenile Justice and Delinquency Prevention (2009), *available at* http://www.ncjrs.gov/pdffiles1/ojjdp/213691.pdf (describing a "strong relationship between juvenile suicide and room confinement").

[46] See e.g., American Correctional Association, *Standards for Juvenile Detention Facilities* 67 (3d ed. 1991).

2. As soon as staff place a youth in room confinement, staff shall notify the unit supervisor. Staff may not keep a youth in room confinement for longer than one hour without explicit approval of the unit supervisor. Staff may not keep youth in room confinement longer than 4 hours without explicit approval of the facility administrator or designee.

3. Room confinement for 24 hours or longer is not routinely imposed. Room confinement of more than 24 hours is reserved for the most serious violations, must be approved by the facility administrator, and is not imposed for more than 72 hours continuously.

If a youth is in room confinement longer than 24 hours, qualified mental health or health professionals visit the youth daily.[47]

ISSUE 4: When a resident has engaged in sexual abuse, the draft regulation permits facilities to condition that resident's access to programming on participation in certain treatment. Withholding programming and punishing juvenile residents for refusing treatment is unduly punitive, and contrary to the purpose and design of the juvenile justice system. It may also alienate and isolate a youth, making treatment success less likely. We recommend removing this provision from the final regulations, as it has no place in effective juvenile justice service delivery.

Access to programming and services should not be withheld because a youth is not participating in treatment. Punishing juvenile residents for refusing treatment cannot be reconciled with the purpose of the juvenile justice system, which is not designed to punish youth, but rather to provide programming and education that will increase the chances that youth will become productive, law-abiding citizens. Additionally, positive incentives are generally more effective than punitive sanctions at encouraging youth to participate in treatment. Furthermore, withholding programming as a punishment for failing to comply with treatment may further alienate or isolate a youth, making rehabilitation less likely in the long term. Therefore, we recommend that the Department remove paragraph (d) from the final regulation.

[47] Juvenile Detention Alternatives Initiative, Detention Facility Self-Assessment 94 § VI.E (2006), *available at* http://www.jdaihelpdesk.org/Docs/Documents/JDAI%20Detention%20Facility%20Assessment%20Practice%20Guide.pdf.

ISSUE 5: The draft regulations focus on discipline for resident perpetrators of abuse, but do not offer guidance on discipline for victims of abuse who violate other facility rules. Youth react to traumatic events in various ways, including emotional outbursts, oppositional behavior, or failure to follow directions. We recommend expanding the final regulation to more clearly apply to victims as well as perpetrators of abuse; to require the disciplinary process to take a youth's prior victimization into account; and to require staff to consult with medical and mental health practitioners when determining an appropriate intervention or sanction.

The draft regulations relating to resident discipline focus on perpetrators of abuse, but offer no guidance as to discipline for residents who break other facility rules after experiencing sexual victimization. Children and adolescents who have been exposed to trauma may not trust adults' ability to ensure their safety and may feel that they need to take matters into their own hands.[48] Victims of abuse sometimes commit disciplinary infractions in order to be housed in segregated settings to avoid their abusers. They may harbor revenge fantasies or appear guarded, oppositional, angry, defensive, or manipulative.[49] They may respond to seemingly unimportant events with emotional outbursts, hurtful comments, or threats of harm.[50] Stress from a traumatic event may interfere with a child's capacity to listen or reason, and punitive interventions typically exacerbate behaviors of concern.[51] Our revisions below propose expanding paragraph (c) of the draft regulation. These edits require the disciplinary process to consider previous victimization, in addition to the existing requirement to consider whether a resident's mental disabilities or mental illness contributed to his or her behavior. The edits also ensure that the provision will clearly apply to both resident perpetrators of abuse as well as resident victims of abuse whose subsequent behavior violates other facility rules.

Proposed Revisions:

(a) Residents shall be subject to disciplinary sanctions **or interventions** pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse **or sexual harassment** or following a criminal finding of guilt for resident-on-resident sexual abuse.

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[48] Gordon R. Hodas, *Responding to Childhood Trauma: The Promise and Practice of Trauma Informed Care*, Pennsylvania Office of Mental Health and Substance Abuse Services (2006), *available at* http://www.nasmhpd.org/general_files/publications/ntac_pubs/Responding%20to%20Childhood%20Trauma%20-%20Hodas.pdf; *see also Children's Reaction to Trauma: Suggestions for Parents*, National Mental Health and Education Center, *available at* http://www.naspcenter.org/safe_schools/trauma.html.
[49] *Id*.
[50] *Id*.
[51] *Id*.

(b) Sanctions shall be commensurate with the nature and circumstances of the abuse **or harassment** committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories.

(c) The disciplinary process **for resident perpetrators of abuse or harassment as well as for resident victims of abuse or harassment whose subsequent behavior violates other facility rules** shall consider whether a resident's mental disabilities**,** ~~or~~ mental illness**, or previous victimization** contributed to his or her behavior when determining what type of **intervention or** sanction~~, if any,~~ should be imposed. **Agency disciplinary staff shall consult with medical and mental health practitioners when determining an appropriate course of action.**

~~(d) If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, the facility shall consider whether to require the offending resident to participate in such interventions as a condition of access to programming or other benefits~~.

(d) In cases involving residents who engage in voluntary, though legally non-consensual sexual contact with other residents, the disciplinary process shall take into account the voluntary nature of this conduct as a mitigating factor when determining what type of intervention or sanction, if any, should be imposed.

(e) The agency may discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact **and that the resident used force or the threat of force**.

(f) For the purpose of disciplinary action, a report of sexual abuse **or sexual harassment** made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation.

(g) Any prohibition on resident-on-resident sexual activity shall not consider consensual sexual activity to constitute sexual abuse **or sexual harassment**.

(h) No resident shall be subject to disciplinary isolation for a continuous period longer than 72 hours as punishment for engaging in resident-on-resident sexual abuse. If a youth is in room confinement for a period longer than 24 hours, qualified mental health or health professionals shall visit the youth daily.

§ 115.381 – Medical and mental health screening; history of sexual abuse

ISSUE 1: The draft regulation does not require that qualified medical or mental health staff talk with residents during the reception and intake process to ascertain information regarding sensitive topics such as past victimization, sexual orientation, and gender identity. Without involving medical and mental health personnel in this information gathering, facilities are less likely to encourage residents to disclose information that would help identify the resident as vulnerable to abuse. In facilities where medical and mental health staff conduct assessments during intake, medical or mental health staff should talk with residents about these sensitive topics instead of non-medical staff.

ISSUE 2: The language in paragraph (c) of the draft regulation is unclear because it requires that "the facility" question youth about prior sexual abusiveness in a regulation about medical and mental health screening. This may lead facilities to think that medical and mental health staff must ask these questions. It is inappropriate for medical and mental health practitioners to be asking residents about prior offending behavior during intake. This paragraph should be removed to avoid confusion. In addition, the timelines for follow-up care with medical and mental health staff for youth reporting prior victimization or sexual abusiveness at intake should be shortened to ensure that their needs are met in a timely manner.

We appreciate that the Department did not adopt the Commission's recommendation that medical and mental health practitioners question youth about their past offending behavior. That requirement would have put helping professionals in the awkward situation of quizzing youth about past offending behavior when they are trying to develop the trust necessary for disclosure of important health and mental health information. However, the language that now appears in this regulation is unclear because it inserts a requirement that "the facility" question youth about prior sexual abusiveness in a regulation about medical and mental health screening. This may lead facilities to think that medical and mental health staff must ask these questions. It is not necessary for the Department to include a requirement that "the facility" ask about prior sexual abusiveness in this regulation since § 115.342(b)(4) already requires facilities to ascertain this information. Therefore, we recommend that either § 115.381(c) be deleted or that the text be moved to § 115.342.

We support the paragraph in the draft regulation requiring a follow-up reception with medical and mental health staff for youth who disclose prior victimization or sexual abusiveness during intake. However, the timeline for such follow-up care is too long considering the mental health and safety needs these residents present. We propose shortening the window of time to three days for those who reported prior victimization and 7 days for those who report prior sexual abusiveness.

Proposed Revisions:

(a) All facilities shall ask residents about prior sexual victimization during the intake process or classification screenings.

(b) In facilities where medical or mental health practitioners conduct medical and mental health screenings as part of the intake or classification process, these practitioners, not other facility staff, shall ask any questions about the resident's sexual orientation, gender identity, prior sexual victimization, mental health status, intersex status, or mental or physical disabilities.

~~(b)~~ **(c)** If a resident discloses prior sexual victimization **to a non-medical staff member**, whether it occurred in an institutional setting or in the community, staff shall ensure that the resident is offered a follow-up reception with a medical or mental health practitioner within ~~14~~ **3** days of the intake screening.

~~(c) Unless such intake or classification screening precedes adjudication, the facility shall also ask residents about prior sexual abusiveness.~~

(d) If a resident discloses prior sexual abusiveness **during the intake process**, whether it occurred in an institutional setting or in the community, staff shall ensure that the resident is offered a follow-up reception with a mental health practitioner within ~~14~~ **7** days of the intake screening.

. . . .

§ 115.383 – Ongoing medical and mental health care for sexual abuse victims and abusers

ISSUE: The draft regulation allows facilities to wait up to 60 days to conduct follow-up mental health evaluations for residents who engage in sexual abuse, which is far too long to wait before linking youth with necessary services. Youth are not generally housed in juvenile facilities for extended periods of time compared with adults. Accordingly, their needs must be addressed on a shorter timeline, particularly given the rehabilitative focus of juvenile facilities. We propose a 7-day window in line with relevant standards established by the National Commission on Correctional Healthcare.

The draft regulation allows too much time to pass between instances of abuse and mental health evaluations of resident abusers. The juvenile justice system was designed to provide a rehabilitative and therapeutic environment for youth. By making youth wait up to 60 days for follow-up evaluations and even longer for treatment, facilities will fail to meet this important mandate. Furthermore, juvenile residents generally do not remain in facilities for extended periods of time, compared with adult inmates. Juvenile residents in crisis should get services on a faster timeline, both to address their needs and to ensure the safety of other residents.

The National Commission on Correctional Healthcare (NCCHC) recommends that mental health assessments be conducted for new residents as soon as possible, but no later than 7 calendar days after admission to a facility.[52] They also state that "[i]mmediate response to an act of sexual assault is of the utmost importance."[53] A 7-day window for assessing known resident abusers in juvenile facilities would be comparable to the NCCHC standards and more appropriate than the 60-day window proposed in the draft regulation.

Proposed Revisions:

(a) The facility shall offer ongoing medical and mental health evaluation and treatment to all residents who, during their present term of incarceration, have been victimized by sexual abuse **or sexual harassment**.
(b) The evaluation and treatment of sexual abuse **and sexual harassment** victims shall include appropriate follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody.

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[52] National Commission on Correctional Healthcare, *Standards for Health Services in Juvenile Detention and Confinement Facilities*, § Y-E-03 (2004).
[53] *Id*. at § Y-G-09.

(c) The facility shall provide resident victims of sexual abuse **and sexual harassment** with medical and mental health services consistent with the community level of care.
(d) The facility shall conduct a mental health evaluation of all known resident abusers within ~~60~~ **7** days of learning of such abuse history and offer treatment when deemed appropriate by qualified mental health practitioners.
(e) Resident victims of sexually abusive vaginal penetration while incarcerated shall be offered pregnancy tests.
(f) If pregnancy results, such victims shall receive timely information about and access to all pregnancy-related medical services that are lawful in the community.

§ 115.386 – Sexual abuse incident reviews

ISSUE: The draft regulation does not require the incident review team to review potentially important factors at the conclusion of a sexual abuse investigation, such as the sufficiency of staff training, input from youth and family members or guardians on how to improve the investigation and response process, and whether an incident may have been motivated or caused by a youth's gender identity. Because these factors are important in helping facilities learn from incidents in a way that will minimize opportunities for future misconduct, our proposed edits require that incident review teams consider them when developing recommendations.

As written, the draft regulation requires incident review teams to use information from past sexual abuse investigations in order to propose ways of preventing future incidents. When developing those recommendations, the draft regulation requires teams to consider many important areas, including policies and procedures, staffing levels, monitoring technology, and limitations of the facility's physical plant. All of these areas are worthy of consideration. However, the final regulation should also require consideration of staff training. Facilities should learn from serious incidents such as sexual misconduct, and should incorporate lessons learned to enhance or add trainings aimed at preventing, detecting, and responding to incidents.

While we support the Department's requirement that facilities consider whether each incident of abuse was motivated by characteristics of the victim or motivated or otherwise caused by other group dynamics at the facility, we are concerned that other considerations in this paragraph are overreaching. First, the regulation's inclusion of the perpetrator's characteristics as a possible motivating factor for abuse is confusing and misplaced. A person's sexual orientation, race, or ethnicity does not motivate or otherwise cause him or her to engage in sexual abuse. Framing an inquiry in this manner could feed into personal prejudices of staff members and will not increase safety for residents. Second, we also are concerned about inquiries that consider whether sexual abuse was "caused by" the victim's race, ethnicity, or sexual orientation. This language could be understood to suggest that such characteristics of the victim are to blame for the abuse that occurred and, thus, such abuse is to be expected and cannot be prevented. Finally, as a victim's gender identity is often a potential motivating factor, gender identity should be included in the final regulation.

The regulation should include input from youth and families on how to improve the investigation and response process. As victims, youth may have particularly valuable insights as to how to prevent future misconduct. Family members and guardians may also be able to provide valuable feedback on improving communication and practices.

Our proposed language below adds staff training, input from youth and family members or guardians, and gender identity to the list of factors that incident review teams must consider.

Proposed Revisions:

(a) The facility shall conduct a sexual abuse **or sexual harassment** incident review at the conclusion of every sexual abuse **or sexual harassment** investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded.

(b) The review team shall include upper management officials, with input from line supervisors, investigators, and medical or mental health practitioners.

(c) The review team shall:

(1) Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse **and sexual harassment**;

(2) Consider how additional or enhanced staff training opportunities could have prevented abuse and how it can prevent future abuse;

(3) Examine any barriers to reporting or filing grievances;

~~(2)~~ **(4)** Consider whether the incident or allegation was motivated ~~or otherwise caused~~ by the ~~perpetrator or~~ victim's race, ethnicity, sexual orientation, **gender identity, or** gang affiliation, or **was motivated or otherwise caused by** other group dynamics at the facility;

~~(3)~~ **(5)** Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse;

~~(4)~~ **(6)** Assess the adequacy of staffing levels in that area during different shifts;

~~(5)~~ **(7)** Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; ~~and~~

(8) Incorporate input from youth and family members or guardians on how to improve the investigation and response process; and

~~(6)~~ **(9)** Prepare a report of its findings and any recommendations for improvement and submit such report to the facility head and PREA coordinator, if any.

§ 115.387 – Data collection

ISSUE: This draft regulation and various others exclusively address sexual abuse, but should also address sexual harassment in order to clarify the responsibilities of all involved and better protect the safety of residents.

Proposed Revisions:

(a) The agency shall collect accurate, uniform data for every allegation of sexual abuse **and sexual harassment** at facilities under its direct control using a standardized instrument and set of definitions.
(b) The agency shall aggregate the incident-based sexual abuse **and sexual harassment** data at least annually.
. . . .

§ 115.388 – Data review for corrective action

ISSUE: The draft regulations recognize the value of learning from previous instances of sexual abuse. However, the draft regulation on corrective action does not require agencies or facilities to take any action based on individual incident reviews; it only requires facilities to review and take action based on aggregate data, which agencies must only compile on an annual basis. Our proposed modification would require that facilities make changes to policies and practices to ensure the safety of youth and staff on an ongoing basis.

The data collection provisions ensure that agencies gather the information necessary to learn about any problems. The draft regulations also recognize that agencies must take appropriate action based on that information. As written, though, the draft regulation on corrective action only requires agencies to review *aggregate* data. The corrective action draft regulation does not require facilities to respond to the recommendations made by the incident review team under § 115.386 following the conclusion of sexual abuse investigations.

Because § 115.387 only requires agencies to compile aggregate data on an annual basis, facilities may miss critical opportunities to implement changes in practices, policies, staffing, training, or monitoring as administrators become aware of potential problem areas. Indeed, it is difficult to imagine how facilities could "tak[e] corrective action on an ongoing basis," as the draft regulation currently requires, without reviewing individual incidents as they arise.

In addition, the language is awkward – although it appears that the Department expects the agency to take corrective action, the draft regulation could be read only to require that an agency's analysis suggest corrective action.

The revised language below ensures that facilities take corrective action on an ongoing basis, reviewing both individual and aggregate data.

Proposed Revisions:

(a) **Annually and also after significant incidents**, **t**~~T~~he agency shall review data **and analyses** collected ~~and aggregated~~ pursuant to **§ 115.386 and** § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training.~~, including~~ **The assessment and improvement activities shall include**: . . . .

§ 115.393 – Audits of standards

ISSUE 1: Audits conducted by independent, qualified professionals are necessary to provide credible, objective assessments of a facility's safety. To be considered qualified and independent, the auditing team must be completely separate from the agency being audited and have expertise in juvenile corrections and sexual violence against youth.

The Department's definition of "independent" – which allows the audits to be conducted by an entity that reports to the agency head or the agency's governing board – is too broad and compromises the integrity of the auditing process. Entities that ultimately answer to the head of the agency being monitored can easily be pressured to minimize or ignore certain concerns. Agencies may prevent these entities from doing their job effectively by failing to allocate sufficient resources to the task. Under these circumstances, an audit cannot be considered "independent" without redefining the meaning of that term. Rather, the audit provision should require that the entity conducting this monitoring be wholly independent from the agency being audited.

The draft regulation fails to specify critical details regarding the qualifications of the auditors. With respect to qualifications, auditors must have an approach that is focused on the health and safety needs of sexual abuse victims, and incorporates expertise in both juvenile corrections and sexual violence against youth. Experience in juvenile corrections, with an understanding of the rehabilitative focus of these institutions, is vital to ensuring that the audits are credible and that they offer realistic recommendations. Equally important, the auditing team must have sufficient training or experience in sexual violence and crisis counseling with adolescents and children in order to gather information appropriately from traumatized youth and pick up cues of possible concerns that residents and others may not feel comfortable sharing. Whether in this provision (as we recommend) or in subsequent regulations (as suggested by the current drafting of this draft regulation), the Department should specify that the auditing team must possess expertise in both of these critical areas.

ISSUE 2: The Department's draft regulations leave unresolved critical details about oversight. The outside auditor should visit every facility during each triennial audit period. If that is not possible, then a combination of for cause and random audits – all determined by the auditor – should be conducted at some facilities, along with review of policies, data, and other documents at all facilities.

Conditions within a system can vary dramatically from one facility to the next. Only by visiting each facility can the monitor ensure that dangerous conditions do not exist. However, if the Department is not going to require that every facility have an on-site inspection by an independent auditor each triennial cycle, then it should establish a tiered system by which every

facility has its policies, records, data and other documents assessed for compliance with the regulations, and a select number of facilities – chosen by the auditing entity based on cause and random selection – are visited. Instituting a hybrid of random and "for cause" audits would provide attention and accountability to the most deficient facilities while also keeping all other institutions "on their toes" to maintain the best possible policies and practices. While the auditor should have some discretion in determining cause, triggering events for making this determination should include: reasonable suspicion of any instance of staff-on-resident abuse, as well as resident-on-resident abuse that appears to be the result of a deficiency in staffing or staff efforts to prevent or respond to abuse; documentation of existing problems or incidents; an auditor's review of documents at a facility that indicates possible non-compliance with the standards; follow-ups to previous audits to assess implementation of corrective action plans; and agency requests for assistance. All facilities should also be required to ensure that staff and residents are aware of the audit process and have a means to contact the auditor confidentially, regardless of whether there will be a facility visit.

ISSUE 3: While the Department requires each agency to conduct some internal assessment, through reviews of each incident and aggregate data, the audit provision is wholly removed from this internal monitoring. Every facility should be required to submit a self-assessment of compliance with the regulations to the auditing entity on a yearly basis.

Internal assessments should include similar measures as external monitoring. This will ensure that facility administrators are actively including the regulations in routine facility management exercises, and will provide an ongoing source of information for the auditing entity. Incorporating internal and external monitoring into the auditing process is a best practice relied upon in both the juvenile and adult contexts, by oversight entities such as the American Correctional Association and the Annie E. Casey Foundation's Juvenile Detention Alternatives Initiative.

ISSUE 4: The draft regulation does not require auditors to consider the sufficiency of staffing plans developed under PREA, nor does it require auditors to evaluate staffing ratios. Our proposed change requires auditors to evaluate staffing when determining compliance with PREA.

As written, the draft regulation does not require auditors to consider the sufficiency of staffing plans developed under PREA and compliance with those plans. Given that the plans outline a facility's overall approach to supervision, the auditor should include them in compliance reviews. Additionally, the final regulation should require that auditors assess the sufficiency of a facility's staffing ratios. Even if the Department does not require minimum staffing levels, ratios for direct care (staff in direct proximity and interacting with youth) are an important indicator of

effective supervision. Our proposed changes require auditors to consider this important information when assessing compliance.

ISSUE 5: The draft regulation does not require auditors to assess the sufficiency of the agency's use of PREA coordinators at the agency and facility level. Knowing whether PREA coordinators have the time and resources to implement and ensure ongoing compliance with the regulations is critical to ensuring PREA's effectiveness. Our proposed change requires auditors to analyze the sufficiency and use of agency- and facility-level PREA coordinators.

Proposed Revisions:

(a) An audit shall be considered independent if it is conducted by:

(1) A correctional monitoring body that is not part of the agency but that is part of, or authorized by, the relevant State or local government; **or**

(2) ~~An auditing entity that is within the agency but separate from its normal chain of command, such as an inspector general or ombudsperson who reports directly to the agency head or to the agency's governing board; or~~

~~(3)~~ Other outside individuals with relevant experience.

. . .

(e) The Department of Justice shall prescribe methods governing the conduct of such audits, including provisions for reasonable inspections of facilities, review of documents, and interviews of staff and inmates. The Department of Justice also shall prescribe the minimum qualifications for auditors**, including sufficient training and/or expertise in juvenile corrections, the dynamics of sexual violence among detained youth, and interviewing traumatized youth.**

(f) The agency shall enable the auditor to **make unannounced visits;** enter and tour **all areas of any facility**~~ies~~, **including contract facilities;** review documents; **review the sufficiency, feasibility of and compliance with the agency's supervision and monitoring plans developed under § 115.313; review the sufficiency of a facility's average direct care staffing ratios; review the sufficiency and use of agency- and facility-level PREA coordinators under § 115.311;** and **conduct private, confidential** interview**s with** staff and ~~**inmates**~~ **residents, as deemed appropriate by the auditor** to conduct a comprehensive audit. **The auditor must have access to all documents and any staff member or resident, including residents held in protective custody or solitary confinement.**

(g) During each triennial auditing cycle, every facility shall be visited and have its policies, records, data and other documents assessed for compliance with the standards. All facilities must ensure that staff and residents are aware of the audit process and have a reasonable means to contact the auditor confidentially, regardless of whether there will be a facility visit.

~~(g)~~ **(h)** The agency shall ensure that the auditor's final report is **provided to the Department of Justice, made available to staff, residents, and parents/guardians of residents, and** published on the agency's website if it has one or is otherwise made readily available to the public.

Question 28: Should audits be conducted at set intervals, or should audits be conducted only for cause, based upon a reason to believe that a particular facility or agency is materially out of compliance with the standards? If the latter, how should such a for-cause determination be structured?

Audits should be conducted at every facility. However, if that is not going to occur, then an effective oversight system must include a hybrid of random and for cause audits. While for cause audits have some value, oversight cannot rely exclusively on this method. Audits based on cause do not serve the important preventative role of identifying problems before they give rise to more serious problems, one of the greatest cost savings potentially derived from the regulations. Moreover, while criteria for establishing cause can be developed, no regulation is fool proof. Youth rarely report sexual abuse, and are even less likely to be able to request an audit effectively. In addition, facilities may have systemic problems that directly go to the means for measuring cause (such as poor recordkeeping or insufficient access to reporting mechanisms and the auditor). Systems with these types of deficiencies would benefit tremendously from random audits, but would be unlikely to be identified in for cause audits.

Despite the limitations of relying exclusively on cause to determine which facilities to audit, for cause audits should be part of the auditing structure. Some juvenile institutions are known to be especially dangerous; facilities with known problems are unquestionably in need of outside guidance. Mandatory audits of these facilities would help identify problems and realistic solutions while providing needed accountability.

Question 29: If audits are conducted for cause, what entity should be authorized to determine that there is reason to believe an audit is appropriate, and then to call for an audit to be conducted? What would be the appropriate standard to trigger such an audit requirement?

A qualified and independent auditor is the best entity to determine when an audit is appropriate. As the value of audits comes from their external nature, allowing agency administrators to choose where to audit would undercut many of the audit's valuable functions. Officials who fear accountability for poorly performing facilities may avoid subjecting those facilities to audits. Even where officials seek outside monitoring to address known dangers, they are unlikely to be able to identify facilities that may have problems that are unnoticed by staff.

The appropriate standard to use in determining cause to trigger an audit depends on the oversight structure established – specifically, the extent to which this structure relies exclusively on cause in determining whom to audit. If the Department adopts the hybrid structure of our alternate recommendation, which includes both random and for cause audits, then the standard for cause can be fairly lenient – affording the auditor sufficient discretion to assess what triggering events would amount to cause. However, if random audits are not being conducted, then the for-cause determination must be more inclusive.

Question 30: Should all facilities be audited or should random sampling be allowed for some or all categories of facilities in order to reduce burdens while ensuring that all facilities could be subject to an audit?

Every facility should be subject to an audit. Even if the Department ultimately does not require that every facility be visited during each triennial audit period, each facility should still undergo a review of its policies, records, data and other documents and have some communication between the administration and the auditor regarding the facility's PREA efforts and any related concerns at some point. There should also be a means by which any staff member or resident can privately communicate with the auditor. As discussed above, these baseline audits should then be supplemented with a hybrid of random and for cause audits, all determined by the auditing entity, not the agency. In addition, once a facility is deemed to be noncompliant based on a document review or a prior audit, the facility should also be subject to a full audit that includes a visit to ensure that the facility is taking the steps needed to come into compliance.

Question 31: Is there a better approach to audits other than the approaches discussed above?

As detailed in our response to prior questions, all facilities should receive a facility audit. In the alternative, a tiered approach of document reviews for all facilities along with visits to facilities selected based on random selection, cause, and prior finding of noncompliance would provide a sufficient balance between comprehensive and cost-effective monitoring.

Question 32: To what extent, if any, should agencies be able to combine a PREA audit with an audit performed by an accrediting body or with other types of audits?

PREA audits can be combined with other audits, but only if they are conducted by auditors who have sufficient independence from the agency and are qualified with expertise both about juvenile corrections and sexual violence against youth. Traditional audits – conducted solely by corrections practitioners and generally linked to voluntary fee-based accreditation – will not suffice.

Question 33: To what extent, if any, should the wording of any of the substantive standards be revised in order to facilitate a determination of whether a jurisdiction is in compliance with that standard?

The nature of the PREA regulations, by necessity, is primarily qualitative. Quantitative indicators help measure compliance but will not sufficiently measure the overall effectiveness of prevention and response efforts. As a result, auditors must be provided with a fair amount of discretion to determine compliance with the regulations and, ultimately, in maintaining safe facilities.

Question 34: How should "full compliance" be defined in keeping with the considerations set forth in the above discussion?

Immediate and absolute compliance with all the PREA regulations is unlikely to be achieved by all agencies at all times, and both the regulations as a whole and the audit provisions in particular should be seen as means of troubleshooting problems and identifying solutions. As a result, the definition of "full compliance" deserves a nuanced approach. In other contexts, the Department of Justice uses a multi-tiered approach that would be equally effective here. This approach defines different types of compliance to be found by the monitor, with corresponding sanctions for failure to achieve substantial compliance:

- *Substantial Compliance*, meaning compliance with all provisions and their components, understanding that noncompliance with mere technicalities, or temporary failure to comply during an otherwise sustained period of compliance do not constitute failure to maintain substantial compliance;
- *Partial Compliance*, resulting when the monitor identifies gaps in compliance that go beyond anecdotal incidents, technicalities, or temporary factors; and
- *Non-compliance*, a designation used when a facility refuses to establish and/or implement an action plan to address gaps that have been identified in prior audits.

The goal of the regulations is to ensure a minimum level of protection in all facilities. We want systems to be motivated to achieve substantial compliance. Relying solely on the penalty of lost funding would create a disincentive to finding noncompliance. Through this multi-tiered system, agencies can have ample opportunity to correct deficiencies, with training and technical assistance provided to help achieve compliance, alternative sanctions providing pressure for taking these obligations seriously, and the loss of funds considered a last resort for extreme situations.

Question 35: To what extent, if any, should audits bear on determining whether a State is in full compliance with PREA?

A compliance determination must incorporate the assessment of an outside monitor in order to have any meaning. Audits obviously play a crucial role. However, they should not be the only indicia relied upon. While not conducting the reviews itself, the Department should verify that each inspection was properly conducted by a qualified monitor, and that corrective action plans are both implemented and monitored.

Auditors should be required to make their reports publicly available, and the agency, the staff, residents, their families, and the general public should have an opportunity to respond. When a facility is found to be out of compliance (in full or in part), it must develop an action plan that sufficiently addresses the concerns raised in the report – after which compliance with the action plan must be at least as decisive as the initial audit in assessing full compliance with PREA.

Answers to Questions Regarding Youth in Adult Facilities

Question 36: Should the final rule include a standard that governs the placement of juveniles in adult facilities?

Question 37: If so, what should the standard require, and how should it interact with the current JJDPA requirements and penalties mentioned above?

Yes, the final regulations should include provisions that protect youth in adult facilities. Because of adolescents' stage of development and cognitive and social immaturity, youth have characteristics that make them particularly vulnerable to abuse. In fact, the Commission's report found that "[m]ore than any other group of incarcerated persons, youth incarcerated with adults are probably at the highest risk for sexual abuse."[54] Adult facilities housing children and adolescents face a dangerous dilemma with respect to choosing between housing youth in the general adult population where they are at substantial risk of sexual abuse and housing youth in segregated settings which cause or exacerbate mental health problems. Neither option is safe and appropriate for youth, nor a good practice for corrections agencies ill-equipped to address the unique needs of minors.

We believe the Department should prohibit the placement of youth in adult jails and prisons as a way to reduce the sexual abuse of youth. At a minimum, the regulations should require that jurisdictions create a new presumption that all youth will be housed in juvenile facilities and can only transfer to an adult facility after a full evidentiary hearing. Finally, for any youth who remain in adult facilities, the regulations should contain extra protections for youth housed in protective custody.

Our proposed changes would protect all youth under the age of 18 held in adult facilities, and therefore go beyond the statutory requirements of the existing Juvenile Justice and Delinquency Prevention Act (JJDPA).[55] To the extent that facilities are currently housing youth in adult facilities in violation of the current JJDPA, these facilities should be found out of compliance with both the JJDPA and PREA. Facilities housing youth in adult facilities in violation of our recommended approach, but that are not in violation of the JJDPA, should be found out of compliance with PREA. We suggest that the funds withheld from jurisdictions for failure to comply with this new PREA regulation be set aside to help facilities come into compliance.

[54] National Prison Rape Elimination Commission, Report, *supra* note 1, at 18.
[55] *See* 42 U.S.C. §§ 5601-5681.

Proposed Revisions – Alternative 1:

[New regulation]

§ 115.44 Prohibition on housing juveniles in adult facilities

(a) No person under the age of 18 may be housed in a jail or prison.
(b) The agency operating the adult facility(ies) shall enter into memoranda of understanding or other agreements with juvenile justice agenc(ies) to receive and immediately house all persons under the age of 18 who are currently, or in the future, assigned to its care.

Proposed Revisions – Alternative 2:

[New regulation]

§ 115.44 Prohibition on housing juveniles in adult facilities

(a) No person under the age of 18 may be housed in a jail or prison, except under the special circumstances and after specific procedures detailed in paragraphs (c) and (e) of this section have been undertaken.
(b) The adult agency shall enter into memoranda of understanding or other agreements with juvenile justice agencies to receive and immediately house all persons under the age of 18 who are currently, or in the future, assigned to its care.
(c) No person under the age of 18 may be transferred to a jail or prison without a written court order after notice and evidentiary hearing, with the youth and his/her counsel present and able to participate, with findings that the youth has:

(1) Seriously injured or endangered the life or health of another youth resident or staff member in the juvenile facility or program; or escaped from the juvenile facility or program; or established a pattern of disruptive behavior not conducive to the established policies and procedures of the juvenile program; and

(2) The youth's behavior cannot be safely managed by disciplinary procedures in the juvenile facility. The court shall consult with medical and mental health practitioners to determine whether a youth's mental disabilities, mental illness, or previous history of victimization contributed to his or her behavior when determining an appropriate course of action. While the disciplinary

history of the youth may impact the recommendation to transfer the youth to the adult facility, the transfer to an adult facility may not be used as a disciplinary sanction or activity.

(d) If persons under the age of 18 are transferred to the facility pursuant to the court order, the facility shall:

(1) Ensure youth do not have sight or sound contact with inmates over the age of 18;

(2) Assess and provide programs and services to meet the special needs of youth including education comparable to that provided in the community, special diets to meet their nutritional needs, developmentally appropriate health and mental health care, daily opportunities for recreation and exercise, and contact visits with family members;

(3) House youth in living conditions with adequate program space to meet the physical, social, and emotional needs of youth. Facilities shall allow for social contact with peers and may not isolate juveniles from other juveniles, unless the juvenile presents an immediate health and/or safety risk to other inmates or staff;

(4) Ensure youth are visually checked by staff at least every 15 minutes; receive daily visits from mental health or health care providers; and have opportunities for social interaction including daily visits by personnel from administrative, clinical, social work, or religious units; and

(5) Ensure that employees working with persons under the age of 18 are trained in the developmental, safety, and other specific needs of youth including:

(i) Adolescent development for girls and boys, including what is normative sexual behavior for adolescents, what is acceptable behavior of adolescents, how to distinguish between normative adolescent behavior and sexually aggressive and dangerous behaviors, the factors that make youth vulnerable to sexual abuse, how to handle disclosures of victimization by youth in a sensitive manner, and the ways in which sexual victimization can affect healthy development;

(ii) The developmental and programming needs of youth;

(iii) The prevalence of trauma and abuse histories of youth, possible behaviors of youth with trauma and abuse histories, and appropriate gender specific ways of responding to those behaviors;

(iv) How to communicate effectively and professionally with specific populations of youth (e.g., gender, race, ethnicity, sexual orientation, gender identity, disability, or youth with limited English proficiency);
(v) The mental health needs of youth including crisis prevention and intervention, suicide prevention, cognitive-behavioral interventions, and substance use and abuse.

(e) The facility shall provide written progress reports on the behavior and welfare of the youth to the court at an evidentiary hearing, after notice, with the youth and counsel present, every 10 days to determine whether the youth should be returned to a juvenile facility with the court providing written findings and placement determination.

Answers to Questions Regarding Cost Benefit Analysis

Question 38: Has the Department appropriately determined the baseline level of sexual abuse in correctional settings for purposes of assessing the benefit and cost of the proposed PREA standards?

The Initial Regulatory Impact Analysis (IRIA) estimated the annual prevalence of four different types of inappropriate sexual contact: rape involving force or threat of force; nonconsensual sexual acts involving pressure or coercion; abusive sexual contacts; and other staff sexual misconduct. The IRIA estimated the prevalence of these four activities in three different confinement settings: adult prisons; adult jails; and juvenile facilities. The IRIA examined the available statistics on the prevalence of each type of inappropriate sexual contact and made difficult methodological choices to determine the baseline.

We agree with several of the methodological decisions made by the Department in determining how to calculate the baseline. We believe the surveys of inmates provide more reliable estimates than facility-reported surveys. We also agree with the decision to adjust the inmate survey responses to account for the flow of inmates or residents who move through a facility. Finally, we support the decision not to make adjustments to the inmate surveys to account for the possibility of false negatives or false positives.

However, the IRIA erred in some areas by underestimating the problem of sexual abuse in facilities. First, the Department failed to estimate the baseline level of prison rape and sexual abuse for youth housed in adult facilities. Second, the Department erred in not attempting to identify and use a methodology that would account for serial victimizations.

Youth in Adult Facilities: The baseline calculations of the prevalence of prison rape and sexual abuse in adult jails and adult prisons did not specifically address the abuse of youth in those facilities. According to BJS statistics, youth under the age of 18 represented 21 percent of all substantiated victims of inmate-on-inmate sexual violence in jails in 2005, and 13 percent in 2006 – a high representation since only one percent of jail inmates are juveniles.[56] The situation for youth held in adult prisons is no less dire; Deborah LaBelle, an attorney working with over 400 youth serving sentences of life without possibility of parole testified before the Commission that 80 percent of those youth had been sexually assaulted within the first year of their incarceration.[57] Many additional examples of sexual abuse against youth in adult facilities were

[56] A.J. Beck, P.M. Harrison & D.B. Adams, *Sexual Violence Reported by Correctional Authorities, 2006,* Department of Justice, Office of Justice Programs, Bureau of Justice Statistics (2007); A.J. Beck, P.M. Harrison & D.B. Adams, *Sexual Violence Reported by Correctional Authorities, 2005*, Department of Justice, Office of Justice Programs, Bureau of Justice Statistics (2007).

[57] *At Risk: Sexual Abuse and Vulnerable Groups Behind Bars, Hearing Before the National Prison Rape Elimination Commission* (August 19, 2005) (testimony of Deborah LaBelle).

brought to light at public hearings of the Commission, including the stories of T.J. Parsell, a 17-year-old boy raped within 24 hours after entering an adult prison;[58] Rodney Hulin, a 16-year-old boy who was raped almost immediately after entering an adult prison and committed suicide after being in the facility for three months;[59] and Chino Hardin, a youth who testified about her experiences of sexual abuse when incarcerated at 15 years of age in an adult women's prison.[60] We believe the IRIA erred in failing to account for the increased risk that youth face when housed in adult jails and prisons, and failing to consider that population separately, both with regard to risk of victimization and also the increased costs associated with victimization at such a young age.

Serial Victimizations: The IRIA was correct in stating that the decision to use prevalence instead of incidence data "will result in underestimating the problem."[61] The Department should have attempted to extrapolate multiple victimizations from the inmate surveys so as not to understate the suffering of persons who are repeatedly victimized. According to the recent BJS study of sexual abuse in juvenile facilities, 81 percent of victims of youth-on-youth abuse reported two or more incidents of victimization and 43 percent reported more than one perpetrator.[62] Each incident brings its own set of costs, and the Department's decision to not adjust the data to account for repeated victimization fails to adequately assess the extent and costs associated with sexual abuse in facilities. Studies conducted inside and outside of correctional facilities confirm that crimes of rape and sexual violence are the most underreported of crimes.[63] Failing to account for the number of incidents of sexual abuse, in light of the already underreported nature of these crimes, is inappropriate.

Question 45: Should the Department adjust the "willingness to pay" figures on which it relies (developed by Professor Mark Cohen for purposes of valuing the benefit to society of an avoided rape) to account for the possibility that some people may believe sexual abuse in confinement facilities is a less pressing problem than it is in society as a whole, and might therefore think that the value of avoiding such an incident in the confinement setting is less than the value of avoiding a similar incident in the non-confinement setting? Likewise, should the Department adjust these figures to take into account the fact that in the general population the vast majority of sexual abuse victims are female, whereas in the confinement setting the victims are overwhelmingly male? Are such differences even relevant for purposes

[58] *Id*. (August 13, 2005) (testimony of T.J. Parsell); *see also* T.J. Parsell, Fish: A Memoir of a Boy in a Man's Prison (2006).
[59] *The Cost of Victimization*, *supra* note 2 (testimony of Linda Bruntmyer); *see also* Human Rights Watch, No Escape 61 (2001).
[60] *Elimination of Prison Rape: Focus on Juveniles, Hearing*, *supra* note 32 (testimony of Chino Hardin).
[61] U.S. Department of Justice, *Initial Regulatory Impact Analysis*, *supra* note 5, at 8.
[62] Allen J. Beck, et al., *supra* note 6, at 12.
[63] Robert W. Dumond, *The Impact of Prisoner Sexual Violence: Challenges of Implementing Public Law 108-79 – The Prison Rape Elimination Act of 2003,* 32 J. Legis. 142, 147 (2006).

of using the contingent valuation method to monetize the cost of an incident of sexual abuse? If either adjustment were appropriate, how (or on the basis of what empirical data) would the Department go about determining the amount of the adjustment?

Congress specifically enacted PREA to ensure that we no longer take prison rape for granted or place a lesser value on the suffering of people in prisons. All sexual abuse is equally unacceptable, regardless of the victim's gender, custody status, or criminal history. The Department should not adjust the "willingness to pay" figures to account for the possibility that society may think prison rape is less pressing or that in the general population the vast majority of sexual abuse victims are female. Further, it is likely that at least some of the survey participants did consider the issue of sexual abuse in the confinement setting. The Cohen study asked survey respondents "to value crime reduction that affects them in some manner – whether through their own household, their families, or coworkers."[64] Given the size of the law enforcement and correctional system in this country, it is likely that persons who were directly impacted by lockups, jails, prisons, and community corrections facilities were surveyed and considered the risks to people in custody.

Question 46: Has the Department appropriately accounted for the increased costs to the victim and to society when the victim is a juvenile? Why or why not?

The IRIA has not appropriately accounted for the increased costs to the victim and society when the victim is a juvenile. The Department's calculations of the lower-bound estimates have not completely taken into account the far-reaching implications of sexual abuse of children. The upper-bound estimates were calculated incorrectly.

Lower-bound estimates of juvenile victims: First, we agree with the decision to count all incidents of staff-youth sexual contact as nonconsensual sexual activity; all staff-youth sexual intercourse is inherently coerced or pressured, and is harmful to the youth and society as a whole.

Second, the IRIA and the underlying cost studies upon which it relies do not include enough information to determine whether the youth estimates have adequately captured known costs of child sexual abuse victims. The 1996 National Institute of Justice Study, *Victim Costs and Consequences: A New Look,* and a more recent study released in 2007, *Costs of Sexual Violence in Minnesota,* provide a comprehensive listing of the costs and consequences associated with sexual abuse. The list of costs in the 2007 study appears to have incorporated several items that did not appear in the 1996 NIJ publication including costs of sexually transmitted diseases,

[64] Mark A. Cohen *et al., Willingness-to-Pay for Crime Control Programs,* 42 Criminology 86, 91 (2004).

unplanned pregnancies, substance abuse by victims and their families, and suicide acts. This suggests that the 2007 study's author made an attempt to update the list of costs to be as comprehensive as possible. However, we are unable to determine from the IRIA, or the studies upon which the IRIA relied, whether the estimates have fully accounted for the multiple ways that child sexual abuse negatively impacts the development of children.

According to a September 2007 Economic Impact Study by Prevent Child Abuse America, children who have been sexually abused are more likely to experience adverse outcomes in a number of areas, including:

- Poor physical health (*e.g.*, chronic fatigue, altered immune function, hypertension, sexually transmitted diseases, obesity);
- Poor emotional and mental health (*e.g.*, depression, anxiety, eating disorders, suicidal thoughts and attempts, post-traumatic stress disorder);
- Social difficulties (*e.g.*, insecure attachments with caregivers, which may lead to difficulties in developing trusting relationships with peers and adults later in life);
- Cognitive dysfunction (*e.g.*, deficits in attention, abstract reasoning, language development, and problem-solving skills, which ultimately affect academic achievement and school performance);
- High-risk health behaviors (*e.g.*, a higher number of lifetime sexual partners, younger age at first voluntary intercourse, teen pregnancy, alcohol and substance abuse); and
- Behavioral problems (*e.g.*, aggression, delinquency, and adult criminality).[65]

We urge the Department to incorporate these findings into the estimates for young people, to fully account for the longer remaining life span, earning potential, years of emotional suffering and other outcomes that would be greater for a young victim than an older one.

Third, as mentioned in our response to Question 38, the sexual abuse of youth in adult facilities was not calculated. We expect the costs associated with youth victimization in an adult facility are likely to be substantially similar to child sexual abuse generally. However, some additional modifications to the juvenile calculations will need to be made to account for the increased suicide risk that youth face when incarcerated in adult facilities. Youth in adult facilities are 36 times more likely to commit suicide than youth incarcerated in juvenile facilities.[66] According to

[65] Ching-Tung Wang & John Holton, *Total Estimated Cost of Child Abuse and Neglect in the United States*, Prevent Child Abuse America Economic Impact Study (2007), *available at* http://www.preventchildabuse.org/about_us/media_releases/pcaa_pew_economic_impact_study_final.pdf.

[66] Campaign for Youth Justice, *Jailing Juveniles* (2007), *available at* http://www.campaignforyouthjustice.org/documents/CFYJNR_JailingJuveniles.pdf.

the Centers for Disease Control and Prevention (CDC), the specific estimates of suicide rates are 2041 per 100,000 for youth held in adult detention facilities and 57 per 100,000 for youth held in juvenile detention centers.[67] The calculations should also account for the increased recidivism of youth held in adult facilities. The CDC and the Department's own Office of Juvenile Justice and Delinquency Prevention, have found that youth who are transferred from the juvenile court system to the adult criminal system are approximately 34% more likely than youth retained in the juvenile court system to be re-arrested for violent or other crime.[68]

Upper-bound estimates of juvenile victims: To calculate the upper-bound estimate for the unit cost of child rape, the Department used the willingness-to-pay (WTP) figures for adults and increased the cost by 33 percent, which was the difference between the actual cost estimates between adult and child victims. We do not believe the Department appropriately calculated the WTP figures for youth. In a recent study, "Estimating the Costs of Bad Outcomes for At-Risk Youth and the Benefits of Early Childhood Interventions to Reduce Them," researchers Mark Cohen, Alex Piquero, and Wesley Jennings employ the WTP methodology and indicate that society has a broader WTP for reduced child abuse.[69] To calculate the costs, the researchers doubled the costs identified in the NIJ study after updating to 2007 dollars.[70] We urge the Department to follow the same methodology and double the costs identified for child rape. Since the Department used $275,000 as the lower bound for the unit cost of rape involving force or threat of force in the juvenile detention setting, the corresponding upper bound should be $550,000 (not the $400,000 figure currently used).

Question 58: With respect to § 115.14, 115.114, 115.214, and 115. 314, will the limitations on cross-gender viewing (and any associated retrofitting and construction of privacy panels) impose any costs on agencies? If so, please provide any data from which a cost estimate can be developed for such measures.

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[67] Department of Health and Human Services, Centers for Disease Control and Prevention, *Effects on Violence of Laws and Polices Facilitating the Transfer of Youth from the Juvenile to the Adult Justice System, A Report on Recommendations of the Task Force on Community Preventive Services* (2007), *available at* http://www.cdc.gov/mmwr/pdf/rr/rr5609.pdf.

[68] Centers for Disease Control and Prevention, *Effects on Violence of Laws and Policies Facilitating the Transfer of Youth from the Juvenile to the Adult Justice System: A Report on Recommendations of the Task Force on Community Prevention Services* (2007), *available at* http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5609a1.htm; Richard E. Redding, U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention, *Juvenile Transfer Laws: An Effective Deterrent to Delinquency?* (2010), *available at* http://www.ncjrs.gov/pdffiles1/ojjdp/220595.pdf.

[69] Mark A. Cohen et al, *Estimating the Costs of Bad Outcomes for At-Risk Youth and the Benefits of Early Childhood Interventions to Reduce Them,* 21(4) Crim. Just. Pol'y Rev. 391, 415 (2010).

[70] *Id*.

Many juvenile facilities already avoid cross-gender viewing of youth in a state of undress by staffing residential units with same-sex staff, at least during times when youth are expected to be showering and changing, assigning same-sex staff to suicide watches, and keeping opposite-sex staff out of residential units during shower and dressing times. Any additional cost associated with privacy panels is far outweighed by the benefit of preventing the unnecessary viewing by opposite sex staff, given the trauma histories that many youth bring with them to confinement settings.

Question 59: Will the requirement in §§ 115.31, 115.231, and 115.331 that agencies train staff on how to communicate effectively and professionally with lesbian, gay, bisexual, transgender, or intersex residents lead to additional costs for correctional facilities, over and above the costs of other training requirements in the standards? If so, please provide any data from which a cost estimate can be developed for such training.

There are no additional costs for juvenile facilities associated with training staff how to communicate effectively and professionally with LGBTI residents that would be over and above the costs of other training requirements. A cost impact analysis of draft regulation § 115.31 has already concluded that adding this training requirement has no cost impact relative to the Commission's standard on training.[71] There is no reason to treat training on this topic differently than any of the other topics on which this regulation requires juvenile facilities to conduct trainings. Like all other training topics, training on effective communication with LGBTI residents will require some curriculum development, training for trainers, and slotted training time. And as with other training topics, facilities will be able to look to government-supported projects for topic-specific staff training curricula and materials. For example, training materials on professional and effective communication with LGBTI residents are, or will soon be, available through the collaborative project of the National Institute of Corrections and American University Washington College of Law, the National Institute of Corrections Cooperative Agreement for a Lesbian, Gay, Bisexual, Transgender and Intersex Guidance Project, and other initiatives.[72] Even if there were some additional cost related to training staff on how to communicate effectively and professionally with LGBTI individuals, given that studies show that these residents disproportionately experience sexual abuse in confinement, this sort of training will ultimately save money by increasing reporting of abuse and reducing incidents of abuse in the future.

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[71] *See Prison Rape Elimination Act (PREA) Regulatory Impact Analysis (RIA), Cost Impact of Revised Standards PP4, PP7, PP-2, TR-1, TR-2, TR-3, TR-4, TR-5, MM-3, SC-1, and SC-2*, at 5 (prisons), 17 (jails), 29 (community corrections), 40 (juvenile detention) (released on regulations.gov 3/1/2011).

[72] *See e.g.*, National Institute of Corrections and American University Washington College of Law, *Project on Addressing Prison Rape: Preventing the Sexual Abuse of Individuals in Custody, training materials*, *available at* http://www.wcl.american.edu/nic/training.cfm.

Question 62: Has the Department used the correct assumptions (in particular the assumption of constant cost) in projecting ongoing costs in the out years? Should it adjust its projections for the possibility that the cost of compliance may decrease over time as correctional agencies adopt new innovations that will make their compliance more efficient? If such an adjustment is appropriate, please propose a methodology for doing so and a source of data from which valid predictions as to "learning" can be derived.

We do believe that institutions will "learn" over time from implementing PREA but do not propose a specific methodological approach to adjust for such learning. For methodological ease, a linear model may be appropriate, particularly for certain regulations such as § 115.11, which discuss the designation and function of PREA coordinators. However, several regulations which were estimated to have either major or moderate ongoing costs are also subject to Constitutional requirements, such as:

§§ 115.31 – 115.35 (Training and education);
§ 115.83 (Ongoing medical and mental health care for sexual abuse victims and abusers); and
§§ 115.41 – 115.43 (Screening for risk of sexual victimization and abusiveness).

Categorizing all ongoing costs associated with these regulations is inappropriate. A revised methodology should reflect a facility's independent obligation outside of PREA to maintain safe facilities. Both the Eighth and the Fourteenth Amendments of the United States Constitution forbid cruel and unusual punishment of incarcerated persons. This prohibition creates a responsibility to protect incarcerated individuals from harm during their incarceration, including a duty to train their employees, provide adequate health and mental health care, and properly classify persons for their risk of abuse. In addition, state laws require juvenile justice systems to rehabilitate youth, numerous child protection statutes impose additional requirements to prevent harm to youth in institutions, and constitutional requirements extend a substantive due process right to reasonably safe conditions of confinement to incarcerated youth, since youth are not confined for the purposes of punishment.[73]

[73] *See Deshaney v. Winnebago County*, 489 U.S. 189, 200 (1989) ("[W]hen the State . . . so restrains an individual's liberty that it renders him unable to care for himself, and at the same time fails to provide for his basic human needs – e.g., food, clothing, shelter, medical care, and reasonable safety – it transgresses the substantive limits on state action set by the Eighth Amendment and the Due Process Clause."); *Youngberg v. Romeo*, 457 U.S. 307, 316 (1982); *Bell v. Wolfish*, 441 U.S. 520 (1979); *Nelson v. Heyne*, 491 F.2d 352, 360 (7th Cir. 1974) ("The 'right to treatment' includes the right to minimum acceptable standards of care and treatment for juveniles and the right to individualized care and treatment.")

Question 63: Are there any data showing how the marginal cost of rape reduction is likely to change once various benchmarks of reduction have been achieved? If not, is it appropriate for the Department to assume, for purposes of breakeven analysis, that the costs and benefits of reducing prison rape are linear, at least within the range relevant to the analysis? Why or why not?

We believe that the marginal cost of rape reduction is likely to change once benchmarks have been achieved, with some regulations having an immediate and greater impact on the reduction of prison rape than others. However, given that the IRIA only assumed a 1 percent reduction in the baseline, we think using a linear model is methodologically appropriate.

Question 64: Are the expectations as to the effectiveness of the proposed standards that are subsumed within the breakeven analysis (e.g., 0.7% - 1.7% reduction in baseline prevalence needed to justify startup costs and 2.06% - 3.13% reduction required for ongoing costs) reasonable? Why or why not? Are there available data from which reasonable predictions can be made as to the extent to which these proposed standards will be effective in reducing the prevalence of rape and sexual abuse in prisons? If so, please supply them.

The assumptions and valuations the Department has made in estimating the benefits of preventing sexual abuse are extremely conservative. By erring on the side of great caution in its projections of those benefits, and then showing that they would still outweigh costs even if the regulations saved only three percent of all victims, the Department's analysis makes clear that, even with additional costs, the regulations will result in substantial savings.

We have also proposed several modifications to strengthen the final regulations, understanding that some changes may increase the costs associated with the standards. Nonetheless, we believe these changes are warranted by PREA itself. Congress passed the Prison Rape *Elimination* Act, not the Prison Rape *Reduction* Act as it had been initially named. If the final regulations with our recommendations were fully implemented, then the shockingly high rates of abuse against incarcerated youth would likely drop far more than three percent.

The additional costs incurred by our recommendations are modest, and will be more than outweighed by the resulting benefits. Fewer incidents of abuse will reduce the costs of the investigations, grievances, and medical and mental health care required after an assault. Safer facilities also have fewer security breaches, less physical violence, and greater staff retention.[74]

[74] *See* Office of the Inspector General, Evaluation and Inspections Division, The Department of Justice's Efforts to Prevent Staff Sexual Abuse of Federal Inmates i (2009), *available at* http://www.justice.gov/oig/reports/plus/e0904.pdf ("In addition to traumatizing prisoners, federal personnel may also neglect their professional duties and subvert their prison's security procedures in order to engage in and conceal their prohibited sexual relationships with prisoners."); National Prison

Most importantly, by reducing the extent to which residents endure the trauma of sexual abuse in detention, these basic measures will decrease recidivism and increase the likelihood that a detained youth grows up to become a law-abiding contributing member of society.

Rape Elimination Commission, Final Report 48 (2009) ("[F]acilities rife with sexual abuse cannot function effectively.").