PREA AUDIT REPORT ☐ INTERIM ☒ FINAL

JUVENILE FACILITIES

Date of report: 11-23-2016

Auditor Information			
Auditor name: David "Will" Weir			
Address: PO Box 1473; Raton NM 87740			
Email: will@preaamerica.com			
Telephone number: 405-945-1951			
Date of facility visit: October 11, 2016			
Facility Information			
Facility name: Great Lakes Recovery			
Facility physical address: 104 Malton Rd., Negaunee, MI 49866			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 906-228-4692			
The facility is:	☐ Federal	☒ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	☐ Private not for profit		
Facility type:	☐ Correctional	☐ Detention	☒ Other
Name of facility's Chief Executive Officer: Jamie Dieterle			
Number of staff assigned to the facility in the last 12 months: 26			
Designed facility capacity: 20			
Current population of facility: 10			
Facility security levels/inmate custody levels: non-secure			
Age range of the population: 12-17			
Name of PREA Compliance Manager: Natalie Patron		**Title:** Supervisor	
Email address: npatron@greatlakesrecovery.org		**Telephone number:** 906-228-4692 ex. 2405	
Agency Information			
Name of agency: Michigan Department of Health and Human Services			
Governing authority or parent agency: *(if applicable)* Click here to enter text.			
Physical address: 235 S. Grand Ave., Lansing, MI 48909			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: 517-335-3489			
Agency Chief Executive Officer			
Name: Nick Lyon		**Title:** MDHHS Director	
Email address: Nancy Grijalva, AA to Director GrijalvaN@michigan.gov		**Telephone number:** Nancy Grijalva (517) 241-1193	
Agency-Wide PREA Coordinator			
Name: Patrick Sussex		**Title:** PREA Juvenile Coordinator / Program Mgr.	
Email address: sussexp@michigan.gov		**Telephone number:** 517-648-6503	

AUDIT FINDINGS

NARRATIVE

PREAmerica LLC was retained in April 2016 to perform the Great Lakes Recovery Center PREA Audit. Michigan PREA Juvenile Coordinator/Program Manager Patrick Sussex facilitated the process. Notices of the on-site audit were posted by 09-30-2016 and the Pre-Audit Questionnaire was received 09-22-2016. The on-site audit was conducted as planned on October 11, 2016. PREAmerica Auditor Will Weir and Project Manager Tom Kovach met with Agency Juvenile PREA Coordinator Patrick Sussex, Director of Children's Services Jamie Dieterle, and PREA Compliance Manager Natalie Patron that morning, participating in a meeting and a tour of the facility. The Audit Team was provided with rosters of residents and staff and began random interviews with residents and staff, document reviews. An exit conference at the conclusion of the on-site audit. The audit team interviewed a total of 11 administrators and staff, including specialized and administrative staff. All 10 residents of the facility were interviewed. The auditor team were impressed by the professionalism of the staff, the organizational skills of the administration, and the positive morale of the residents. Other positives discussed during the exit conference was the nearly constant availability of therapists to residents, the excellent PREA training provided to residents, and the rich slate of programming offered to residents including art and equine therapy, a greenhouse, and much more. This facility sits on 29 beautiful acres. There are weekly team meetings for staff to insure they are updated regarding every resident, providing a level of communication and transparency between team members that is only aspired to in many organizations.

Partial list of documents reviewed: Mission Statement; building schematic; rosters of staff and residents; investigations and notifications; Email communications from PREA Coordinator, Compliance Manager, and Director; Random HR files; First Responder Duties; PREA Policies; Search Policies; Grievance Policies and forms; Screening, Hiring, and Employment Policies; Employment Application and Follow-Up Questions; Visitation Policy and Rules; DHHS Division of Child Welfare Licensing Reports; Coordinated Response; Random examples of PREA Intake [Risk] Assessment; MOU with Women's Center; MOU with Negaunee City Police; PREA Pre-Audit Questionnaire; Youth Orientation Packet; audit postings; third party reporting postings; advocacy and PREA reporting postings and notices; Organizational Chart; Mission Statement; Staff Training Curriculum and documentation; Refresher Training and verification; Notice of Zero Tolerance Policy for Volunteers, Contractors, and Interns (along with training packet and signature page); Staffing Plan; Staffing Plan Review; Resident PREA Training; Unannounced Rounds Log; Interpreter/Translator Services in DHHS Administrative Policies for Facilities/Hospital; Verification that Marquette General Hospital does SANE Exams; and Facility and Agency Annual Reports.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Great Lakes facility is a large mostly rectangular building located on the edge of verdant grounds with a forest and historical walking trail. It has video monitoring recording system. The entrance has a security door that leads to the comfortable lobby with a living room like atmosphere and includes a fireplace. There is an office to the right and three rooms set aside for The Great Lakes Recovery Look Uncover Nurture and Act (LUNA) Neuro-Trauma Assessment program. These offices have observation areas and two interview rooms. The building surrounds an exterior courtyard.

Past the LUNA offices are a utility closet, restroom, weight room and Community Outreach room with a large screen for remote doctor visits. There is an office next to the large classroom. This leads to the lounge area. The lounge is adjacent to and observation office and client rooms and laundry. There are 4 multiple occupancy cell housing units with bathrooms in this area.

The dining area has kitchen and storage areas which are off limits to residents. The mechanical room is next, just before the second lounge area, and there are another set of 4 multiple occupancy units with bathrooms. The multipurpose room opens off from the lounge and to the six staff and administrative offices. The medical room is just before the lobby, completing the rectangle.

SUMMARY OF AUDIT FINDINGS

On October 11, 2016, PREAmerica, LLC, DOJ certified PREA auditor Will Weir conducted an onsite audit at Great Lakes Recovery Center in Negaunee, Michigan, to determine the facility's compliance with the Standards of the Prison Rape Elimination Act. Great Lakes Recovery Center was found to be compliant with the Standards.

Number of standards exceeded: 1

Number of standards met: 40

Number of standards not met: 0

Number of standards not applicable: 0

Standard 115.311 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

Great Lakes Recovery Center has a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment, and a policy outlining how it will implement the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment. The policy includes definitions of prohibited behaviors regarding sexual abuse and sexual harassment and it includes sanctions for those found to have participated in prohibited behaviors. The policy includes a description of agency strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents. According to Director of Children's Services Jamie Dieterle and Program Supervisor/PREA Compliance Manager Natalie Patron, as well as interviews with staff and residents, the facility has an ongoing commitment to zero tolerance and safety. Ms. Patron has sufficient time and authority to develop, implement and oversee facility efforts to comply with the PREA standards. State of Michigan DHHS JJP PREA Coordinator Patrick Sussex also indicates he has sufficient time and authority to do this work on the statewide level. Organizational Charts were provided to the auditor. The zero tolerance policy is mentioned throughout agency and facility policies as well an in postings around the facility and in written materials given to residents and staff. Policy GLO149.0 Reporting of Sexual Contact states on page 2, "Residential juvenile justice staff must have zero tolerance for sexual abuse and sexual harassment of residents. Facilities must ensure that preventive plans are in place and, should allegations regarding sexual abuse or harassment be made, that staff are appropriately trained to take actions to rapidly restore safety, attend to and support the victim, and promptly initiate the investigative process."

Standard 115.312 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

Great Lakes Recovery does not contract for the confinement of its juveniles but the State of Michigan does. PREA Standards state that a public agency that contracts for the confinement of its residents with private agencies or other entities, including other government agencies, shall include in any new contract or contract renewal the entity's obligation to adopt and comply with the PREA standards. This standard applies to Michigan DHHS, and the agency requires PREA compliance. Standard language for contracts is as follows:
"The contractor shall comply with all provisions of the Prison Rape Elimination Act (PREA). Compliance with PREA will be monitored by [Michigan Department of Human Services Bureau of Children and Adult Licensing] BCAL. Actions should be taken and documented that: (a) Ensure staff training on PREA compliance; (b) Ensure a readily available objective reporting and investigation procedure; (c) Ensure youth knowledge of PREA regulations; and (d) Ensures all volunteers, employees, contractors and other regular facility visitors with resident contact have been screened in compliance with PREA standards."

Standard 115.313 Supervision and monitoring

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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A review of policy, staffing plans, staffing plan reviews, and unannounced rounds logs indicate the GLR Center exceeds this Standard. The facility develops, documents, and makes its best efforts to comply with a staffing plan that provides for adequate levels of staffing to protect residents against abuse. In calculating adequate staffing levels and determining the need for video monitoring, it takes into consideration: Generally accepted juvenile detention and residential practices; Any judicial findings of inadequacy; Any findings of inadequacy from Federal investigative agencies; Any findings of inadequacy from internal or external oversight bodies; All components of the facility's physical plant (including "blind spots" or areas where staff or residents may be isolated); The composition of the resident population; The number and placement of supervisory staff; Institution programs occurring on a particular shift; Any applicable State or local laws, regulations, or standards; The prevalence of substantiated and unsubstantiated incidents of sexual abuse; and Any other relevant factors. In the past 12 months the average daily number of residents has been 8, less than the number of residents on which the staffing plan was predicated which was 20, with no deviations from the ratios in the last 12 months. 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 monitoring technology, or the allocation of agency or facility resources to commit to the staffing plan to ensure compliance with the staffing plan. The facility requires that intermediate-level or higher-level staff conduct unannounced rounds to identify and deter staff sexual abuse and sexual harassment. GLR Center documents unannounced rounds on all shifts with a prohibition of staff alerting other staff of the conduct of the rounds. Documentation of these rounds were reviewed by the audit team. Great Lakes Recovery Center exceeds both DHHS and PREA minimum requirements for staffing by having a staff-to-youth ratio of 1:6 during waking hours and 1:8 during sleeping hours. PREA Standards require 1:8 and 1:16.

The Staffing Plan and Review states, in part,

"Great Lakes Recovery requires minimum direct care staff to youth ratios of 1 :6 during waking hours and 1 :8 during sleeping hours. These minimum ratios must be met at all times except in the case of unforeseen and temporary circumstances. Any time that the minimum staffing ratios are not met the circumstances must be documented in an incident report that lists the reason(s) and the duration that the minimum staff-to-youth ratio was not met and any actions taken to correct the situation. This exceeds requirements as set forth in Michigan regulations and in PREA. Great Lakes Recovery is a non-secure facility.

In practice, GLR Youth Residential Services will frequently exceed generally accepted secure residential practices during the daytime by having additional Administrative and support staff on duty. These staff will only be considered in the staff-to-youth ratio when they are directly observing youth. Any staff considered in the staff-to-youth ratio must have received appropriate training in crisis intervention, PREA, and first aid.

Direct care staffs are required to maintain line-of-sight supervision of youths at all times except when youth are in their sleeping rooms, or performing bodily functions such as showering, changing clothes, or using the toilet. During sleeping hours, staff must make frequent, random checks on youths. Staff must complete a minimum of 25 hours of training annually, including training on delivery of programming specific to the composition of the resident population, crisis intervention training, and training on preventing, detecting, and responding effectively to sexual abuse and sexual harassment of youth."

The applicable portions of this staffing plan have been in place well over 12 months.

GRL PREA Policy Section I, #6: " Mid or upper level Supervision must make documented unannounced rounds to identify and deter staff sexual misconduct and sexual abuse."

Standard 115.315 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

The facility does not conduct cross-gender searches of residents. Interviews indicate this policy has not been violated, and there has not been exigent circumstances requiring cross-gender searches. The facility policy requires that all cross-gender strip searches, cross-gender visual body cavity searches, and cross-gender pat-down searches be documented and justified if they occur. Policies and procedures require staff of the opposite gender to announce their presence when entering a resident housing unit or area where residents are likely to be showering, performing bodily functions, or changing clothing. The facility has a policy prohibiting staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. No such searches occurred in the past 12 months. Interviews conducted (of both staff and residents), and documentation received, indicate staff are properly trained, cross gender staff are announced, and searches are conducted consistently and according to policy.
Policy citations: GRL PREA Policy Section C, #4-5; GLR PREA Policy Section D, #4-5; and GLR PREA Policy Section B, #6.

Standard 115.316 Residents with disabilities and residents who are limited English proficient

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

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 and sexual harassment. The agency has established procedures to provide residents with limited English proficiency 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. 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 under ß 115.364, or the investigation of the resident's allegations. In the past 12 months, there have been no instances where 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 under ß 115.364 or the investigation of the resident's allegations. Staff and residents indicate the agency will go the extra mile to assist anyone to understand what they need to understand in order to be safe and exercise their rights. Many residents have cognitive deficits, mental illness, and learning difficulties. Staff interviews and GLR Center policy reviews indicate these efforts have been required and practiced in the agency culture for a number of years. Policy citations: GLR PREA Policy Section A, #2; and, Interpreter/Translator Services in DHHS Administrative Policies for Facilities/Hospital.

Standard 115.317 Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

The facility 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 (as defined in 42 U.S.C. 1997); 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 above. The facility 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. GLR Center policy requires that before it hires any new employees who may have contact with residents, it conducts criminal background record checks, consults any child abuse registry maintained by the state or locality in which the employee would work; and consistent with Federal, State, and local law, makes their 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. During the past 12 months all staff and contract persons who may have contact with residents have had criminal background record checks. The facility policy requires that either criminal background records checks be conducted at least every two years (PREA Standard requires this every 5 years) of current employees and contractors who may have contact with residents or that a system is in place for otherwise capturing such information for current employees. The Agency policy states that material omissions regarding such misconduct or the provision of materially false information, shall be grounds for termination. Unless prohibited by law, the facility will 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. Compliance with this standard was verified through a close reading of policy and other documentation provided, such as the employment application and related paperwork, as well as a review of random personnel files pulled at the auditor's request, and through interviews with administrators, including the HR Director.

Standard 115.318 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

GLR Center has not acquired a new facility or made a substantial expansion or modification to existing facilities in the past 12 months and has not installed or updated a video monitoring system, electronic surveillance system or other monitoring technology. Documentation provided, as well as interviews with administrators, indicate PREA will be considered when updates occur in the future. The video monitoring system was demonstrated during the facility tour, and is expandable.

Standard 115.321 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

The agency/facility is responsible for conducting administrative or criminal sexual abuse investigations (including resident-on-resident sexual abuse or staff sexual misconduct). Child Protective Services, local law enforcement and district attorneys have the criminal investigative responsibilities. When conducting a sexual abuse investigation, the investigators follow a uniform evidence protocol that is developmentally appropriate for youth and 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. As verified by policy and interviews with DHHS PREA Coordinator Patrick Sussex, GLR PREA Compliance Manager Natalie Patron and Director Jamie Dieterle, all residents who experience sexual abuse have access to off site forensic medical examinations. These examinations are offered without financial cost to the victim and are conducted by Sexual Assault Forensic Examiners (SAFEs) or (SANEs) at Marquette General Hospital Emergency Room. When SANEs or SAFEs are not available, a qualified medical practitioner performs forensic medical examinations. The facility documents efforts to provide SANEs or SAFEs. These PREA Policies and Procedures were verified in line staff interviews as well. No forensic medical exams have been performed during the past 12 months because there were no allegations indicating an exam. The facility attempts to make a victim advocate from a rape crisis center available to the victim, in person or by other means and these efforts are documented. If they are not available to provide victim advocate services, the facility provides a qualified staff member. The facility maintains MOU's with the Women's Center and the Police Department to support these efforts.

Standard 115.322 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

GLR Center ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. In the past 12 months no allegations of sexual abuse or sexual harassment were received. The facility has a policy that requires that all 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 potential criminal behavior. The agency documents all referrals of allegations of sexual abuse or sexual harassment for criminal investigation. Interviews of staff and residents indicated there have been no allegations, and that staff and residents believe allegations will be taken seriously. MOU with police department reviewed. Policy citation: GLR PREA Policy Section H.

Standard 115.331 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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As verified by interviews with staff and documentation of their understanding of training received, the audit team verified that the facility trains all employees who may have contact with residents on the following required matters: zero-tolerance policy for sexual abuse and sexual harassment; how to fulfill responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures; residents' right 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 juvenile facilities; the common reactions of juvenile victims of sexual abuse and sexual harassment; how to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents; how to avoid inappropriate relationships with residents; how to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents; and how to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities, and including relevant laws regarding the applicable age of consent. Such training is tailored to the gender, as well as any unique needs and attributes of residents. Between trainings, the facility provides employees with refresher information about current policies regarding sexual abuse and sexual harassment in handouts and staff meetings. Policy: GLR PREA Policy Section C

Standard 115.332 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Volunteers and contractors who will have contact with residents have been trained on their responsibilities regarding sexual abuse and sexual harassment prevention, detection and response. The level and type of training provided to volunteers and contractors is based on the services they will provide and level of contact they will have with residents. All volunteers and contractors who will have contact with residents will have at least been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents. The agency maintains documentation confirming that volunteers/contractors understand the training they have received. The audit team reviewed the training materials as well as the signed documentation of understanding of the training. One handout given to every contractor and volunteer includes these statements:

"1. Great Lakes Recovery Centers has a zero tolerance policy regarding sexual abuse. Great Lakes Recovery Centers fully subscribes to the rules and practices set forth in the Prison Rape Elimination Act.

2. Volunteers/Contractors/Student Interns fall under the same policies and procedures as staff in regard to boundaries and contact. Volunteers/Contractors/Student Interns must not have physical contact with the youths beyond a simple handshake, excepting contact necessary and appropriate to perform required functions such as cutting hair or providing medical or dental services.

Volunteers/Contractors/Student Interns are not allowed to be isolated with a youth at any time. Volunteers/Contractors/Interns will not impede line of sight supervision by staff.
3. Volunteers/Contractors/Student Interns must not disclose their personal addresses or telephone numbers to youths. Volunteers/Contractors must not allow the residents to send mail through them, use cell phones, or make contact with anyone outside of the facility through them.
4. Volunteers/Contractors/Student Interns must not disclose information of a personal nature to youths. Discussion topics will be general and will be youth oriented. If a resident says or does anything that the Volunteers/Contractors/Student Interns thinks inappropriate, the Volunteers/Contractors/Student Interns must notify a staff member immediately.
5. Youth and Volunteers/Contractors/Student Interns are not allowed to write or telephone each other while the youth is in the facility.
6. Volunteers must consult with the youth's worker if the volunteer wants to continue having contact with the youth following release from Great Lakes Recovery Centers. Great Lakes Recovery Centers will not in any way approve, promote, or facilitate those contacts.
7. No other visitors may attend a visit at Great Lakes Recovery Centers with the Volunteers/Contractors/Student Interns, such as relatives, children, etc.
8. Volunteers/Contractors/Student Interns must stay in designated areas only. Bathrooms are available.
9. Volunteers/Contractors/Student Interns must not give anything to the youth during visits, including food items, treats, candy, and gum, excepting items as appropriate and required for medical and dental treatment. Volunteers/Contractors/Student Interns may not bring cell phones, tobacco products, drugs or substances of any sort, or weapons into the facility. Medical personnel may possess communication devices necessary for their professional practice.
10.Volunteers/Contractors/Student Interns are allowed inside the facility only as scheduled by the Social Workers, Administration, or other authorized facility personnel.
11. If Volunteers/Contractors/Student Interns suspect sexual abuse they must immediately report to facility staff.
12.Volunteers/Contractors/Student Interns must verify by their signature that have read and understand these rules and procedures, and that they have read and understand Great Lakes Recovery Centers' policy on prevention of resident sexual abuse."

Standard 115.333 Resident education

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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GLR Center residents receive information at the time of intake about the zero-tolerance policy and how to report incidents or suspicions of sexual abuse or sexual harassment. The facility provides resident education in formats accessible to all residents, including those who are limited English proficient, deaf, visually impaired or otherwise disabled, as well as to residents who have limited reading skills. The facility also ensures that key information is continuously and readily available or visible to residents through posters, resident handbooks or other written formats, including an excellent handout. All residents admitted during the past 12 months have received this information in an age appropriate fashion, according to interviews and information provided. Many have received the information at previous placements as well. The facility maintains documentation of resident participation in PREA education sessions and this was provided to the auditor.
Policy citation: GLR PREA Policy Section A

Standard 115.334 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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GLR Center does its own administrative but not criminal investigations. The State of Michigan requires that investigators are trained in conducting sexual abuse investigations in confinement settings. Specialized training includes techniques for interviewing juvenile sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings and the criteria and evidence required to substantiate a case for administrative action or prosecution referral. Investigating agencies are required to maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations. Documentation reviewed and interviews with administrators, verify that GLR Center does not conduct criminal sexual abuse investigations at this time, but it cooperates with authorities and collects information needed to make determinations regarding resident treatment and safety. The facility employs 2 trained PREA investigators.

Standard 115.335 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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DHHS and GLR Center both have written policies related to the training of medical and mental health practitioners who work regularly in its facilities. The training includes: How to detect and assess signs of sexual abuse and sexual harassment; How to preserve physical evidence of sexual abuse; How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment; and How and to whom to report allegations or suspicions of sexual abuse and sexual harassment. During interviews these staff, including the PREA Coordinator, demonstrated a general understanding of the processes utilized by medical and forensic professionals, although GLR Center does not perform forensic exams. GLR PREA Policy Section C, #6 states, "All full and part time medical and mental health care practitioners who work regularly with residents must receive specialized training on: Detecting signs of sexual abuse, preserving physical evidence, effective response, and reporting. Training will be documented in personnel records."

Standard 115.341 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

GLR Center has a policy that requires screening (upon admission to the facility or transfer from another facility) for risk of sexual abuse victimization or sexual abusiveness toward other residents. The policy requires that residents be screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their intake. Such assessments are conducted using an objective screening instrument. At a minimum, the facility attempts to ascertain information about: (1) Prior sexual victimization or abusiveness; (2) Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse; (3) Current charges and offense history; (4) Age; (5) Level of emotional and cognitive development; (6) Physical size and stature; (7) Mental illness or mental disabilities; (8) Intellectual or developmental disabilities; (9) Physical disabilities; (10) The resident's own perception of vulnerability; and (11) Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions or separation from certain other residents. This information is ascertained through conversations with the resident during the intake process and medical and mental health screenings; during classification assessments; and by reviewing court records, case files, facility behavioral records and other relevant documentation from the resident's files. Controls are in place 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. Interviews indicate that all residents are screened and the facility is reassessing when a resident is high risk and when new information regarding risk factors come to their attention.

Standard 115.342 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

GLR Center uses information from the risk screening required by ß115.341 to inform housing, bed, work, education and program assignments. The facility prohibits placing lesbian, gay, bisexual, transgender, or intersex residents in particular housing, bed or other assignments solely on the basis of such identification or status. The facility prohibits considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive. The agency or facility makes housing and program assignments for transgender or intersex residents in the facility on a case-by-case basis. The facility uses all information obtained pursuant to § 115.341 and subsequently to make housing, bed, program, education and work assignments for residents with the goal of keeping all residents safe and free from sexual abuse. Residents may be isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe and then only until an alternative means of keeping all residents safe can be arranged. Placement and programming assignments for each transgender or intersex resident shall be reassessed at least twice each year to review any threats to safety experienced by the resident. A transgender or intersex resident's own views with respect to his or her own safety shall be given serious consideration. Transgender and intersex residents shall be given the opportunity to shower separately from other residents. Interviews indicate there are no openly LGBTI residents at the facility at this time. Policy citations include GLR PREA Policy Section B.

Standard 115.351 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the

relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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.

The agency and facility 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 facility provides at least one way for residents to report abuse or harassment to a public or private entity or office that is not part of the facility. This is accomplished through the DHHS hotline: 1-855-444-3911 or calling Child Protective Services. There are no residents detained solely for civil immigration purposes at this time. 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. Staff are required to document verbal reports by the end of their shifts. The facility does provide residents with access to tools to make written reports of 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 agency has also established procedures for staff to privately report sexual abuse and sexual harassment of residents. Policy citations include: GLR PREA Policy Section D and GLR PREA Policy Section F #1-2. PREA Mandated Reporter website link: http://www.michigan.gov/mdhhs/0,5885,7-339-73971_7119_50648_44443-157836--,00.html

Standard 115.352 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

The facility has an administrative procedure for dealing with resident grievances regarding sexual abuse. The facility policy allows a resident to submit a grievance regarding an allegation of sexual abuse at any time regardless of when the incident allegedly occurred. There is no time limit for a resident to submit a grievance regarding an allegation of sexual abuse, and the resident is not required to use an informal grievance process, or otherwise to attempt to resolve with staff, an alleged incident of sexual abuse. The facility's policy allows a resident to submit a grievance alleging sexual abuse without submitting it to the staff member who is the subject of the complaint. The facility's procedure requires that a resident grievance alleging sexual abuse not be referred to the staff member who is the subject of the complaint. The facility has policy that 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 facility notifies the resident in writing when the agency files for an extension, including notice of the date by which a decision will be made. The facility policy 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. Policy requires that if the resident declines to have third-party assistance in filing a grievance alleging sexual abuse, the agency documents the resident's decision to decline. Policy allows legal guardians of residents to file a grievance, including appeals, on behalf of such resident, regardless of whether or not the resident agrees to having the grievance filed on their behalf. The agency has a policy for filing an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse. These emergency grievances require an initial response within 48 hours and that a final agency decision be issued within 5 days. Interviews conducted, and documentation received, indicate there have been no grievances alleging substantial risk of imminent sexual abuse that were filed in the past 12 months. The agency has a 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. Policy citations include: GLR PREA Policy Section J; GLR PREA Policy Section E, #4; GLR PREA Policy Section G; GLR PREA Policy Section A #1(g).

Standard 115.353 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

The facility provides residents access to outside victim advocates for emotional support services related to sexual abuse by giving residents (posting, or otherwise making accessible) mailing addresses and telephone numbers (including toll-free hotline numbers where available) of local, State or national victim advocacy or rape crisis organizations. In addition, these are provided by the SANE nurse at Marquette Hospital in the event there is a forensic exam. The auditor verified the Referral and Qualified Service Agreement between GLR Center and the Women's Center by interviewing the Executive Director of the Women's Center by phone. The Women's Center is happy to partner with GLR Centers. She verifies services are in place and states there have not been calls received or concerns raised, regarding any abuse or harassment at GLR Center. Policy reference includes GLR PREA Policy Section E, #1.

Standard 115.354 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

The agency provides a method to receive third-party reports of resident sexual abuse or sexual harassment. Policy clearly states any staff can take complaints and that complaints can be anonymous. Anyone can call the Michigan reporting line by calling 855-444-3911. In addition, the facility distributes information on how to report resident sexual abuse or sexual harassment on behalf of residents by posting notices and posters in public areas. Also, DHHS agency website explains ways to report: http://www.michigan.gov/mdhhs/0,5885,7-339-73971_7119_50648_44443-157836--,00.html

Standard 115.361 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

Interviews with staff and administrators, as well as a review of policy, verify that all staff are required to report immediately: 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. They also must report any retaliation against residents or staff who reported such an incident. They must report staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. The agency requires all staff to comply with all applicable mandatory child abuse reporting laws. 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. Medical and mental health professionals are required to report sexual abuse to designated supervisors, as well as to the designated State or local services agency where required by mandatory reporting laws. Such practitioners shall be required to inform residents at the initiation of services of their duty to report and the limitations of confidentiality. Upon receiving any allegation of sexual abuse, the facility head or his or her designee will promptly report the allegation to the appropriate agency office and to the alleged victim's parents or legal guardians, unless the facility has official documentation showing the parents or legal guardians should not be notified. If the alleged victim is under the guardianship of the child welfare system, the report is be made to the alleged victim's caseworker instead of the parents or legal guardians. If a juvenile court retains jurisdiction over the alleged victim, the facility head or designee will also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation. The facility shall report all allegations of sexual abuse and sexual harassment, including third party and anonymous reports, for investigation. Policy referenced includes GLR PREA Policy Section F, #1-2 and GLR PREA Policy Section H, #1(i).

Standard 115.362 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

When the facility learns that a resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident. Interviews indicate staff take this responsibility seriously. In the past 12 months, there were no times the agency or facility determined that a resident was subject to substantial risk of imminent sexual abuse. GLR PREA Policy Section G states, "The facility Director or designee must take immediate steps to protect the alleged victim from further potential sexual assault or rape (if still at the facility) by separating the alleged victim from the alleged perpetrator(s) including arranging for separate housing, dining, and/or other elements of daily routine to the extent necessary to ensure protection. These same protections must also be provided to youth(s) believed to be in imminent danger of sexual abuse."

Standard 115.363 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

GLR Center has a policy, verified by the director, requiring that, upon receiving an allegation that a resident was sexually abused while confined at another facility, the Director, as soon as possible (but no later than 72 hours), must notify the head of the facility or appropriate office of the agency or facility where sexual abuse is alleged to have occurred. The agency documents that it has provided such notification within 72 hours of receiving the allegation. The agency/facility policy requires that allegations received from other facilities/agencies are investigated in accordance with the PREA standards. In the past 12 months, there has been one allegation of sexual abuse or harassment investigated regarding another facility.

Standard 115.364 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

The facility has a first responder policy for allegations of sexual abuse. The agency policy requires that, upon learning of an allegation that a resident was sexually abused, the first security staff member to respond to the report shall be required to: preserve and protect any crime scene until appropriate steps could be taken to collect any 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; 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. In the past 12 months there were no allegations of sexual abuse. Interviews with staff indicate they understand first responder duties. Training logs and training curriculum indicate all these duties are covered in training.

Standard 115.365 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

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; and this was provided to the auditor and reviewed.

Standard 115.366 Preservation of ability to protect residents from contact with abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

GLR Center is not part of a Collective Bargaining Contract and maintains its ability to protect its residents and employees from abusers.

Standard 115.367 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

GLR Center has a protocols to protect all residents and staff or any cooperating individual who reports sexual abuse or sexual harassment or cooperates with sexual abuse or sexual harassment investigations from retaliation by other residents or staff. All mid and upper level management are in charge of monitoring for possible retaliation. They monitor the conduct or treatment of residents or staff who reported sexual abuse 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. They examine resident disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff. They understands their responsibilities require them to continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need. In the case of residents, such monitoring will also include periodic status checks. The agency/facility acts promptly to remedy any such retaliation.

Standard 115.368 Post-allegation protective custody

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

The facility has a policy that residents who have alleged to have suffered sexual abuse may only be placed in isolation as a last resort if less restrictive measures are inadequate to keep them and other residents safe, and only until an alternative means of keeping all residents safe can be arranged. The facility policy requires that residents who are placed in isolation because they allege to have suffered sexual abuse have access to legally required educational programming, special education services, and daily large-muscle exercise. In the past 12 months no residents who have alleged sexual abuse have been placed in isolation or segregated.

Standard 115.371 Criminal and administrative agency investigations

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

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.

GLR Center has a policy related to criminal and administrative agency investigations. Negaunee City Police have agreed in writing to conduct criminal investigations. The agency does not terminate an investigation solely because the source of the allegation recants the allegation. Substantiated allegations of conduct that appear to be criminal are referred for prosecution. The agency retains all written reports pertaining to the administrative or criminal investigation of alleged sexual abuse or sexual harassment for as long as the alleged abuser is incarcerated or employed by the agency, plus five years. When the quality of evidence appears to support criminal prosecution, the investigative agency will conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution. The credibility of an alleged victim, suspect or witness will be assessed on an individual basis and not be determined by the person's status as resident or staff. No polygraphs are required. Administrative investigations, conducted by the facility include an effort to determine whether staff actions or failures to act contributed to the abuse. Such investigations will be documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings. Criminal investigations will be documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible. Substantiated allegations of conduct that appears to be criminal shall be referred for prosecution. The departure of the alleged abuser or victim from the employment or control of the facility or agency will not provide a basis for terminating an investigation. When outside agencies investigate sexual abuse, the facility will cooperate with outside investigators and will endeavor to remain informed about the progress of the investigation.

Standard 115.372 Evidentiary standard for administrative investigations

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

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.

Written policy and interviews with administrators verify that the agency imposes a standard of a preponderance of the evidence standard of proof when determining whether allegations of sexual abuse or sexual harassment are substantiated.

Standard 115.373 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

Policy requires that any resident who makes an allegation that he or she suffered sexual abuse 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. In the past 12 months there have been no criminal and/or administrative investigations of alleged resident sexual abuse that were completed by the agency/facility. 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. Following a resident's allegation that a staff member has committed sexual abuse against the resident, the facility subsequently informs the resident (unless the facility has determined that 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 that the staff member has been indicted on a charge related to sexual abuse within the facility; or The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility. There have not been any allegations of sexual abuse committed by a staff member against a resident in the facility in the past 12 months. Following a resident's allegation that he or she has been sexually abused by another resident in an agency facility, the agency subsequently informs the alleged victim whenever: The agency learns that 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. The agency has a policy that all notifications to residents described under this standard are documented. This can be found in GLR PREA Policy Section E, #2-3.

Standard 115.376 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

GLR Center staff are subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies. In the past 12 months no staff from the facility were alleged to have violated agency sexual abuse or sexual harassment policies. 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. 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. In the past 12 months, there have been no staff from the facility that have been reported to law enforcement or licensing boards following their termination (or resignation prior to termination) for violating agency sexual abuse or sexual harassment policies.

Standard 115.377 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

GLR policy, as explained in volunteer training and handouts, requires that any contractor or volunteer who engages in sexual abuse be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies. Policy requires that any contractor or volunteer who engages in sexual abuse, or any other violation of agency sexual abuse or sexual harassment policies, be prohibited from contact with residents. In the past 12 months, there have been no known incidents of contractors or volunteers engaging in sexual abuse of residents.

Standard 115.378 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

Residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding, or criminal finding, that the resident engaged in resident-on-resident sexual abuse. In the past 12 months there have been no findings of resident-on-resident sexual abuse that have occurred at the facility. In the event a disciplinary sanction for resident-on resident sexual abuse results in the isolation of a resident, the facility policy requires that residents in isolation have daily access to large muscle exercise, legally required educational programming, and special education services, and all other programming, and the resident also gets daily medical and mental health care. The facility does not practice restraints and would have to call 911 if a resident became harmful to self or others. Their in-house disciplinary sanction is referred to as "reflection" and is usually very brief. The facility offers therapy, counseling or other interventions designed to address and correct the underlying reasons or motivations for abuse and considers whether to require the offending resident to participate in such interventions as a condition of access to any rewards-based behavior management system or other behavior based incentives. Yet, access to general programming or education is not conditional on participation in such interventions. The facility disciplines residents for sexual contact with staff only upon finding that the staff member did not consent to such contact. 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. The agency prohibits all sexual activity between residents, but deems such activity to constitute sexual abuse only if it determines that the activity is coerced. Policy: GLR PREA Policy Section A #1(g).

Standard 115.381 Medical and mental health screenings; history of sexual abuse

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

All residents at this facility who have disclosed any prior sexual victimization during a screening pursuant to ß115.341 are offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. In the past 12 months all residents who disclosed prior victimization during screening were offered a follow up meeting with a medical or mental health practitioner. Medical and mental health staff maintain secondary materials documenting compliance with the above required services. All residents who have previously perpetrated sexual abuse, as indicated during the screening pursuant to ß 115.341, are also offered a follow-up meeting with a mental health practitioner. Information related to sexual victimization or abusiveness that occurred in an institutional setting is strictly limited to medical and mental health practitioners and other staff strictly limited to informing security and management decisions, including treatment plans, housing, bed, work, education and program assignments, or as otherwise required by law.

Standard 115.382 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

According to agency policy and interviews conducted, resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services. The residents answered questions in such a way to show they believe they will be cared for should something happen to them. Also, facility policies spell this out. The nature and scope of such services are to be determined by medical and mental health practitioners according to their professional judgment. Medical and mental health staff document the timeliness of emergency medical treatment and crisis intervention services provided; the appropriate response by non-health staff in the event health staff are not present at the time the incident is reported; and the provision of appropriate and timely information and services concerning contraception and sexually transmitted infection prophylaxis. 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. Treatment services will be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with the investigation. Policy regarding this standard can be found in GLR PREA Policy Section F, #4-6.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

GLR PREA Policy Section F, #4-6, states, "4. Following emergency response and completion of the rape kit (if applicable) a youth believed or determined to have been the victim of a sexual assault/rape must also be examined by medical staff for possible injuries, regardless of when the alleged sexual assault occurred. Female youths must be provided with pregnancy tests. 5. Victims and perpetrators of sexual assault must be encouraged to complete tests for sexually transmitted diseases, including an HIV test. In the case of a substantiated incident of sexual assault, the perpetrator must be requested to complete an HIV test. If the perpetrator will not voluntarily take an HIV test, the facility Director or designee must seek a court order compelling the test. 6. The victim of sexual assault or attempted sexual assault must be provided mental health assistance and counseling as determined necessary and appropriate. Resident victims of sexual abuse will be 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. Female victims of sexually abusive vaginal penetration must be offered pregnancy tests. If pregnancy results from sexual abuse while incarcerated, victims will receive timely and comprehensive information about, and timely access to, all lawful pregnancy-related medical services. All medical and counseling services will be provided at no charge to the victim." Interviews indicate residents, even resident on resident abusers, will be offered evaluation and follow-up services, treatment plans; and when necessary, referrals for continued care following transfer to other facilities or release from custody.

Standard 115.386 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

According to policy, Great Lakes Recovery Center conducts a sexual abuse incident review at the conclusion of every sexual abuse criminal or administrative investigation, unless the allegation has been determined to be unfounded. In the past 12 months, there have been no criminal and/or administrative investigations of alleged sexual abuse completed at the facility. Interviews with the facility administrators verify that in the event of an investigation, they are trained and ready to follow this Standard. GLR PREA Policy Section I, #4, states: "A sexual abuse incident review will be conducted at the conclusion of every sexual abuse investigation unless the allegation has been determined to be unfounded. The sexual abuse incident review team will include at a minimum an upper level Administrator and a supervisor. The review will occur within 30 days

of the conclusion of the investigation. The review team must review each incident of sexual abuse for cause, staffing, and physical barriers, and make recommendations for prevention. Recommendations must be implemented or the reason(s) if not implemented must be."

Standard 115.387 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

Director Dieterle verifies that, as per policy, the agency collects accurate, uniform data for every allegation of sexual abuse at Great Lakes Recovery Center using a standardized instrument and set of definitions and provides this to the State of Michigan. As the Agency PREA Coordinator, Patrick Sussex states that he facilitates the collection and analysis of the data. The agency maintains, reviews, and collects data as needed from all available incident-based documents, including reports, investigation files and sexual abuse incident reviews. Great Lakes Recovery Center and the State of Michigan will provide the Department of Justice with data from the previous calendar year upon request, but has not yet been requested to do so.

Standard 115.388 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

DHHS JJP PREA Coordinator Patrick Sussex states that Great Lakes Recovery Center provides ongoing and annual data to the State of Michigan DHHS JJP, which in turn acts as the "agency" for this standard. DHHS reviews data collected and aggregated pursuant to ß115.387 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. Mr. Sussex further verifies that DHHS collects accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions, which 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. The agency aggregates the incident-based sexual abuse data annually and maintains, reviews and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. DHHS obtains incident-based and aggregated data from every private facility with which it

contracts for the confinement of its residents. The data from private facilities complies with SSV reporting regarding content. The annual report includes a comparison of the current year's data and corrective actions with those from prior years and provides an assessment of the agency's progress in addressing sexual abuse. DHHS makes its annual report readily available to the public annually through its website, as approved by the agency head.

Agency Website where information on how to report is included: annual and data reports
http://www.michigan.gov/dhs/0,4562,7-124-5453_34044_39057---,00.html

Standard 115.389 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

Michigan Juvenile Justice Services ensures that incident-based and aggregate data are securely retained. 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 annually, through its website. Before making aggregated sexual abuse data publicly available, the agency removes all personal identifiers. The agency maintains sexual abuse data collected pursuant to ß115.387 for at least 10 years after the date of initial collection, unless Federal, State or local law requires otherwise.

Below is the link to the DHHS public website that contains aggregated data on sexual abuse allegations, data comparisons and annual report, how to report sexual abuse, and public facility final reports from PREA audits.
http://www.michigan.gov/dhs/0,4562,7-124-5453_34044_39057---,00.html

AUDITOR CERTIFICATION

I certify that:

☒ 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, and

☒ I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

D. Will Weir _____ 11-23-2016 _____

Auditor Signature Date