PREA Facility Audit Report: Final

Name of Facility: Alpha House Men's Pre-Release
Facility Type: Community Confinement
Date Interim Report Submitted: 06/27/2022
Date Final Report Submitted: 12/16/2022

Auditor Certification	
The contents of this report are accurate to the best of my knowledge.	■
No conflict of interest exists with respect to my ability to conduct an audit of the agency under review.	■
I have not included in the final report any personally identifiable information (PII) about any inmate/resident/detainee or staff member, except where the names of administrative personnel are specifically requested in the report template.	■
Auditor Full Name as Signed: Kenneth E Arnold	**Date of Signature:** 12/16/2022

AUDITOR INFORMATION	
Auditor name:	Arnold, Kenneth
Email:	kenarnold220@gmail.com
Start Date of On-Site Audit:	04/18/2022
End Date of On-Site Audit:	04/19/2022

FACILITY INFORMATION	
Facility name:	Alpha House Men's Pre-Release
Facility physical address:	3109 1st Avenue North, Billings, Montana - 59101
Facility mailing address:	

Primary Contact	
Name:	John Williams
Email Address:	jwilliams@altinc.net
Telephone Number:	406-259-9695

Facility Director	
Name:	John Williams
Email Address:	jwilliams@altinc.net
Telephone Number:	406-259-9695

Facility PREA Compliance Manager	
Name:	
Email Address:	
Telephone Number:	

Facility Characteristics	
Designed facility capacity:	203
Current population of facility:	194
Average daily population for the past 12 months:	170
Has the facility been over capacity at any point in the past 12 months?	No
Which population(s) does the facility hold?	Males
Age range of population:	18+
Facility security levels/resident custody levels:	MT DOC Inmate Status; FBOP Community Corrections. Work in community, resides at facility.
Number of staff currently employed at the facility who may have contact with residents:	48
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	1
Number of volunteers who have contact with residents, currently authorized to enter the facility:	1

AGENCY INFORMATION	
Name of agency:	Alternatives, Inc.
Governing authority or parent agency (if applicable):	
Physical Address:	1001 South 27th Street, Billings, Montana - 59101
Mailing Address:	
Telephone number:	406-294-9609

Agency Chief Executive Officer Information:	
Name:	David O. Armstrong
Email Address:	darmstrong@altinc.net
Telephone Number:	406-294-9609 ext 207

Agency-Wide PREA Coordinator Information			
Name:	Rick Deady	**Email Address:**	rdeady@altinc.net

SUMMARY OF AUDIT FINDINGS

The OAS automatically populates the number and list of Standards exceeded, the number of Standards met, and the number and list of Standards not met.

Auditor Note: In general, no standards should be found to be "Not Applicable" or "NA." A compliance determination must be made for each standard. In rare instances where an auditor determines that a standard is not applicable, the auditor should select "Meets Standard" and include a comprehensive discussion as to why the standard is not applicable to the facility being audited.

Number of standards exceeded:	
1	• 115.213 - Supervision and monitoring
Number of standards met:	
40	
Number of standards not met:	
0	

POST-AUDIT REPORTING INFORMATION

GENERAL AUDIT INFORMATION

On-site Audit Dates

1. Start date of the onsite portion of the audit:	2022-04-18
2. End date of the onsite portion of the audit:	2022-04-19

Outreach

10. Did you attempt to communicate with community-based organization(s) or victim advocates who provide services to this facility and/or who may have insight into relevant conditions in the facility?	(●) Yes ( ) No
a. Identify the community-based organization(s) or victim advocates with whom you communicated:	YWCA Billings Gateway

AUDITED FACILITY INFORMATION

14. Designated facility capacity:	203
15. Average daily population for the past 12 months:	170
16. Number of inmate/resident/detainee housing units:	3
17. Does the facility ever hold youthful inmates or youthful/juvenile detainees?	( ) Yes ( ) No (●) Not Applicable for the facility type audited (i.e., Community Confinement Facility or Juvenile Facility)

Audited Facility Population Characteristics on Day One of the Onsite Portion of the Audit

Inmates/Residents/Detainees Population Characteristics on Day One of the Onsite Portion of the Audit

36. Enter the total number of inmates/ residents/detainees in the facility as of the first day of onsite portion of the audit:	193
38. Enter the total number of inmates/ residents/detainees with a physical disability in the facility as of the first day of the onsite portion of the audit:	0
39. Enter the total number of inmates/ residents/detainees with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) in the facility as of the first day of the onsite portion of the audit:	5
40. Enter the total number of inmates/ residents/detainees who are Blind or have low vision (visually impaired) in the facility as of the first day of the onsite portion of the audit:	0
41. Enter the total number of inmates/ residents/detainees who are Deaf or hard-of-hearing in the facility as of the first day of the onsite portion of the audit:	0
42. Enter the total number of inmates/ residents/detainees who are Limited English Proficient (LEP) in the facility as of the first day of the onsite portion of the audit:	0

43. Enter the total number of inmates/ residents/detainees who identify as lesbian, gay, or bisexual in the facility as of the first day of the onsite portion of the audit:	4
44. Enter the total number of inmates/ residents/detainees who identify as transgender or intersex in the facility as of the first day of the onsite portion of the audit:	1
45. Enter the total number of inmates/ residents/detainees who reported sexual abuse in the facility as of the first day of the onsite portion of the audit:	0
46. Enter the total number of inmates/ residents/detainees who disclosed prior sexual victimization during risk screening in the facility as of the first day of the onsite portion of the audit:	1
47. Enter the total number of inmates/ residents/detainees who were ever placed in segregated housing/isolation for risk of sexual victimization in the facility as of the first day of the onsite portion of the audit:	0
48. Provide any additional comments regarding the population characteristics of inmates/residents/detainees in the facility as of the first day of the onsite portion of the audit (e.g., groups not tracked, issues with identifying certain populations):	The narrative parallels that articulated in 30, above.

Staff, Volunteers, and Contractors Population Characteristics on Day One of the Onsite Portion of the Audit

49. Enter the total number of STAFF, including both full- and part-time staff, employed by the facility as of the first day of the onsite portion of the audit:	33

50. Enter the total number of VOLUNTEERS assigned to the facility as of the first day of the onsite portion of the audit who have contact with inmates/residents/detainees:	1
51. Enter the total number of CONTRACTORS assigned to the facility as of the first day of the onsite portion of the audit who have contact with inmates/residents/detainees:	1
52. Provide any additional comments regarding the population characteristics of staff, volunteers, and contractors who were in the facility as of the first day of the onsite portion of the audit:	The auditor notes that the one contractor is actually an escorted and supervised vendor. Accordingly, it does not appear that he/she qualifies as a contractor within the context of 115.217 and 115.232.

INTERVIEWS

Inmate/Resident/Detainee Interviews

Random Inmate/Resident/Detainee Interviews

53. Enter the total number of RANDOM INMATES/RESIDENTS/DETAINEES who were interviewed:	11
54. Select which characteristics you considered when you selected RANDOM INMATE/RESIDENT/DETAINEE interviewees: (select all that apply)	☑ Age ☑ Race ☑ Ethnicity (e.g., Hispanic, Non-Hispanic) ☑ Length of time in the facility ☑ Housing assignment ☑ Gender ☐ Other ☐ None

55. How did you ensure your sample of RANDOM INMATE/RESIDENT/DETAINEE interviewees was geographically diverse?	Given the fact that there are three distinct units, the auditor randomly selected interviewees from each wing and the cottage at the rear of the facility.
56. Were you able to conduct the minimum number of random inmate/ resident/detainee interviews?	(●) Yes ( ) No
57. Provide any additional comments regarding selecting or interviewing random inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation):	None.

Targeted Inmate/Resident/Detainee Interviews

58. Enter the total number of TARGETED INMATES/RESIDENTS/DETAINEES who were interviewed:	10

As stated in the PREA Auditor Handbook, the breakdown of targeted interviews is intended to guide auditors in interviewing the appropriate cross-section of inmates/residents/detainees who are the most vulnerable to sexual abuse and sexual harassment. When completing questions regarding targeted inmate/resident/detainee interviews below, remember that an interview with one inmate/resident/detainee may satisfy multiple targeted interview requirements. These questions are asking about the number of interviews conducted using the targeted inmate/ resident/detainee protocols. For example, if an auditor interviews an inmate who has a physical disability, is being held in segregated housing due to risk of sexual victimization, and disclosed prior sexual victimization, that interview would be included in the totals for each of those questions. Therefore, in most cases, the sum of all the following responses to the targeted inmate/resident/detainee interview categories will exceed the total number of targeted inmates/ residents/detainees who were interviewed. If a particular targeted population is not applicable in the audited facility, enter "0".

60. Enter the total number of interviews conducted with inmates/residents/ detainees with a physical disability using the "Disabled and Limited English Proficient Inmates" protocol:	0

a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	☑ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/ residents/detainees).	Pursuant to random conversations with staff, as well as, auditor observation during the facility tour, he did not observe, nor was he alerted to, any physically disabled residents.
61. Enter the total number of interviews conducted with inmates/residents/ detainees with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) using the "Disabled and Limited English Proficient Inmates" protocol:	5
62. Enter the total number of interviews conducted with inmates/residents/ detainees who are Blind or have low vision (i.e., visually impaired) using the "Disabled and Limited English Proficient Inmates" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	☑ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.

b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	Pursuant to random conversations with staff, as well as, auditor random conversations with residents during the facility tour and interviews, he did not observe, nor was he alerted to, any blind or low vision residents.
63. Enter the total number of interviews conducted with inmates/residents/detainees who are Deaf or hard-of-hearing using the "Disabled and Limited English Proficient Inmates" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	Pursuant to random conversations with staff, as well as, auditor interactions with residents during the facility tour and interviews, he did not observe, nor was he alerted to, any deaf or hard of hearing residents.
64. Enter the total number of interviews conducted with inmates/residents/detainees who are Limited English Proficient (LEP) using the "Disabled and Limited English Proficient Inmates" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.

b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/ residents/detainees).	Pursuant to random conversations with staff, as well as, auditor conversations with residents during the facility tour and interviews, he did not observe, nor was he alerted to, any LEP residents.
65. Enter the total number of interviews conducted with inmates/residents/ detainees who identify as lesbian, gay, or bisexual using the "Transgender and Intersex Inmates; Gay, Lesbian, and Bisexual Inmates" protocol:	4
66. Enter the total number of interviews conducted with inmates/residents/ detainees who identify as transgender or intersex using the "Transgender and Intersex Inmates; Gay, Lesbian, and Bisexual Inmates" protocol:	1
67. Enter the total number of interviews conducted with inmates/residents/ detainees who reported sexual abuse in this facility using the "Inmates who Reported a Sexual Abuse" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/ residents/detainees).	The one resident who reported a marginal sexual abuse incident during the last 12 months was not confined at AH during the on-site audit.

68. Enter the total number of interviews conducted with inmates/residents/ detainees who disclosed prior sexual victimization during risk screening using the "Inmates who Disclosed Sexual Victimization during Risk Screening" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/ residents/detainees).	The one resident who reported sexual abuse in another facility during the last 12 months was not confined at AH during the on-site audit.
69. Enter the total number of interviews conducted with inmates/residents/ detainees who are or were ever placed in segregated housing/isolation for risk of sexual victimization using the "Inmates Placed in Segregated Housing (for Risk of Sexual Victimization/Who Allege to have Suffered Sexual Abuse)" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.

b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	The auditor notes that there is no segregated housing at AH.
70. Provide any additional comments regarding selecting or interviewing targeted inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews):	NA.

Staff, Volunteer, and Contractor Interviews

Random Staff Interviews

71. Enter the total number of RANDOM STAFF who were interviewed:	11
72. Select which characteristics you considered when you selected RANDOM STAFF interviewees: (select all that apply)	☑ Length of tenure in the facility ☑ Shift assignment ☑ Work assignment ☑ Rank (or equivalent) ☐ Other (e.g., gender, race, ethnicity, languages spoken) ☐ None
If "Other," describe:	NA.
73. Were you able to conduct the minimum number of RANDOM STAFF interviews?	○ Yes ◉ No

a. Select the reason(s) why you were unable to conduct the minimum number of RANDOM STAFF interviews: (select all that apply)	☐ Too many staff declined to participate in interviews. ☐ Not enough staff employed by the facility to meet the minimum number of random staff interviews (Note: select this option if there were not enough staff employed by the facility or not enough staff employed by the facility to interview for both random and specialized staff roles). ☑ Not enough staff available in the facility during the onsite portion of the audit to meet the minimum number of random staff interviews. ☐ Other
74. Provide any additional comments regarding selecting or interviewing random staff (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation):	With staff on off days, annual leave, etc., the auditor could only interview 11 random staff and still complete specialty interviews.

Specialized Staff, Volunteers, and Contractor Interviews

Staff in some facilities may be responsible for more than one of the specialized staff duties. Therefore, more than one interview protocol may apply to an interview with a single staff member and that information would satisfy multiple specialized staff interview requirements.

75. Enter the total number of staff in a SPECIALIZED STAFF role who were interviewed (excluding volunteers and contractors):	12
76. Were you able to interview the Agency Head?	◉ Yes ○ No
77. Were you able to interview the Warden/Facility Director/Superintendent or their designee?	◉ Yes ○ No

78. Were you able to interview the PREA Coordinator?	(●) Yes ( ) No
79. Were you able to interview the PREA Compliance Manager?	(●) Yes ( ) No ( ) NA (NA if the agency is a single facility agency or is otherwise not required to have a PREA Compliance Manager per the Standards)

80. Select which SPECIALIZED STAFF roles were interviewed as part of this audit from the list below: (select all that apply)	☐ Agency contract administrator ☐ Intermediate or higher-level facility staff responsible for conducting and documenting unannounced rounds to identify and deter staff sexual abuse and sexual harassment ☐ Line staff who supervise youthful inmates (if applicable) ☐ Education and program staff who work with youthful inmates (if applicable) ☐ Medical staff ☑ Mental health staff ☑ Non-medical staff involved in cross-gender strip or visual searches ☑ Administrative (human resources) staff ☑ Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE) staff ☑ Investigative staff responsible for conducting administrative investigations ☑ Investigative staff responsible for conducting criminal investigations ☑ Staff who perform screening for risk of victimization and abusiveness ☐ Staff who supervise inmates in segregated housing/residents in isolation ☑ Staff on the sexual abuse incident review team ☑ Designated staff member charged with monitoring retaliation ☑ First responders, both security and non-security staff

	☑ Intake staff ☐ Other
81. Did you interview VOLUNTEERS who may have contact with inmates/ residents/detainees in this facility?	◉ Yes ○ No
a. Enter the total number of VOLUNTEERS who were interviewed:	1
b. Select which specialized VOLUNTEER role(s) were interviewed as part of this audit from the list below: (select all that apply)	☐ Education/programming ☐ Medical/dental ☐ Mental health/counseling ☑ Religious ☐ Other
82. Did you interview CONTRACTORS who may have contact with inmates/ residents/detainees in this facility?	○ Yes ◉ No
83. Provide any additional comments regarding selecting or interviewing specialized staff.	The contractor(s) are actually escorted and supervised vendors. Accordingly, the auditor determined that these individuals do not meet the intent of 115.232.

SITE REVIEW AND DOCUMENTATION SAMPLING

Site Review

PREA Standard 115.401 (h) states, "The auditor shall have access to, and shall observe, all areas of the audited facilities." In order to meet the requirements in this Standard, the site review portion of the onsite audit must include a thorough examination of the entire facility. The site review is not a casual tour of the facility. It is an active, inquiring process that includes talking with staff and inmates to determine whether, and the extent to which, the audited facility's practices demonstrate compliance with the Standards. Note: As you are conducting the site review, you must document your tests of critical functions, important information gathered through observations, and any issues identified with facility practices. The information you collect through the site review is a crucial part of the evidence you will analyze as part of your compliance determinations and will be needed to complete your audit report, including the Post-Audit Reporting Information.

84. Did you have access to all areas of the facility?	(●) Yes ( ) No

Was the site review an active, inquiring process that included the following:

85. Observations of all facility practices in accordance with the site review component of the audit instrument (e.g., signage, supervision practices, cross-gender viewing and searches)?	(●) Yes ( ) No
86. Tests of all critical functions in the facility in accordance with the site review component of the audit instrument (e.g., risk screening process, access to outside emotional support services, interpretation services)?	( ) Yes (●) No
a. Explain which critical functions you were unable to test per the site review component of the audit instrument and why:	While all functions were tested, the same were tested from the auditor's home. As indicated throughout this report, during the on-site audit, the auditor received zero complaints regarding access to telephones or operational efficiency.

87. Informal conversations with inmates/ residents/detainees during the site review (encouraged, not required)?	(●) Yes ( ) No
88. Informal conversations with staff during the site review (encouraged, not required)?	(●) Yes ( ) No
89. Provide any additional comments regarding the site review (e.g., access to areas in the facility, observations, tests of critical functions, or informal conversations).	None.

Documentation Sampling

Where there is a collection of records to review-such as staff, contractor, and volunteer training records; background check records; supervisory rounds logs; risk screening and intake processing records; inmate education records; medical files; and investigative files-auditors must self-select for review a representative sample of each type of record.

90. In addition to the proof documentation selected by the agency or facility and provided to you, did you also conduct an auditor-selected sampling of documentation?	(●) Yes ( ) No
91. Provide any additional comments regarding selecting additional documentation (e.g., any documentation you oversampled, barriers to selecting additional documentation, etc.).	11 random staff HR files. 12 random staff training files. 14 random resident files. 1 administrative sexual abuse/harassment investigative file.

SEXUAL ABUSE AND SEXUAL HARASSMENT ALLEGATIONS AND INVESTIGATIONS IN THIS FACILITY

Sexual Abuse and Sexual Harassment Allegations and Investigations Overview

Remember the number of allegations should be based on a review of all sources of allegations (e.g., hotline, third-party, grievances) and should not be based solely on the number of investigations conducted. Note: For question brevity, we use the term “inmate” in the following questions. Auditors should provide information on inmate, resident, or detainee sexual abuse allegations and investigations, as applicable to the facility type being audited.

92. Total number of SEXUAL ABUSE allegations and investigations overview during the 12 months preceding the audit, by incident type:

	# of sexual abuse allegations	# of criminal investigations	# of administrative investigations	# of allegations that had both criminal and administrative investigations
Inmate-on-inmate sexual abuse	1	0	1	0
Staff-on-inmate sexual abuse	0	0	0	0
Total	1	0	1	0

93. Total number of SEXUAL HARASSMENT allegations and investigations overview during the 12 months preceding the audit, by incident type:

	# of sexual harassment allegations	# of criminal investigations	# of administrative investigations	# of allegations that had both criminal and administrative investigations
Inmate-on-inmate sexual harassment	0	0	0	0
Staff-on-inmate sexual harassment	0	0	0	0
Total	0	0	0	0

Sexual Abuse and Sexual Harassment Investigation Outcomes

Sexual Abuse Investigation Outcomes

Note: these counts should reflect where the investigation is currently (i.e., if a criminal investigation was referred for prosecution and resulted in a conviction, that investigation outcome should only appear in the count for “convicted.”) Do not double count. Additionally, for question brevity, we use the term “inmate” in the following questions. Auditors should provide information on inmate, resident, and detainee sexual abuse investigation files, as applicable to the facility type being audited.

94. Criminal SEXUAL ABUSE investigation outcomes during the 12 months preceding the audit:

	Ongoing	Referred for Prosecution	Indicted/ Court Case Filed	Convicted/ Adjudicated	Acquitted
Inmate-on-inmate sexual abuse	0	0	0	0	0
Staff-on-inmate sexual abuse	0	0	0	0	0
Total	0	0	0	0	0

95. Administrative SEXUAL ABUSE investigation outcomes during the 12 months preceding the audit:

	Ongoing	Unfounded	Unsubstantiated	Substantiated
Inmate-on-inmate sexual abuse	0	0	0	1
Staff-on-inmate sexual abuse	0	0	0	0
Total	0	0	0	1

Sexual Harassment Investigation Outcomes

Note: these counts should reflect where the investigation is currently. Do not double count. Additionally, for question brevity, we use the term “inmate” in the following questions. Auditors should provide information on inmate, resident, and detainee sexual harassment investigation files, as applicable to the facility type being audited.

96. Criminal SEXUAL HARASSMENT investigation outcomes during the 12 months preceding the audit:

	Ongoing	Referred for Prosecution	Indicted/ Court Case Filed	Convicted/ Adjudicated	Acquitted
Inmate-on-inmate sexual harassment	0	0	0	0	0
Staff-on-inmate sexual harassment	0	0	0	0	0
Total	0	0	0	0	0

97. Administrative SEXUAL HARASSMENT investigation outcomes during the 12 months preceding the audit:

	Ongoing	Unfounded	Unsubstantiated	Substantiated
Inmate-on-inmate sexual harassment	0	0	0	0
Staff-on-inmate sexual harassment	0	0	0	0
Total	0	0	0	0

Sexual Abuse and Sexual Harassment Investigation Files Selected for Review

Sexual Abuse Investigation Files Selected for Review

98. Enter the total number of SEXUAL ABUSE investigation files reviewed/ sampled:	1

99. Did your selection of SEXUAL ABUSE investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	(●) Yes ( ) No ( ) NA (NA if you were unable to review any sexual abuse investigation files)
Inmate-on-inmate sexual abuse investigation files	
100. Enter the total number of INMATE-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	1
101. Did your sample of INMATE-ON-INMATE SEXUAL ABUSE investigation files include criminal investigations?	( ) Yes (●) No ( ) NA (NA if you were unable to review any inmate-on-inmate sexual abuse investigation files)
102. Did your sample of INMATE-ON-INMATE SEXUAL ABUSE investigation files include administrative investigations?	(●) Yes ( ) No ( ) NA (NA if you were unable to review any inmate-on-inmate sexual abuse investigation files)
Staff-on-inmate sexual abuse investigation files	
103. Enter the total number of STAFF-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	0
104. Did your sample of STAFF-ON-INMATE SEXUAL ABUSE investigation files include criminal investigations?	( ) Yes ( ) No (●) NA (NA if you were unable to review any staff-on-inmate sexual abuse investigation files)

105. Did your sample of STAFF-ON-INMATE SEXUAL ABUSE investigation files include administrative investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any staff-on-inmate sexual abuse investigation files)
Sexual Harassment Investigation Files Selected for Review	
106. Enter the total number of SEXUAL HARASSMENT investigation files reviewed/sampled:	0
a. Explain why you were unable to review any sexual harassment investigation files:	Zero sexual harassment investigations during the last 12 months.
107. Did your selection of SEXUAL HARASSMENT investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	○ Yes ○ No ◉ NA (NA if you were unable to review any sexual harassment investigation files)
Inmate-on-inmate sexual harassment investigation files	
108. Enter the total number of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	0
109. Did your sample of INMATE-ON-INMATE SEXUAL HARASSMENT files include criminal investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any inmate-on-inmate sexual harassment investigation files)

110. Did your sample of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files include administrative investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any inmate-on-inmate sexual harassment investigation files)

Staff-on-inmate sexual harassment investigation files

111. Enter the total number of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	0
112. Did your sample of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files include criminal investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any staff-on-inmate sexual harassment investigation files)
113. Did your sample of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files include administrative investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any staff-on-inmate sexual harassment investigation files)
114. Provide any additional comments regarding selecting and reviewing sexual abuse and sexual harassment investigation files.	None.

SUPPORT STAFF INFORMATION

DOJ-certified PREA Auditors Support Staff

115. Did you receive assistance from any DOJ-CERTIFIED PREA AUDITORS at any point during this audit? REMEMBER: the audit includes all activities from the pre-onsite through the post-onsite phases to the submission of the final report. Make sure you respond accordingly.	○ Yes ◉ No

Non-certified Support Staff

116. Did you receive assistance from any NON-CERTIFIED SUPPORT STAFF at any point during this audit? REMEMBER: the audit includes all activities from the pre-onsite through the post-onsite phases to the submission of the final report. Make sure you respond accordingly.	○ Yes ◉ No

AUDITING ARRANGEMENTS AND COMPENSATION

121. Who paid you to conduct this audit?	◉ The audited facility or its parent agency ○ My state/territory or county government employer (if you audit as part of a consortium or circular auditing arrangement, select this option) ○ A third-party auditing entity (e.g., accreditation body, consulting firm) ○ Other

Standards

Auditor Overall Determination Definitions

- Exceeds Standard
  (Substantially exceeds requirement of standard)

- Meets Standard
  (substantial compliance; complies in all material ways with the stand for the relevant review period)

- Does Not Meet Standard
  (requires corrective actions)

Auditor Discussion Instructions

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor’s analysis and reasoning, and the auditor’s conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.211	Zero tolerance of sexual abuse and sexual harassment; PREA coordinator
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Pursuant to the PAQ, the Director self reports the agency has a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment in facilities it operates directly or under contract. The Director further self reports the facility has a written policy outlining how it will implement the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment. The facility has a written policy which includes definitions of prohibited behaviors regarding sexual abuse and sexual harassment and the policy includes sanctions for those found to have participated in prohibited behaviors. Additionally, the policy includes a description of agency strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents. Alternatives, Inc. Policy and Procedural Statement A22 (SOP A22) entitled Sexual Abuse Prevention and Response (PREA), pages 1-12 addresses 115.211(a). Alternatives, Inc. Policy and Procedural Statement H17 (SOP H17) entitled Sexual Harassment, pages 1-3 also addresses 115.211(a). In addition to the above, Alternatives, Inc. Policy and Procedural Statement H33 (SOP H33) entitled Staff Conduct with Offenders, pages 1-3 addresses expectations of staff conduct while Alternatives, Inc. Policy and Procedural Statement H43 (SOP H43) entitled Fraternization Policy, page 3, section IV(C) defines fraternization with offenders and potential consequences. Finally, the Alternatives, Inc. Employee Handbook, page 8, section entitled Sexual/Textual Harassment and Discrimination Policy; pages 30 and 31, section entitled Fraternization and Conflict of Interest; and page 34, section entitled Discipline and Corrective Action addresses definitions, expectations of staff, and consequences for violation of such policies. Pages 32 and 33 of the Alternatives, Inc. Policy and Procedural Statement K24A (SOP K24A) entitled Resident Handbook, section entitled Standard Rules/Violations for Montana Pre-Release Centers addresses disciplinary sanctions for offenders. The auditor's review of two 2021 and two 2022 acknowledgments regarding various documents, inclusive of the Alpha House (AH) Resident Handbook reveals the resident is knowledgeable about the location of the same. The document is located in the resource library tab in the kiosk. The resident acknowledges receipt of that information pursuant to affixation of their initials on the aforementioned acknowledgment. Pursuant to the PAQ, the Director self reports the agency employs or designates an upper-level, agency-wide PREA Coordinator, Alternatives, Inc. PREA Coordinator (APC), who has sufficient time and authority to develop, implement, and oversee

	agency efforts to comply with the PREA standards in all of its community confinement facilities. The Director reports the APC is in the agency's organizational structure and the auditor verified the same pursuant to review of the Alternatives, Inc. Organizational Chart. The auditor notes the Alternatives, Inc. PREA/Safety Coordinator serves as the APC. He is included in the Alternatives, Inc. Organizational Chart, reporting to the Contract Assurance Coordinator who reports to the Chief Executive Officer (CEO). The auditor finds this arrangement to be acceptable in terms of information flow and accessibility to the CEO for "all things PREA." The AH Director is designated as the PREA Compliance Manager (PCM) at AH. Pursuant to interview with the APC, the auditor learned he does feel he has sufficient time to manage all of his PREA related responsibilities. Each facility has a PCM (two total for AH and Passages). As PREA/Safety Coordinator, the APC spends substantial time at both AH and Passages. Pursuant to Management by Wandering Around (MBWA), he assesses PREA matters, as well as, life safety matters. He reviews posters and educational materials, revises the majority of policies/educational materials for residents/ and staff/staff training, etc. He is a trained sexual abuse/harassment investigator and is involved in "all things PREA". In regard to policy development/amendment, the APC can make recommended changes to policy however, the same are routed through a review process. Similarly, he can make changes to staff and resident training however, the same must be approved by facility Directors. Monetary expenditures must be routed through facility Directors, the CEO, and the Board of Directors based on dollar amount. In view of the above, the auditor finds AH substantially compliant with 115.211.

115.212	Contracting with other entities for the confinement of residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Pursuant to the PAQ, the Director self reports that Alternatives, Inc. and AH do not contract with other facilities or companies to house residents designated for confinement at AH. The auditor's research and written communications with the APC validates the same. Alternatives Inc. uses county jails to house residents who are pending removal from the facility. The Montana Department of Corrections (MDOC) and Federal Bureau of Prisons (FBOP) require the use of county jails for such purposes and the jails are mandated to accept them. No contract between Alternatives, Inc. and the county jail(s) is/are required. Given the lack of evidence substantiating non-compliance with 115.212, the auditor finds AH substantially compliant with the same.

115.213	Supervision and monitoring
	Auditor Overall Determination: Exceeds Standard
	Auditor Discussion
	Pursuant to the PAQ, the Director self reports the agency develops and documents a staffing plan that provides for adequate levels of staffing, and where applicable, video monitoring, to protect residents against sexual abuse. The Director self reports the average daily number of residents since the last PREA audit is 170 and the average daily number of residents on which the staffing plan is predicated is 203. Alternatives, Inc. Policy and Procedural Statement ALT-A22 (SOP A22) entitled Sexual Abuse Prevention and Response (PREA), page 3, section IV(B)(2)(a) addresses 115.213(a). Additionally, Alternatives, Inc. Policy and Procedural Statement K42(S) (SOP K42S) entitled Client Advisor Shift Scheduling, pages 1 and 2 addresses 115.213(a). Pursuant to the latter SOP, ideal staffing at AH is four staff assigned to the Day and Night Shifts while five staff are assigned to the Swing Shift. The Director/PCM asserts the facility does have a staffing plan. Adequate staffing levels and video monitoring to protect residents against sexual abuse are considered in the plan. The staffing plan is documented and maintained on-line for privileges access by the operations supervisor (os) and programs supervisor (ps). With respect to specific issues factoring into staffing plan development, the Director and APC assert the following: a. When developing the PREA staffing plan, they constantly review sexual abuse incident reviews and incidents to address camera needs. Cameras are positioned to address/inhibit/reduce blind spots. Revision of security tour rounds is also considered as the same may be necessary to offset supervision weaknesses. The Director can recommend staffing increases to the Chief Executive Officer (CEO) and he can subsequently address the same to the Board of Directors. b. Few security threat group members are housed at AH. Accordingly, such threats to resident and sexual safety are minimized. The AH racial balance appears to be okay. The LGBTI population is not significant in terms of numbers and staff are attentive to any potential concerns. Sexual offenders may be housed at AH and there are no concerns with that population. Sexual offenders must be Montana Sexual Offender Treatment (MSOTA) approved. c. One sexual abuse/harassment case has been realized during the last year. Accordingly, as of this point, sexual abuse cases are minimal. An increase in cases may trigger additional staffing and/or camera considerations. d. If incidents occur, staff-to-resident ratios in the area of the incident are considered. In regard to compliance with the staffing plan, the Director maintains perpetual contact with the os. During Monday management meetings with the os, scheduling

	software is monitored to ensure staffing plan compliance. This software is also monitored on a daily basis in an effort to be proactive. The os contacts the Director regarding any call-offs and she subsequently fills behind the vacancy or administrators work the shift. If a deviation from the PREA staffing plan should occur, an email report is submitted from the os to the Director to the Chief Operating Officer (COO) to the CEO. The auditor has found no evidence of AH failure to maintain compliance with the staffing plan. Pursuant to the PAQ, the Director self reports in circumstances where the staffing plan is not complied with, the facility documents and justifies all deviations from the plan. The Director further self reports there were no instances of deviation from the staffing plan during the last 12 months. Alternatives, Inc. Policy and Procedural Statement K42(S) (SOP K42S) entitled Client Advisor Shift Scheduling, pages 1 and 2, sections IV(E) and (G) addresses 115.213(b). The Director's statement regarding documentation of staffing plan non-compliance is reflected above in the narrative for 115.213(a). The auditor's observation of staffing during the facility tour and during non-regular business hours reveals substantial compliance with 115.213. The auditor did note camera surveillance is sufficient to augment staffing, thereby serving to facilitate resident sexual safety. Camera placements are addressed above. Pursuant to the PAQ, the Director self reports at least once every year, the facility reviews the staffing plan to see whether adjustments are needed to: The staffing plan; Prevailing staffing patterns; The deployment of video monitoring systems and other monitoring technologies; or The allocation of facility/agency resources to commit to the staffing plan to ensure compliance with the same. Alternatives, Inc. Policy and Procedural Statement K42(S) (SOP K42S) entitled Client Advisor Shift Scheduling, page 2, section IV(H) addresses 115.213(c) According to the Director/PCM, the facility staffing plan is reviewed at least once each year. Annual Staffing Plans are reviewed and agreed to as a group with the Facility Director, however, there are no signature/date lines for the Director and APC within the Staffing Plan. The auditor strongly recommends that such signature and date lines be added to the Annual Staffing Plan format. The auditor's review of the February 12, 2022 PREA Annual Staffing Plan Review reveals substantial compliance with 115.213(c). The plan addresses the nine

	requisite consideration factors for prisons and jails, as opposed to, the four factors required for community confinement facilities. Accordingly, AH exceeds standard expectations with respect to 115.213(c). The auditor's review of two AH PREA Staffing Plan Review documents also reveals substantial compliance with 115.213(b) and (c). Specifically, the document addresses the consideration factors required pursuant to the Prisons and Jails standards. Additionally, general narrative regarding the staffing plan and electronic surveillance strategies is included in the same. The auditor notes that the names of the review committee are included in the document. Minimally, the CEO, COO, and facility Director participate in the process. The APC's interview statement validates the process pursuant to his description of the development process. He does assert that the APC actually develops and writes the staffing plan. In view of the above, the auditor finds AH exceeds standard expectations with respect to 115.213.

115.215	Limits to cross-gender viewing and searches
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Pursuant to the PAQ, the Director self reports cross-gender strip searches or cross-gender visual body cavity searches of the anal or genital opening are not conducted at AH as all such searches are facilitated by same gender staff or medical staff approved by the CEO. The Director further self reports zero strip or cross-gender visual body cavity searches of offenders were conducted at AH during the last 12 months. Alternatives, Inc. Policy and Procedural Statement SOP K14(S) entitled Searches, pages 3 and 4, section IV(H and I) addresses 115.213(a). Such searches can be completed for articulable reason(s) and approved through the chain of command, with two same sex staff (same sex as the offender) present. The non-medical staff (who may be involved in cross-gender strip or visual searches) interviewee asserts such searches are not facilitated at AH. However, based on sound correctional practice, in the event no male staff are available and there is reasonable suspicion a resident is conveying a weapon in his rectum, the same may be considered an exigent circumstance. The auditor has found no evidence of cross-gender strip or visual searches conducted by non-medical staff, at AH during the last 12 months. Pursuant to the PAQ, the Director self reports female offenders are not housed at AH. The auditor validated the same pursuant to observation during the facility walk through. Accordingly, the auditor finds that 115.215 (b) is not applicable to AH. Pursuant to the PAQ, the Director self reports facility policy requires all cross-gender strip searches and cross-gender visual body cavity searches are documented. As reflected in the narrative for 115.15(b), female offenders are not housed at AH. The APC asserts that strip searches may be done only for articulable reasons. The in-charge client advisor must obtain permission from the os, the Director and CEO. Only same gender searches would be conducted in utmost privacy and with two same gender staff (in comparison to the offender) present. A full written report shall be routed to the Director within 24 hours. Cavity searches would only be authorized by the CEO and must be conducted in private by appropriate medical personnel (excluding facility medical providers). Alternatives, Inc. Policy and Procedural Statement SOP K14(S) entitled Searches, page 3, section IV(H) addresses 115.213(c). Pursuant to the PAQ, the Director self reports the facility has implemented policies

	and procedures that enable residents to shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks (this includes viewing via video camera). The Director further self reports policies and procedures require staff of the opposite gender to announce their presence when entering a resident housing unit. During the facility tour, the auditor noted that opposite gender staff did announce their presence when entering male resident housing areas. Alternatives, Inc. Policy and Procedural Statement SOP K24(A) entitled Resident Handbook, page 15, Personal Hygiene/Housekeeping addresses proper attire outside rooms (no t-shirts/underwear) and closing shower curtains while showering/closing doors while toileting. Alternatives, Inc. Policy and Procedural Statement SOP K06(S) entitled Head Count, Walk-through, and Daily Room Maintenance Checks, page 2, section IV(A)(3)(a-e) and IV(A)(5) addresses 115.215(d). All 11 random resident interviewees self report opposite gender staff announce their presence, by gender, when entering their housing area. All 11 interviewees also self report they are never naked or in full view of female staff (not including medical staff such as doctors, nurses) when toileting, showering, or changing clothing. All 12 random staff interviewees self report opposite gender staff announce their presence, by gender, when entering housing and shower/toilet areas at AH. Similarly, all interviewees self report residents are able to dress, shower, and toilet without being viewed by staff of the opposite gender. Pursuant to the PAQ, the Director self reports the facility has a policy prohibiting staff from strip searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. According to the Director, no such searches were facilitated during the last 12 months. Alternatives, Inc. Policy and Procedural Statement SOP K14(S) entitled Searches, page 3, section IV(H) addresses 115.215(e). All 12 random staff interviewees self report the facility prohibits staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status and that they are aware of the relevant policy. The transgender resident interviewee states she has not been placed in in an area only for transgender or intersex residents. Furthermore, she has no reason to believe she was strip-searched for the sole purpose of determining genital status. Pursuant to the PAQ, the Director self reports 100% of all security staff have received training on conducting cross-gender pat-down searches of female residents and searches of transgender/intersex residents in a professional and respectful manner, consistent with security needs. Presentation of the National Institute of Corrections (NIC) video and curriculum for Guidance on Cross-Gender and Transgender Pat Searches are provided to ca staff on an ongoing basis. Senior ca

	staff provide ongoing Pat Search training to staff during regular ca meetings. The auditor's review of a handout entitled Cross Gender Supervision Handout, Cross Gender Supervision Power Point Presentation, and PRC Power Point Presentation entitled Guidance in Cross-Gender and Transgender Pat Searches reveals substantial compliance with 115.215(f). Of note, case law is cited in both the Handout and the Cross Gender Supervision Power Point Presentation to assist participants with comprehension of standard requirements and nuances. The auditor has also reviewed the aforementioned video. The auditor's on-site review of ten of twelve 2020, 2021, and 2022 Pre-Service and PREA Annual Refresher Training (ART) S11 Statement of Understanding forms and staff training records reveals substantial compliance with 115.215(f). The auditor notes the above narrative encompasses staff of all disciplines. Ten of 12 random staff interviewees assert they received agency training regarding cross-gender pat down searches of female residents and professional and respectful searches of transgender/intersex residents. The auditor notes that pursuant to review of one of the two training files associated with the staff who allegedly did not receive this training, evidence reflects he did receive the same. Training is provided in a video, discussion, power point, demonstration, and/or testing format during both PREA Pre-Service and Annual PREA Annual Refresher Training (ART) sessions. In view of the above, the auditor finds AH substantially compliant with 115.215.

115.216	**Residents with disabilities and residents who are limited English proficient**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Pursuant to the PAQ, the Director self reports the agency has established procedures to provide disabled residents equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse/harassment. According to the APC, case managers, licensed addition counselors (lacs), and licensed clinical professional counselors (lcpcs) provide assistance to residents with disabilities in conjunction with medical staff to ensure the resident has an equal opportunity to participate in or benefit from all agency efforts to protect, detect and respond to sexual abuse/harassment. Alternatives, Inc. Policy and Procedural Statement SOP A22 entitled Prison Rape Elimination Act of 2003, page 4, section IV(c) addresses 115.216(a). Additionally, Alternatives, Inc. Policy and Procedural Statement SOP L56(S) entitled Case Management Intake and Orientation, page 2, section IV(A)(2) addresses 115.216(a). According to the APC, a TTY is available at AH. There are no MOU’s with community providers. For a blind resident, the Orientation video would be played with audio, thereby enabling the resident to listen to the same. Documents would be converted to Braille as necessary. For low functioning or mentally impaired residents, CA staff, intake staff, case managers, etc. would work with the resident to explain all PREA related issues/ forms/documents including reading the form in an effort to ensure they understand the meaning and sign as appropriate. Severely mentally ill residents are not housed at Alpha House. We have had residents in wheel chairs, residents who are missing limbs or appendages, etc. and accommodations were made for them as ADA and program requirements dictate. According to the Agency Head interviewee, the agency has established procedures to provide residents with disabilities and residents who are Limited English Proficient (LEP) equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Specifically, LanguageLine is used, when necessary, to communicate with LEP residents. Generally Spanish and Japanese speaking staff translators can also be used. Mental health staff assist with the "Special Needs" population. All five disabled (four receiving mental health treatment and one low reading resident) interviewees self report the facility provides information about sexual abuse/harassment that they are able to understand. The low reading interviewee advised that he cannot read or write and a particular staff member helped him

	receive information in a format he could understand. The auditor notes posters are positioned at reasonable heights for a physically disabled resident's review. Additionally, printed materials appear to be written at a reading level appropriate to the resident population. The Director asserts when needed, staff read and explain materials to blind residents and deaf or hard of hearing residents read materials themselves. Staff also read aloud PREA information to mentally incompetent residents. Pursuant to the PAQ, the Director self reports the agency has established procedures to provide residents with limited English proficiency (LEP) equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Alternatives, Inc. Policy and Procedural Statement SOP A22 entitled Prison Rape Elimination Act of 2003, page 4, section IV(c) and page 10, section IV(L)(4) address 115.216(a). Additionally, Alternatives, Inc. Policy and Procedural Statement SOP L56(S) entitled Case Management Intake and Orientation, page 2, section IV(A)(2) addresses 115.216(a). The auditor notes there are two Spanish and one Japanese staff interpreters on staff at AH and Passages. The auditor's review of the LanguageLine Solutions contract and instructions reveals substantial compliance with 115.216(b). The auditor did test the LanguageLine telephone number and the same was accurate and functional. He did reach the point until a pin number was required. The pin number would be provided to AH and Passages pursuant to the contract. This telephone call was placed from the auditor's home however, it is noted that only staff would facilitate this telephone call from staff telephones. The line was functional and operational. The APC advises that zero limited English proficient (LEP) residents were housed at AH during the on-site audit. Accordingly, the LEP interview could not be completed. Pursuant to the PAQ, the Director self reports agency policy prohibits use of resident interpreters, resident readers, or other types of resident assistants, except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties, or the investigation of the resident's allegations. The Director further self reports the facility documents the limited circumstances in individual cases where resident interpreters, readers, or other types of resident assistants are used. Finally, in the last 12 months, there were no instances wherein resident interpreters, readers, or other types of resident assistants have been used and it was not the case that an extended delay in obtaining another interpreter could compromise the resident's safety, the performance of first response duties, or the investigation of the resident's allegations. Alternatives, Inc. Policy and Procedural Statement SOP K13(S) entitled Resident

	Control of Other Residents, page 1, section IV(B) generally addresses 115.216(c) however, the same provides no specificity as required by the standard provision. The auditor notes there are two Spanish and one Japanese staff interpreters on staff at AH and Passages. Since the standard provision specifically speaks to policy requirements regarding implementation of 115.216(c) strategies and the specifics of the provision are not articulated in the aforementioned policy, the auditor finds AH non-compliant with 115.216(c). Accordingly, the APC will initiate a policy amendment to address the following: Use of resident interpreters, resident readers, or other types of resident assistants, except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.264, or the investigation of the resident's allegations, is prohibited. Upon completion of the amended policy, the APC will upload the same into OAS. Additionally, the APC will effectively train staff stakeholders regarding the same. This can be accomplished by distribution of a memorandum to all staff regarding the same. The auditor recommends that the amended policy and explanation regarding amended portions, be forwarded to staff via email. If that method of transmission is implemented, the APC will also upload a copy of the actual email, as well as, a listing of the staff recipients of the email. Additionally, the specific information will be included in any and all training syllabi. Copies of those amendments will likewise be uploaded into OAS. The due date for completion of this corrective action is November 16, 2022. October 18, 2022 Update: Pursuant to the auditor's review of Alternatives, Inc. SOP: K13(s) entitled Resident Control of Other Residents, page 1, section IV(A)(2), corrective action has been implemented and completed. An email dated September 26, 2022, inclusive of a September 26, 2022 discussion regarding the above policy change validates completion of the recommended corrective action. Ten of 12 random staff interviewees were aware of at least one condition under which a resident translator, interpreter, reader, or assistant can be used to assist with translation in the event a disabled or Limited English Proficient (LEP) resident attempts to report sexual abuse. Interviewees cited resultant further physical injury to the victim or loss of evidence/investigation as the basis for invocation of 115.216(c) strategies. The auditor notes interviewees quickly identified the condition(s) following dissection of a scenario. All 12 interviewees self report no such instances of using translators pursuant to the circumstances articulated in 115.216(c) have presented during the last 12 months. Throughout the on-site audit, the auditor found no evidence of staff use of other

	residents as prescribed in 115.216(c). In view of the above, the auditor now finds AH substantially compliant with 115.216.

115.217	Hiring and promotion decisions
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Pursuant to the PAQ, the Director self reports agency policy prohibits hiring or promoting anyone who may have contact with residents and prohibits enlisting the services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution; Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or Has been civilly or administratively adjudicated to have engaged in the activity described in the above paragraph. Montana Department of Corrections (MDOC) polices require that all staff hired by Alternatives, Inc., successfully complete a criminal background check, inclusive of provision of fingerprints to the Department prior to employment selection. The Department of Corrections facilitates the background check and either approves or denies the hiring of the individual(s). Human Resources (HR) staff facilitate this process by bringing the prospective employee to the Yellowstone County Jail to be fingerprinted, ensuring they sign releases to authorize completion of the background checks. MDOC ensures that the background checks include PREA considerations and standards compliance. HR conducts reference checks with previous employers. If a previous employer is a correctional facility or program, HR staff discuss with the APC or Manager or Human Resources (HR) staff at the facility to ask specifically about any PREA related issues. Alternatives, Inc. Policy and Procedural Statement SOP H26 entitled Staff Background Checks, page 2, section IV(A)(5)(a-c), 7, 8, and 11addresses 115.217(a). Of note, MDOC Probation and Parole (P&P) approves all applicants who will have contact with residents, considering 115.217(a) considerations. Policy also reflects that P&P facilitates initial and 5-year reinvestigations of staff and AH HR completes such reinvestigations regarding contractors pursuant to 115.217(e). Of note, policy is silent regarding promotional applicants. The APC asserts that the employee signs and responds to three specific PREA related questions on form NCIC/CJIN Background Check ALT78. Employees, Volunteers, Interns, Contractors all sign this form. The auditor's review of this document reveals substantial compliance with 115.217(a). The auditor's on-site review of 11 random staff HR files reveals that theALT-78 form as previously described was completed in six cases. The remaining five files pertained to staff who were hired prior to 2019 and accordingly, the same are not

	applicable to this audit period. Of note, the criminal background record checks pertinent to these six cases did not reveal any 115.217(a) deviations. The same was also noted with respect to two promotion cases. As noted in the narrative for 115.232, the Director advises there are three vendors (not contractors) on board at AH who have contact with residents. The auditor finds AH compliant with 115.217(a). Pursuant to the PAQ, the Director self reports agency policy requires the consideration of any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents. Alternatives, Inc. Policy and Procedural Statement SOP H26 entitled Staff Background Checks, page 2, section IV(A)(5)(a-c), 7, 8, and 11addresses 115.217(a). Of note, MDOC Probation and Parole (P&P) approves all applicants who will have contact with residents, considering 115.217(a) and (b) considerations. FBOP RRC staff facilitate the same approvals for staff working with FBOP residents. According to the APC, the 115.217(b) question regarding sexual harassment is asked on the ALT 78 form. The auditor's review of that form validates the statement of the APC. As criminal background record checks do not address sexual harassment, the form referenced in the preceding paragraph is the only document available to validate the 14-2H CC. While the HR interviewee asserts the facility does consider prior incidents of sexual harassment when determining whether to hire or to promote anyone, or to enlist the services of any contractor, who may have contact with residents, the ALT78 does address sexual harassment and asks whether the applicant has engaged in the same. New hires complete the ALT78 and all employees complete the same on an annual basis, thereby covering promotional applicants. Montana Department of Corrections polices require that all staff hired by Alternatives, Inc., have a criminal background check completed, including providing fingerprints to the Department prior to employment. The Department of Corrections runs the background check and either approves or denies the hiring of the individual(s). HR staff facilities this process by brining the prospective employee to Yellowstone County Jail to be fingerprinted and sign releases allowing the background checks to be completed. MTDOC ensures that the background checks includes PREA compliance. HR conducts reference checks with previous employers. If a previous employer is a correctional facility or program, HR will talk with the PREA Coordinator or Manager or HR at the facility to ask specifically about any PREA related issues. Pursuant to the PAQ, the Director self reports agency policy requires before it hires any new employees who may have contact with residents, it (a) conducts criminal

	background record checks and (b) consistent with federal, state, and local law, makes its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse. The Director further self reports 18 applicants were hired during the last 12 months who may have contact with residents and all have had criminal background record checks. Alternatives, Inc. Policy and Procedural Statement SOP H26 entitled Staff Background Checks, page 2, section IV(A)(5) addresses 115.217(c). AH HR facilitates requisite reference checks. Documentary evidence of 115.217(c) compliance is addressed in the narrative for 115.217(a). The auditor's on-site review of six random staff HR files covering staff hired at AH since 2019, reveals criminal background record checks were conducted prior to (four of six cases) or within days of the date of hire. The HR interviewee asserts criminal background record checks are completed at hire and at five year intervals. MDOC facilitates CJIN criminal background record checks for those staff who work with MDOC residents while the FBOP facilitates NCIC checks for those staff who work with FBOP residents. Both entities approve representative staff, taking into account 15.217(a) and (b) considerations. Neither jurisdiction provides specifics regarding findings, only selection or non-selection. With respect to promotion, new criminal background record checks are not conducted. As the promotion applicant has been in the continuous employment of Alternatives, Inc., internal vouchering is employed. The 115.217 narrative also addresses procedural processing of criminal background record checks regarding promotions and contractors. Pursuant to contact with the APC, the auditor has learned that HR does conduct reference checks and documents them on a form. However, pursuant to the auditor's on-site review of two random staff HR files wherein the work history reflected prior institutional employers, the auditor found no documentary evidence of such checks and accordingly, actual practice is not established. Additionally, the auditor has not been provided any evidence to substantiate compliance with 115.217(c). In view of the above, the auditor finds AH non-compliant with 115.217(c) and he imposes a 180-day corrective action period wherein AH will attain compliance with and institutionalization of the provision. The due date for completion of the corrective action is November 16, 2022. To demonstrate compliance and institutionalization, the APC, in conjunction with HR, will develop a form addressing the subject-matter of 115.217(c). Specifically, the form will be tailored to the prior institutional employer encompassing, minimally, questions regarding substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse. To provide another layer of validation regarding 115.217(a) and (b) questions, the auditor strongly recommends that such questions be included.

	The form must include signature and date lines for the responding authority at the prior institutional employer. If the questions will be asked telephonically, a signature and date line for the Alternatives, Inc. interviewer must be included. Space must be included to capture the statement of the respondent from the prior institutional employer. Subsequent to completion of this form, training of all stakeholders must be completed. In this case, it appears that HR staff are responsible for this task and accordingly, completion and understanding of training documentation must be completed by attendees. The form and training documentation will subsequently be uploaded. Additionally, completed forms for all applicable new hires between the date of this interim report and corrective action due date will be uploaded. The auditor will subsequently review all documentation and render a compliance decision. October 18, 2022 Update: The auditor's review of the newly created form entitled Correctional Institution Employment Reference Request Form reveals the same demonstrates compliance with 115.217(c). An email dated September 26, 2022 reveals that the HR Manager did discuss the aforementioned form with two of her staff who have direct responsibility for the process. Finally, the auditor notes that none of the four staff hired since the on-site audit presented with any prior institutional experience. In view of the above, the auditor finds AH substantially compliant with 115.217(c). Pursuant to the PAQ, the Director self reports agency policy requires that a criminal background record check is completed before enlisting the services of any contractor who may have contact with residents. The Director further self reports there were zero contracts for services where a criminal background record check was conducted during the last 12 months. Alternatives, Inc. Policy and Procedural Statement SOP H26 entitled Staff Background Checks, page 2, section IV(A)(5) and 11addresses 115.217(d). The auditor's review of three criminal background record checks regarding Billings Vending contractors (vendors with minimal contact with residents) reveals non-existence of 115.217(a) issues. Pursuant to the PAQ, the Director self reports agency policy requires that either criminal background record checks are conducted at least every five years for current employees and contractors who may have contact with residents or a system is in place for otherwise capturing such information for current employees. 115.217(e) policy provision(s) are addressed throughout the above narrative. During her interview, the HR interviewee stated HR collects relevant privacy documents. et. and forwards the same to MDOC and FBOP points of contact. As

	reflected in the narrative for 115.217(c), the respective agencies run requisite checks. She utilizes a spread sheet to address reinvestigation due dates. She sets the alert for at least six months from the due date. The auditor's on-site review of five applicable random staff HR files reveals that the last 5 year reinvestigation was timely. The auditor is aware, as reflected in previous paragraphs, that the ALT78 form is completed annually by all staff as required by the above policy. Additionally, the document is completed at on boarding for new hires or contractors. This practice meets the requirements regarding promotion applicants and performance evaluations. The HR interviewee substantiates the auditor's understanding of the 115.217(f) practice at AH. The aforementioned form is minimally presented at orientation and during Pay Com annual training. Additionally, the continuing affirmative duty to disclose any such misconduct caveat is reflected on the ALT38 Form that is signed and dated on an annual basis. The auditor's on-site random review of 10 of 11 staff HR files reveals that ALT 78 form was completed for 2022. In six of the 11 cases, at least two years of ALT 78 forms are present. These generally apply to staff hired prior to 2021. Pursuant to the PAQ, the Director self reports agency policy states material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination of employment. The APC asserts that the Employee Discipline Policy and Background check policy address material omissions or provision of false information under PREA standards as grounds for dismissal. Alternatives, Inc. Policy and Procedural Statement SOP H26 entitled Staff Background Checks, page 2, section IV(A)(6) addresses 115.217(g). Pursuant to section IV(A)(6), the ALT38 Form is completed by staff annually. This document constitutes an annual affirmation that the employee is required to report any 115.217(a) violations on a continuing basis. Alternatives, Inc. Policy and Procedural Statement SOP H20 entitled Employee Discipline , page 2, section IV(A)(10) addresses 115.217(g). According to the Director, during the last 12 months, zero requests for information were received from an institutional employer, to whom an AH or ex-AH employee has applied to work, relative to substantiated allegations of sexual abuse or sexual harassment. The HR interviewee asserts when a former employee applies for work at another institution, upon request from that institution, the facility provides information on substantiated allegations of sexual abuse/sexual harassment involving the former

	employee, unless prohibited by law. Such information is released by Corporate staff. In view of the above, the auditor now finds AH substantially compliant with 115.217.

115.218	Upgrades to facilities and technology
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Pursuant to the PAQ, the Director self reports the facility has not acquired a new facility or made a substantial expansion or modification to existing facilities since the date of the last PREA audit. Accordingly, the auditor finds 115.218(a) not applicable to AH. Since the last PREA audit, pursuant to the PAQ, the Director self reports the facility has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology. The APC asserts that the current system was upgraded in 2019 and continues to meet the needs of AH. Of note, both the Agency Head and Director interviewees validate the above. Accordingly, the auditor finds AH substantially compliant with 115.218 as there are no deviations from the standard.

115.221	Evidence protocol and forensic medical examinations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Pursuant to the PAQ, the Director self reports the facility is responsible for conducting administrative sexual abuse investigations (including resident-on-resident sexual abuse or staff sexual misconduct). The Director further self reports the Billings Police Department (BPD) facilitates criminal investigations relative to AH residents. When conducting a sexual abuse investigation, the agency investigator(s) follow a uniform evidence protocol and BPD responsibilities are articulated in their protocol(s). This caveat is articulated in the MOU between Alternatives, Inc. and BPD. The APC asserts BPD has primary jurisdiction over criminal investigations. The MDOC Investigations Bureau may conduct a criminal investigation (with respect to MDOC residents) if BPD declines to investigate. The APC further self reports that if the PREA incident requires collection of physical evidence, agency staff will secure the location and ensure that the scene is not tampered with or disturbed until BPD staff can collect physical evidence, following uniform evidence protocols, and releases the scene for clean up and reoccupation. Alternatives, Inc. Policy and Procedural Statement ALT A29 entitled Internal PREA Investigator Description and Duties, pages 1 and 2, section IV(B) addresses 115.221(a). Additionally, Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA, pages 8 and 9, section IV(J)(1-6) addresses 115.221(a). All 12 random staff interviewees assert they know and understand the agency's protocol for obtaining usable physical evidence if a resident alleges sexual abuse. The responses regarding first responder duties essentially encompass evidence preservation. BPD investigators conduct criminal investigations and they are responsible for physical evidence collection while security staff are responsible to secure the crime scene and guard against destruction of physical evidence by the victim and perpetrator. Of note, non-security staff 1st responders are responsible for requesting that the victim not destroy physical evidence and subsequent reporting to security staff. Seven of 12 random staff interviewees were able to correctly identify all four first responder (evidence preservation) or two tasks, dependent upon the nature of their respective duties as cited at 115.264(a and b). The majority of misinformation centers on telling or ensuring that both the victim and perpetrator do not destroy physical evidence, as opposed to, requesting that the victim and ensuring the perpetrator do not destroy physical evidence. Nine of 12 random staff interviewees assert the APC is one of the administrative sexual abuse/harassment investigators while 11 interviewees assert BPD investigators facilitate criminal investigations.

	Pursuant to the PAQ, the Director self reports zero youth are housed at AH and accordingly, that component of 115.221(b) is not applicable to the facility. During the facility tour and pursuant to random conversations with staff and resident interviewees, the auditor validated the Director's assertion. The Director further self reports the facility protocol was adapted from or is otherwise based on the most recent edition of the DOJ's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/ Adolescents, " or similarly comprehensive and authoritative protocols developed after 2011. While Alternatives, Inc. has no ability to dictate evidence protocols to BPD, assurance has been provided that BPD's trained evidence technicians are trained in the most current protocols for evidence collection in sexual assault cases. The auditor notes that the co-signer of the aforementioned MOU affirms compliance with 115.221. Pursuant to the PAQ, the Director self reports the facility offers to all residents who experience sexual abuse access to forensic medical examinations. Forensic medical examinations are offered without financial cost to the victim. Where possible, examinations are conducted by SAFE/SANE Nurse Examiners. When SAFE/SANE Nurses are unavailable, a qualified medical practitioner performs forensic medical examinations. According to the Director, no forensic medical examinations were conducted during the last 12 months. Sexual abuse forensic examinations are facilitated by Billings Clinic staff. Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA, pages 6 and 7, sections IV(G and H) addresses 115.221(c). The APC asserts the Billings Clinic has SANE nurses on staff and on call 24/7/365. AH staff transport any resident to the Billings Clinic for a forensic medical examination by a trained SANE examiner upon notification by the resident or as instructed by BPD. ALT A22, section (H)(2)(c) requires provision of a report to the Director regarding interactions with the patient, treatment given, and medical recommendations by attending clinical staff. If transported to the Billings Clinic for a SANE examination and the victim refuses medical or mental health services, the same is documented on the Medical Treatment Refusal Form (ALT 48). Additional Information regarding the examination is gathered from the Clinic and BPD as appropriate and/or released to Alternatives, Inc. The SANE interviewee asserts she is one of 11 on-call trained International Association of Forensic Nurses (IAFN) SANE nurses who facilitate forensic examinations for AH and Passages residents, as well as, members of the community. Training consists of a 41 or 43 hour on-line segment, as well as, three to four clinical examinations (hands-on under the watchful eye of the instructor or senior SANE). Other Emergency Department (ED) nurses are partially SANE trained.

	The interviewee reports that zero forensic examinations have been missed by her group within the last several years (since 2015). If, for some reason a SANE examination cannot be completed for some reason, the same is ordinarily delayed (short term) until a SANE room or SANE nurse is available. The other option is commencement of the SANE examination by one of the partially trained ED nurses. SANEs are available on a 24/7 basis. Pregnancy tests are provided for females in conjunction with forensic examinations. Information regarding pregnancy-related services, as well as, sexually transmitted infection prophylaxis for both males and females are also provided. Finally, emergency contraception is provided for females. Pursuant to the PAQ, the Director self reports the facility attempts to make a VA from a rape crisis center available to the victim, either in person or by other means, and these efforts are documented. The Director further self reports the facility provides VA services pursuant to an MOU between AH and the Billings YWCA Gateway Program. Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA, page 5, section IV(F)(2) and (5) and page 6, section IV(G)(1)(2)(b) addresses 115.221(d). The APC asserts that the Billings YWCA Gateway Program is the agency designated as the Rape Crisis Center for Yellowstone County. Alternatives, Inc. has entered into an MOU which outlines services required under PREA. According to the Director, victim advocacy services are available to AH residents pursuant to the MOU as reflected above. Referrals to Billings YWCA Gateway are documented in the Total Offender Management System (TOMS) case notes by the resident's case manager (cm). Billings YWCA privacy policies require the individual to sign a release of confidentiality in order to share information regarding the counseling and information provided to and by the YWCA. The resident is not obligated to sign the release. The APC also asserts that two staff LCPCs are available to provide VA services to residents during a sexual abuse crisis. However, as the auditor notes, there is no evidence substantiating that either AH LCPC completed any course of study [either university level or the National Institute of Corrections (NIC) course] regarding victim advocacy. The APC asserts one sexual abuse incident was reported at AH during the last 12 months. A discussion regarding the same is captured in the narrative for 115.222(a). Pursuant to the PAQ, the Director self reports if requested by the victim, a victim advocate (VA) accompanies and supports the victim through the forensic medical examination process and investigatory interviews and provides emotional support, crisis intervention, information, and referrals.

	The APC asserts that if requested by the victim, a victim advocate is accessed through the aforementioned Billings YWCA Gateway Program to accompany the victim and provide emotional support, crisis intervention, information, and referrals during the forensic medical examination process and investigatory interviews. While the above tenets are not specifically referenced in the aforementioned MOU, the MOU with Billings YWCA Gateway references the provision of VAs and counseling/emotional support services, as requested, when a resident has been sexual abused. Accordingly, the auditor finds AH compliant with 115.221(e). In view of the above, the auditor strongly recommends that 115.217(e) language be inserted into the MOU in terms of provision of VA services during forensic examination(s) and investigatory interview(s). This should be accomplished as soon as possible. As reflected throughout this narrative, BPD investigators facilitate criminal sexual abuse/harassment investigations. Two Alternatives, Inc. facility investigators conduct administrative sexual abuse/harassment investigations. The Alternatives, Inc. MOU with BPD spells out many of the requisite PREA standard provisions, inclusive of 115.221(f). As reflected above, facility staff cannot perform in the role of VAs for purposes of 115.221(d) and (e) as there is no evidence that either have completed relevant coursework or the NIC specialized VA training. Given the fact that AH utilizes the Billings YWCA Gateway Program, the agency designated by the Montana Department of Health and Human Services as the Rape Crisis Center for Yellowstone County, VA credentials are deemed to be appropriate. In view of the above, the auditor finds AH substantially compliant with 115.221.

115.222	Policies to ensure referrals of allegations for investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Pursuant to the PAQ, the Director self reports the agency ensures an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment (including resident-on-resident sexual abuse and staff sexual misconduct). In the last 12 months, one allegation of sexual abuse/harassment was received at AH. The auditor notes that three sexual abuse/harassment investigations were included with the PAQ information. One administrative investigation pertained to allegations occurring during 2020. While the investigation was thorough and it was continued to conclusion, the same falls outside the last 12 months parameter. The second investigation pertained to a resident's report of an incident that occurred at another facility. That incident falls under the parameters of 115.263. The last administrative investigation (allegations marginally identified as sexual abuse) was likewise thorough and continued to conclusion. Alternatives, Inc. Policy and Procedural Statement SOP A22 entitled PREA, page 7, section IV(I)(4) addresses 115.222(a). Additionally, Alternatives, Inc. Policy and Procedural Statement SOP A29 entitled Internal PREA Investigator Description and Duties, pages 1 and 2, section IV(B) addresses 115.222(a). According to the Agency Head interviewee, an administrative or criminal investigation is completed for all allegations of sexual abuse or sexual harassment. Allegations are reported through MDOC or the FBOP. Administrative investigations are completed by two PREA trained Alternatives, Inc. investigators and BPD criminal investigators complete criminal investigations of sexual abuse/harassment. MDOC investigators can facilitate criminal investigations relative to MDOC residents in the event BPD declines to investigate. In regard to the protocol relative to administrative/criminal sexual abuse or sexual harassment investigations, the Agency Head interviewee asserts that in a criminal matter, BPD is notified and advised of the allegation. Additionally, MDOC staff and FBOP staff are also notified. With respect to administrative investigations, the facility Director generally receives the call (allegation) and he/she reports the same up the chain of command. The on-call administrator is involved and the Director delegates the administrative investigation to one of the trained investigators. Investigations include normal investigative protocols. Investigators work hand-in-hand with staff in a collaborative approach. Pursuant to the PAQ, the Director self reports the agency has a policy that requires allegations of sexual abuse or sexual harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations, including the

	agency if it conducts its own investigations, unless the allegation does not involve potentially criminal behavior. The Director further self reports agency policy regarding the referral of allegations of sexual abuse or sexual harassment for criminal investigation is published on the agency website. The agency documents all referrals of allegations of sexual abuse or sexual harassment for criminal investigation. Alternatives, Inc. Policy and Procedural Statement SOP A22 entitled PREA, page 7, section IV(I)(4)(b) addresses 115.222(b). Additionally, Alternatives, Inc. Policy and Procedural Statement SOP A29 entitled Internal PREA Investigator Description and Duties, pages 1 and 2, section IV(B) addresses 115.222(b) The investigative staff interviewee asserts agency policy requires allegations of sexual abuse/harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior. BPD or the MDOC Investigations Bureau sexual abuse investigators conduct criminal investigations for AH. The auditor's review of the Alternatives, Inc. website reveals the appropriate policies, as reflected above, regarding criminal referrals and the investigative responsibilities for administrative and criminal investigative entities are posted on the same. Alternatives, Inc. Policy and Procedural Statement SOP A22 entitled PREA, page 7, section IV(I)(4)(b) addresses 115.222(c). Additionally, Alternatives, Inc. Policy and Procedural Statement SOP A29 entitled Internal PREA Investigator Description and Duties, pages 1 and 2, section IV(B) addresses 115.222(c). The auditor's review of the previously mentioned MOU between Alternatives, Inc. and BPD (addressed in the narrative for 115.221) reveals substantial compliance with 115.222(c). In view of the above, the auditor finds AH substantially compliant with 115.222.

115.231	Employee training
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Pursuant to the PAQ, the Director self reports the agency trains all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment; How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures; Resident's rights to be free from sexual abuse and sexual harassment; The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment; The dynamics of sexual abuse and sexual harassment in confinement; The common reactions of sexual abuse and sexual harassment victims; How to detect and respond to signs of threatened and actual sexual abuse; How to avoid inappropriate relationships with residents; How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, and intersex, or gender non-conforming residents; and How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities. The APC asserts that Alternatives, Inc. policies mandate 40 hours of annual training for all full-time employees and 32 hours for part-time employees. PREA and Sexual Harassment training are mandatory training for all employees with mandatory annual refresher training (PREA ART). Alternatives, Inc. utilizes the online NIC PREA training system for new employees and requires all staff to complete "PREA: Your role in Responding to Sexual Abuse" and "Communicating Effectively and Professionally with LGBTQI+ Offenders." CMs, LACs (lac), LCPCs (lcpc), treatment assistants (ta), specialized mental health therapists (mht), recreation managers (rm), and Intake/assessment coordinators (i/ac) are required to take "Behavioral Health Care for Sexual Assault Victims in a Confinement Setting. Site specific refresher documents are created and used at regular staff training to update and refresh staff on PREA Standards. The APC further self reports that training is received during new employee orientation, as reflected above. PREA ART is provided in February for Sexual Harassment and March for PREA. All staff are required to complete training and the same is tracked using the PAYCOM Learning Management System (LMS) training system. PREA Refreshers are used as an additional reminder/training for staff on PREA related issues. All staff are mandated to attend/take annual PREA Training. Over the last couple of years, due to COVID restrictions, the annual PREA training has been completed via an online LMS. Training material is provided to HR who then uploads the training to the LMS system and staff are assigned the training electronically. The training consists of a review of the ALT A22 PREA policy, the

	Sexual Harassment Policy, and includes other training, such as a 24 question Frequently Asked Questions (FAQ) Power Point presentation that was included in the LMS along with the PREA refresher documents. In previous years, in person PREA training was provided to all staff with various topics highlighted. PREA Jeopardy, crime scene protocols, etc. were some of the highlighted topics. Also, throughout the year, staff meet as part of their specific teams and they review 6 minute trainings, inclusive of the PREA six minute trainings. Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA, pages 9 and 10, section IV(L)(2) addresses 115.231(a). The auditor's review of the aforementioned NIC curriculum reveals substantial compliance with 115.231(a). The auditor's on-site review of random staff PAQ PREA Orientation Statements of Understanding forms (this document includes the "I understand the subject-matter presented" caveat and is signed/dated by the employee participant) reveals two of six staff members hired during April, 2020 or subsequently, completed PREA orientation prior to contact with residents. Review of 12 random staff Individual Employment Training Records reveals all completed In-Service PREA training during 2022. Given the results of staff interviews and documentation reviews as articulated in the preceding paragraph, the auditor is reasonably assured that a viable staff PREA training program is in place at AH. However, in light of a Frequently Asked Question (FAQ) as articulated on the PREA website, the auditor finds AH non-compliant with 115.231(a). Specifically, there is insufficient evidence, based on random document review, to establish that Pre-Service PREA training or staff PREA Orientation is completed prior to staff contact with residents. Accordingly, the auditor is assigning a 180-day corrective action period wherein Alternatives, Inc. staff will demonstrate compliance with and institutionalization of 115.231(a). The due date for completion of the corrective action is November 16, 2022. To demonstrate compliance with and institutionalization of 115.231(a), the APC will reinforce with HR and training staff the necessity of provision of PREA Orientation training to all newly hired staff prior to contact with residents. This may be accomplished pursuant to a documented ALT A22 refresher, complete with an instructional memorandum or lesson plan. The APC will upload a copy of instructional materials, as well, as evidence substantiating the stakeholder's completion of the training. The APC will subsequently upload a roster of all AH staff hired between the date of this interim report and the corrective action due date. The auditor will randomly select five to ten staff names and the APC will upload the corresponding PREA Orientation Statements of Understanding for the corresponding staff and the auditor will review for compliance.

November 13, 2022 Update:

The auditor's review of completed MDOC Staff PREA Acknowledgments, Completion of PREA Training Acknowledgments, and PREA Orientation Statements of Work for three staff hired between the date of the interim report and September 13, 2022 reveals completion of requisite training prior to assumption of duties with residents. A memorandum email dated October 26, 2022 reveals that a fourth new hire resigned within two hours of commencement of training. This evidence has been uploaded to OAS.

In view of the above, the auditor finds that AH is now substantially compliant with 115.231(a). Of note, training materials were discussed above.

All 12 random staff interviewees self report they received training regarding the aforementioned 10 PREA topics either during Pre-Service and/or PREA ART training, dependent upon their date of hire.

Pursuant to the PAQ, the Director self reports training is tailored to the male gender of the residents housed at the facility. Employees who are reassigned from facilities housing the opposite gender are given additional training.

Alternatives, Inc. Policy and Procedural Statement SOP A22 entitled PREA, pages 9 and 10, section IV(L)(2) addresses 115.231(a).

The auditor's review of the afore-mentioned training curriculum reveals the same is commensurate with 115.231(b).

The APC asserts the training that staff receives is applicable to both male and female residents. As Alternatives, Inc. specifically prohibits cross-gender pat searches and strip searches, the staff transferring will follow the same-gender policies and they understand the requirement of opposite gender announcements if entering the housing units.

Pursuant to the PAQ, the Director self reports that 57 staff, thirty-six of whom are currently employed and who may have contact with residents, were trained or retrained in PREA requirements. This equates to 100% of the staff complement.

The APC asserts that all staff are required to attend PREA ART. Throughout the year, all staff are required to review six minute PREA trainings. The agency provides, in addition to the 13 PREA Refresher documents, 6-minute Trainings for staff to reference during weekly staff meetings.

Given the fact 115.231(c) requires refresher training every two years to ensure all employees know the agency's current sexual abuse/harassment policies and procedures and the fact annual PREA ART is facilitated at AH, the auditor finds AH exceeds standard requirements with respect to 115.231(c).

Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA, pages 9

	and 10, section IV(L)(1) addresses 115.231(c). Pursuant to the PAQ, the Director self reports the agency documents that employees, who may have contact with residents, understand the training they received through employee signature or electronic verification. The APC asserts that as part of the new employee on-boarding and Orientation process, the employee attends a week long orientation session covering PREA, sexual harassment and agency required training. The staff person signs forms Employee Standards of Conduct; Fraternization and Conflict of Interest; and the PREA Statement of Understanding following their orientation /training. Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA, pages 9 and 10, section IV(L)(1) addresses 115.231(d). The auditor's on-site review of staff training files, as reflected in the narrative for 115.231(a), reveals staff signed and dated the requisite Alternatives, Inc. form acknowledging their understanding of the subject-matter presented. Accordingly, the auditor finds AH substantially compliant with 115.231(d). In view of the above, the auditor finds AH substantially compliant with 115.231.

115.232	Volunteer and contractor training
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Pursuant to the PAQ, the Director self reports all volunteers and contractors who have contact with residents are trained on their responsibilities under the agency's policies and procedures regarding sexual abuse/harassment prevention, detection, and response. The Director further self reports one trained volunteer and three vendors (vending contract) have provided services at AH during the last 12 months. In view of COVID constraints, volunteer services were discontinued however, in May, 2021, one volunteer was authorized to resume provision of services at the facility. In regard to the vendors, they have supervised contact, minimally, with residents and do not fall within the context of regular contractors. Alternatives, Inc. Policy and Procedural Statement SOP H2 entitled Volunteers/Intern Procedures, pages 11 and 12, section V addresses 115.232(a). The same policy addresses previously mentioned Policy ALT-22 and both policies are included in the Volunteer Training packet. The auditor's review of the AH Volunteer Training Packet reveals that each contractor/volunteer receives a copy of the Alternatives, Inc. PREA policy (ALT A22) and Form S11 entitled PREA Orientation Statement of Understanding, revealing substantial compliance with 115.232. The same provides sufficient information and background enabling all contractors/volunteers to fulfill their PREA responsibilities. The auditor's review of the volunteer training packet pertaining to the single volunteer providing services at AH reveals substantial compliance with 115.232(a). The packet, as well as, PREA training was completed on June 3, 2021. Document(s) maintained within the packet reflect that volunteers must attend annual PREA training, minimally. The APC asserts that volunteers and contractors meet with the APC and/or agency trainer to review the Orientation Packet. Volunteer training is updated annually. The APC further asserts that volunteers are only entered into the spreadsheet by the APC following completion of the Orientation process and completion of the criminal background record check. The auditor's review of the volunteer's S11 dated June 3, 2021 and S12 dated June 3, 2021 reveals substantial compliance with 115.232. The lone volunteer interviewee states he has been trained in his responsibilities regarding sexual abuse and sexual harassment prevention, detection, and response, per agency policy and procedure. He states that he met with the APC, received a copy of the PREA policy and discussed the same, and he received the Contractor/ Volunteer Handbook. He also signed and dated the PREA Orientation Statement of Understanding form. Finally, the interviewee states that he has been notified of the agency's zero tolerance policy on sexual abuse/harassment, as well as, informed

	about how to report such incidents. Pursuant to the PAQ, the Director self reports the level and type of training provided to volunteers and contractors is based on the services they provide and level of contact they have with residents. The Director further self reports volunteers and contractors, who have contact with residents, have been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents. The APC asserts that volunteer, intern, and contractor training is done either in individual or group settings. All are provided with a copy of the aforementioned policy ALT A22 and ALT A17 Sexual Harassment policies which are reviewed during orientation and taken with them. Volunteers are informed to report to the client advisor (ca) at the CA Desk and ask to talk in private to make a report of sexual abuse/harassment. The APC asserts that contractors and volunteers are trained to report any PREA incidents or information to the ca. They are provided instruction that if the ca to whom they are reporting is the alleged perpetrator, they must then report to another ca or contact the APC. Pursuant to the PAQ, the Director self reports the agency maintains documentation confirming that volunteers/contractors understand the training they have received. The APC asserts that pursuant to Alternatives, Inc. SOP H2 Volunteer/Intern Policy/ Procedure, volunteers and contractors are provided orientation either in a group setting or individually. Documentation of the training is maintained by the APC. The Orientation Checklist is signed by the volunteer as are the PREA Statement of Understanding and other required documents. The APC signs as a witness to these forms. Alternatives, Inc. Policy and Procedural Statement SOP H2 entitled Volunteer/Intern Procedures, document entitled Acknowledgment for Receipt of Volunteer/Intern Handbook addresses 115.232(c). In view of the above, the auditor finds AH substantially compliant with 115.232.

115.233	Resident education
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Pursuant to the PAQ, the Director self reports residents receive information at the time of intake about the zero-tolerance policy, how to report incidents or suspicions of sexual abuse or harassment, their rights to be free from sexual abuse/sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents. The Director further self reports 379 residents were provided requisite information at intake during the last 12 months, equating to 100% of residents admitted during the last 12 months who were provided this information at intake. Alternatives, Inc. Policy and Procedural Statement SOP A22 entitled PREA, page 4, section IV(C) addresses 115.233(a). Alternatives, Inc. Policy and Procedural Statement SOP K24A entitled Resident Handbook, pages 7 and 8, section entitled PREA addresses 115.233(a). The APC asserts that residents receive an initial orientation, watch the PREA video, sign the PREA Statement of Understanding from their PREA packet, and receive their resident Handbook. The intake staff interviewee self reports he provides residents with information about the Alternatives, Inc. and AH zero-tolerance policy and how to report incidents or suspicions of sexual abuse or sexual harassment at intake. This information is presented in the PREA video and an intake packet inclusive of the AH Handbook, a pamphlet, and document addressing zero tolerance and reporting options. The resident signs and dates the PREA Statement of Understanding, signifying receipt of this information. The interviewee further self reports that he educates residents verbally regarding reporting options, confidentiality, etc. Of note, the PREA video is generally presented by the cm. All eleven random resident interviewees state that when they first arrived at AH, they received information about the facility's rules against sexual abuse/ harassment. Interviewees validated the statement of the intake staff interviewee in terms of PREA materials they received. Additionally, some interviewees spoke of receipt of a PREA Frequently Asked Questions (FAQ) document. All 11 interviewees state when they came to AH, they were told about the following: Their right not to be sexually abused/harassed; How to report sexual abuse/harassment; and Their right not to be punished for reporting sexual abuse/harassment. Ten of 11 interviewees stated that they were provided this information at intake. The auditor's on-site review of 14 random resident files reveals timely PREA information was provided to them at intake in every case. A follow-up meeting was facilitated by the cm within three weeks of intake wherein the PREA video was

	generally presented. Pursuant to the PAQ, the Director self reports the facility provides residents who are transferred from a different community confinement facility with refresher information as referenced above. The APC asserts that all residents entering AH are provided PREA orientation. Alternatives, Inc. Policy and Procedural Statement SOP A22 entitled PREA, page 4, section IV(C) addresses 115.233(b). The intake staff interviewee self reports residents are made aware of the rights articulated in the narrative for 115.233(a) within the first day of admission and prior to placement in a bunk. All 11 random resident interviewees reported being transferred to AH from state correctional facilities, federal prisons, other community confinement facilities, or county jail(s). Pursuant to the PAQ, the Director self reports resident PREA education is available in accessible formats for all residents, including those who are limited English proficient, deaf, visually impaired, otherwise disabled, as well as, to residents who have limited reading skills. The APC asserts staff meet one-on-one with residents who are limited English Proficient, use staff members who are proficient in the resident's native language, utilize the LanguageLine Interpreter Service, use a smart phone/tablet translation app, or provide copies of the document(s) translated into their native language using the Babylon Translation program. PREA education videos are available in English, English with English Subtitles, Spanish and Spanish with Spanish subtitles. Alternatives, Inc. Policy and Procedural Statement SOP A22 entitled PREA, page 4, section IV(C) addresses 115.233(c). Additionally, a document is included in the PAQ informational packet wherein the name(s), telephone number(s), and email address(es) are highlighted with respect to sign language interpreters. Resident education formats and accessibility of the same to the resident population are addressed in the narrative for 115.216 above. Pursuant to the PAQ, the Director self reports the agency maintains documentation of resident participation in PREA education sessions. The APC asserts that on the last page of the PREA Orientation packet, there is a statement of understanding which all residents sign subsequent to completion of the orientation session. The document is collected by staff and given to administrative support staff to upload into TOMS. The auditor's review of three 2021 and 2022 Statements of Understanding validates the above statement. Executed documents, as discussed above, are applicable to three residents, in addition to the on-site random resident file reviews. Pursuant to the PAQ, the Director self reports the agency ensures key information

	about the agency's PREA policies is continuously and readily available or visible through posters, resident handbooks, or other written formats. The auditor's review of numerous documents referenced throughout the narrative for 115.233 reveals substantial compliance with 115.233(e). Additionally, the auditor's review of four posters submitted with PAQ information reveals zero tolerance towards sexual abuse/harassment and reporting options. Some of these posters were also presented in Spanish. The auditor validated the preceding statement during the facility tour. Posters are plentiful and positioned in strategic locations throughout the facility. In view of the above, the auditor finds AH substantially compliant with 115.233.

115.234	Specialized training: Investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Pursuant to the PAQ, the Director self reports agency policy requires that investigators are trained in conducting sexual abuse investigations in confinement settings. The APC asserts that staff administrative PREA Investigators initiate an investigation into all alleged PREA incidents. If the initial investigation appears to have a criminal basis, BPD investigator(s) are called and the investigation is turned over to them. Should BPD decline to investigate, staff contact the MDOC Investigations Bureau to initiate their investigation relative to State of Montana residents. Alternatives, Inc. Policy and Procedural Statement SOP A29 entitled Internal PREA Investigator Description and Duties, page 1, section III and IV(A) addresses 115.234(a). The auditor's review of the training syllabus for the NIC course entitled PREA: Conducting Sexual Abuse Investigations in a Confinement Setting reveals the same addresses the requirements of both 115.234(a) and (b). The auditor has reviewed this training syllabus in conjunction with other PREA audits. According to the administrative investigative staff interviewee, he completed the Basic and Advanced three hour on-line NIC training courses entitled PREA: Conducting Sexual Abuse Investigations in a Confinement Setting. Some scenario based training was included in the same, as well as, a testing process. According to the interviewee, he also completed an eight hour in-person MDOC sexual abuse investigative training. The administrative investigative interviewee asserts the courses included topics such as execution of Miranda and Garrity warnings, the evidence standard necessary to substantiate a case for administrative action or prosecution referral, techniques for interviewing sexual abuse victims, and sexual abuse evidence collection in confinement settings. The criminal investigative interviewee states that his training included execution of Miranda warnings, the evidence standard necessary to substantiate a case for prosecution referral, techniques for interviewing sexual abuse victims, and sexual abuse evidence collection in confinement settings. The auditor's review of three NIC certificates (two for the APC and one for the contract assurance coordinator) reveals substantial compliance with 115.234(a) and (c). The criminal investigative staff interviewee states that he received initial sexual abuse investigative training at the academy. Specialty sexual abuse training was completed at other law enforcement departments wherein subject-matter experts provided the same. All trainings were facilitated in an in-person format.

	Pursuant to the PAQ, the Director self reports the agency maintains documentation showing investigators have completed the required training. As previously indicated, the Director also self reports the agency maintains documentation showing two current investigators have completed the required training. The APC asserts that the agency maintains Certificate(s) of Completion for each internal investigator relative to the NIC PREA Investigating Sexual Abuse in a Confinement Setting course(s). Documentation substantiating completion of requisite training is addressed in the narrative for 115.234(a). In view of the above, the auditor finds AH substantially compliant with 115.234.

115.235	Specialized training: Medical and mental health care
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Pursuant to the PAQ, the Director self reports that the agency has a policy related to the training of medical and mental health practitioners who work regularly in its facilities. Five medical and mental health care practitioners who work regularly at this facility have received the training required by agency policy. This equates to 100% of all medical and mental health care practitioners who work regularly at this facility who have received the training required by agency policy. Pursuant to the 2021-2022 Annual Training Plan, medical practitioners complete the NIC course entitled Medical Health Care for Sexual Abuse Victims in a Confinement Setting and mental health practitioners (lacs, lcpcs, tas, and smhts) complete Behavioral Health Care for Sexual Abuse Victims in a Confinement Setting. The auditor's review of one certificate as described above for a medical practitioner and two certificates for mental health practitioners reveals some compliance with 115.235(a) and (c). Certificates are missing for two practitioners. The auditor's on-site review of random staff training files reveals that one of the two remaining medical/mental health practitioners has completed requisite specialty training. While there is substantial compliance with 115.235(a), the last medical practitioner (Entry on Duty date of November, 2021) must complete requisite specialty training and a copy of her certificate shall be uploaded. Both the medical and mental health interviewees assert they completed specialized training regarding sexual abuse/harassment. The training consisted of a three hour on-line course, inclusive of a testing component. The training addressed the following: How to detect and assess signs of sexual abuse/harassment; How to preserve physical evidence of sexual abuse; How to respond effectively and professionally to victims of sexual abuse and sexual harassment; and How and to whom to report allegations or suspicions of sexual abuse and sexual harassment. Pursuant to the PAQ, the Director self reports that agency medical staff at this facility do not conduct forensic medical examinations. The auditor validated the same during the on-site audit and accordingly, he finds 115.235(b) not applicable to AH. Pursuant to the PAQ, the Director self reports that the agency maintains documentation reflecting that medical and mental health practitioners have completed the required NIC training previously mentioned. An analysis of findings in this regard is clearly articulated in 115.235(a).

	Pursuant to the PAQ, the Director self reports that medical and mental health care practitioners also receive the training mandated for employees under § 115.231 or for contractors and volunteers under § 115.232, depending upon the practitioner's status with the agency. The auditor's review of Individual Training Records for random AH medical/mental health providers reveals all completed PREA ART, minimally. Accordingly, the auditor finds AH substantially compliant with 115.235(d). In view of the above, the auditor finds AH compliant with 115.235.

115.241	Screening for risk of victimization and abusiveness
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Pursuant to the PAQ, the Director self reports the agency has a policy that requires screening (upon admission to a facility or transfer to another facility) for risk of sexual abuse victimization or sexual abusiveness toward other residents. Alternatives, Inc. Policy and Procedural Statement SOP L56S entitled Case Management Intake and Orientation, page 2, section IV addresses 115.241(a) and (b). Alternatives, Inc. Policy and Procedural Statement ALT217 entitled PREA: Risk Assessment, page 1 addresses 115.241(c and d). The staff who performs screening for risk of victimization and abusiveness interviewee self reports she does screen residents upon admission to AH or transfer from another facility for risk of sexual victimization or sexual abusiveness toward other residents. Additionally, she reports that new commitments are screened within 72 hours of intake. As a matter of fact, new commitments are screened within 24 hours of intake. Ten of 11 random resident interviewees state when they first arrived at AH, they were asked questions like: Whether they had been in jail or prison before; Whether they have ever been sexually abused; Whether they identify as being LGBTI; and Whether they think they may be in danger of being sexually abused at AH. The auditor's on-site review of 14 random resident files reveals initial sexual victimization/sexual abusiveness screening was conducted within 24 hours of arrival at AH and in a comprehensive manner in all cases. This review included the one resident who stated he was not asked all relevant questions and/or the initial assessment was not conducted within 24 hours of arrival. The auditor observed the office wherein new commitments are screened. He finds no evidence of deviation from standard or policy as a result. Pursuant to the PAQ, the Director self reports 115.241(a) screening shall ordinarily take place within 72 hours of arrival at the facility. The below policy requires that screening is conducted within 48 hours of arrival at AH. The Director self reports during the last 12 months, 379 residents entering the facility (either through intake or transfer) whose length of stay in the facility was 72 hours or more, were screened for risk of sexual victimization or risk of sexually abusing other residents, within 72 hours of their entry into the facility. This equates to 100% of residents admitted to the facility during the last 12 months, for 72 hours or more. Alternatives, Inc. Policy and Procedural Statement SOP L56S entitled Case Management Intake and Orientation, page 3, section IV(D) addresses 115.241(b).

	Alternatives, Inc. Policy and Procedural Statement ALT217 entitled PREA: Risk Assessment, page 1 addresses 115.241(c and d). The auditor's review of three initial assessments conducted during 2021 and 2022 reveals substantial compliance with 115.241(b). Alternatives, Inc. policy requires completion of the initial assessment within 48 hours of arrival and the same were comprehensive/timely. Discussion regarding the results of the auditor's on-site random review of resident files is reflected in the narrative for 115.241(a). The staff responsible for risk screening interviewee states that screenings are completed within 24 hours of arrival at AH. The Screening Committee (comprised of the Director, screening and disciplinary coordinator, and os) reviews each packet of materials for incoming residents, assessing any PREA key indicators. They follow-up with the in-charge client advisor (ca) regarding their findings and any housing considerations. Pursuant to the PAQ, the Director self reports risk assessment is conducted using an objective screening instrument. Alternatives, Inc. Policy and Procedural Statement ALT217 entitled PREA: Risk Assessment, page 1 addresses 115.241(c and d). The auditor's review of the Alternatives, Inc. Sexual Predator/Vulnerability PREA Screening Checklist reveals the same is an objective screening tool. All 115.241(d) objective topics, as well as others identified by Alternatives, Inc. as germane to indicators of sexual victimization/aggression, are considered in the instrument. Additionally, specific questions and responses are weighted differently to establish propensity towards sexual victimization/aggressiveness. The auditor's review of the Sexual Abuse Screening Tool reveals substantial compliance with 115.241(d). Specifically, the document addresses the following issues: 1) Whether the resident has a mental, physical, or developmental disability; 2) The age of the resident; 3) The physical build of the resident; 4) Whether the resident has previously been incarcerated; 5) Whether the resident's criminal history is exclusively nonviolent; 6) Whether the resident has prior convictions for sex offenses against and adult or child; 7) Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming; 8) Whether the resident has previously experienced sexual victimization; and 9) The resident's own perception of vulnerability. The staff who performs screening for risk of sexual victimization and abusiveness interviewee self reports the following factors are considered in the sexual victimization/abusiveness screening:

	History of sexual abuse in the community or in a confinement setting; Height; Weight; LGBTI self identifications and the interviewer's observations; Developmental disabilities; History of violence; Predatory sexual behavior; and Whether the resident has any concerns with sexual safety at AH. The screening interview is conducted in the screening office or the office adjacent to the ca office behind closed doors. Both offices are equipped with windows. The interview is conducted in a one-on-one setting. The interviewee reads the questions to the resident. Finally, the interviewee does review the pre-arrival packet prior to facilitation of the screening and accordingly, she follows-up with the resident with respect to responses, in question. The auditor's review of the Sexual Abuse Screening Tool reveals substantial compliance with 115.241(e). Specifically, the same addresses prior acts of sexual violence, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse. Alternatives, Inc. Policy and Procedural Statement ALT217 entitled PREA: Risk Assessment, page 1 addresses 115.241(e). Pursuant to the PAQ, the Director self reports the policy requires the facility reassesses each resident's risk of victimization or abusiveness within a set time period, not to exceed 30 days after the resident's arrival at the facility, based upon any additional relevant information received by the facility since the intake screening. The Director self reports during the last 12 months (until the date on which the PAQ was completed), 342 residents entering the facility either through intake or transfer, were reassessed for their risk of sexual victimization or of being sexually abusive, within 30 days after their arrival at the facility based upon any additional relevant information received since intake. The Director further self reports this represents 100% of residents entering the facility for more than 30 days. The APC asserts that 37 of the 379 total residents received at AH during the last 12 months were released prior to 30 days. New FBOP requirements have resulted in several FBOP residents being granted early release, several of those were in the 37 that released prior to 30 days and/or reassessment. The APC asserts that all residents are reassessed for risk of victimization or abusiveness within 30 days of their arrival. The TOMS system sends a task reminder to the case manager at the 25th day to remind of the need to complete the 30-day follow-up if not already completed. Alternatives, Inc. Policy and Procedural Statement SOP L56S entitled Case Management Intake and Orientation, page 3, section IV(D)(1) addresses 115.241(f).

	The auditor's review of the three resident files mentioned in the narrative for 115.241(b) reveals that the 30-day reassessment was conducted in a timely and thorough manner. The auditor's on-site review of eight of 14 random resident files reveals that timely and comprehensive 30-day reassessments were facilitated. In view of the resident's date of arrival, three additional 30-day reassessments were not yet due at the time of the on-site audit. Three of the on-site reassessments were facilitated outside the 30-day window. According to the staff who performs screening for risk of victimization and abusiveness interviewee, reassessments are conducted within 30 days of arrival at AH. TOMS is utilized to track due dates. Reassessments are completed within the 21-30 day range following arrival at AH. Five of 11 random resident interviewees report they were asked the questions reflected in the narrative for 115.241(a) above since arrival at AH. The questions were allegedly asked within 30 days of arrival at the facility. Of note, four reassessments are not yet due as of the dates of the on-site audit. The auditor's review of one of two resident files related to those interviewees who assert they were not reassessed at AH reveals the same was reassessed in a timely and comprehensive manner. Pursuant to the PAQ, the Director self reports policy requires that a resident's risk level be reassessed when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness. The APC asserts that cms complete an additional risk assessment when any additional information is disclosed by the resident or becomes available to staff/ agency or following an allegation of sexual abuse/harassment. He further asserts no additional information of sexual abuse/victimization has been received during the last 12 months that has triggered a reassessment. Alternatives, Inc. Policy and Procedural Statement SOP L56S entitled Case Management Intake and Orientation, page 3, section IV(D)(1) addresses 115.241(g). Pursuant to the PAQ, the Director self reports the policy prohibits disciplining residents for refusing to answer (or for not disclosing complete information related to) questions regarding: Whether or not the resident has a mental, physical, or developmental disability; Whether or not the resident is or is perceived to be lesbian, gay, bisexual, transgender, intersex, or gender nonconforming; Whether or not the resident has previously experienced sexual victimization; and The resident's own perception of vulnerability. Alternatives, Inc. Policy and Procedural Statement SOP L56S entitled Case Management Intake and Orientation, page 3, section IV(D)(2) addresses 115.241(h). According to the staff who performs screening for risk of sexual victimization and

	abusiveness interviewee, residents are not disciplined in any way for refusing to respond to (or for not disclosing complete information related to): Whether or not the resident has a mental, physical, or developmental disability; Whether or not the resident is or is perceived to be lesbian, gay, bisexual, transgender, intersex, or gender nonconforming; Whether or not the resident has previously experienced sexual victimization; and The resident's own perception of vulnerability. According to the APC, the agency has outlined who should have access to a resident's risk assessment within the facility in order to protect sensitive information from exploitation. Initial assessments and reassessments are uploaded into TOMS and those staff with privileges can access the same. Cas, cms, the os, pm, and the Director have access to the same. The staff who performs screening for risk of sexual victimization and abusiveness interviewee states the Director, pm, LAC and LCPC, and cm have access to this information. In view of the above, the auditor finds AH substantially compliant with 115.241.

115.242	Use of screening information
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Pursuant to the PAQ, the Director self reports the facility uses information from the risk screening to inform housing, bed, work, education, and program assignments with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive. The APC asserts that when the case manager enters the results of the risk assessment into TOMS, an email is sent to the os, ps, Director and APC identifying the status of the resident. Ca Supervisors also receive this information to assist them with room placement or, if necessary, changing room(s) to ensure resident safety. If the staff making room assignment(s) need(s) additional guidance regarding room assignment(s), they email or contact the os or the APC to secure final guidance. The TOMS program also provides notification of PREA Risk Status on the room change function screen to alert staff of the need to review all roommate statuses prior to making any room change. The Active Room Assignment Report and Security Head Count reports also Identify the resident's PREA Risk Assessment status so security staff may be observant for possible safety issues. Alternatives, Inc. Policy and Procedural Statement SOP L56S entitled Case Management Intake and Orientation, page 3, section IV(D) addresses 115.242(a). Additionally, Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA, page 5, section IV(E)(2) addresses 115.242(a). The APC asserts the agency uses information gleaned from the risk screening during intake to keep residents safe from being sexually victimized or sexually abusive. This information is used primarily with housing decisions as the facility is open in terms of structure, etc. Potential and known victims (PVs/KVs) are separated from potential and known predators (PPs/KPs). Residents classified as "NA" may be placed with PVs/KVs or PPs/KPs. According to the staff who performs screening for risk of victimization and abusiveness interviewee, PVs/KVs are physically separated (housing only) from PPs/KPs in terms of housing. Any classification can be housed with an individual who scores as "NA". Programming activities are supervised by staff and work assignments are generally off-site. The auditor's cursory review of Active Room Assignments and AH Head Count Log dated March 29, 2022 reveals consistency in terms of geographic separation (by room) of KVs/PVs and KPs/PPs. During the on-site audit, the auditor identified no deviations from practice, policy, or standard provision. Pursuant to the PAQ, the Director self reports the facility makes individualized determinations about how to ensure the safety of each resident.

	Alternatives, Inc. Policy and Procedural Statement SOP L56S entitled Case Management Intake and Orientation, page 3, section IV(D) addresses 115.242(b). Additionally, Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA, page 5, section IV(E)(2) addresses 115.242(b). Pursuant to the PAQ, the Director self reports the facility makes housing and program assignments for transgender or intersex residents in the facility on a case-by-case basis. The APC asserts that when a resident who identifies as transgender, intersex, or gender non-conforming (non-binary), housing decisions will be staffed by the APC, os, and Director to determine the safest housing and work assignments. Alternatives, Inc. Policy and Procedural Statement SOP L56S entitled Case Management Intake and Orientation, page 3, section IV(D) addresses 115.242(c). Additionally, Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA, page 5, section IV(E)(2) addresses 115.242(c). The APC asserts all incoming residents are placed in a sexually safe situation based on screening results. PVs/KVs and PPs/KPs are housed with NAs or the same classification can be housed together. However, KVs/PVs are not housed with KPs/PPs. LGBTI residents are not placed in designated areas within the facility. There are no designated location(s) for transgender/intersex resident housing. Bed assignments are based on careful matching to ensure assignments are properly made pursuant to the aforementioned formula. The agency does consider whether the placement will ensure the resident's health and safety. Similarly, the agency does consider whether the placement would present management or security concerns. The interviewee who self reported she is transgender states she is questioned regarding her safety frequently. She does not report that she has been placed in a housing area designated solely for transgender/intersex residents. Furthermore, she does not believe she has been strip searched for the sole purpose of determining genitalia. The APC asserts transgender/intersex resident's own views with respect to their safety are given serious consideration in placement and programming assignments. The staff who conducts screening for risk of victimization and abusiveness interviewee confirms the APC's statement in this regard. According to the APC, transgender and intersex residents are given the opportunity to shower separately from other residents. He asserts that three bathrooms are available with showers and toilets. Residents approved to use these bathrooms are issued keys. The staff responsible for risk screening interviewee corroborates the statement of the APC as reflected above. The transgender resident interviewee states she does have separate shower privileges as articulated throughout this narrative.

	The APC asserts the facility is not subject to a consent decree, legal settlement, or legal judgment requiring that it establish a dedicated facility, unit, or wing for LGBTI residents. The APC further asserts he has access to random room assignment documentation, inclusive of assessments. At least monthly, he reviews the same to ensure LGBTI residents are not housed in specific rooms/locations within the facility. Transgender/intersex residents are dispersed throughout the facility. The auditor's cursory review of room/bed assignments reveals no deviation from standard. In view of the above, the auditor finds AH substantially compliant with 115.242.

115.251	Resident reporting
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Pursuant to the PAQ, the Director self reports the agency has established procedures allowing for multiple internal ways for residents to report privately to agency officials about: Sexual abuse or 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 such incidents. The APC asserts that residents can report to any staff member, volunteer, intern, contractor, medical or mental health staff, use the formal grievance process, place a note in the locked PREA box, use a medical kite, etc. Alternatives, Inc. Policy and Procedural Statement SOP K24A entitled Resident Handbook, page 7, section entitled PREA a-c addresses 115.251(a). Additionally, Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA, pages 4 and 5, section IV(D)(1)(a-d and f) addresses 115.251(a). The auditor's review of the AH Resident Handbook, as cited in the preceding paragraph, reveals multiple methods for private resident reporting of sexual abuse and sexual harassment incidents. All 12 random staff interviewees are able to cite at least two methods available to residents for reporting sexual abuse/harassment, retaliation by other residents/staff for reporting sexual abuse/harassment, or staff neglect/violation of responsibilities that may have contributed to an incident of sexual abuse/harassment. Methods of reporting include: Telephonic contact with Great Falls Transitional Center (GFTC); Verbal report to staff; Submit a kite; 9-1-1 call; Anonymous report; Submit an Emergency Grievance; and Third-party report. All 11 random resident interviewees are able to cite at least one method available to them to for reporting. Options include: A verbal report to staff; Contact GFTC; Contact BPD; Submit a grievance; Submit a kite to staff; and

	Third-party report. As previously addressed in the narrative for 115.233, posters (regarding procedures for reporting sexual abuse/harassment of residents) are available throughout the facility. Pursuant to the PAQ, the Director self reports the agency provides at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency. Alternatives, Inc. Policy and Procedural Statement SOP K24A entitled Resident Handbook, page 7, section entitled PREA (c) addresses 115.251(b). Additionally, Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA, page 5, section IV(D)(1)(d) addresses 115.251(b). The auditor's review of the MOU between Alternatives, Inc. and Great Falls Prerelease Services, Inc. (GFPS) reveals substantial compliance with 115.251(b). It appears this MOU represents a reciprocal agreement relative to 115.251(b) reporting and turnaround of such reports. Pursuant to the auditor's review of the resources mentioned in the narrative for 115.251(a), GFTC and BPD are the most prevalent validation of compliance with 115.251(b). According to the APC, residents can call or write the GFTC to report sexual abuse or harassment. The same is addressed on posters, in the AH Resident Handbook, and during orientation. Sexual abuse reports are forwarded to the APC. The auditor did contact GFTC to test the above non-affiliated sexual abuse/ harassment reporting source. The telephone call was placed from the auditor's home. The auditor notes that he received zero complaints from residents regarding non-functionality of the resident telephones during the entire audit period. Subsequent to reporting the test to GFTC staff, the auditor inquired as to the protocol after receiving the report. The receiver of the call articulated the questions he would ask the caller and advised that he subsequently provides this information to the GFTC PC. Subsequent to the above, the auditor discussed the process with the ex-GFTC PC who was recently promoted. He advised that the APC is notified of the report and all accompanying information shortly after receipt of the same. The auditor notes that this protocol parallels that articulated in the aforementioned MOU with GFPS. The APC asserts that personal information (pin number, register number, telephone card number, etc.) is required from the resident when making this telephone call. Thus, the telephone call can be made anonymously. Nine of 11 random resident interviewees assert that residents are allowed to make a report without having to give their name.

	Pursuant to the PAQ, the Director self reports the agency has a policy mandating that staff accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties. The Director also self reports staff are required to document verbal reports. The Director further self reports staff are required to document verbal reports "immediately" following receipt of the same. Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA, page 7, section IV(I)(1 and 9) addresses 115.251(c). Additionally, Alternatives, Inc. Policy and Procedural Statement ALT K24A entitled Resident Handbook, page 7, section entitled PREA (f) addresses 115.251(c). All 12 random staff interviewees assert when a resident alleges sexual abuse, he can do so verbally, in writing, anonymously, and from third parties. All 12 interviewees assert they immediately document any verbal reports of sexual abuse/ harassment received from residents. Ten of 11 random resident interviewees assert reports of sexual abuse/harassment can be made both in person and in writing. Furthermore, nine of 11 interviewees assert a friend or relative can make the report for the resident without giving his name. Pursuant to the PAQ, the Director self reports the agency has established procedures for staff to privately report sexual abuse and sexual harassment of residents. The APC asserts that all staff can request to talk to their immediate supervisor or in-charge ca, the APC, the cac, the Director or the CEO in private to discuss the report they received. Staff are routinely reminded to not discuss resident related or security related topics in areas where residents may be able to hear the conversation. Staff are alerted to reporting procedures pursuant to Pre-Service and In-Service training. Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA, page 7, section IV(I)(1)(a) addresses 115.251(d). Additionally, Alternatives, Inc. Policy and Procedural Statement SOP ALT H1 entitled Employee Handbook, pages 29-31 address 115.251(d) All 12 random staff interviewees are able to cite at least two methods of privately reporting sexual abuse/harassment of residents. Methods cited are: Placement of a telephone call or e-mail to the in-charge ca/Director/os/program supervisor/APC; Closed door meeting with the above staff; Report to Director via his cell phone during non-regular business hours; GFTC contact; Contact BPD; submit a written report; and Submit a third-party report. In view of the above, the auditor finds AH substantially compliant with 115.251.

115.252	Exhaustion of administrative remedies
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Pursuant to the PAQ, the Director self reports the agency has an administrative procedure for dealing with resident grievances regarding sexual abuse. The APC asserts that residents may use the grievance process for reporting an alleged sexual abuse at any time, as well as, use other reporting methods. Alternatives, Inc. Policy and Procedural Statement SOP L18S entitled Resident/Client Grievance Policy, pages 5 and 6, section entitled Emergency Grievance addresses 115.252(a). The auditor notes that this policy provision does not specify any time frames for filing an emergency grievance (includes sexual abuse allegations). Pursuant to the PAQ, the Director asserts agency policy or procedure allows a resident to submit a grievance regarding an allegation of sexual abuse at any time, regardless of when the incident is alleged to have occurred. The APC asserts that the reporting resident may use the grievance process for reporting an alleged abuse at anytime. The auditor notes that the above is commensurate with the policy articulated in the narrative for 115.252(a). Pursuant to the PAQ, the Director asserts agency policy does not require a resident to use an informal grievance process, or otherwise to attempt to resolve with staff, an alleged incident of sexual abuse. The APC asserts that reporting of incidents of sexual abuse are not handled through an informal grievance process. Specifically, all grievances filed with an alleged incident of sexual abuse are reviewed by the grievance coordinator and automatically sent to the facility Director. PREA Packet A520 page 4, section entitled PREA for Intake Orientation, section B(1) addresses 115.252(b). The APC asserts that reporting of incidents of sexual abuse are not handled through the informal grievance process. All grievances filed with an alleged incident of sexual abuse are reviewed by the grievance coordinator and automatically sent to the facility director. Additionally, Alternatives, Inc. Policy and Procedural Statement SOP K24A entitled Resident Handbook, page 7, section entitled PREA (b) addresses 115.252(b). Pursuant to the PAQ, the Director self reports that the agency's policy and procedure allows a resident to submit a grievance alleging sexual abuse without submitting it to the staff member who is the subject of the complaint. Further, the Director asserts the agency's policy and procedure requires that a resident grievance alleging sexual abuse not be referred to the staff member who is the subject of the complaint. Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA, page 4, section IV(D)(1)(c) addresses 115.252(c). The APC asserts residents are instructed that submitting a grievance or a report of

	sexual abuse/harassment does not have to be reported to the staff member who is subject of the complaint. They can contact any other staff or place the report in the locked grievance box. This caveat is clearly captured in the aforementioned PREA Handbook citation on pages 7 and 8 of Policy K24A. Pursuant to the PAQ, the Director self reports agency policy and procedure requires that a decision on the merits of any grievance or portion of a grievance alleging sexual abuse be made within 90 days of the filing of the grievance. The Director further self reports that an extension of 70 days may be taken to address the matter, if required, and documentation of the extension, inclusive notice of the date by which a decision will be made, is provided to the resident. During the last 12 months, zero grievances were filed that alleged sexual abuse. Alternatives, Inc. Policy and Procedural Statement SOP L18S entitled Resident/Client Grievance Policy, page 4, section IV(Q) addresses 115.252(d). The APC advised the auditor that zero residents who reported a sexual abuse incident at AH were housed at the facility during the on-site audit. Comparison of the single investigation conducted at AH during the last 12 months against the current resident roster validates the APC's assertion. Pursuant to the PAQ, the Director asserts agency policy and procedure permits third parties, including fellow residents, staff members, family members, attorneys, and outside advocates to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse and to file such requests on behalf of residents. Agency policy and procedure requires that if a resident declines to have third-party assistance in filing a grievance alleging sexual abuse, the agency documents the resident’s decision to decline. The Director further self reports that zero grievances alleging sexual abuse were filed by residents in the last 12 months wherein the resident declined third-party assistance. Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA, page 5, sections IV(D)(1)(f) and IV(D)(2) address 115.252(e). Pursuant to the PAQ, the Director self reports the agency has a policy and established procedures for filing an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse. The Director further self reports agency policy and procedure for emergency grievances alleging substantial risk of imminent sexual abuse requires an initial response within 48 hours. Policy and procedure for emergency grievances alleging substantial risk of imminent sexual abuse also requires that a final agency decision be issued within 5 days. Zero emergency grievances alleging substantial risk of imminent sexual abuse were filed in the last 12 months. Alternatives, Inc. Policy and Procedural Statement SOP L18S entitled Resident/Client Grievance Policy, page 5, section entitled Emergency Grievance (a) addresses 115.252(f).

	Pursuant to the PAQ, the Director self reports the agency has a written policy that limits its ability to discipline a resident for filing a grievance alleging sexual abuse to occasions where the agency demonstrates that the resident filed the grievance in bad faith. In the last 12 months, zero resident grievances alleging sexual abuse resulted in disciplinary action by the agency against the resident for having filed the grievance in bad faith. Alternatives, Inc. Policy and Procedural Statement SOP L18S entitled Resident/Client Grievance Policy, page 6, section entitled Emergency Grievance (e) addresses 115.252(g). Additionally, Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA, page 5, section IV(D)(5) addresses 115.252(g). In view of the above, the auditor finds that AH is substantially compliant with 115.252.

115.253	Resident access to outside confidential support services
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Pursuant to the PAQ, the Director self reports the facility provides residents with access to outside victim advocates for emotional support services related to sexual abuse by: Giving residents mailing addresses and telephone numbers (including toll-free hotline numbers where available) for local, state, or national victim advocacy or rape crisis organizations; and Enabling reasonable communication between residents and these organizations in as confidential manner as possible. Alternatives, Inc. Policy and Procedural Statement SOP K24A entitled Resident Handbook, page 7, section entitled PREA (d) addresses 115.253(a). Additionally, Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA, pages 4 and 5, section IV(D)(1)(e) addresses 115.253(a). Finally, Alternatives, Inc. A520 PREA Packet Standard Intake Orientation (resident), page 2, section B(1)(c) addresses 115.253(a). The APC asserts that the address for the Billings YWCA Gateway Program is in the PREA Orientation and Resident Handbook. Posters are also posted throughout the facility with the telephone number and address of the YWCA Gateway Program. All cms, lacs, lcpcs and security staff have the information to provide to residents. Of note, the auditor validated the above pursuant to review of the aforementioned policies, orientation materials, handbooks, and posters. Seven of 11 random resident interviewees state there are services available outside the facility for dealing with sexual abuse, if the resident needed them. Five interviewees specifically cited services are available through the Billings YWCA Gateway program (one interviewee), counseling, mental health or crisis center, or Riverstone Health. The remaining six interviewees stated they were not aware of the names of specific services or the services provided. Eight interviewees report such information is available in the AH Resident Handbook or review of posters throughout the facility. Nine interviewees assert the telephone calls are free of charge and nine interviewees state the telephone calls can be made at any time. The APC states that the telephone system does not require any PIN or registration number or any identifying information for the resident to contact the Billings YWCA Gateway program. Additionally, telephone calls are not monitored or listened to by staff. Of note, such telephone calls are free of charge. The auditor did test the telephone number to the YWCA Billings Gateway Program and spoke with a staff member employed with the same. The staff member validated that telephone calls from AH and Passages residents who are in need of VA services following a sexual abuse incident should be properly placed to the

	telephone number called by the auditor. While the telephone call was placed from the auditor's home, there was no evidence of resident telephone malfunction during the course of the on-site audit. The APC asserts zero residents who reported sexual abuse at AH were confined at the facility during the on-site audit. Pursuant to the PAQ, the Director self reports the facility informs residents, prior to giving them access to outside support services, of the extent to which such communications will be monitored. The Director further self reports the facility informs residents, prior to giving them access to outside support services, of the mandatory reporting rules governing privacy, confidentiality, and/or privilege that apply to disclosures of sexual abuse made to outside victim advocates, including any limits to confidentiality under relevant federal, state, or local law. The auditor finds no evidence wherein residents are informed, prior to giving them access to outside support services, of the mandatory reporting rules governing privacy, confidentiality, and/or privilege that apply to disclosures of sexual abuse made to outside VAs, including any limits to confidentiality under relevant federal, state, or local law. Additionally, the auditor finds no advisement that VAs are also mandatory reporters and accordingly, if residents verbalize criminal activity either at AH or on the streets, thoughts of self injurious or homicidal behavior either pertaining to the resident or others, or a threat to the security and good order of the facility, the VA must report the same. While medical and mental health licensed staff advise residents of the limitations of confidentiality and mandatory reporting requirements during visits, group sessions, etc., the same is not applicable to 115.253(b) as the same pertains to conversations between AH residents and Billings YWCA Gateway VAs. Accordingly, the auditor finds AH non-compliant with 115.253(b) and imposes a 180-day corrective action period ending on or before November 16, 2022. During the aforementioned corrective action period, the APC and AH staff will demonstrate compliance with the provision, as well as, institutionalization of the same. To demonstrate compliance and institutionalization, the PCM will devise a plan to ensure residents are adequately informed of 115.53(b) information. The auditor recommends that this plan include amendment or updating of the AH Resident Handbook to address the subject-matter reflected in the preceding two paragraphs. Upon completion of the informational updates, the PCM will upload the same for the auditor's review. He will then post a memorandum (English and Spanish) in all units, minimally, regarding the limitations of confidentiality between AH residents and Billings YWCA Gateway Program VAs. Additionally, all staff stakeholders will be trained regarding the updated information, ensuring they are able to address any resident questions regarding the same. The APC will upload the lesson plan, as well as, training documentation certifying staff completion of said training.

October 17, 2022 Update:

The auditor's review of a PREA Packet document entitled 2022 AH PREA Index, page 4, section B(1)(c)(1 and 2) reveals completion of the recommended corrective action in terms of information provided to residents at intake. This updated information was not included in the AH Resident Handbook. Additionally, a memorandum entitled Outside Confidential Support Services Memorandum (presented in English and Spanish) reflects the same information as the 2022 AH PREA Index, page 4, section B(1)(c)(1 and 2). Photographs of postings of these memorandums are included in the corrective action update(s). The memorandums are posted in unit hallways, near resident telephones, outside staff office(s), and in operational areas.

November 13, 2022 Update:

The auditor's review of a training syllabus regarding 115.253(b) subject-matter reveals substantial compliance with the same. Specifically, residents are provided information regarding VA mandatory reporting requirements. This training was facilitated to ensure staff could adequately convey requirements to residents should they ask. The auditor's review of a training sign-in sheet reveals nine staff stakeholders signed the same, inclusive of their title.

In view of the above, the auditor finds AH substantially compliant with 115.253(b).

Nine of 11 random resident interviewees assert that what is said to people from the outside services remains private. One interviewee asserts such conversations could be told to or listened to by someone else if self injurious or homicidal thoughts are discussed.

At the conclusion of each interview wherein the interviewee was unaware of the appropriate responses to these questions, the auditor provided correct response(s) and directed the interviewee(s) to resources for further review.

In view of the above, the auditor finds AH non-compliant with 115.253(b).

Pursuant to the PAQ, the Director self reports the facility maintains memoranda of understanding (MOUs) or other agreements with community service providers that are able to provide residents with emotional support services related to sexual abuse. The Director further self reports the facility maintains a copy of the agreement.

The auditor's review of the MOU between Alternatives, Inc. and the Billings YWCA Gateway Program reveals the same is commensurate with 115.253(c).

In view of the above, the auditor finds AH substantially compliant with 115.253.

115.254	Third party reporting
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Pursuant to the PAQ, the Director self reports the facility provides a method to receive third-party reports of resident sexual abuse or sexual harassment. The APC asserts that pursuant to the MOU with Great Falls Transition Center, a third party can contact the Great Falls Transition Center who, in turn, notifies the APC. Posters and Handbooks contain the information the resident can provide to any 3rd party to report to Great Falls Transition Center, the PREA Coordinator, the Director, or CEO or any staff member. The Director further self reports the agency or facility publicly distributes information on how to report resident sexual abuse or sexual harassment on behalf of residents. The APC asserts Policy ALT A22 contains contact information for 3rd parties and the same is published on the agency website, as is the MOU for the Great Falls Transition Center. The names and contact information for the APC, the facility PCM, and Director of each facility are also linked on the website. The Alternatives, Inc. website provides information regarding third-party reporting options. The auditor did observe a PREA poster reflecting sexual abuse/harassment reporting telephone numbers as he registered at the facility entrance. Additionally, Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA, pages 4 and 5, section IV(D)(1)(a,d, and f) address 115.254(a). In view of the above, the auditor finds AH substantially compliant with 115.254.

115.261	Staff and agency reporting duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Pursuant to the PAQ, the Director self reports the agency requires 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 a facility, whether or not it is part of the agency; Any retaliation against residents or staff who reported such an incident; or Any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. While Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA, page 7, section IV(I)(1)(a) requires immediate reporting, according to agency policy, any knowledge, suspicion, or information received regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency and staff neglect or violation of responsibilities that may have contributed to an incident or retaliation, the last tenet of the 115.261(a) requirement is not addressed. Specifically, retaliation against residents or staff who reported such an incident is not addressed in this staff reporting requirement. While the requirements that residents be provided protection from retaliation, staff's right to be free from retaliation, protection of the alleged victim or staff from retaliation are addressed in other portions of ALT22 and other policies, the reporting requirement for retaliation against residents or staff who reported such an incident is not addressed as a staff reporting requirement. As reflected in the following paragraph, all 12 interviewees were clearly aware of the totality of their reporting requirements. Accordingly, the auditor concludes that staff have been trained regarding the same. However, to avoid any future confusion with audit processes, the auditor strongly recommends that the retaliation caveat be added to the previously referenced policy citation. All 12 random staff interviewees state the agency requires all staff to report any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in any facility; any retaliation against residents or staff who reported such an incident; and any neglect or violation of responsibilities that may have contributed to an incident or retaliation. Nine of 12 interviewees assert policy requires immediate reporting to the Director, APC, os, or in-charge ca. Pursuant to the PAQ, the Director self reports that apart from reporting to designated supervisors or officials and designated state or local service agencies, agency policy prohibits staff from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions. The APC asserts that

	the Employee Handbook has a complete section on confidentiality and the PREA policy reiterates the need for confidentiality when dealing with reports of sexual abuse and sexual harassment. Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA, page 10, section IV(L)(2)(e) addresses 115.261(b). Alternatives, Inc. Policy and Procedural Statement SOP H1 entitled Employee Handbook, page 31 addresses 115.261(b). In addition to the above, all staff review and sign the Statement of Confidentiality of Client Information (ALT 29) at the time of employment. Pursuant to the PAQ, the Director self reports that unless otherwise precluded by federal, state, or local law, medical and mental health practitioners shall be required to report sexual abuse pursuant to paragraph (a) of this section and to inform residents of the practitioner's duty to report, and the limitations of confidentiality, at the initiation of services. Both the medical and mental health practitioner interviewees state that at the initiation of services, they disclose the limitations of confidentiality and their duty to report. The mental health interviewee states she documents the same pursuant to an Informed Consent Form signed by the resident. The medical interviewee states she verbalizes mandatory reporting requirements and documents the same in the resident's treatment notes. Both interviewees state they are required to report any knowledge, suspicion, or information regarding an incident of sexual abuse/harassment to a designated supervisor or official immediately upon learning of the same. The mental health interviewee states she would report the same to the APC or cs and the medical interviewee states she would report the same to the Director. Neither interviewee has ever become aware of such incidents. Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA, page 8, section IV(I)(7) addresses 115.261(d). Both the Director and APC assert zero residents under the age of 18 are housed at AH. In regard to MDOC vulnerable adults, incidents of sexual abuse would be reported to Adult Protective Services (APS). Contacts would be made to DPHHS. With respect to FBOP residents, such report(s) would be made to the RRM. Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA, page 7, section IV(I)(1) addresses 115.261(e). The Director asserts all allegations of sexual abuse and sexual harassment, including those from third-party and anonymous sources, are reported directly to the designated facility investigator(s). The Director asserts he receives all reports of sexual abuse/harassment and he delegates investigations accordingly. In view of the above, the auditor finds AH substantially compliant with 115.261.

115.262	Agency protection duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Pursuant to the PAQ, the Director self reports when the agency or facility learns that a resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident (e.g., it takes some action to assess and implement appropriate protective measures without unreasonable delay). The Director further self reports in the last 12 months, there was zero instances wherein facility staff determined that a resident was subject to substantial risk of imminent sexual abuse. Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA, page 5, section IV(F) addresses 115.262(a). The Agency Head interviewee advises immediate removal of the potential victim from the danger zone and removal of the perpetrator, if known, constitute the initial response to a report of substantial risk of imminent sexual abuse. It may be feasible to move the potential victim to another housing unit within the facility, dependent upon the circumstances. The contractual requirements of the governmental partner will dictate the ability to transfer both the potential victim and potential perpetrator. The Director asserts when staff learn a resident is at risk of imminent sexual abuse, he is removed from the danger zone and placed in a safe place under staff supervision while the fact pattern is developed. If there is substantial evidence of the threat of imminent sexual abuse, contact with either MDOC or the FBOP liaisons would be facilitated in an effort to remove the alleged perpetrator, if known, from the AH resident population. All 12 random staff interviewees corroborate the assertions of the Agency Head and the Director to the extent the potential victim would be immediately removed from the danger zone. In view of the above, the auditor finds AH substantially compliant with 115.262.

115.263	Reporting to other confinement facilities
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Pursuant to the PAQ, the Director self reports the agency has a policy requiring that, upon receiving an allegation a resident was sexually abused while confined at another facility, the head of the facility must notify the head of the facility or appropriate office of the agency or facility where sexual abuse is alleged to have occurred. The Director further self reports in the last 12 months, the facility received one allegation that a resident was sexually abused while confined at another facility. Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA, page 5, section IV(D)(1)(g) addresses 115.263(a). The auditor's review of a letter authored by the AH Director to the Executive Director of another community confinement facility reveals substantial compliance with 115.263. An incident of potential sexual abuse at another facility was reported to AH staff on November 8, 2021 and the incident was subsequently reported as reflected above on November 10, 2021. In view of the above, the auditor finds AH compliant with 115.263(a-c). Pursuant to the PAQ, the Director self reports agency policy requires that the facility head provides such notification as soon as possible but no later than 72 hours after receiving the allegation. The same policy citation as reflected in the narrative for 115.263(a) is applicable to 115.263(b). Pursuant to the PAQ, the Director self reports the facility documents that it has provided such notification within 72 hours of receiving the allegation. Compliance with this provision is demonstrated in the narrative for 115.263(a). Pursuant to the PAQ, the Director self reports facility policy requires allegations received from other facilities/agencies are investigated in accordance with PREA standards. The Director further self reports in the last 12 months, zero allegations of sexual abuse originating at AH, were received from other facilities. Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA, pages 3 and 4, section IV(B)(2)(b) addresses 115.263(a). The Agency Head interviewee advises if another agency or facility within another agency refers allegations of sexual abuse or sexual harassment that occurred within an Alternatives, Inc. facility, the APC is generally the administrator who receives the call. Subsequent to receipt of such a call, the APC would advise the Director of the facility and he (the APC) would open an investigation. Dependent upon the circumstances, the investigator would initiate an administrative investigation or

	contact BPD to initiate a criminal investigation. According to the Director, when an allegation is received from another facility regarding an incident that allegedly occurred at AH, a full investigation would be initiated pursuant to standard operating procedure. The Director asserts no such referrals were received within the last 12 months. In view of the above, the auditor finds AH substantially compliant with 115.263.

115.264	Staff first responder duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Pursuant to the PAQ, the Director self reports the agency has a first responder policy for allegations of sexual abuse. Specifically, upon learning of an allegation a resident was sexually abused, the first security staff member to respond to the report shall be required to: Separate the alleged victim and abuser; Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence; If the abuse occurred within a time period that still allows for the collection of physical evidence, request that the alleged victim not take any actions that could destroy physical evidence including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; and If the abuse occurred within a time period that still allows for the collection of physical evidence, ensure the alleged abuser does not take any actions that could destroy physical evidence such as those described in paragraph 3 above. The Director further self reports that zero sexual abuse incidents occurred at AH during the last 12 months however, the auditor has determined that one marginally defined sexual abuse allegation was investigated. The victim reported these historical incidents to his counselor, thereby invoking 115.264(b) requirements. The counselor reported the allegation to her supervisor and subsequently to the APC. Given the time frames of the fact pattern, the reporting staff member acted pursuant to the requirements of 115.264(b). Alternatives, Inc. Policy and Procedural Statement SOP K32S entitled First Responder, pages 2 and 3, section IV(A)(8) addresses 115.264(a). Pursuant to research, the auditor notes that page 6 of Alternatives, Inc. Policy and Procedural Statement ALT A22, section IV(F)(4)(b) reflects that staff do not allow the victim and the perpetrator to destroy physical evidence. This does not align with the standard which requires that staff request the victim and ensure the perpetrator do not destroy physical evidence. The accurate standard verbiage is reflected at SOP K32S entitled First Responder, pages 2 and 3, section IV(A)(8). While the correct standard verbiage is properly articulated in one policy and interviewees properly identified the correct 1st responder steps, the auditor strongly recommends that the APC amend Alternatives, Inc. Policy and Procedural Statement ALT A22 to correspond with 115.264(a). Both the security and non-security staff first responder interviewees articulated the first responder steps reflected at 115.264(a) and (b). The auditor's review of the Security Staff PREA 1st Responder Quick Reference Card reveals substantial compliance with 115.264(a). Staff carry the card on a lanyard

	while on duty. Pursuant to the PAQ, the Director self reports agency policy requires that if the first responder is not a security staff member, that responder shall be required to: Request the alleged victim not take any actions that could destroy physical evidence; and Notify security staff. The Director further self reports zero incidents of sexual abuse wherein the first responder was a non-security staff member occurred within the last 12 months. The auditor has not been provided any policy citations wherein non-security staff 1st responder duties are articulated. However, the auditor's review of the PREA Non-Security Staff Quick Reference Card reveals substantial compliance with 115.264(b). Since the 115.264(a) is addressed in policy as described above, the auditor finds that 115.264(b) requirements should likewise be addressed in policy. Since the standard provision language does not specify that policy addresses the same (the PAQ specifies policy language), the interviewees cited 1st responder duties commensurate with the standard provision, and the aforementioned card is commensurate with the provision, the auditor finds no basis for a non-compliance finding. The APC asserts that during New Employee Orientation, 1st responder duties are discussed with all new employees. The Security Staff and Non-Security Staff quick reference cards are provided to each employee based on their job duties. Discussion is held for both types of 1st responders, discussion/training is completed, and delineation of responsibilities is discussed. In view of the above, the auditor strongly recommends that relevant policy(ies) be amended to reflect the differentiation in responsibilities. In the alternative, the auditor recommends that all staff receive the same 115.264(a) training during orientation and annual training. It is the agency's discretion if all staff are trained as security 1st responders or security and non-security 1st responders are trained pursuant to separate requirements. Security and non-security staff 1st responder interviewee statements are addressed in the narrative for 115.221(a). In view of the above, the auditor finds AH substantially compliant with 115.264.

115.265	Coordinated response
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Pursuant to the PAQ, the Director self reports the facility has developed a written institutional plan to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership. Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA, pages 5, section IV(F) through page 9, section IV(K) addresses 115.265(a). The auditor's review of this plan, in addition to the aforementioned policy citations, reveals a comprehensive and substantive plan to enable proper staff response to an incident of sexual abuse. According to the Director, the facility does have a plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership in response to an incident of sexual abuse. The Incident Command System (ICS) is utilized. Policy provides comprehensive guidance and the ALT 219 Sexual Assault Response Checklist captures important dates, times, and information. In view of the above, the auditor finds AH substantially compliant with 115.265.

115.266	Preservation of ability to protect residents from contact with abusers
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Pursuant to the PAQ, the Director self reports the facility is not involved in any collective bargaining process, either currently or since the last PREA audit. During the on-site audit, the auditor confirmed this assertion. The Agency Head and Director self report there is no collective bargaining agreement at AH. Since the auditor finds no AH deviation from standard, compliance with 115.266 is established.

115.267	Agency protection against retaliation
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Pursuant to the PAQ, the Director self reports the agency has a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperates with sexual abuse or sexual harassment investigations from retaliation by other residents or staff. According to the PAQ, the Director self reports a PREA investigator or designee (case manager) is/are designated as the retaliation monitor for staff and residents. The same is articulated in the below policy. Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA, page 4, section IV(C) and page 10, section IV(I)(1)(a) and 2(a) addresses 115.267(a). Additionally, Alternatives, Inc. Policy and Procedural Statement ALT A29 entitled Internal PREA Investigator Description & Duties, page 2, section 4(B) addresses 115.267(a). The administrative sexual abuse investigator(s) or a case manager will serve as the retaliation monitor, dependent upon the circumstances. The Director asserts that one sexual abuse allegation was investigated during the last 12 months. Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA, page 6, section IV(G)(2)(d) addresses 115.267(b). According to the Agency Head interviewee, staff and residents who report sexual abuse/sexual harassment allegations are protected from retaliation pursuant to weekly retaliation monitoring check-ins (residents/staff). Staff and residents are trained regarding retaliation and the fact there is zero tolerance for the same. Violators are admonished regarding the potential consequences of 115.267 retaliation. The APC oversees retaliation monitoring and delegates responsibility for the conduct of weekly meetings. According to the Director and staff member charged with monitoring retaliation, the APC alerts her to retaliation monitoring needs. Generally, the perpetrator would have already been transferred or minimally, placed in a high supervision area. Throughout the retaliation monitoring process, the interviewee can recommend to the APC options to enhance victim safety. She follows up with the victim pursuant to formal weekly meetings, assessing potential and/or actual retaliation. She does follow-up with resident victims immediately following notification of the allegation. Housing changes, administrative removal of the perpetrator from AH, recommended Employee Assistance Program (EAP) for staff and increased emotional support services for residents, and implementation of additional security and safety rounds aimed to closely monitor the victim are some of the strategies that may be employed pursuant to retaliation monitoring.

	Relocation of the perpetrator is the primary response and secondarily, the victim, dependent upon the circumstances. Staff perpetrators are removed from contact with resident victims pursuant to placement on administrative leave or they may be moved to another facility, dependent upon the circumstances. Minimally, the victim's housing within the facility is considered and, if appropriate, the same could be changed. With respect to staff victims, the perpetrator may be moved to a different shift/post/facility, if prudent. According to the APC, zero victim(s) of sexual abuse at AH or witnesses, etc. were housed at AH during the on-site audit. Pursuant to the PAQ, the Director self reports the facility monitors the conduct or treatment of residents or staff who report sexual abuse/harassment and of residents who were reported to have suffered sexual abuse to see if there are any changes that may suggest possible retaliation by residents or staff. The Director further self reports retaliation monitoring is continued for at least 90 days or more, if necessary. The APC asserts case managers or other designated staff and PREA investigators monitor residents who have incurred sexual abuse at AH and supervisory staff monitor staff victims of retaliation. Residents will also be provided with mental health counseling in house or through the Billings YWCA Gateway Program or other outside services as necessary, without cost to the resident. Staff will be referred to the EAP program and may also participate in a crisis intervention stress management debriefing. The facility does act promptly to remedy such retaliation. The facility continues such monitoring beyond 90 days if the initial monitoring indicates a continuing need. The Director self reports retaliation has not occurred within the last 12 months. Alternatives, Inc. Policy and Procedural Statement ALT A29 entitled Internal PREA Investigator Description & Duties, page 2, section 4(B) addresses 115.267(c). The Director and staff member charged with retaliation monitoring interviewees assert they monitor change(s) in resident behavior, change(s) in associations, eating habits, hygiene, sleep deprivation, isolation, emotional changes, changes in sexual preferences, failure to program/frequent program change requests and frequent housing change requests. Staff victims may display many of the above behaviors, in addition to, excessive or increased call-offs and an increase in shift change requests. Of note, the Director asserts that if a facility change for the perpetrator is deemed to be prudent, he coordinates with MDOC or FBOP officials for approval. Monitoring is continued for a minimum of 90 days however, the same may be extended dependent upon the circumstances. There is no maximum time frame for retaliation monitoring as the same is based on progress and circumstances. Theoretically, monitoring could be continued until release. The APC or the Director makes the final decision regarding extension of retaliation monitoring.

	The auditor's review of a blank Form ALT 220 entitled PREA Retaliation Monitoring Sheet reveals space for weekly entries (total of thirteen). The auditor's review of a completed ALT 220 relative to the victim of a sexual abuse incident at AH during the last 12 months, reveals substantial compliance with 115.267(c). As mentioned in the narrative for 115.267(c), formal monitoring is documented, minimally, on a weekly basis. The process and evidence of "actual practice" is described in the narrative. If additional check-ins are required, the same would be documented accordingly. Pursuant to contact with the APC, he is not aware of any other incidents that occurred during the last 24 months wherein other individual(s), who cooperated with an investigation, expressed a fear of retaliation. When a resident who cooperates with an investigation expresses a fear of retaliation, the Agency Head interviewee asserts he receives the same benefits and treatment as articulated in the narratives for 115.267(b-d) above. In view of the above, the auditor finds AH substantially compliant with 115.267.

115.271	Criminal and administrative agency investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Pursuant to the PAQ, the Director self reports the facility has a policy related to criminal and administrative agency investigations. Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA, page 3, section IV(B)(3); pages 7 and 8, sections IV(I)(4 and 5) addresses 115.271(a). The APC asserts facility PREA investigators conduct the initial investigation of alleged sexual abuse or sexual harassment. Criminal sexual abuse incidents are referred to BPD for investigation. The MDOC Investigations Bureau may also be a resource. According to the administrative investigative staff interviewee, an investigation is initiated immediately following receipt of an allegation of sexual abuse/harassment, if he is on-site. If the sexual abuse allegation is reported during off-duty hours, he would immediately report to the facility to commence a sexual abuse investigation. Dependent upon the circumstances, he may report to the facility for a sexual harassment allegation however, minimally, he would direct on-duty supervisor(s) regarding relevant protocols, commencing the investigation the next day. In regard to anonymous or third-party reports of sexual abuse/harassment, both the administrative and criminal investigative interviewees state they are handled the same as any sexual abuse/harassment investigation. Policy citations with respect to the subject-matter of 115.271(b) are addressed in the narratives for 115.234(a) and 115.271(a). Trained sexual abuse/harassment investigators and certifications are addressed in the narrative for 115.234. According to the administrative investigative staff interviewee, he completed a three hour on-line NIC training course entitled PREA: Investigating Sexual Abuse in a Confinement Setting, as well as, the advanced course. Scenario based training was included in both training formats with the advanced course involving extensive scenarios, as well as, testing processes. Additionally, he completed an eight hour in-person sexual abuse investigative training through MDOC. The interviewee did recall that the courses included topics such as interviewing techniques relative to victims in a confinement setting, execution of Miranda and Garrity warnings, evidence collection in sexual abuse cases, and the evidence standard necessary to substantiate a case for administrative action or prosecution referral. The auditor has reviewed the NIC lesson plan and finds the same to be compliant with 115.271(b).

	Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA, page 9, section IV(J)(4) addresses 115.271(c). The administrative investigative staff interviewee asserts the initial steps to initiate an investigation and time frames for implementation of each step are as follows: Threshold questioning of the victim (0-30 minutes); If the incident is criminal, in nature, notify BPD (15 minutes); Check the crime scene 1st responder duties (15 minutes); Brief interview with the perpetrator (0-30 minutes); Review all reports (five to ten minutes per report); Interview witnesses (ensure they are separated from one another and the rest of the population- 10-15 minutes per witness); Review video (Up to two hours); Review files, inclusive of PREA risk assessments and previous reports of sexual abuse/harassment (15-30 minutes); and Write report (90-120 minutes). The criminal investigation process mirrors the above with the exception of physical evidence collection. The criminal investigative staff interviewee states the investigative steps are as follows: Dispatch receives the initial sexual abuse report; A patrolman is dispatched based on priority; The patrolman generally arrives at the facility within 30-60 minutes of the report; The patrolman discusses the report with the facility supervisor; The patrolman facilitates threshold questioning of the victim; The patrolman assesses the need for forensic examination; The patrolman establishes the crime scene and assesses evidence; Review video; Review all written reports surrounding the allegation; Sweep crime scene for physical evidence; Conduct interviews with the victim and witnesses (staff and clients); Review staff and client files; Interview perpetrator; and Write report.

	Of note, the interviewee states that all patrolmen are sexual abuse trained through the academy and field training. Direct and circumstantial evidence the administrative interviewee is responsible for collecting entails written statements, interview notes, video footage, and files. All physical evidence is collected by BPD investigator(s) or special evidence unit. The criminal investigative interviewee states the patrolman and/or other investigators are responsible for collection of bedding, clothing, linens, letters, beverage containers, etc. The administrative investigative staff interviewee asserts compelled interviews are not conducted by AH staff. The same would be facilitated by BPD investigator(s) and accordingly, they would maintain contact with prosecutors. The criminal investigative interviewee states there is little contact, if any, between patrolmen and prosecutors regarding compelled interviews. However, investigators do maintain such contact, if necessary. Generally, compelled interviews may be facilitated with witnesses. Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA, page 9, section IV(J)(6) addresses 115.271(e). In regard to credibility assessments relative to staff and resident witnesses, the administrative and criminal investigative staff interviewees state credibility is established based on the extent to which the victim's/witness'/perpetrator's statement matches the totality of evidence. Victim, witness, and perpetrator statements are deemed to be credible until proven otherwise. The interviewees further relate they would not, under any circumstances, require a resident who alleges sexual abuse to submit to a polygraph examination or truth-telling device as a condition for proceeding with an investigation. Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA, page 9, section IV(J)(2) addresses 115.271(f). With respect to determining whether staff actions or failure to act contributed to the incident of sexual abuse, the administrative investigative staff interviewee states he assesses known facts against policy and ethical considerations. The interviewee states administrative investigations are documented in written reports. The reports generally address the following format: Executive Digest, inclusive of timeline; Chronological timeline of interviews/evidence until conclusion of the incident; Staff and resident interview credibility analysis; Video and file review findings; Conclusion(s); and Finding(s).

	The administrative investigative staff interviewee asserts criminal investigations are documented. In actuality, the reports are similar, in terms of content, to the administrative reports completed by the interviewee and as described above in the narrative for 115.271(f). Physical evidence credibility is also addressed in the criminal investigative report. Criminal investigations are not generally distributed to facility staff. The criminal investigative interviewee states the criminal report follows this format: Executive Digest- Establishes the allegation and investigative timelines; Physical evidence credibility assessment; Interviews credibility assessments; Conclusion; and Findings. The Director asserts zero AH criminal investigation reports have been provided to him during this audit period. Pursuant to the PAQ, the Director self reports BPD is responsible for referrals for prosecution of substantiated allegations of conduct that appear to be criminal. The Director further self reports there was zero criminal findings that were referred for prosecution since the last PREA audit. The APC asserts that BPD is the entity that investigates allegations that appear to be criminal. Alternatives, Inc. advocates for all substantiated allegations to be referred for prosecution. If BPD determines they do not refer for prosecution, MDOC will review and if warranted the MDOC Investigations Bureau will contact the Yellowstone County Attorney in follow-up for prosecution. The final decision is with the Yellowstone County Attorney. The criminal investigative interviewee states that when probable cause and a violation of state criminal statute(s) are present, the case will be referred for prosecution consideration. Of note, all sexual abuse cases are referred to the county attorney for review and prosecution consideration. The administrative investigative staff interviewee asserts cases are referred for criminal investigation whenever the evidence and fact pattern points to the existence of a criminal code violation. Referrals for prosecution are generally facilitated by BPD when it appears the evidentiary standard has been met. Pursuant to the PAQ, the Director self reports the agency retains all written reports referenced in the above paragraphs of this section for as long as the alleged abuser is incarcerated or employed by the agency, plus five years. Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA, page 10, section IV(M)(3) addresses 115.271(i).

	The auditor has not identified any deviations from 115.271(i). Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA, page 9, section IV(j)(5) addresses 115.271(j). The administrative and criminal investigative interviewees state they continue the investigation regardless of whether a staff member alleged to have committed a sexual abuse act terminates employment prior to a completed investigation into his/her conduct and/or when a victim who alleges sexual abuse/harassment or an alleged abuser leaves the facility prior to a completed investigation into the incident. The Director and APC assert the APC would maintain telephonic and electronic contact with the BPD investigator(s) on a weekly basis, checking on the status of criminal investigations. Follow-up contact is documented via email. According to the investigative staff interviewee, he acts as a liaison or facilitator (e.g. addresses any evidentiary needs, interview coordination/scheduling, etc.) whenever BPD investigators investigate sexual abuse/harassment incident(s). He provides support throughout the process. In view of the above, the auditor finds AH compliant with 115.271.

115.272	Evidentiary standard for administrative investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Pursuant to the PAQ, the Director self reports the agency imposes a standard of a preponderance of the evidence or a lower standard of proof when determining whether allegations of sexual abuse or sexual harassment are substantiated. Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA, page 9, section IV(J)(2) and addresses 115.272(a). As indicated in the narrative for 115.271(a), one sexual abuse/harassment allegation was made during 2021 and 2022. The auditor's review of that investigation reveals substantial compliance with both 115.271 and 115.272(a). The administrative investigative staff interviewee asserts he relies on a preponderance of evidence to substantiate allegations of sexual abuse/harassment. He asserts this equates to 51% of the totality of evidence or "more evidence is available leading to the conclusion the incident happened, than not." The criminal investigative interviewee states probable cause is the minimal evidentiary standard required for prosecutorial referral of allegations of criminal sexual abuse/ harassment. In view of the above, the auditor finds AH substantially compliant with 115.272.

115.273	Reporting to residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Pursuant to the PAQ, the Director self reports the agency has a policy requiring that any resident who makes an allegation he or she suffered sexual abuse in an agency facility is informed, verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation by the agency. The Director further self reports one administrative sexual abuse investigation was completed during the last 12 months. Alternatives, Inc. Policy and Procedural Statement ALT A29 entitled Internal PREA Investigator Description & Duties, page 2, section IV(B) addresses 115.273(a). According to the Director, the facility does notify a resident who makes an allegation of sexual abuse when the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation. The investigative staff interviewee asserts he does notify a resident who makes an allegation of sexual abuse as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation. Pursuant to the PAQ, the Director self reports that if an outside entity conducts such investigations, the agency requests the relevant information from the investigative entity in order to inform the resident of the outcome of the investigation. The Director further self reports, in the last 12 months, zero sexual abuse/harassment investigations were completed by an outside agency. The MOU with BPD specifies in Section 1(a)(v) that upon request from Alternatives, Inc., BPD will submit a complete written report of all investigations, including copies of all documentary evidence where feasible. Alternatives, Inc. uses this information to provide the resident with information of the substantiated, unsubstantiated, or unfounded conclusion of the BPD investigation. The APC asserts that BPD provides AH with relevant information to document their investigation following a request on agency letterhead faxed to their records department. Pursuant to the PAQ, the Director self reports following a resident's allegation that a staff member has committed sexual abuse against the resident, the facility subsequently informs the resident (unless the agency has determined the allegation is unfounded) whenever: The staff member is no longer posted within the resident's unit; The staff member is no longer employed at the facility; The agency learns the staff member has been indicted on a charge related to sexual abuse within the facility; or The agency learns the staff member has been convicted on a charge related to

	sexual abuse within the facility. The Director asserts that zero substantiated or unsubstantiated staff-on-resident sexual abuse or sexual misconduct allegation(s) have been received during during the last 12 months. Alternatives, Inc. Policy and Procedural Statement ALT A29 entitled Internal PREA Investigator Description & Duties, page 2, section IV(B) addresses 115.273(c). Pursuant to the PAQ, The Director self reports that following a resident's allegation he has been sexually abused by another resident at AH, the agency subsequently informs the alleged victim whenever: The agency learns the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility. While the provision does not specifically require policy development and implementation, policy, absent 115.273(d) language, has been provided to the auditor as evidence. Accordingly, the auditor strongly recommends that such language be added to Alternatives, Inc. Policy and Procedural Statement ALT A29 entitled Internal PREA Investigator Description & Duties. The auditor finds one investigation regarding resident-on-resident sexual abuse conducted during the last 12 months wherein 115.273(d) is not appropriate given the fact the the perpetrator was neither indicted nor convicted as specified in the provision. Pursuant to the PAQ, the Director self reports the agency has a policy that all notifications to residents described under this standard are documented. As previously addressed in the narrative for 115.273(a), one such allegation and subsequent investigation was facilitated at AH during the last 12 months. Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled Internal PREA, page 9, section IV(K)(3) addresses 115.273(e). The auditor's review of the investigation and accompanying documentation reveals that the victim was advised of the outcome of the investigative findings. In view of the above, the auditor finds AH substantially compliant with 115.273.

115.276	Disciplinary sanctions for staff
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Pursuant to the PAQ, the Director self reports staff is subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies. Alternatives, Inc. Policy and Procedural Statement SOP H20 entitled Employee Discipline, page 2, section IV(A)(8), (9), (12), and (14) addresses 115.276(a). Other applicable policy citations are as follows: Alternatives, Inc. Policy and Procedural Statement SOP H43 entitled Fraternization Policy, pages 1 and 3, sections I and IV(C); Alternatives, Inc. Policy and Procedural Statement SOP A17 entitled Sexual Harassment, page 3, sections IV(C)(5 and 6); Alternatives, Inc. Policy and Procedural Statement SOP H1 entitled Employee Handbook, pages 8 and 9; and Alternatives, Inc. Policy and Procedural Statement SOP H33 entitled Staff Conduct with Offenders, page 1, section IV(A)(1 and 2). Pursuant to the PAQ, the Director self reports in the last 12 months, zero facility staff members were alleged to have violated agency sexual abuse/ harassment policies. The Director further self reports zero employees were either terminated or resigned prior to termination for violating agency sexual abuse or sexual harassment policies. According to the APC, staff sign the employee handbook acknowledgment signifying they have received, read and understand the content of the same. With newer employees, the documents are electronically scanned into the PAYCOM system while the Handbook Acknowledgment form is maintained in the hard copy file of tenured employees. New staff also sign the ALT 78 NCIC/CJIN 3 PREA questions, including allegations of past sexual harassment allegations; S14 Standards of Conduct form paragraph 9 regarding sexual misconduct with residents; S17 Fraternization & Conflict of Interest Statement, 3rd Paragraph (initialed by staff) and form signed with acknowledgment statement; S11 PREA Orientation Statement of Understanding; and S15 Sexual Harassment Orientation Acknowledgment Form. The auditor's review of the above documents reveals substantial compliance with 115.276(b). Pursuant to the PAQ, the Director self reports disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) are commensurate with the nature and circumstances of

	the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories. The Director further self reports that in the last 12 months, zero staff from the facility have been disciplined, short of termination, for violation of agency sexual abuse or sexual harassment policies. Relevant policy citations are noted in the narrative for 115.276(a). Pursuant to the PAQ, the Director self reports all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, are reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies. The Director further self reports during the last 12 months, zero facility staff members have been reported to law enforcement or licensing boards following termination for a Code of Conduct violation. The APC asserts that Alternatives, Inc. reports all staff who violate the agency's sexual abuse and sexual harassment polices and have either been terminated or resigned prior to termination. Alternatives, Inc. also reports the actions of the former employee to their relevant licensing body. In view of the above, the auditor finds AH substantially compliant with 115.276.

115.277	Corrective action for contractors and volunteers
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Pursuant to the PAQ, the Director self reports agency policy requires that any contractor or volunteer who engages in sexual abuse is reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies. Additionally, the Director self reports agency policy requires any contractor or volunteer who engages in sexual abuse is prohibited from contact with residents. According to the Director, in the last 12 months, zero contractors or volunteers have been reported to law enforcement agencies and relevant licensing bodies. Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA, page 1, section III entitled Employee or Staff addresses 115.277(a). Alternatives, Inc. Policy and Procedural Statement SOP H2 entitled Volunteer/Intern Procedures, pages 7, 8. 11, 12, and 14, sections entitled Sexual Harassment and Discrimination Policy, Fraternization and Conflict of Interest, and Discipline and Corrective Action address 115.277(a). The APC asserts that any report of a contractor or volunteer engaging in sexual abuse will be reported to law enforcement and relevant licensing agencies. Furthermore, all volunteers or contractors who engage in sexual abuse with residents will be permanently prohibited from entering any Alternatives, Inc., facility. Pursuant to staff/resident interviews and documentation reviews, the auditor has not found any incidents wherein the requirements of 115.277 were invoked or would require the same. Pursuant to the PAQ, the Director self reports the facility takes appropriate remedial measures and considers whether to prohibit further contact with residents in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer. The Director asserts he automatically suspends contractor/volunteer facility access privileges and eliminates contact with residents, pending the results of an investigation, should a contractor/volunteer be involved in a sexual abuse/ harassment incident with a resident. He terminates the contractor/volunteer contact with residents if the investigation is substantiated. The Director finally asserts zero such situations have been realized during the last 12 months. In view of the above, the auditor finds AH substantially compliant with 115.277.

115.278	Disciplinary sanctions for residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Pursuant to the PAQ, the Director self reports residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse. The Director further self reports residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following a criminal finding of guilt for resident-on-resident sexual abuse. In the last 12 months, one administrative investigation of resident-on-resident sexual abuse was completed at the facility. The APC asserts that the perpetrator in the aforementioned case was a United States Probation Office (USPO) short term resident. The USPO revoked him from Alpha House, placed him at Yellowstone County Detention Facility, and subsequently transferred him to Great Falls. The perpetrator appeared before a federal judge, and he was returned to federal prison. The USPO does not use the FBOP's CDC process. The APC asserts that pursuant to MDOC and FBOP policies and procedures, a resident who is criminally charged with a new crime will be removed from the facility through a formal process. Alternatives, Inc. Policy and Procedural Statement SOP K17S entitled DOC Class I and II Disciplinary Procedures , page 4, section IV(D) addresses 115.278(a). Alternatives, Inc. Policy and Procedural Statement SOP K16S entitled Federal Disciplinary Procedures, pages 1, 2, 3, 4, 6, and 7, sections entitled Formal Hearing and The Hearing also addresses 115.278(a). Finally, Alternatives, Inc. Policy and Procedural Statement SOP K24A entitled Resident Handbook, pages 32, 33, 41, and 42 addresses sexual abuse/harassment administrative charges for both FBOP and MDOC. The parameters of 115.278(b) and (c) are addressed in the narrative for 115.278(a). According to the Director, AH staff generate the incident report, investigate the same, and represent agency interests (recommended sanctions) at a hearing facilitated by MDOC staff. Removal from the program is the most severe sanction available. With respect to the FBOP, AH staff write the incident report and investigate the same, conduct a Center Discipline Committee Hearing (CDC), and address any appeal. The Discipline Hearing Officer (DHO) reviews the CDC Hearing packet and ratifies the same, etc. Disciplinary transfer, disallowance of Good Conduct Time (GCT), and loss of non-vested GT can be imposed by the DHO. With respect to equality of sanctions imposed for comparable offenses, the Director asserts the same is accomplished. As previously referenced, the DHO ensures the same with respect to FBOP matters. With respect to mental disability or mental illness considerations when determining sanctions, FBOP and MDOC staff schedule

	such evaluations prior to sanction considerations. Pursuant to the PAQ, the Director self reports the facility does offer therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse. Facility staff consider whether to require the offending resident to participate in such interventions as a condition of access to programming or other benefits. The APC asserts that a resident is assessed or reassessed and appropriate therapy, counseling or other interventions are developed to address reasons or motivations for abusive nature. Should the perpetrator remain at the facility, the resident would be required to meet with appropriate therapeutic or counseling staff, participate in groups, etc, as a condition of remaining in the program. Alternatives, Inc. Policy and Procedural Statement SOP K17S entitled DOC Class I and II Disciplinary Procedures , page 4, section IV(D) addresses 115.278(a). Alternatives, Inc. Policy and Procedural Statement SOP K16S entitled Federal Disciplinary Procedures, pages 1, 2, 3, 4, 6, and 7, sections entitled Formal Hearing and The Hearing also address 115.278(a). Finally, Alternatives, Inc. Policy and Procedural Statement SOP K24A entitled Resident Handbook, pages 32, 33, 41, and 42 address sexual abuse/harassment administrative charges for both FBOP and MDOC residents. The mental health interviewee states she does offer therapy, counseling, or other intervention services designed to address and correct the underlying reasons or motivations for sexual abuse. She also considers whether to offer these services to the offending resident. She provides post incident follow-up and offers services to the offending resident. If they decline services, the affected resident signs a declination form. As receipt of such services is voluntary, unless court ordered, a resident's participation in the same is not requisite for access to programming or other benefits. Pursuant to the PAQ, the Director self reports the agency disciplines residents for sexual conduct with staff only upon finding that the staff member did not consent to such contact. Alternatives, Inc. Policy and Procedural Statement SOP K24A AH entitled Resident Handbook, page 32, Disciplinary Violation 209, states that no resident may engage in heterosexual/homosexual acts with another resident, staff, etc. and are subject to disciplinary actions pursuant to the violation. The APC asserts that all Alternatives Inc. programs are considered no-touch programs. The auditor finds no allegations or investigations relative to resident sexual contact with staff, conducted during the last 12 months, and addressing the subject-matter of 115.278(e). According to the Director, during the last 12 months, there were no allegations or

	investigations relative to resident sexual contact with staff meeting the parameters of 115.278(e). Pursuant to the PAQ, the Director self reports the agency prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation. Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA, page 5, section IV(D)(5) addresses 115.278(f). The auditor has found no evidence of deviation from the requirements of 115.278(f). Pursuant to the PAQ, the Director self reports the agency prohibits all sexual activity between residents. The Director further self reports the agency deems such activity to constitute sexual abuse only if it determines that the activity is coerced. Pursuant to the APC, consensual sex between residents is considered unacceptable behavior to Alternatives, Inc., MDOC, and the FBOP. Consensual sex is a Class II violation or prohibited act. Alternatives, Inc. Policy and Procedural Statement SOP K17S entitled DOC Class I and II Disciplinary Procedures , page 4, section IV(D) addresses 115.278(g). Alternatives, Inc. Policy and Procedural Statement SOP K16S entitled Federal Disciplinary Procedures, pages 1, 2, 3, 4, 6, and 7, sections entitled Formal Hearing and The Hearing also addresses 115.278(g). Finally, Alternatives, Inc. Policy and Procedural Statement SOP K24A entitled Resident Handbook, pages 32, 33, 41, and 42 addresses sexual abuse/harassment administrative charges for both FBOP and MDOC The auditor did not find any incidents of resident discipline for sexual abuse linked to consensual sex. In view of the above, the auditor finds AH substantially compliant with 115.278.

115.282	Access to emergency medical and mental health services
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Pursuant to the PAQ, the Director self reports resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services. The Director further self reports the nature and scope of such services are determined by medical and mental health practitioners according to their professional judgment. The Director self reports that such secondary materials are maintained at AH. The APC asserts that a 20 hour per week LPN and two mental health professionals are on staff at AH. AH has access to 24-hour emergency medical and mental health services. Mental health care is available through the Mental Health Center, the Billings Clinic PACT team, and Crisis Intervention Center. Mental health and medical staff document crisis intervention services provided using the TOMS system. They enter case notes of services provided, follow-up services, and referrals. Medical and mental health staff will document services provided in secure medical files. Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA, pages 6 and 7, section IV(G) and (H) addresses 115.282(a). Both the medical and mental health interviewees state that resident victims of sexual abuse receive timely and unimpeded access to emergency treatment and crisis intervention services. In regard to the process of provision of timely and unimpeded access to emergency treatment and crisis intervention services, the mental health interviewee states that the APC or a ca would contact her, advising of the allegation. She would reach out to the victim as soon as possible to offer services. Specifically, she would reach out to the victim immediately following notification. With respect to the medical staff interviewee, she states that medical coverage is available from 8:00AM to 4:00PM or 8:00AM to 8:00PM. On-call coverage is implemented during non-regular business hours. If a sexual abuse incident occurred during non-regular business hours, the interviewee immediately reports to the facility (within 30 minutes). During regular business hours, medical staff reports immediately. Both the medical and mental health interviewees state that the nature and scope of these services are determined according to their professional judgment. The interview narratives for security and non-security first responder interviewees, as reflected in 115.221, 115.262, and 115.264, address preliminary steps taken by first responders to protect the victim. Additionally, the statements of random staff interviewees are likewise reflected in one or more of these narratives. Specific responsibilities in terms of medical evaluation and the conduct of forensic examinations are articulated in the narrative and relevant policy cited in 115.265.

	As previously mentioned, zero incidents occurred during this audit period wherein medical care and follow-up were warranted. Pursuant to the PAQ, the Director self reports resident victims of sexual abuse while incarcerated are offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA, pages 6 and 7, section IV(G) and (H) addresses 115.282(c). According to the medical staff interviewee, victims of sexual abuse are offered timely information about access to emergency contraception and sexually transmitted infection prophylaxis. This occurs during the forensic examination at Billings, Clinic. Pursuant to the PAQ, the Director self reports treatment services are provided to every victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA, pages 6 and 7, section IV(G) and (H) addresses 115.282(d). In view of the above, the auditor finds AH substantially compliant with 115.282.

115.283	Ongoing medical and mental health care for sexual abuse victims and abusers
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Pursuant to the PAQ, the Director self reports the facility offers medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility. Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA, page 6, section IV(G)(2) addresses 115.283(a). Pursuant to follow-up regarding the one applicable 115.283(a) case, the auditor learned that one resident divulged a sexual relationship in which he was involved, while housed at another facility. Accordingly, the allegation triggered the need for a 115.283(a) meeting within 14 days of reporting during his victimization/abusiveness reassessment. While the auditor was provided case management notes regarding the alleged incident, there is no evidence validating that a follow-up meeting with medical/mental health staff was offered. Accordingly, the auditor finds AH non-compliant with 115.283(a). In view of the above, the auditor is assigning a 180-day corrective action period wherein AH staff will demonstrate compliance with and institutionalization of 115.283(a) requirements. The due date for corrective action completion is November 16, 2022. To demonstrate compliance with and institutionalization of 115.283(a) requirements, the APC will provide training to all sexual victimization/aggressor screeners, as well as, medical/mental health providers regarding 115.283(a) requirements. This training will include documentation of requisite referrals/protocols and resident declinations or acceptance of such meetings. The auditor recommends that a form be developed to capture the same. Subsequent to provision of this training, the APC will upload a copy of the training plan, any new form(s), as well as, staff training documentation memorializing their completion of the same. Additionally between the date of this interim report and the previously stated corrective action due date, the APC will upload any new cases wherein 115.283(a) requirements are invoked. Uploads will include the screening instrument, etc., any referral documentation, and the medical/mental health notes related to the encounter(s). The auditor will subsequently make a determination regarding compliance. November 13, 2022 Update: The auditor's review of a training syllabus regarding 115.283(a) subject-matter reveals substantial compliance with the same. Specifically, if a resident alleges

	prior sexual abuse in confinement during initial risk assessment, the screener will refer the resident to mental health/medical staff for a meeting and follow-up. This training was facilitated to ensure that stakeholders (case managers, program supervisor, and lcpc) were aware of their responsibilities and could perform the same. The auditor's review of a training sign-in sheet reveals nine staff stakeholders signed the same, inclusive of their title. The auditor has not been advised of receipt of any residents at AH who encountered such sexual abuse, since the date of the interim report. In view of the above, the auditor finds AH substantially compliant with 115.283(a). Pursuant to the PAQ, the Director self reports evaluation and treatment of such victims 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. Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA, page 6, section IV(G)(2)(a) and (b) addresses 115.283(b) The medical staff interviewee asserts she offers emotional support and a clothed inspection for bleeding and bruising. Vitals could be taken, dependent upon the outcome of the clothed inspection and victim agreement. In the event of bleeding, emergency first-aid is provided. Medical documentation is completed with times and dates. Treatment is documented in the notes. The mental health staff interviewee states that she accompanies the victim to the forensic examination to provide support. She checks on the emotional status/ behavior and advises of services available to the victim. She also calms the victim pursuant to implementation of verbal deescalation techniques. Both the medical and mental health interviewees state that the medical and mental health services provided are consistent with the community standard of care. Specifically, services provided are commensurate with the scope of practice. Once the victim is transported for a forensic examination, the community standard of care is synonymous with the hospital. Given the fact that male residents, only, are housed at AH, 115.283(d) and (e) are deemed to be not applicable to AH. Pursuant to the PAQ, the Director self reports resident victims of sexual abuse while incarcerated are offered tests for sexually transmitted infections as medically appropriate. Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA, page 7, section IV(H)(2)(b) addresses 115.283(f). Pursuant to the PAQ, the Director self reports treatment services are provided to the victim without financial cost and regardless of whether the victim names the abuser

	or cooperates with any investigation arising out of the incident. Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA, page 6, section IV(G)(2) addresses 115.283(g). Pursuant to the auditor's review of the one sexual abuse investigation facilitated during the last 12 months, he finds no evidence validating that any victim was removed from the facility to a local hospital for a forensic examination, etc. Pursuant to the PAQ, the Director self reports the facility attempts to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offers treatment when deemed appropriate by mental health providers. Alternatives, Inc. Policy and Procedural Statement SOP L4(A) entitled Resident Intake, Contract, and Referral, pages 2 and 3, sections IV(C-G) addresses 115.283(h). The mental health interviewee states that a contractor would facilitate the 115.283(h) mental health evaluation. Mental health evaluation would be scheduled in a timely manner, as soon as, AH staff are aware of the historical resident-on-resident sexual abuse. In view of the above, the auditor finds AH substantially compliant with 115.283.

115.286	Sexual abuse incident reviews
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Pursuant to the PAQ, the Director self reports the facility conducts a sexual abuse incident review at the conclusion of every criminal or administrative sexual abuse investigation, unless the allegation has been determined to be unfounded. The Director further self reports in the last 12 months, one administrative sexual abuse investigation was facilitated at AH. Alternatives, Inc. Policy and Procedural Statement ALT A29 entitled Internal PREA Investigator Description and Duties, page 2 and Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA , page 9, section IV(K)(5) address 115.286(a-e). The auditor's review of one Sexual Abuse Incident Review (SAIR) report reveals the review was conducted in a timely and substantive manner. This is the only case that is applicable to 115.286. The SAIR team was comprised of the requisite members as identified in policy. The review was comprehensive in terms of the requisite considerations. Pursuant to the PAQ, the Director asserts the facility ordinarily conducts a sexual abuse incident review within 30 days of the conclusion of the criminal or administrative sexual abuse investigation. In the last 12 months, one administrative investigation of alleged sexual abuse was completed at the facility and the same was followed by a sexual abuse incident review within 30 days. Pursuant to the PAQ, the Director self reports the SAIR includes upper-level management officials and allows for input from line supervisors, investigators, and medical or mental health practitioners. The Director asserts the facility has a SAIR. He further asserts the team includes upper-level management officials and allows for input from line supervisors, investigators, and medical/mental health practitioners. Specifically, the CEO, Chief Operating Officer (COO), Director, APC, cos, programs supervisor (ps) may comprise the team at any given time. Pursuant to the PAQ, the Director self reports that a report of its findings is prepared from sexual abuse incident reviews, including but not necessarily limited to determinations made pursuant to paragraphs (d)(1)-(d)(5) of this section and any recommendations for improvement, and the same is submitted to the facility head and APC. The Director asserts that the goal of the SAIR and accompanying report is to "enhance all things PREA" at AH. Additionally, the SAIR team: Considers whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification,

	status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility; Examines the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse; Assesses the adequacy of staffing levels in that area during different shifts; and Assesses whether monitoring technology should be deployed or augmented to supplement supervision by staff. Of note, the SAIR interviewee corroborates the statement of the Director in terms of report content. The APC asserts that he generally writes the SAIR report and routes the same through the Director. In the event of recommendations, the APC asserts the same are implemented or the basis for non-implementation is articulated in writing. Pursuant to the PAQ, the Director self reports the facility implements the recommendations for improvement or documents its reasons for not doing so. Provision inclusion in policy is addressed in the narrative for 115.283(a). The auditor's review of the previously mentioned SAIR report reveals recommendation(s) were not articulated in the same. In view of the above, the auditor finds AH substantially compliant with 115.286.

115.287	Data collection
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Pursuant to the PAQ, the Director self reports the agency collects accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. The Director further self reports the standardized instrument includes, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice. Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA , pages 10 and 11, section IV(M)(1-3) addresses 115.287(a). The auditor's review of 2019, 2020, and 2021 PREA Annual Reports reveals substantial compliance with 115.287(a) and (c). Pursuant to the PAQ, the Director self reports the agency aggregates the incident-based sexual abuse data at least annually. Pursuant to review of 115.287(a) documentation, it is clear that incident based data is aggregated annually. Pursuant to the PAQ, the Director self reports the standardized instrument includes, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence (SSV) conducted by the Department of Justice. The APC asserts that the agency uses the SSV-IA and SSV4 forms for the basis of the data collection process. The auditor's review of the aforementioned Annual PREA Reports reveals substantial compliance with 115.287(c). Pursuant to the PAQ, the Director self reports the agency maintains, reviews, and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. The APC asserts that the agency maintains all documentation regarding incidents. Pursuant to the PAQ, the Director asserts that Alternatives, Inc. does not contract with other entities for the confinement of its residents. The auditor's on-site observations, review of random documentation, and conversations with staff substantiate the Director's assertion. Accordingly, the auditor finds that 115.287(e) is not applicable to 115.287. Pursuant to the PAQ, the Director asserts that the agency has not provided the Department of Justice (DOJ) with data from the previous calendar year as the same has not been requested. Accordingly, the auditor finds that 115.287(f) is not applicable to AH. In view of the above, the auditor finds AH substantially compliant with 115.287.

115.288	Data review for corrective action
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Pursuant to the PAQ, the Director self reports the agency reviews data collected and aggregated pursuant to 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, and training, including: Identifying problem areas; Taking corrective action on an ongoing basis; and Preparing an annual report of its findings from its data review and any corrective actions for each facility, as well as, the agency as a whole. The auditor's review of the 2019, 2020, and 2021 AH Annual Reports reveals substantial compliance with all components of 115.288. Specifically, a comparison of current year data and corrective actions vs. those of prior years provides an assessment of the agency's progress in addressing sexual abuse. The 2021 report is approved by the Agency Head, and the reports are posted on the Alternatives, Inc. website. The reports reveal no redactions pursuant to 115.288(d). The Agency Head asserts company practice places a premium on PREA policies and procedures. Annually aggregated data is used to assess staffing, needed facility improvements, and technology upgrades, etc. Information is gleaned from SAIR reports, with trends assessed to "improve all things PREA". The APC asserts the agency compiles an annual report of findings from its data review and any corrective actions for each facility, as well as, the agency as a whole. Compilation of the annual report now lies with the APC. Specifics regarding information utilized in the compilation of the annual PREA reports are addressed in the narrative for 115.289. Pursuant to the PAQ, the Director self reports the annual report includes a comparison of the current year's data and corrective actions with those from prior years. The annual report provides an assessment of the agency's progress in addressing sexual abuse. Pursuant to the PAQ, the Director self reports the agency makes its annual report readily available to the public at least annually through its website. The annual reports are approved by the agency head. The auditor notes the aforementioned annual reports are published on the Alternatives, Inc. website. The Agency Head asserts he approves annual reports written pursuant to 115.288. As previously mentioned in the narrative for 115.288(a), the auditor's review of relevant documentation validates the Agency Head's assertion.

	Pursuant to the PAQ, the Director self reports when the agency redacts material from an annual report for publication, the redactions are limited to specific materials where publication would present a clear and specific threat to the safety and security of the facility. The Director further asserts the agency indicates the nature of material redacted. The APC asserts personal identifiers are typically redacted from the annual report. Information that constitutes a threat to vital security information may also be redacted. In view of the above, the auditor finds AH substantially compliant with 115.288.

115.289	Data storage, publication, and destruction
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Pursuant to the PAQ, the Director asserts the agency ensures that incident-based and aggregate data are securely retained. The APC asserts the data is maintained in a secure filing cabinet in the APC's office and electronically under access of the APC. The auditor notes that the APC'S office is located in another building a few miles from AH. Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA , page 10, section IV(M)(2 and 3) addresses 115.289(a). The APC asserts the agency reviews data collected and aggregated pursuant to 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies and training. He maintains Average Daily Population (ADP) information, hard copies of investigations and supporting documentation, scanning the same into his network ID. The same is password protected and other Alternatives, Inc. staff have no access to the same. SSVs and SAIRs are maintained electronically. Pursuant to the PAQ, the Director self reports agency policy requires that aggregated sexual abuse data from facilities under its direct control and private facilities with which it contracts be made readily available to the public at least annually through its website. The APC asserts that the Annual Report is presented to the CEO and placed on the agency's web site under the PREA Tab. The auditor's review of the Alternatives, Inc. PREA Tab substantiates the APC's assertion as Annual PREA Reports are available on the same. Pursuant to the PAQ, the Director self reports that before making aggregated sexual abuse data publicly available, the agency removes all personal identifiers. Additionally, the Director self reports that the agency maintains sexual abuse data collected pursuant to §115.287 for at least 10 years after the date of initial collection, unless federal, state, or local law requires otherwise. The APC asserts that aggregated data is publicly available and he removes all personal identifiers. Alternatives, Inc. maintains all data collected for at least 10 years from the date of the initial collection unless laws require otherwise. Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA , page 11, section IV(M)(5) addresses 115.289(c). Additionally, Alternatives, Inc. Policy and Procedural Statement ALT A22 entitled PREA , page 10, section IV(M)(2) addresses 115.289(c). During the on-site audit, the auditor identified zero deficiencies with respect to 115.289(c).

	Pursuant to the PAQ, the Director self reports the agency maintains sexual abuse data collected pursuant to 115.287 for at least 10 years after the date of initial collection, unless federal, state, or local law requires otherwise. A discussion regarding 115.289(d) requirements is articulated in the narrative for 115.289(c). In view of the above, the auditor finds AH substantially compliant with 115.289.

115.401	Frequency and scope of audits
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Both AH and Passages were subjected to a PREA audit during 2019. Staff were very facilitative throughout the entire audit process. Pre-audit information was delivered in a timely and comprehensive manner. Interview scheduling and the conduct of the same flowed in an efficient manner. The auditor was provided all appropriate access to the facility, residents, and staff. The auditor experienced no difficulty in terms of facilitation of private staff and resident interviews both during the facility tour and subsequent interviews. The auditor received zero correspondence from AH residents, staff, volunteers, or vendors.

115.403	Audit contents and findings
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The Final PREA Report dated October, 2019 is posted on the Alternatives, Inc. website.

Appendix: Provision Findings		
115.211 (a)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment?	yes
	Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment?	yes
115.211 (b)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	Has the agency employed or designated an agency-wide PREA Coordinator?	yes
	Is the PREA Coordinator position in the upper-level of the agency hierarchy?	yes
	Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its community confinement facilities?	yes
115.212 (a)	**Contracting with other entities for the confinement of residents**	
	If this agency is public and it contracts for the confinement of its residents with private agencies or other entities, including other government agencies, has the agency included the entity's obligation to adopt and comply with the PREA standards in any new contract or contract renewal signed on or after August 20, 2012? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.)	na
115.212 (b)	**Contracting with other entities for the confinement of residents**	
	Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.)	na

115.212 (c)	**Contracting with other entities for the confinement of residents**	
	If the agency has entered into a contract with an entity that fails to comply with the PREA standards, did the agency do so only in emergency circumstances after making all reasonable attempts to find a PREA compliant private agency or other entity to confine residents? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.)	na
	In such a case, does the agency document its unsuccessful attempts to find an entity in compliance with the standards? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.)	na
115.213 (a)	**Supervision and monitoring**	
	Does the facility have a documented staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring to protect residents against sexual abuse?	yes
	In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The physical layout of each facility?	yes
	In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The composition of the resident population?	yes
	In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The prevalence of substantiated and unsubstantiated incidents of sexual abuse?	yes
	In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any other relevant factors?	yes
115.213 (b)	**Supervision and monitoring**	
	In circumstances where the staffing plan is not complied with, does the facility document and justify all deviations from the plan? (NA if no deviations from staffing plan.)	yes

115.213 (c)	**Supervision and monitoring**	
	In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the staffing plan established pursuant to paragraph (a) of this section?	yes
	In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to prevailing staffing patterns?	yes
	In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the facility's deployment of video monitoring systems and other monitoring technologies?	yes
	In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the resources the facility has available to commit to ensure adequate staffing levels?	yes
115.215 (a)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from conducting any cross-gender strip searches or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners?	yes
115.215 (b)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from conducting cross-gender pat-down searches of female residents, except in exigent circumstances? (N/A if the facility does not have female inmates.)	na
	Does the facility always refrain from restricting female residents' access to regularly available programming or other outside opportunities in order to comply with this provision? (N/A if the facility does not have female inmates.)	na
115.215 (c)	**Limits to cross-gender viewing and searches**	
	Does the facility document all cross-gender strip searches and cross-gender visual body cavity searches?	yes
	Does the facility document all cross-gender pat-down searches of female residents?	yes

115.215 (d)	**Limits to cross-gender viewing and searches**	
	Does the facility have policies that enable residents to shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks?	yes
	Does the facility have procedures that enable residents to shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks?	yes
	Does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing?	yes
115.215 (e)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident’s genital status?	yes
	If the resident’s genital status is unknown, does the facility determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner?	yes
115.215 (f)	**Limits to cross-gender viewing and searches**	
	Does the facility/agency train security staff in how to conduct cross-gender pat down searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs?	yes
	Does the facility/agency train security staff in how to conduct searches of transgender and intersex residents in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs?	yes

115.216 (a)	Residents with disabilities and residents who are limited English proficient	
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency’s efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are deaf or hard of hearing?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency’s efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are blind or have low vision?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency’s efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have intellectual disabilities?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency’s efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have psychiatric disabilities?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency’s efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have speech disabilities?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency’s efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other (if "other," please explain in overall determination notes.)	yes
	Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing?	yes
	Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary?	yes
	Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication	yes

	with residents with disabilities including residents who: Have intellectual disabilities?	
	Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills?	yes
	Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Who are blind or have low vision?	yes
115.216 (b)	**Residents with disabilities and residents who are limited English proficient**	
	Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient?	yes
	Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary?	yes
115.216 (c)	**Residents with disabilities and residents who are limited English proficient**	
	Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.264, or the investigation of the resident's allegations?	yes

115.217 (a)	Hiring and promotion decisions	
	Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)?	yes
	Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse?	yes
	Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the two questions immediately above ?	yes
	Does the agency prohibit the enlistment of the services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)?	yes
	Does the agency prohibit the enlistment of the services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse?	yes
	Does the agency prohibit the enlistment of the services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the two questions immediately above ?	yes
115.217 (b)	**Hiring and promotion decisions**	
	Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone who may have contact with residents?	yes
	Does the agency consider any incidents of sexual harassment in determining to enlist the services of any contractor who may have contact with residents?	yes

115.217 (c)	**Hiring and promotion decisions**	
	Before hiring new employees who may have contact with residents, does the agency: Perform a criminal background records check?	yes
	Before hiring new employees who may have contact with residents, does the agency, consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse?	yes
115.217 (d)	**Hiring and promotion decisions**	
	Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents?	yes
115.217 (e)	**Hiring and promotion decisions**	
	Does the agency either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees?	yes
115.217 (f)	**Hiring and promotion decisions**	
	Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions?	yes
	Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees?	yes
	Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct?	yes

115.217 (g)	**Hiring and promotion decisions**	
	Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination?	yes
115.217 (h)	**Hiring and promotion decisions**	
	Does the agency provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work? (N/A if providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.)	yes
115.218 (a)	**Upgrades to facilities and technology**	
	If the agency designed or acquired any new facility or planned any substantial expansion or modification of existing facilities, did the agency consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not acquired a new facility or made a substantial expansion to existing facilities since August 20, 2012 or since the last PREA audit, whichever is later.)	na
115.218 (b)	**Upgrades to facilities and technology**	
	If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, did the agency consider how such technology may enhance the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not installed or updated any video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012 or since the last PREA audit, whichever is later.)	na
115.221 (a)	**Evidence protocol and forensic medical examinations**	
	If the agency is responsible for investigating allegations of sexual abuse, does the agency follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions? (N/A if the agency/facility is not responsible for conducting any form of criminal or administrative sexual abuse investigations.)	yes

115.221 (b)	**Evidence protocol and forensic medical examinations**	
	Is this protocol developmentally appropriate for youth where applicable? (NA if the agency/facility is not responsible for conducting any form of criminal or administrative sexual abuse investigations.)	yes
	Is this protocol, as appropriate, adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/ Adolescents," or similarly comprehensive and authoritative protocols developed after 2011? (NA if the agency/facility is not responsible for conducting any form of criminal or administrative sexual abuse investigations.)	yes
115.221 (c)	**Evidence protocol and forensic medical examinations**	
	Does the agency offer all victims of sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate?	yes
	Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible?	yes
	If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)?	yes
	Has the agency documented its efforts to provide SAFEs or SANEs?	yes
115.221 (d)	**Evidence protocol and forensic medical examinations**	
	Does the agency attempt to make available to the victim a victim advocate from a rape crisis center?	yes
	If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member?	yes
	Has the agency documented its efforts to secure services from rape crisis centers?	yes

115.221 (e)	**Evidence protocol and forensic medical examinations**	
	As requested by the victim, does the victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory interviews?	yes
	As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals?	yes
115.221 (f)	**Evidence protocol and forensic medical examinations**	
	If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating agency follow the requirements of paragraphs (a) through (e) of this section? (N/A if the agency/facility is responsible for conducting criminal AND administrative sexual abuse investigations.)	yes
115.221 (h)	**Evidence protocol and forensic medical examinations**	
	If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.221(d) above).	na
115.222 (a)	**Policies to ensure referrals of allegations for investigations**	
	Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse?	yes
	Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment?	yes

115.222 (b)	Policies to ensure referrals of allegations for investigations	
	Does the agency have a policy in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior?	yes
	Has the agency published such policy on its website or, if it does not have one, made the policy available through other means?	yes
	Does the agency document all such referrals?	yes
115.222 (c)	**Policies to ensure referrals of allegations for investigations**	
	If a separate entity is responsible for conducting criminal investigations, does the policy describe the responsibilities of both the agency and the investigating entity? (N/A if the agency/facility is responsible for conducting criminal investigations. See 115.221(a).)	yes

115.231 (a)	Employee training	
	Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment?	yes
	Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures?	yes
	Does the agency train all employees who may have contact with residents on: Residents' right to be free from sexual abuse and sexual harassment?	yes
	Does the agency train all employees who may have contact with residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment?	yes
	Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in confinement?	yes
	Does the agency train all employees who may have contact with residents on: The common reactions of sexual abuse and sexual harassment victims?	yes
	Does the agency train all employees who may have contact with residents on: How to detect and respond to signs of threatened and actual sexual abuse?	yes
	Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents?	yes
	Does the agency train all employees who may have contact with residents on: How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents?	yes
	Does the agency train all employees who may have contact with residents on: How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities?	yes

115.231 (b)	**Employee training**	
	Is such training tailored to the gender of the residents at the employee's facility?	yes
	Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa?	yes
115.231 (c)	**Employee training**	
	Have all current employees who may have contact with residents received such training?	yes
	Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures?	yes
	In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies?	yes
115.231 (d)	**Employee training**	
	Does the agency document, through employee signature or electronic verification, that employees understand the training they have received?	yes
115.232 (a)	**Volunteer and contractor training**	
	Has the agency ensured 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?	yes
115.232 (b)	**Volunteer and contractor training**	
	Have all volunteers and contractors who have contact with residents been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents)?	yes

115.232 (c)	**Volunteer and contractor training**	
	Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received?	yes
115.233 (a)	**Resident education**	
	During intake, do residents receive information explaining: The agency’s zero-tolerance policy regarding sexual abuse and sexual harassment?	yes
	During intake, do residents receive information explaining: How to report incidents or suspicions of sexual abuse or sexual harassment?	yes
	During intake, do residents receive information explaining: Their rights to be free from sexual abuse and sexual harassment?	yes
	During intake, do residents receive information explaining: Their rights to be free from retaliation for reporting such incidents?	yes
	During intake, do residents receive information regarding agency policies and procedures for responding to such incidents?	yes
115.233 (b)	**Resident education**	
	Does the agency provide refresher information whenever a resident is transferred to a different facility?	yes

115.233 (c)	**Resident education**	
	Does the agency provide resident education in formats accessible to all residents, including those who: Are limited English proficient?	yes
	Does the agency provide resident education in formats accessible to all residents, including those who: Are deaf?	yes
	Does the agency provide resident education in formats accessible to all residents, including those who: Are visually impaired?	yes
	Does the agency provide resident education in formats accessible to all residents, including those who: Are otherwise disabled?	yes
	Does the agency provide resident education in formats accessible to all residents, including those who: Have limited reading skills?	yes
115.233 (d)	**Resident education**	
	Does the agency maintain documentation of resident participation in these education sessions?	yes
115.233 (e)	**Resident education**	
	In addition to providing such education, does the agency ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats?	yes
115.234 (a)	**Specialized training: Investigations**	
	In addition to the general training provided to all employees pursuant to §115.231, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators receive training in conducting such investigations in confinement settings? (N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a)).	yes

115.234 (b)	Specialized training: Investigations	
	Does this specialized training include: Techniques for interviewing sexual abuse victims?(N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a)).	yes
	Does this specialized training include: Proper use of Miranda and Garrity warnings?(N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a)).	yes
	Does this specialized training include: Sexual abuse evidence collection in confinement settings?(N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a)).	yes
	Does this specialized training include: The criteria and evidence required to substantiate a case for administrative action or prosecution referral? (N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a)).	yes
115.234 (c)	**Specialized training: Investigations**	
	Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? (N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a).)	yes

115.235 (a)	**Specialized training: Medical and mental health care**	
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to victims of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
115.235 (b)	**Specialized training: Medical and mental health care**	
	If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations? (N/A if agency does not employ medical staff or the medical staff employed by the agency do not conduct forensic exams.)	na
115.235 (c)	**Specialized training: Medical and mental health care**	
	Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes

115.235 (d)	**Specialized training: Medical and mental health care**	
	Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.231? (N/A for circumstances in which a particular status (employee or contractor/volunteer) does not apply.)	yes
	Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.232? (N/A for circumstances in which a particular status (employee or contractor/volunteer) does not apply.)	na
115.241 (a)	**Screening for risk of victimization and abusiveness**	
	Are all residents assessed during an intake screening for their risk of being sexually abused by other residents or sexually abusive toward other residents?	yes
	Are all residents assessed upon transfer to another facility for their risk of being sexually abused by other residents or sexually abusive toward other residents?	yes
115.241 (b)	**Screening for risk of victimization and abusiveness**	
	Do intake screenings ordinarily take place within 72 hours of arrival at the facility?	yes
115.241 (c)	**Screening for risk of victimization and abusiveness**	
	Are all PREA screening assessments conducted using an objective screening instrument?	yes

115.241 (d)	Screening for risk of victimization and abusiveness	
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has a mental, physical, or developmental disability?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The age of the resident?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The physical build of the resident?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously been incarcerated?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident's criminal history is exclusively nonviolent?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has prior convictions for sex offenses against an adult or child?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming (the facility affirmatively asks the resident about his/her sexual orientation and gender identity AND makes a subjective determination based on the screener's perception whether the resident is gender non-conforming or otherwise may be perceived to be LGBTI)?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously experienced sexual victimization?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The resident's own perception of vulnerability?	yes

115.241 (e)	**Screening for risk of victimization and abusiveness**	
	In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior acts of sexual abuse?	yes
	In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior convictions for violent offenses?	yes
	In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: history of prior institutional violence or sexual abuse?	yes
115.241 (f)	**Screening for risk of victimization and abusiveness**	
	Within a set time period not more than 30 days from the resident's arrival at the facility, does the facility reassess the resident's risk of victimization or abusiveness based upon any additional, relevant information received by the facility since the intake screening?	yes
115.241 (g)	**Screening for risk of victimization and abusiveness**	
	Does the facility reassess a resident's risk level when warranted due to a: Referral?	yes
	Does the facility reassess a resident's risk level when warranted due to a: Request?	yes
	Does the facility reassess a resident's risk level when warranted due to a: Incident of sexual abuse?	yes
	Does the facility reassess a resident's risk level when warranted due to a: Receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness?	yes
115.241 (h)	**Screening for risk of victimization and abusiveness**	
	Is it the case that residents are not ever disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to paragraphs (d)(1), (d)(7), (d)(8), or (d)(9) of this section?	yes

115.241 (i)	**Screening for risk of victimization and abusiveness**	
	Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident’s detriment by staff or other residents?	yes
115.242 (a)	**Use of screening information**	
	Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Housing Assignments?	yes
	Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Bed assignments?	yes
	Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Work Assignments?	yes
	Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Education Assignments?	yes
	Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Program Assignments?	yes
115.242 (b)	**Use of screening information**	
	Does the agency make individualized determinations about how to ensure the safety of each resident?	yes

115.242 (c)	**Use of screening information**	
	When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident’s health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns residents to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this standard)?	yes
	When making housing or other program assignments for transgender or intersex residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident’s health and safety, and whether a placement would present management or security problems?	yes
115.242 (d)	**Use of screening information**	
	Are each transgender or intersex resident’s own views with respect to his or her own safety given serious consideration when making facility and housing placement decisions and programming assignments?	yes
115.242 (e)	**Use of screening information**	
	Are transgender and intersex residents given the opportunity to shower separately from other residents?	yes

115.242 (f)	**Use of screening information**	
	Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: lesbian, gay, and bisexual residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.)	yes
	Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: transgender residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.)	yes
	Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: intersex residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.)	yes
115.251 (a)	**Resident reporting**	
	Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment?	yes
	Does the agency provide multiple internal ways for residents to privately report: Retaliation by other residents or staff for reporting sexual abuse and sexual harassment?	yes
	Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents?	yes

115.251 (b)	**Resident reporting**	
	Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency?	yes
	Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials?	yes
	Does that private entity or office allow the resident to remain anonymous upon request?	yes
115.251 (c)	**Resident reporting**	
	Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties?	yes
	Do staff members promptly document any verbal reports of sexual abuse and sexual harassment?	yes
115.251 (d)	**Resident reporting**	
	Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents?	yes
115.252 (a)	**Exhaustion of administrative remedies**	
	Is the agency exempt from this standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address resident grievances regarding sexual abuse. This does not mean the agency is exempt simply because a resident does not have to or is not ordinarily expected to submit a grievance to report sexual abuse. This means that as a matter of explicit policy, the agency does not have an administrative remedies process to address sexual abuse.	yes

115.252 (b)	**Exhaustion of administrative remedies**	
	Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this standard.)	yes
	Does the agency always refrain from requiring a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.)	yes
115.252 (c)	**Exhaustion of administrative remedies**	
	Does the agency ensure that: a resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.)	yes
	Does the agency ensure that: such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.)	yes
115.252 (d)	**Exhaustion of administrative remedies**	
	Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.)	yes
	If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time (the maximum allowable extension is 70 days per 115.252(d)(3)), does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.)	yes
	At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.)	yes

115.252 (e)	Exhaustion of administrative remedies	
	Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.)	yes
	Are those third parties also permitted to file such requests on behalf of residents? (If a third party files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.)	yes
	If the resident declines to have the request processed on his or her behalf, does the agency document the resident’s decision? (N/A if agency is exempt from this standard.)	yes

115.252 (f)	Exhaustion of administrative remedies	
	Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.)	yes
	After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.)	yes
	After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.)	yes
	After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.)	yes
	Does the initial response and final agency decision document the agency’s determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.)	yes
	Does the initial response document the agency’s action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.)	yes
	Does the agency’s final decision document the agency’s action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.)	yes
115.252 (g)	**Exhaustion of administrative remedies**	
	If the agency disciplines a resident for filing a grievance related to alleged sexual abuse, does it do so ONLY where the agency demonstrates that the resident filed the grievance in bad faith? (N/A if agency is exempt from this standard.)	yes

115.253 (a)	**Resident access to outside confidential support services**	
	Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by giving residents mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations?	yes
	Does the facility enable reasonable communication between residents and these organizations, in as confidential a manner as possible?	yes
115.253 (b)	**Resident access to outside confidential support services**	
	Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws?	yes
115.253 (c)	**Resident access to outside confidential support services**	
	Does the agency maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse?	yes
	Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements?	yes
115.254 (a)	**Third party reporting**	
	Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment?	yes
	Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident?	yes

115.261 (a)	**Staff and agency reporting duties**	
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency?	yes
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment?	yes
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation?	yes
115.261 (b)	**Staff and agency reporting duties**	
	Apart from reporting to designated supervisors or officials, do staff always refrain from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions?	yes
115.261 (c)	**Staff and agency reporting duties**	
	Unless otherwise precluded by Federal, State, or local law, are medical and mental health practitioners required to report sexual abuse pursuant to paragraph (a) of this section?	yes
	Are medical and mental health practitioners required to inform residents of the practitioner’s duty to report, and the limitations of confidentiality, at the initiation of services?	yes
115.261 (d)	**Staff and agency reporting duties**	
	If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable persons statute, does the agency report the allegation to the designated State or local services agency under applicable mandatory reporting laws?	yes

115.261 (e)	**Staff and agency reporting duties**	
	Does the facility report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility’s designated investigators?	yes
115.262 (a)	**Agency protection duties**	
	When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, does it take immediate action to protect the resident?	yes
115.263 (a)	**Reporting to other confinement facilities**	
	Upon receiving an allegation that a resident was sexually abused while confined at another facility, does the head of the facility that received the allegation notify the head of the facility or appropriate office of the agency where the alleged abuse occurred?	yes
115.263 (b)	**Reporting to other confinement facilities**	
	Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation?	yes
115.263 (c)	**Reporting to other confinement facilities**	
	Does the agency document that it has provided such notification?	yes
115.263 (d)	**Reporting to other confinement facilities**	
	Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards?	yes

115.264 (a)	**Staff first responder duties**	
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser?	yes
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence?	yes
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence?	yes
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence?	yes
115.264 (b)	**Staff first responder duties**	
	If the first staff responder is not a security staff member, is the responder required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff?	yes
115.265 (a)	**Coordinated response**	
	Has the facility developed a written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse?	yes

115.266 (a)	**Preservation of ability to protect residents from contact with abusers**	
	Are both the agency and any other governmental entities responsible for collective bargaining on the agency's behalf prohibited from entering into or renewing any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted?	yes
115.267 (a)	**Agency protection against retaliation**	
	Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff?	yes
	Has the agency designated which staff members or departments are charged with monitoring retaliation?	yes
115.267 (b)	**Agency protection against retaliation**	
	Does the agency employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations?	yes

115.267 (c)	Agency protection against retaliation	
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor any resident disciplinary reports?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency:4. Monitor resident housing changes?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor resident program changes?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor negative performance reviews of staff?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor reassignment of staff?	yes
	Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need?	yes

115.267 (d)	**Agency protection against retaliation**	
	In the case of residents, does such monitoring also include periodic status checks?	yes
115.267 (e)	**Agency protection against retaliation**	
	If any other individual who cooperates with an investigation expresses a fear of retaliation, does the agency take appropriate measures to protect that individual against retaliation?	yes
115.271 (a)	**Criminal and administrative agency investigations**	
	When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).)	yes
	Does the agency conduct such investigations for all allegations, including third party and anonymous reports? (N/A if the agency/ facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).)	yes
115.271 (b)	**Criminal and administrative agency investigations**	
	Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations as required by 115.234?	yes
115.271 (c)	**Criminal and administrative agency investigations**	
	Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data?	yes
	Do investigators interview alleged victims, suspected perpetrators, and witnesses?	yes
	Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator?	yes

115.271 (d)	**Criminal and administrative agency investigations**	
	When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution?	yes
115.271 (e)	**Criminal and administrative agency investigations**	
	Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual’s status as resident or staff?	yes
	Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding?	yes
115.271 (f)	**Criminal and administrative agency investigations**	
	Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse?	yes
	Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings?	yes
115.271 (g)	**Criminal and administrative agency investigations**	
	Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible?	yes
115.271 (h)	**Criminal and administrative agency investigations**	
	Are all substantiated allegations of conduct that appears to be criminal referred for prosecution?	yes

115.271 (i)	**Criminal and administrative agency investigations**	
	Does the agency retain all written reports referenced in 115.271(f) and (g) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years?	yes
115.271 (j)	**Criminal and administrative agency investigations**	
	Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the facility or agency does not provide a basis for terminating an investigation?	yes
115.271 (l)	**Criminal and administrative agency investigations**	
	When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).)	yes
115.272 (a)	**Evidentiary standard for administrative investigations**	
	Is it true that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated?	yes
115.273 (a)	**Reporting to residents**	
	Following an investigation into a resident’s allegation that he or she suffered sexual abuse in an agency facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded?	yes
115.273 (b)	**Reporting to residents**	
	If the agency did not conduct the investigation into a resident’s allegation of sexual abuse in an agency facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.)	yes

115.273 (c)	Reporting to residents	
	Following a resident’s allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident’s unit?	yes
	Following a resident’s allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility?	yes
	Following a resident’s allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility?	yes
	Following a resident’s allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility?	yes
115.273 (d)	**Reporting to residents**	
	Following a resident’s allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility?	yes
	Following a resident’s allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility?	yes

115.273 (e)	**Reporting to residents**	
	Does the agency document all such notifications or attempted notifications?	yes
115.276 (a)	**Disciplinary sanctions for staff**	
	Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies?	yes
115.276 (b)	**Disciplinary sanctions for staff**	
	Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse?	yes
115.276 (c)	**Disciplinary sanctions for staff**	
	Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) commensurate with the nature and circumstances of the acts committed, the staff member’s disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories?	yes
115.276 (d)	**Disciplinary sanctions for staff**	
	Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Law enforcement agencies, unless the activity was clearly not criminal?	yes
	Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Relevant licensing bodies?	yes

115.277 (a)	**Corrective action for contractors and volunteers**	
	Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents?	yes
	Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies (unless the activity was clearly not criminal)?	yes
	Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies?	yes
115.277 (b)	**Corrective action for contractors and volunteers**	
	In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility take appropriate remedial measures, and consider whether to prohibit further contact with residents?	yes
115.278 (a)	**Disciplinary sanctions for residents**	
	Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, are residents subject to disciplinary sanctions pursuant to a formal disciplinary process?	yes
115.278 (b)	**Disciplinary sanctions for residents**	
	Are sanctions commensurate with the nature and circumstances of the abuse committed, the resident’s disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories?	yes
115.278 (c)	**Disciplinary sanctions for residents**	
	When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident’s mental disabilities or mental illness contributed to his or her behavior?	yes

115.278 (d)	**Disciplinary sanctions for residents**	
	If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to require the offending resident to participate in such interventions as a condition of access to programming and other benefits?	yes
115.278 (e)	**Disciplinary sanctions for residents**	
	Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact?	yes
115.278 (f)	**Disciplinary sanctions for residents**	
	For the purpose of disciplinary action does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation?	yes
115.278 (g)	**Disciplinary sanctions for residents**	
	Does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.)	yes
115.282 (a)	**Access to emergency medical and mental health services**	
	Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment?	yes

115.282 (b)	**Access to emergency medical and mental health services**	
	If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do security staff first responders take preliminary steps to protect the victim pursuant to § 115.262?	yes
	Do security staff first responders immediately notify the appropriate medical and mental health practitioners?	yes
115.282 (c)	**Access to emergency medical and mental health services**	
	Are resident victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate?	yes
115.282 (d)	**Access to emergency medical and mental health services**	
	Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?	yes
115.283 (a)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility?	yes
115.283 (b)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the evaluation and treatment of such victims 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?	yes
115.283 (c)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the facility provide such victims with medical and mental health services consistent with the community level of care?	yes

115.283 (d)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if “all-male” facility. Note: in “all-male” facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.)	na
115.283 (e)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	If pregnancy results from the conduct described in paragraph § 115.283(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if “all-male” facility. Note: in “all-male” facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.)	na
115.283 (f)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate?	yes
115.283 (g)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?	yes
115.283 (h)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners?	yes

115.286 (a)	**Sexual abuse incident reviews**	
	Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded?	yes
115.286 (b)	**Sexual abuse incident reviews**	
	Does such review ordinarily occur within 30 days of the conclusion of the investigation?	yes
115.286 (c)	**Sexual abuse incident reviews**	
	Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners?	yes
115.286 (d)	**Sexual abuse incident reviews**	
	Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse?	yes
	Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility?	yes
	Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse?	yes
	Does the review team: Assess the adequacy of staffing levels in that area during different shifts?	yes
	Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff?	yes
	Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.286(d)(1)-(d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager?	yes

115.286 (e)	**Sexual abuse incident reviews**	
	Does the facility implement the recommendations for improvement, or document its reasons for not doing so?	yes
115.287 (a)	**Data collection**	
	Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions?	yes
115.287 (b)	**Data collection**	
	Does the agency aggregate the incident-based sexual abuse data at least annually?	yes
115.287 (c)	**Data collection**	
	Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice?	yes
115.287 (d)	**Data collection**	
	Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews?	yes
115.287 (e)	**Data collection**	
	Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.)	na
115.287 (f)	**Data collection**	
	Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.)	na

115.288 (a)	**Data review for corrective action**	
	Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas?	yes
	Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis?	yes
	Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole?	yes
115.288 (b)	**Data review for corrective action**	
	Does the agency’s annual report include a comparison of the current year’s data and corrective actions with those from prior years and provide an assessment of the agency’s progress in addressing sexual abuse?	yes
115.288 (c)	**Data review for corrective action**	
	Is the agency’s annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means?	yes
115.288 (d)	**Data review for corrective action**	
	Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility?	yes
115.289 (a)	**Data storage, publication, and destruction**	
	Does the agency ensure that data collected pursuant to § 115.287 are securely retained?	yes

115.289 (b)	**Data storage, publication, and destruction**	
	Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means?	yes
115.289 (c)	**Data storage, publication, and destruction**	
	Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available?	yes
115.289 (d)	**Data storage, publication, and destruction**	
	Does the agency maintain sexual abuse data collected pursuant to § 115.287 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise?	yes
115.401 (a)	**Frequency and scope of audits**	
	During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.)	yes
115.401 (b)	**Frequency and scope of audits**	
	Is this the first year of the current audit cycle? (Note: a “no” response does not impact overall compliance with this standard.)	no
	If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is not the second year of the current audit cycle.)	yes
	If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is not the third year of the current audit cycle.)	na

115.401 (h)	**Frequency and scope of audits**	
	Did the auditor have access to, and the ability to observe, all areas of the audited facility?	yes
115.401 (i)	**Frequency and scope of audits**	
	Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)?	yes
115.401 (m)	**Frequency and scope of audits**	
	Was the auditor permitted to conduct private interviews with residents?	yes
115.401 (n)	**Frequency and scope of audits**	
	Were inmates, residents, and detainees permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel?	yes
115.403 (f)	**Audit contents and findings**	
	The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports. The review period is for prior audits completed during the past three years PRECEDING THIS AUDIT. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or, in the case of single facility agencies, there has never been a Final Audit Report issued.)	yes