PANEL 7

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MR. MCFARLAND: Good afternoon. Hope you all had a good lunch. Thanks to the CDCR for the catered lunch.

Our next panel will begin with Dr. Terry Kupers who needs to leave right at 3:00. We will hear his opening remarks and then direct any questions that we have particularly for him, and then hear from the others. And if you are still around at that point, you can chime in on any questions that we might direct to them, too.

Pleasure to have you here, Doctor.

DR. KUPERS: Pleasure and honor to be here.

MR. MCFARLAND: Oh, we have to swear you in.

(Oath administered by Mr. McFarland.)

DR. KUPERS: It is a pleasure and honor to

be here with you. I apologize in advance I have to leave at three. My time kept getting pushed back. I have patients back in Oakland.

I am a psychiatrist. I did turn in some written comments, and Mr. McFarland finally did write me some very apt questions which I have

answered in the written testimony and will comment briefly about here, and I hope to leave us some time for discussion.

I do general psychiatry, and I am a professor at The Wright Institute. I got roped into testifying in court about jail and prison conditions in 1974, actually in L.A. County, in the Rutherford case, talking about how crowding impacted the mental health services, the adequacy of mental health services, rape in the jail and that kind of thing.

I then went on from one case to another. So it's been a sidelight of my career. I've never worked in corrections. However, I testified in over 30 large class action lawsuits. I have consulted to the Civil Rights Division of the Department of Justice, consulted to Amnesty International Human Rights Watch. I am a contributing editor for Correctional Mental Health Report, and I have written extensively, including a book, Prison

Madness, which is a mental health crisis behind bars.

The basis for my expertise in this area is, first of all, I had a number of cases specifically about sexual assault. In women's prisons it's tended to be custodial misconduct. In men's prisons

it's tended to be prisoner on prisoner. I had two rather high profile cases where a staff sexually assaulting female prisoners.

But that isn't really the basis of much of my expertise. The real basis is that interviewed thousands and thousands of prisoners around the country because I get asked for opinions in litigation or I get asked to step in as a consultant to help a case after litigation has commenced. And in the process I interview lots and lots of prisoners, and I feel very privileged to do that. Because, for the most part, as you know, people on the outside don't know much what goes on in prison, so I have in-depth interviews with lots and lots of prisoners. They tend to be people with serious mental illness and very shockingly high proportion of them have been sexually assaulted which is what I testified when I talked to the Parole PREA Commission.

MR. SEXTON: Previous to their attendance in prisons?

DR. KUPERS: No, after, in jail or prison, but previous to my interview with them.

And so I hear about a lot of unreported sexual assault and rape, and that is actually the bulk of

my experience. That far outweighs the overt cases I testified in.

I started my written comments, and I will repeat it here, mentioning someone I saw the week before I wrote this, now two weeks ago. He is a very tough prisoner in another state who was being tried for murder because he killed another prisoner and the other prisoner attacked him. This is a maximum security prisoner who can be attacked by a very rough actual gang member who had a deadly weapon and he killed him in a hand-to-hand combat.

When I was talking to him, after a few hours of talking with him -- that is a significant fact in itself -- told me and broke down in tears crying that he had been raped and he had been attacked in his cell by three men wearing masks, other prisoners. To this day he doesn't know who did it. He never reported this, but it certainly changed his life in prison. And it is after that rape that he

went and got himself a shank.

Having made that comment, I want to reiterate what I said in writing, for the most people who have been -- survived sexual assault and rape in prison, they are not dangerous people. They tend to stay to themselves. In fact, their symptoms psychiatrically

tend to be on the depressive side. They either have intrusive symptoms, like nightmares and flashbacks or they fall into a very deep depression where they isolate themselves. That is the majority of people I have seen who survive prison rape.

However, there are cases and some of them have been very high profile. People have turned to extreme violence in reaction to having been so brutally assaulted and raped.

Conditions, of course, are very important, crowding in California where unprecedented level of crowding. I testified in a number of cases that were about the ill effects of prison crowding. And we know for sure that violence, psychiatric breakdown and suicide all rise precipitously with crowding. We are now very crowded in California and around the country. Some states are crowded. Some states are renting beds.

What happens with crowding is all forms of

violence and mental illness rise, and among the violent incidence are a number of sexual assaults. People with serious mental illness are especially prone to sexual assault. There are many reasons for that. One of the reasons is they tend not to have a lot of social skills, and in prison if you want to

rape or sexually assault someone, you want to assault someone who doesn't have friends. You can be retaliated against.

I mention in the report a study that was just released in September by the federal Bureau of Justice statistics, which has shockingly high prevalence rates for serious mental illness. The study, I will caution you in advance that I really recommend reading it, is about reported symptoms, not about diagnosis by clinicians. Those two figures are slightly different, but not large, not a large difference. But the figures come out over 50 percent, really, on average of prisoners suffering from serious mental illness. The other thing the study goes into is these prisoners with serious mental illness are more than twice as likely to be attacked in correctional settings, which I think is an unprecedented study and backs up what I have been finding in my interviews, which is people with

mental illness tend to be the victims of various violent crimes, including rape.

So in terms of what to do to prevent prison rape and sexual assault, I will just be attending to the unmed treatment needs of people with serious mental illness which would be very important,

including providing them a safe place.

Staff training is a thorny issue. I will mention it quickly now. We can talk about it more. There are trainings and there are trainings. We have learned this in the workplace with sexual harassment. One of the best legal defenses for a public agency or corporation in terms of sexual harassment litigation is to do staff training. So that they can then say if sued, "We did our best. This individual did what he did, but we did a training for the staff."

People who do those trainings, and I have done a few, but I don't do a lot of them, tell me that the most important thing about those trainings is to get people engaged. So you have these sort of sitting in the back of the room with arms crossed phenomena. The trainers go into a police department or fire department where there is an accusation of race discrimination or sexual harassment, attacks on

gay or lesbian workers, and you walk into a room, and it is an involuntary situation. The trainer is being asked in and the workers are required to go. And there will be a bunch of men, usually, sitting in the back of the room with arms crossed, and the trainers tell me that the trick is to get those guys

involved in the training. They have tricks on how to do that.

What I went to recommend about training is that it is not just about scratching the surface; that training has to be about deep issues that lie behind sexual assault. For instance, misogyny, homophobia, racism. In order to do training with staff around those issues, and I say staff because whether the perpetrator of sexual assault is a prisoner or a staff member, the staff are very involved. And if the staff can improve on attitudes, that will make the incidence of sexual assault go down. So there needs to be training that isn't just scratching the surface, where they really get to the people being trained and talk how it feels to be the object of sexual gender choice or rational discrimination. And that can be done. We know how to do that. We have trainers in the community. I know in the California Department of

Corrections and Rehabilitation is consulting some of those trainers. National Institute of Corrections does that. And I would just emphasize whatever the expertise in the area, if we are training about relations with homosexual, gay, lesbian, transgender, bisexual people, there is an expertise

in the community about that. That should be brought into the correctional training situation.

I mentioned a case that I testified in. I can mention the name. I've checked with the attorneys in the case. That is the Roderick Johnson case in Texas. I really recommend that you become familiar with that case. I testified in that case for two days. Roderick Johnson was, is a black gay man who was made into the sex slave of gangs in the Texas prisons. Very high profile case. While this was going on, he was spending a year and a half in a prison, very tough prison where there were a lot of gangs.

He went to the classification committee six times requesting to be put in protective custody. They denied him. According to testimony in the case, other prisoners testified and supported his testimony. He was laughed at in those classification hearings. He was told, "You have to

go get yourself a man" and he was told other very degrading things in those classification hearings.

And what we do know on the record is, of course, those degrading things are not recorded. We know that he was denied safekeeping. And by testimony in court and subsequent research it is

clear that all of this did happen, that he was brutally sexually attackd over and over again and made into a sex slave, and the staff and authorities did nothing to help him.

Now Texas is cleaning up their act. There are changes in the Texas Department of Criminal Justice. But his case illustrates how complicity of the staff is required in what seems to be prisoner-on-prisoner rape. And I have seen it happen in terms of staff assigning two people to a cell where one is a known rapist, and they do that to punish the one who is not. So that what they are basically doing is punishing someone with rape that the staff set up by where they assign people. Various situations like that. There are various permutations.

Mr. McFarland asked me about the standards. I testified before PREA about standards. I think I made a mistake when I testified before PREA, and that is there are no explicit standards written out

as one, two, three, these are the steps you take. However, what I believe is -- and there is a consensus among experts in the field, it's reflected in the National Institute of Corrections' documents. It is reflected in the L.A. County protocol you discussed this morning. It's reflected in the Human

Rights Watch reports. I mentioned two of them. The one about women sexual assault and the one about men.

There are standards. There is consensus in the field, and probably we will need a more explicit standard in what confidentiality means, what protects means, what it means not to put someone in segregation after reporting being sexually assaulted.

The largest issue, as far as I am concerned, in prisons is respect. That is where the staff respect the prisoners as fellow human beings. They are doing time. They are human beings, and they deserve respect. Those with mental illness deserve treatment for their condition. Those who are sexually assaulted deserve a respectful response on the part of staff. Where that attitude is in place, then the problem is much less. And I think a zero tolerance attitude on the part of the administration

and staff is really a major way to cut down on prison sexual assault.

In that regard I was asked to comment about officers unions, and I sadly have some negative to say about that. That is that I think that blind loyalty among the troops, that is the blue code or

the failure of officers to report others who are perpetrators of crimes is absolutely unacceptable and abhorrent, and it has been the practice of the California Correctional Police Officers Association; that is, at anytime when their members are on trial for alleged sexual assault, they throw total support behind the defendant's case or their own members rather than doing some kind of neutral investigation to determine whether there is any validity to the allegations, and, if so, then they should be the first ones to say this is not proper conduct.

I want to say a few things about classification, and I know that you have been talking about classification a lot. I am not an expert on classification, technically, but as an expert on mental health and psychiatric services I learned a lot about classification.

First of all, classification is entirely related to the issue of reporting and the issue of

retaliation. It is interesting when the lieutenant this morning spoke, he said the incidence of homosexuality in his jail, and I believe he is from Orange County, is 2 percent. We know that is way low. We know that more than 2 percent of people entering jail are gay because of national

statistics.

Why are gay and lesbian people underreporting their sexual preference? It has to do with what happens to them if they report it. They are put in either protection, which is no easy ride in jail or prison, or they are put in segregation. It must be at least 8 percent of the population is failing to report their gender orientation. They are afraid of the consequences. That is much more so in regard to sexual assault.

The word in the jails and prisons is if you are afraid of retaliation by a perpetrator of prisoner-on-prisoner rape and that perpetrator is well connected, meaning gang or just having friends or just being a senior ranking prisoner, they can get to you anywhere in the system, including protection. I have seen this over and over. Classification breaks down, and where classification breaks down sexual assault happens. Generally, on

average, and this is different in each system, protection is not classified. That is, protection is a category, protective custody of safekeeping, whatever level of protection there is. So one is placed in that category and that is where they sink or swim.

Now if an individual is in a gang and snitches, you are familiar with that term, and the gang outs him, there is a contract on his head, and he asks for protection, he is going to be put in the same protection unit on average as the pedophile, the police officer and the survivor of a prison rape. Those people are all going to end up in protection together. There is going to be no classification in protection. So what I have been asked to do in several occasions is to testify in a case where a rape happened inside protective custody and the perpetrator was a gang member and the victim usually people who are vulnerable to rape and sexual assault or low level offenders. They are not very savvy about crime in the streets and such or they are in for drug charges or minor charges, and they may be in, as we were talking about this morning, with lifers or people who are much more hardened, just vulnerable to sexual assault.

So classification needs to attend to that. So there needs to be a classification system where protection can be granted to the degree.

MR. SEXTON: We keep hearing the same thing over and over. What is the solution? Do we not -- how much time do we spend saying, "Don't come

to jail"? How do we solve this problem that you and everybody else is -- I think we are on the seventh panel. Everybody is saying the same thing. What is the solution? You, Doctor, tell us.

DR. KUPERS: Well, there has to be a wraparound solution. The classification system that exists breaks down with crowding and not enough time is spent. As you heard this morning, if there is an empty bed, someone is going to be placed in it. We need to stop that practice. The reason to stop it is because rapes occur and murders occur.

So classification needs to be taken more seriously. Where it is a problem of insufficient staffing, given the crowd of prisoners, then that situation has to be ameliorated.

MR. SEXTON: Corrections and the sheriff's office doesn't get to answer that. That comes from the budgetary commission, comes from the Legislature, whatever. I can be honest with you.

They don't care.

There is many folks out there, throw them in and throw away the key. There is a lot of folks that have that mentality. But my question is: Given what we have, how do you fix the problem? And the other question is: Eight percent, where is that

figure coming from?

DR. KUPERS: Ten percent of the population is homosexual.

MR. SEXTON: You are quoting a statistic. Where does that come from?

DR. KUPERS: All of the literature. I can't cite you a specific source off the top of my head. That is generally what is the prevalence in the population; 10 percent of population is gay.

MR. SEXTON: The bad news is the population is going up. We are seeing an increase in violent crimes in middle and larger cities. How do we solve the problem? That's what we are here for. How would you recommend solving the problem?

DR. KUPERS: Im going to respectfully agree and disagree. I agree it's not the sheriff's fault or the California Department of Corrections fault. It is the Legislature's and the public, and it is about priorities.

Where I disagree with you is the existence of this panel, for instance, comes out legislation, and it is possible to change the situation. I think our sentencing policies need to be looked at. In California currently a significant number of women are going to do alternative incarceration for minor

offenses. That can be looked at. That will reduce the population.

Unless we reduce the population, the problem isn't going to be solved. That doesn't mean we shouldn't talk about the details of solving the problem. One of the details I am suggesting is classification be more rigorous. For instance, there be classification within protection. So I think that is a step. That you're right, that step alone wouldn't solve the problem.

MR. MCFARLAND: I'm sorry, Dr. Kupers. By classification in protection, do you mean classification for everybody in ad seg?

DR. KUPERS: No. That is another point I want to make. Protection should not involve the deprivation of any amenities or activities that the person is entitled because of classification level. Otherwise, too often protection means segregation. And the problem with that, besides it is just the

inhuman conditions of segregation is that that then causes people not to seek protection because segregation is so toxic for them.

So protection needs to be at a comparable level of programming as that individual would have were they not in protection. That is a very

important point. Unless you correct that problem, people will not seek protection. Then you are going to have vulnerable people being assaulted.

MR. MCFARLAND: What do you mean by classification being more rigorous in protection?

DR. KUPERS: Levels of protection, levels of classification inside protection. So, for instance, the outed gang member is not at the same level of classification within protection, is not on the same yard as the individual who has suffered a sexual assault or has filed -- of the police officer.

MR. SEXTON: I am somewhat confused. If you have a Level I individual who is assaulted, your first time nonviolent offender, he gets assaulted then. So are you going to move your perpetrator, and you are talking about moving them over to ad seg. Then you are talking about basically returning that individual back to a Level I setting.

DR. KUPERS: He should be at the level of custody that his points gain him, independent of protection.

MR. SEXTON: You are talking about protective custody at Level I.

DR. KUPERS: If that is necessary, yes.

Actually, contrary to what we think, intuitively a lot of sexual assaults happen at lower levels in prisons because there is more freedom to that, more dorms.

MR. SEXTON: I understand that. I am not aware, right offhand I am not aware of any protective custody at Level I facilities. I am just -- normally what happens, you're returned back to general pop.

DR. KUPERS: That's right.

MR. SEXTON: Not a protective status. There is not a protective custody in general population.

DR. KUPERS: That's right, and I think that's a problem. I agree with you the whole system needs to be looked at. I am not suggesting a one strike correction. There is a lot of people who are assaulted in that situation exactly because there is no protection. It would not be so difficult to

restructure classification such that people can be given protection, relative protection. Some people need more than others. Some people can manage if they are just in closer observation in a unit that has more direct observation than another unit. Within any institutions the staff know which units

make people more vulnerable and which units give them more supervision.

What I'm saying is I don't have a fix-it proposal about this, but it needs to be looked at very closely so that the classification is done carefully. And it is not the case that everyone who asks for protection is lumped together and gets no further consideration as their individual problems dictate.

MR. MCFARLAND: Are there other ideas you have for solutions? You mentioned classifying within ad seg, reviewing sentencing policies, reducing population and having programming within protection deck so there is not a disincentive.

DR. KUPERS: I want to make one more point that is about consensual sex. I know you hear about this all the time. In order for there to be consensual sex, there needs to be an alternative to having sex. And if an individual who is vulnerable

is frightened in a prison and agrees to consensual sex with someone in order to have protection, in my mind that is not consensual sex.

There needs to be the things I am recommending. For instance, protection such that consensual sex, if it's legal, can happen.

Otherwise there is no consensual sex. What is happening is all the vulnerable prisoners are agreeing to sex in order not to be killed. No, not consensual.

In terms of other solutions -- by the way, Mr. Sexton is right, sentencing is not the prerogative of the sheriff or the Department of Corrections. Sentencing needs to be looked at very clearly. We have massive overcrowding in the prison, and that is leading the problem.

MR. SEXTON: I don't think there is a state that I am aware that does not have some sort of alternative sentencing commission, community corrections. And I hate to be the one to tell you this, but crime is continuing to go up. The problem -- that is why I am asking first for solutions. I don't foresee this going away. We are headed right back where we were in the late '80s and early '90s with our crime trends.

DR. KUPERS: I don't think that's the crime trend. If you look at the differences between states, you will find that the correlations break down. I think the crime rates go up by a point or two. The prison populations go up ten times.

MR. SEXTON: You may want to go look at

the UCR crime rates this year, and then the most recent studies done by Police Executive Research Foundation on major and medium sized cities to the point now the increase over the past year was the highest that we have seen in 14 years.

DR. KUPERS: I would be happy to review with you that information is broken down by states, and what my guess is is that there is no --

MR. SEXTON: Just happen to have a copy of it.

DR. KUPERS: There is no correlation between the states that are increasing at a higher rate than the states that are not, and the crime rate. Actually, there is many variables mixed into that. There is a very complicated discussion about sentencing and crime rates. My point is, yes, states have diversion programs. They are not sufficiently used such that in California the prison population is growing by leaps and bounds. There is

no need that that be the case.

That is not the problem of Department of the Corrections and Rehabilitation. That is a state problem. The Legislature needs to look at it. The public needs to look at it. I think that is my list. I think I will stop there.

I did mention mental health treatment. I think the work of -- your work and the work of providing adequate mental health care -- mental health care includes housing people in a situation that is safe and where they can receive the care they need. So it involves intensity of mental health care as well as protection in the ways they need protection.

MS. ELLIS: Dr. Kupers, one of my contentions is we don't know enough about trauma in our society, whether it's the trauma experience as a result of sexual assault or homicide survival or the impact of crime on robbery victims. We talk about it a lot, but I don't think we really understand it. I would like from your advantage as a psychiatrist to talk briefly about trauma. I know this could take days. I would like for you to give a good solid definition of the social wounds.

DR. KUPERS: Of?

MR. ELLIS: Trauma, the social wound as we see it in victim services, that it is something that gets beneath that skin where we are not protected.

DR. KUPERS: I think I see where you are coming from. And let me just mention that if you study the incidence of past trauma in victims of

crime and perpetrators of crime, you will find that the numbers are extremely high. So for instance, people going to prison, the published statistics by the federal Bureau of Justice Statistics is 56 percent of women entering prison have been physically or sexually abused in the past. I think that a comparable figure would fit the crime victim group.

So what we've got is massive trauma in our society, and it is perpetrated against children, which is the most damaging aspect of it. Within that context, people are doing crimes against each other. Some people are the victims of crime and some people are perpetrators. We need to do something about trauma. It involves poverty. It involves domestic violence. It involves illicit substances. Those problems need to be addressed so people can grow up in a society without the prominence of trauma that we now have. Yes, we have

prominence of trauma in victims who are retraumatized by the crime, and we have trauma in the criminals who perpetrate the crimes. We need to attend to the trauma. Because unattended to, the results of trauma in terms of a psychological realm is repeat trauma of one kind or another, either

revictimization or becoming a perpetrator in terms of acting out the past trauma. It is a very large problem, a problem in our society.

I think there has been more attention to that lately. It is known how many people in prison have a history of trauma. Complex posttraumatic stress disorder is a diagnosis not yet in the DSM, which represents the problem of people who have multiple traumas. And I think that is a very important new angle in psychiatry, and I agree it is a very big problem and we need to pay attention to it.

MR. ELLIS: We need a lot of time educating regarding trauma.

DR. KUPERS: Absolutely.

MS. ELLIS: Let me ask you in terms of race. We have been talking a lot about culture. We have been talking about what goes on inside the walls, so to speak, and I want to ask you to discuss the issue of race in the prisons and also with

respect to the impact on society at large because I think we have to remember that originally the legislation regarding PREA that kind of drove this whole idea had a lot to do with information gathered about society and concerns of society from a health standpoint, from a mental health standpoint as well.

If you will, would you please address that issue?

DR. KUPERS: I would be happy to. I assume I have a very short time because we have two other distinguished speakers.

David Thatcher was the Surgeon General under Clinton. He was a colleague of mine at Charles Drew Medical School at the beginning of my career.

He placed racism and racial discrimination at the absolute top of the list of public health hazards, not just psychiatry hazards. Race matters quite a bit in terms of suffers from what disease and what treatment they get, whether they fall into poverty or not, et cetera. Certainly race is a pervasive concept in our society and the prison population itself reflects the problem.

We have -- just about 50 percent of prisoners are African-American, way beyond their proportion in

the community. What I find in prison is that there are racial tensions, and the reason there are racial tensions is because people are frustrated and dissatisfied and angry, and they are going to take it out on someone, across some line, and they will manufacture the line. So the younger people are

attacking the older people. The straight ones are attacking the gay ones. And race becomes the most obvious line across which the battles ensue.

So when you have crowding, which causes violence, including increased rape, it tends to happen across racial lines. That is where it all breaks down. But I wouldn't say that the race difference is what caused the problem. I would just say that becomes the nidus [phonetic] or where the whole thing breaks down.

MR. SEXTON: I have a quick question, please. You mentioned staff being a problem in their allowing these things to go on. Have you interviewed any staff in your psychological evaluations?

DR. KUPERS: Yes, I have.

MR. SEXTON: Are they traumatized by the action of inmates towards them?

DR. KUPERS: Often they are, of course.

Correct.

MR. SEXTON: They are victims inside the wall.

DR. KUPERS: Everybody is a victim or a perpetrator, yes. I am not trying to blame staff. I don't think -- I think staff -- the more I talk to

staff around the country about the problems of prisoners with mental illness, the more I hear universally is the complaint I don't want to be taking care of people who are crazy, who have mental illness. I am not trained to do it. I don't want to be doing it. Some of those staff beat up those people with mental illness, and I think it happens out of frustration or meanness or whatever.

Whatever reason there is for it, it is not okay. It is abusive. It should not be allowed. I don't blame the prison staff for the awful things that happen in prison. Some of them perpetrate very abusive acts, and they should be punished for that and not allowed to take care of people in prison. But on the most part, prison officers and staff are public servants trying to do a job. They become frustrated by the very things we are talking about: crowding, racial tensions, lack of resources to treat people with mental illness. And abuses occur.

They should be properly investigated, and there should be whatever proper recourse we establish as a society.

MR. SEXTON: Thank you.

MR. MCFARLAND: Dr. Kupers, I was fascinated by your testimony on Page 5 about the

proclivity of victims of sexual assault who have some serious mental disabilities and what their reaction or how they react to that trauma.

Do I understand correctly that it's been your experience and your professional opinion that when they are traumatized by sexual assault they would become delusional and actually -- if they would -- if they have that, whatever their mental problem was it gets worse, and if they were prone to depression and suicide, it would exacerbate as opposed to becoming necessarily aggressive or defensive of themselves or acting out against somebody else.

DR. KUPERS: That's essentially correct. The point I was making in response to your question was we have a condition, posttraumatic stress disorder, which we have by convention made into a psychiatric diagnosis subsequent to trauma, and we define trauma. Now if you looked at the history of people suffering from schizophrenia or bipolar

disorder, what you will find is repeated severe traumas. But they don't present clinically as suffering from posttraumatic stress disorder. The nightmares and flashbacks aren't as prominent in their symptom picture as are hallucinations and other signs and symptoms of schizophrenia or bipolar

disorder. That is the point I was making. The population of people who've been traumatized is much larger than that population who technically fit the diagnosis of PTSD. In fact, the population of people with serious mental illness trauma is very pervasive.

MR. MCFARLAND: One of your solutions that you recommended is separate housing?

DR. KUPERS: Yes. Part of the treatment for posttraumatic stress disorder is the first step in Herman's book Trauma and Recovery is safety. We have to first establish safety. Someone who has been raped in prison is not safe. I will guarantee you that, for whatever reason, whether it is the perpetrator is going to retaliate if they report or that the same process is in effect under which they got raped; that is, they are vulnerable for some reason. Their reputation is such that they are going to be raped again. They are not safe. They

have to be provided safety. The same is true of anyone suffering from a mental illness. They are more vulnerable than others, and they need a treatment that takes first into consideration their safety.

So separate units, step down units in prison,

which can be separate wings or separate units for people who are suffering from mental illness. Treatment might be a little more intensive, not as intensive as a crisis center or a hospital. California is doing that in administrative segregation.

The first step, there are problems in mental health in the California Department of Corrections and Rehabilitation. The first step is to separate people with serious mental illness from those that don't have mental illness. And part of the reason is because it wasn't good for the people who don't suffer from serious mental illness to be next door to someone who is up screaming all night.

Currently in California I believe the administrative segregation units are split such that the people with mental illness are in a separate pod or unit than the others.

MR. SEXTON: I thought there was a

separate mental health unit here in Folsom.

DR. KUPERS: That's correct. That's not what I am talking about. There is a lot of people, over 50 percent of the prisoners according to the federal Bureau of Justice, some of them serious. Some of them are in the EOP program, which is what I

think you toured if you saw the program here. Some of them are in administration segregation units elsewhere throughout the system. And the point is that there has been a policy change because of recognizing the problem of mixing people with mental illness and people that don't. That administrative segregation units are split. Maybe someone from the Department can explain that better for you, explain that better, more detail.

MR. MCFARLAND: Thank you very much, Dr. Kupers. You, of course, are welcome to stay as long as you can.

Our next witness is Robert Dumond, and he has provided us with written testimony which we have read. He is a board certified, licensed clinical mental health counselor with a specialty in exactly the subject we're talking about. We are privileged to have you, Mr. Dumond.

MR. DUMOND: Thank you very much. I want