State of Iowa Department of Corrections
Policy and Procedures

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PREA Standards: 115.6, 21(c)(d)(h), 31(a)(10), 35(a)(b)(c)(d), 61(c)(d), 81(d)(e), 82(a)(c)(d), 83(a)(b)(c)(d)(e)(f)(g)(h)
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Authority:

1. PURPOSE

To provide guidelines to meet the mental and physical needs of an alleged sexual abuse victim under the supervision/custody of the Iowa Department of Corrections (IDOC).

2. POLICY

It is the policy of the Iowa Department of Corrections that patients who report sexual abuse while incarcerated shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services; be offered psychological (mental health) and medical services; and, when appropriate, a forensic examination or sexual abuse examination will be completed by a qualified professional. Treatment services shall be consistent with the community level of care and provided without financial cost regardless of whether the victim names the aggressor or cooperates with any investigation arising out of the incident. **(PREA 115.82(a)(d), 83(a)(c)(g))**

3. DEFINITIONS

A. Sexual Abuse - Sexual abuse of an offender, detainee, or resident by another offender, detainee, or resident; and sexual abuse of an

offender, detainee, or resident by a staff member, contractor, or volunteer. Sexual abuse of an offender, detainee, or resident by another offender, detainee, or resident includes any of the following acts, if the victim does not consent or refuse:

1. Contact between the penis and vulva or the penis and the anus, including penetration, however, slight;

2. Contact between the mouth and the penis, vulva, or anus;

3. Contact between the mouth and any body part where the staff member, contractor, or volunteer has the intent to abuse, arouse, or gratify sexual desire;

4. Penetration of the anal or genital opening, however, slight, by a hand, finger, object, or other instrument, that is unrelated to official duties or where the staff member, contractor, or volunteer has the intent to abuse, arouse, or gratify sexual desire;

5. Any other intentional contact, either directly or through the clothing, of or with the genitalia, anus, groin, breast, inner thigh, or the buttocks, that is unrelated to official duties or where the staff member, contractor, or volunteer has the intent to abuse, arouse, or gratify sexual desire;

6. Any attempt, threat, or request by a staff member, contractor, or volunteer to engage in the activities described in paragraphs (1)-(5) of this section;

7. Any display by a staff member, contractor, or volunteer of his or her uncovered genitalia, buttocks, or breast in the presence of an offender, detainee, or resident; and

8. Voyeurism by a staff member, contractor, or volunteer means an invasion of privacy of an offender, detainee, or resident by staff for reasons unrelated to official duties, such as peering at an offender who is using a toilet in his/her cell to perform bodily functions; requiring an offender to expose his/her buttocks, genitals, or breasts; or taking images of all or part of an offenders naked body or of an offender performing bodily functions. **(PREA 115.6)**

B. PREA - Prison Rape Elimination Act.

C. Qualified Staff Member - An IDOC staff member who has been screened for appropriateness to serve as a victim advocate and has received education concerning sexual abuse and forensic examination issues in general. **(PREA 115.21(h))**

D. Victim Advocate - A staff member or volunteer from the Iowa Coalition Against Sexual Assault (Iowa CASA) or an Iowa sexual assault/rape crisis center who is certified by Iowa CASA under **Iowa Code 915.20A**, and whose responsibilities include services to survivors of sexual abuse and correctional staff in Iowa's correctional institutions: renders support and assistance, provides and technical assistance.

E. See IDOC Policy **AD-GA-16** for additional Definitions.

4. PROCEDURE

A. Medical staff shall promptly examine the patient. In addition to required medical care, Health Services shall document all injuries and note the same in Medical ICON. Co-pay does not apply to PREA incidents.

1. Assess the victim's needs for immediate care for potentially life-threatening or serious injuries. Administer necessary first aid.

2. If injuries do not appear serious, emphasize to victims the need for medical evaluation and address related health concerns. Also explain the purpose of the exam and what happens during the exam process, keeping in mind that the amount of information that victims want at this time varies.

3. The initial interaction with on-site health services will be completed by a licensed medical practitioner if available, along with a member of the nursing staff.

4. Document the victim's demeanor and statements related to the abuse.

5. IDOC shall offer all victims of sexual abuse access to forensic medical examinations at an outside facility, without financial cost, where evidentiary or medically appropriate. Such examinations shall be performed by Sexual Assault Forensic

Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) wherever possible. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified medical practitioners. Efforts to provide SAFEs or SANEs is documented in each institution's Memorandum of Understanding (MOU). **(PREA 115.21(c))**

6. Medical staff shall reassure the patient that Health Services' involvement is to ensure that the necessary evaluation and treatment of any injuries is obtained, and that psychological support is offered.

7. If a procedure is declined, reasons why should be documented if the patient provides such information.

8. Medical staff shall:

    a. Upon stabilization of any serious injuries, medical staff will refer the victim to a predetermined outside medical facility for completion of a sexual abuse examination and collection of forensic evidence.

    b. Encourage victim's interaction with advocates as soon as possible after disclosure of the abuse, even if victims choose not to receive medical care.

    c. Facilitate an off-site sexual abuse examination by communication of pertinent information known about the incident, including infectious disease status of the alleged aggressor to medical staff of the off-site provider.

    d. Complete an examination if the alleged abuse has occurred after 72 hours to address any medical concerns and/or injuries, including patient and aggressor evaluation for infectious diseases. A referral to an outside medical facility may not be appropriate after 72 hours.

    e. Explain to the patient the benefit or rationale of the department's decision to utilize community medical services.

f. Offer patients of sexual abuse timely information and access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care where medically appropriate. **(PREA 115.82(c), 83(f))**

g. Offer patients of sexually abusive vaginal penetration pregnancy tests if appropriate. If pregnancy results from the sexual abuse, patients shall receive timely and comprehensive information and timely access to all lawful pregnancy-related medical services. **(PREA 115.83(d)(e))**

h. The Shift Supervisor shall attempt to make available to the patient a victim advocate from a community crime victim center. If a community crime victim center is not available to provide victim advocate services, the Shift Supervisor shall make these services available through a qualified staff member from a community-based organization, or a qualified IDOC staff member. The Shift Supervisor shall document such efforts. **(PREA 115.21(d))**

i. Explain to the patient reporting the sexual abuse that, as part of the examination, there may be a need to draw blood to evaluate their current status for infectious disease, and that follow-up infectious disease testing may be indicated.

j. Document in the EMR if the alleged victim refuses post-abuse examination, which will include all actions taken, communications with the patient and discussion of the advantages to follow through. A *Treatment Refusal form*, **HSF-305**, must be completed.

k. Assure the patient has been scheduled for a psychologist encounter.

l. Ensure that all community medical facility information and follow-up recommendations are reviewed by an IDOC licensed medical practitioner.

B. Mental Health Staff Responsibilities

1. Upon notification, or on the next work day, mental health professionals will assess the patient's mental health needs and provide necessary crisis counseling. Mental health staff will confer with PREA investigators regarding any clinical issues relevant to the interview.

2. All institutions shall attempt to conduct a mental health evaluation of all known patient-on-patient aggressors within 60 days of learning of such sexual violence history and offer treatment when deemed appropriate by mental health practitioners. **(PREA 115.83(h))**

C. Confidentiality

1. Any information related to sexual violence that occurred in an institutional setting shall be strictly limited to medical and mental health practitioners and other staff, as necessary, to inform of treatment plans and security and management decisions, including housing, bed, work, education and program assignments, or as otherwise required by Federal, State or local law. **(PREA 115.81(d))**

2. Medical and mental health practitioners shall obtain informed consent from inmates before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the incarcerated individual is under the age of 18. **(PREA 115.81 (e))** Consent shall be obtained on **HSF-628** *Sexual Victimization Reporting Consent Form* and documented in ICON Medical.

3. If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable persons statue, Health Services shall report the allegation to the designated State or local services agency under applicable mandatory reporting laws **(PREA 115.61(d))**

D. Specialized Training

1. Each institution shall ensure that all full- and part-time medical and mental health care staff who work regularly in its facilities have been trained in:

    a. How to detect and assess signs of sexual violence;

b. How to preserve physical evidence of sexual violence;

c. How to respond effectively and professionally to victims of sexual violence; and

d. How and who to report allegations or suspicions of sexual violence. **(PREA 115.35(a))**

2. The institution shall maintain documentation that medical and mental health practitioners have received the training reference in this standard either from the agency or elsewhere. **(PREA 115.35(c))**

3. Medical and mental health care practitioners shall also receive the training mandated for all employees, depending on the practitioner's status at the agency. See also Policy **AD-TS-05**, *In-Service Training*. **(PREA 115.35(d))**

4. Medical and mental health care practitioners shall also receive training on how to comply with relevant laws related to mandatory reporting of sexual violence to outside authorities. **(PREA 115.31(a)(10))**

E. Post-Exposure

1. Encourage patients to accept prophylaxis against STIs if indicated.

2. If prophylaxis is declined at the time of the initial exam, it is medically prudent to obtain cultures and arrange for a follow-up examination and testing (it is recommended that all patients are reexamined). Document patients' decisions and rationales for declining prophylaxis in their medical records.

F. Hepatitis B Virus (HBV) and Post-Exposure Prophylaxis (PEP)

1. Patients who have completed a full hepatitis B vaccination regimen prior to the abuse are protected from HBV infection and do not need further doses.

2. For those who were not fully vaccinated prior to the abuse, the vaccine should be completed as scheduled. Patients unvaccinated prior to the abuse or unsure of whether they have been vaccinated should receive active post-exposure

prophylaxis, e.g. hepatitis B vaccine alone, upon the initial clinical evaluation. Unless suspects are known to have acute hepatitis B, HBIG (Hepatitis B Immune Globulin) is not required.

3. Encourage follow-up STI exams, testing, immunizations, counseling, and treatment as directed. Although patients may be reluctant to go for follow-up exams for STIs, such exams are essential because they provide an opportunity to detect new infections acquired during or after the abuse.

4. The Centers for Disease Control and Prevention (CDC) recommends a follow-up appointment within one (1) to two (2) weeks of the abuse. If patient tested negative at the time of the medical forensic exam and chose not to receive prophylaxis, follow-up testing should be conducted.

5. The CDC recommends follow-up testing for patients who received treatment only if they report having symptoms consistent with an STI. However, patients who were treated should be informed of the option of follow-up testing to confirm the presence or lack of infection. The CDC recommends that testing for syphilis and HIV infection should be repeated 6 weeks, 3 months, and 6 months after the abuse if initial test results were negative and if these infections are likely to be present in assailants.

6. Address concerns about HIV infection. Although the risk of human immunodeficiency virus (HIV) infection from a sexual abuse appears to be low, it is typically of grave concern for sexual abuse patients.

7. Examiners should talk with patients about their concerns regarding the possibility of contracting HIV. Although a definitive statement of benefit cannot be made regarding Post Exposure Prophylaxis (PEP) after sexual abuse, the possibility of HIV exposure from the abuse should be assessed at the time of the examination. The possible benefit of PEP in preventing HIV infection should also be discussed with the patient if the details of the abuse pose an elevated risk for HIV exposure. These particular factors may include: the likelihood that the assailant has HIV, the time elapsed since the event, the exposure characteristics, and local epidemiology of HIV/AIDS.

8. Baseline HIV testing is not typically an exam component. However, if the abuse is considered a high risk for HIV exposure, patients should establish their baseline HIV status within 72 hours after the abuse and then be tested per blood borne exposure protocol. However, even if the abuse is not considered a high risk for HIV exposure, some patients may still wish to be tested. HIV testing should be done in settings where counseling can be offered to explain results and implications.

9. The use of antiretroviral agents after possible exposure through sexual abuse must balance potential benefits of treatment with its possible adverse side effects. Health care personnel must evaluate patients' risk of exposure to HIV and consider whether to offer treatment based on their perceived risk. Examiners unfamiliar with known risks associated with exposure or side effects of post-exposure therapeutic agents should consult with a specialist in HIV treatment. Numerous factors may influence the decision to offer treatment, such as the time since the exposure occurred; the probability that the assailant is infected with HIV; the likelihood that transmission could occur from the abuse; and the prevalence of HIV in the geographic area or institutional setting, e.g. a prison, where the abuse occurred.

10. When given following a sexual abuse, post-exposure prophylaxis is the same as for occupational exposure to HIV. Careful monitoring and follow-up by a health care provider or agency experienced in HIV issues is required. Patients should be alerted to symptoms of primary HIV infection, e.g. fever, fatigue, sore throat, lymphadenopathy, rash, and seek care if these symptoms arise.

11. The decision to begin or withhold treatment should be made by patients and health care personnel after patients have been adequately informed of the risks and benefits of treatment options.

G. Pregnancy Risk Evaluation and Care

1. The risk of pregnancy from sexual abuse is estimated to be two (2) to five (5) percent, similar to the risk of pregnancy from a one-time sexual encounter.

2. Any female of reproductive capability (Tanner Stage 3 and above, irrespective of menarche) can potentially become pregnant from any single exposure.

3. Although many transgender male individuals believe they are infertile as a result of using testosterone, cases have been reported of unexpected pregnancies. Therefore, if a transgender male individual has not had a hysterectomy, is still within childbearing years, and the nature of the abuse suggests it, the possibility of pregnancy should be discussed, even if he has not been menstruating.

4. Discuss options with the patient and information regarding the timeframe for emergency contraception provision, so they can make an informed decision. Inform the patient that the provision of any emergency contraception will not prevent sexually transmitted infections. The conversation with the patient should include a thorough discussion, including mechanism of action for each treatment option, side effects, dosing, and follow-up. This information should also be provided in writing in the preferred language of the patient, if possible.

5. Offer/provide the patient with emergency contraception pills and anti-nausea medication if they are at risk. Emergency contraception is a hormonal method of preventing pregnancy that can be used after sexual abuse. There are multiple products available for EC. It is recommended, however, that Levonorgestrel, a synthetic hormone be used. This option is recommended for its higher efficacy rate and ease of dosing, and the fewest number of side effects, particularly nausea and vomiting. Levonorgestrel will not end a pregnancy that is already in progress and is considered a safe and easy treatment for victims of abuse in preventing a pregnancy. Levonorgestrel is most effective if used within 120 hours and can reduce the risk of pregnancy by up to 89 percent. Traditional dosing of Levonorgestrel includes administering two doses of 0.75 mg taken orally 12 hours apart. However, some studies indicate that single dosing with 1.5 mgs of Levonorgestrel is just as effective and better tolerated by the patient.

H. Follow-up

1. Make sure patients' medical and mental health needs related to the abuse have been addressed. Discuss with patients whether they have any other medical and/or mental health concerns related to the abuse.

2. The evaluation and treatment of victims of sexual violence in any prison, jail, lockup, or juvenile facility shall include, as 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. **(PREA 115.83(b))**