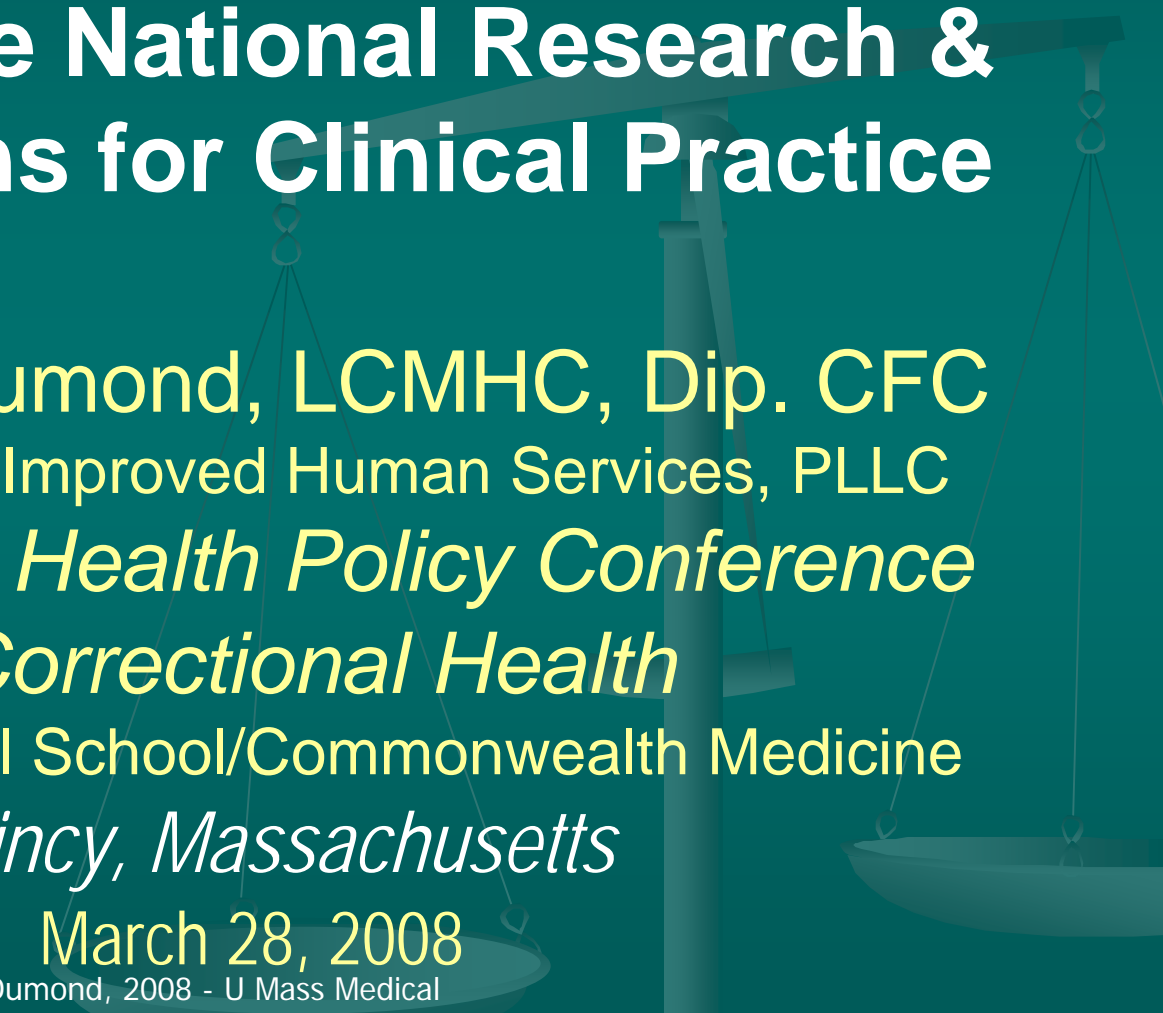


Prisoner Sexual Violence: A Look At the National Research & Implications for Clinical Practice



Robert W. Dumond, LCMHC, Dip. CFC

Consultants for Improved Human Services, PLLC

Academic & Health Policy Conference

on Correctional Health

U Mass. Medical School/Commonwealth Medicine

Quincy, Massachusetts

March 28, 2008

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Learning Objectives

- To understand current research on the prevalence of prisoner sexual violence as established by federal network established by the Prison Rape Elimination Act - PREA
- To examine the range and types of mental health consequences for victims of prisoner sexual violence and the appropriate mental health strategies appropriate to mitigate the resultant trauma.
- To evaluate the challenges to implementation within correctional environments and improve clinical response.

Prisoner Sexual Violence Has Been Known in US Since 1826

- Rev. Louis Dwight, President of the Boston Discipline Society decried the “dreadful degradation” of boys being “prostituted to the lust of old convicts.” (1826)

Joseph Fishman (1923/1934), Inspector of Federal Prisons, reported a large number of boys “made homosexual, temporarily or permanently” & that many prison staff “turned a blind eye to sexual abuses”

Court Cases & Reports Raised Concern and Led to Federal Law

- Number of court cases identified issues of concern about prison sexual violence, staff sexual misconduct
- Reports by human rights groups and research highlighted issue, and created groundswell of concern
- Led to creation of a federal law with multiple components to assist correctional agencies in responding
- Law unanimously passed by Congress & signed by President Bush in 2003.

Public Law 108:79 - the Prison Rape Elimination Act of 2003

- Establishes “ZERO TOLERANCE” standard
- Makes PREVENTION a top priority
- Engages full range of federal agencies
- Promotes systematic data collection - BJS
- Provides grants, assistance & training to state and national correctional agencies
- Creates National Prison Rape Elimination Commission to develop standards & Review Panel to examine agencies.

National Prison Rape Statistics

PREA directs US Dept. of Justice, Bureau of Justice Statistics to manage a multi-year national effort to collect PS Violence data.

- Review/analyze common characteristics of victims/perpetrators and prisons & systems w. highest incidence of prison rape
- Based on random, scientific sample of NOT < 10% of Federal, State, County & municipal prisons
- Officials required to participate in surveys

BJS Data Collection Strategies

Several strategies to collect data:

(1) FORMAL REPORTS TO AGENCY:

Administrative Records Collection (*Survey of Sexual Violence*) by US Census Bureau

(2) ANONYMOUS SELF-REPORTS by inmates in adult corrections & juveniles in juvenile facilities (using audio-CASI)

(3) ANONYMOUS SELF-REPORTS by soon-to-be released jail inmates & former state prisoners (using PAPI & CAI survey methods)

Exact Extent of Prisoner Sexual Violence in US Corrections Unknown

- **Sexual violence is the most underreported crime in US - recent range (5% - 38%)**
- **In the last 35 years, prior to 2005, there had been <20 empirically based studies**
 - **In total, <50 prisoners examined**
 - **Majority focused on male facilities**
 - **Only one jail setting examined (Davis, 1968)**
 - **One national probability study (BJS, 1997)**
 - **Inconsistent definitions used**

BJS Survey of Sexual Violence in Correctional Facilities – 2004 - 2006

- Major innovation helping to understand the national scope of the problem
- 2004 - Surveyed 2,730 correctional facilities (prisons, local jails, juvenile and public/private correctional facilities)
- 2005 & 2006 – surveyed all federal & state DOCs, 10% sample of private prisons, jails, etc. (Juvenile data separate).
- Utilized standardized, behaviorally specific definitions of acts of prisoner sexual violence (PSV)

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BJS Survey of Sexual Violence – 2004 & 2006 (continued)

Administrative records collection -

Prison rape measured using four (4)

**definitions formulated by the National
Center for Injury Prevention & Control & the
Centers for Disease Control (CDC):**

- **Nonconsensual sexual acts**
- **Abusive sexual contacts**
- **Staff sexual misconduct**
- **Staff sexual harassment**

BJS Survey of Sexual Violence 2004 – 2006 (continued)

NON CONSENSUAL SEXUAL ACTS

essentially uses legal elements of

- **penetration**
- **of any orifice**
- **against the person's will**
- **with the use of threat or force**

ABUSIVE SEXUAL CONTACT

**Any other sexual touch without
penetration against a person's will**

BJS Survey of Sexual Violence – 2004 - 2006 (continued)

STAFF SEXUAL MISCONDUCT

Any kind of sexual contact between any staff or prisoner, whether or not it was “consensual” or “romantic”

STAFF SEXUAL HARASSMENT

Repeated verbal statements or comments of a sexual nature to an inmate, employee, volunteer, etc. w. demeaning references/gestures

BJS Survey of Sexual Violence – 2004 & 2005 Results

2004 BJS Survey

5,386 PSV allegations reported: rate 2.46 allegations per 1,000 inmates held in 2004.

- 42% staff sexual misconduct
- 37% inmate-on-inmate nonconsensual acts
- 11% staff sexual harassment
- 10% abusive sexual contact

2005 BJS Survey

6,241 PSV allegations reported: rate 2.83 allegations per 1,000 inmates held in 2005.

- 38% staff sexual misconduct
- 35% inmate-on-inmate nonconsensual acts
- 17% staff sexual harassment
- 10% abusive sexual contact

BJS Survey of Sexual Violence – 2005 & 2006 (continued)

■ 2005 BJS Survey

**6,241 PSV allegations
reported: rate 2.83
allegations per 1,000**

- 38% staff sexual misconduct**
- 35% inmate-on-inmate nonconsensual acts**
- 17% staff sexual harassment**
- 10% abusive sexual contact**

■ 2006 BJS Survey

**6,528 PSV allegations
reported: rate 2.91
allegations per 1,000**

- 36% staff sexual misconduct**
- 34% inmate-on-inmate nonconsensual acts**
- 17% staff sexual harassment**
- 13% abusive sexual contact**

BJS Outcome Definitions

BJS identifies four (4) potential outcomes:

- **SUBSTANTIATED** – determined to HAVE occurred
- **UNSUBSTANTIATED** – evidence INSUFFICIENT to make determination that allegation/event occurred
- **UNFOUNDED** – allegation determined NOT to have occurred
- **INVESTIGATION ON-GOING** – final determination has NOT been made at the time of the data collection

BJS Surveys – Major Findings

- **Many correctional agencies were NOT tracking PSV data**
- **Each year, number & rate of PSV allegations have increased**
- **Most common - staff sexual misconduct & inmate-inmate rape**
- **Most common outcome - lack of evidence (unsubstantiated)**
- **Nationally, males most often victims and predators of PSV**

BJS Surveys – Differences Between Jails & Prisons

**Substantial differences between
Federal/State Prisons and Local Jails
all 3 years for staff sexual misconduct
& harassment:**

FEDERAL & STATE PRISONS (2006):

- **65% of VICTIMS were MALE**
- **58% of PERPETRATORS were FEMALE**

LOCAL JAILS:

- **80% of VICTIMS were FEMALE**
- **79% of PERPETRATORS were MALE**

Summary – Mass. DOC

Survey Results – 2004 - 2006

- Population 10,683 as of 06/30/06
- Non-Consensual Sexual Acts -
44 allegations - 11 substantiated,
14 unsubstantiated, 18 unfounded, 1 on-going
- Abusive Sexual Contacts –
76 allegations - 24 substantiated,
29 unsubstantiated, 23 unfounded
- Staff Sexual Misconduct -
159 allegations – 13 substantiated,
20 unsubstantiated, 45 unfounded, 81 on-going
- Staff Sexual Harassment - 17 allegations - 1
substantiated, 7 unsub, 5 unfounded, 4 - ongoing

MASS Jail Results 2004 - 2006

8 different **counties** surveyed between 2004 - 2006

- 3 Counties (2004); 4 Counties (2005) & 6 Counties (2006)
- **17 incidents of inmate-inmate rape**
(0 substantiated, 10 unsubstantiated, 7 unfounded)
- **4 incidents of abusive sexual contacts**
(2 substantiated, 2 unsubstantiated)
- **13 incidents of staff sexual misconduct**
(7 substantiated, 1 unsubstantiated, 4 unfounded & 1 investigation on-going)
- **5 incidents of staff sexual harassment**
(1 substantiated, 3 unsubstantiated, 1 on-going)
- **Most common outcome: "unsubstantiated" for inmate-inmate; "substantiated" for staff sex misc.**

Audio - CASI Survey Results (Beck & Harrison, 2007)

Using Audio Computer Assisted Self Interview format in 146 facilities, results much higher nationally.

National Estimates of Prisoner Sexual Violence:

60,500 prisoners - 4.5% of all US inmates

27,500* inmate-on-inmate (2.1%)

(16,800 inmate-inmate rape - 1.3%)

38,600* staff-on-inmate (2.9%)

* Incidents may be reported in multiple categories

Audio - CASI Survey Results (cont'd) (Beck & Harrison, 2007)

- Many inmates have multiple assaults
- Using weighted samples, estimated number of incidents nationwide totaled 165,400 incidents of PSV
 - 65,100 nonconsensual sexual acts & 100,300 incidents of UNWILLING sexual contact with staff
- There were an estimated 94,900 incidents nationwide involved “willing” sexual contacts with staff.

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Audio-CASI Results (cont'd)

- Expressed as a rate, nationwide an estimated 123 incidents of sexual victimization per 1,000 inmates held in State and Federal prisons were reported by inmates.
- 10 facilities had prevalence rates of 9.3% or greater
- 11 facilities had nonconsensual sex rates of 300 or more per 1,000 inmates [Range: 303 – 931/1,000]

National Ranking of Facilities

- Estelle Unit, TX 15.7%
- Clements Unit, TX 13.9%
- Tecumseh State Corr. Inst., NE 13.4%
- Charlotte Corr. Inst. FL 12.1%
- Great Meadow Corr. Fac., NY 11.3%
- Rockville Corr. Fac., IN 10.8%
- Valley State Prison for Women, CA 10.3%
- Allred Unit, TX 9.9%
- Mountain View Unit, TX 9.5%
- Coffield Unit, TX 9.3%

Summary – Massachusetts DOC Audio-CASI Data - 2007

National Inmate Survey (Beck & Harrison, 2007)

One (1) MA DOC prison selected:

Old Colony Correctional Center

68% response rate

in custody 932

sampled 250

ineligible 3

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Summary – MASS DOC Audio-CASI Data - 2007 (cont'd)

Old Colony Correctional Center - OCCC

% reporting sexual victimization since admission +/- or in last 12 months = **6.7%**

6.6% weighted 2.2% SE

Actual % victimization between 4.4% - 8.8%

***Inmate - Inmate* % victimized = 3.5%**

physical force = 2.7% pressured = 3.5%

***Staff - Inmate* % victimized = 3.2%**

physical force = 2.3% pressured = 2.5%

Implications

- Prisoner sexual violence regularly occurs in correctional agencies
- What is formally reported to correctional agencies appears to be substantially less than what is actually occurring in jails & prisons
- Nationally, the predominant forms of PSV are staff sexual misconduct, followed by non-consensual sexual acts (acts legally considered rape)
- Number of US prisoners affected

Effect of Prisoner Sexual Violence in Correctional Institutions

PSV destabilizes institutional safety & security – contributing factor in:

- Prison homicides
- Violence against youth and staff
- Institutional insurrections and riots
- Some targets become aggressors
- Male & female facilities differ
- Vulnerable, weak males repeatedly targeted

Dynamics of Prisoner Sexual Violence

Predators look for **MEANS, OPPORTUNITY & VULNERABILITY**, selecting targets who

- **Are least able to defend themselves,**
- **who may be less believed or believable,**
- **who are disliked, often despised and easily ostracized** (Dumond, 2005)

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Who Is At Risk of Victimization?

Anyone can be at risk, but certain inmates are more vulnerable:

- **The young and inexperienced**
- **First time offenders/new to incarceration**
- **Those with mental illness and/or developmental disabilities**
- **Those who are not gang affiliated**

(Cotton & Groth, 1982, 1984; Davis, 1968; Dumond, 2003, 2000, 1992; Dumond & Dumond, 2002a, 2002b; Lockwood, 1980).

Additional Male Vulnerability Issues While Incarcerated

- Physically small and weak
- Those “not tough” / “street wise”
- Homosexual, transgendered or who appear “effeminate”
- Those who are “rats” or “snitches”
- Those disliked by staff or other inmates
- Those convicted of sexual crimes
- Those **PREVIOUSLY SEXUALLY ASSAULTED**, especially in jail/prison

(Cotton & Groth, 1982, 1984; Davis, 1968; Dumond, 2003, 2000, 1992; Lockwood, 1980; Mariner, 2001; Scacco, 1982; Wooden & Parker, 1982).

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What Happens to Victims of Sexual Assault ?

- Sexual victimization is a crisis which can precipitate profound, catastrophic outcomes – the effects may last for **many years or even a lifetime**

(Allison & Wrigthsman, 1993, Kilpatrick et al, 1987).

- Each person responds uniquely
- Victims may suffer **PHYSICALLY, EMOTIONALLY, & SOCIALLY:**

Consequences of Sexual Victimization

Male & female victims of sexual violence may experience wide range of problems:

PHYSICAL: injuries, HIV/AIDS, STDs, other communicable diseases (TB, Hep. A, B, C)

EMOTIONAL:

- * suicidal feelings
- * anxiety / depression
- * posttraumatic stress disorder (PTSD)
- * rape trauma syndrome
- * dissociative dx
- * exacerbation of preexisting psychiatric disorders

Donaldson, 1993; Dumond, 2005, 2000, 1992, Dumond & Dujmond, 2002; Cotton & Groth, 1982, 1984; Lockwood, 1980; Wooden & Parker, 1982)

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Sexual victimization in Jails & Prisons may be more harmful

Incarcerated victims are more often physically assaulted during attacks & may experience repetitive assaults by multiple assailants over period of time.

(Dumond, 2003, 1992; Herman, 1992; Kupers, 1999; Struckman-Johnson & Struckman-Johnson, 2000; Struckman-Johnson et al, 1996)

- **Repeated, on-going trauma may cause debilitating “complex PTSD”**
(Herman, 1992)
- **Grave social consequences: loss of status, increased vulnerability, “turned-out” .**
- **“Double-bind” – whatever do a problem!**

Suicide is the most serious concern of prisoner sexual violence

In circumstances of repeated, unrelenting physical & sexual victimization, some may **view suicide as the only viable option.**

- Contemplating and/or attempting suicide is far **more likely** among victims of sexual violence.
- Rape victims are **4 times** more likely than noncrime victims to have **contemplated** suicide and **13 times** more likely to have actually **made** a suicide attempt
(Kilpatrick, Whalley and Edmunds, 2002)
- **Number of prisoners attempted or completed suicide as a result of sexual violence unknown**

Recent BJS Surveys on Correctional Homicide/Suicide

- Sept. 2005 BJS survey reports a decline in homicides and suicides in US corrections (Mumola, 2005)
- Suicide rate in local jails (47 per 100,000 inmates) was over 3 times the rate in State prisons (14 per 100,000 inmates).
- In prisons nationwide, 337 State prisoners committed suicide during 2001-02 for a rate of 14 per 100,000. (Mumola, 2005)
- 2007 BJS Survey - Suicide is the leading cause of death for state prison inmates < age 35 years (Mumola, 2007)

Two Major Diagnostic Formulations for Victims

PTSD

- ***Intrusive symptoms*** (flashbacks, reliving events, nightmares);
- ***Constrictive*** (fears, being alone, feeling numb, hopelessness);
- ***Hyperarousal*** (anger, irritability, insomnia, startle reactions, can't concentrate)

Rape Trauma (RTS)

3 Phases: Acute, Re-Organization, Resolution

Expressive style -

hysterical, crying, rage, sobbing, smiling, joking, restlessness, tenseness, distraught or anxious

Controlled style - numb, in-shock & disbelief, calm, composed, quiet, reserved, difficulty expressing themselves

Other Psychiatric Disorders

Staggering number of individuals with mental illness are incarcerated in both adult correctional facilities (James & Glaze, 2006; Maruscak, 2006) and juvenile correctional facilities (Teplin et. Al, 2006).

- At increased risk/more severely impacted;
- Depression & anxiety known to accompany PTSD (Dumond, 2005; Kupers, 2005).
- Dissociative disorders related to trauma
- Clinicians must be to treat the full range of mental health disorders which may emerge.

Degree & Severity of Mental Health Consequences Vary

Consequences vary from victim to victim, exacerbated by certain issues.

Recovery, in general, mediated by three (3) classes of variables: (Markesteyn, 1992)

- victim's pre-victimization characteristics
- victims' post-victimization coping style
- factors related to the criminal event

Victims often manifest feelings of guilt, shame, despair, confusion, humiliation

An Individual's Coping Style is a Major Factor in Healing

Victim's often feel they are "going crazy";

Recovery more difficult for those who

- have poor coping skills,
- have had previous physical/sexual victimization,
- pre-existing mental disorders, and/or
- when there has been long-term, on-going abuse and torture.

(Cutler & Nolen-Hoeksame, 1991; Herman, 1992; Lazarus, 1983; Wainrib & Bloch, 1998).

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There are Gender and Age Differences on Impact of PSV

Incarcerated women have

- Increased rate of physical & sexual victimization as child, teen & prior to their incarceration which exacerbates impact upon women's imprisonment and compromises their coping & recovery
- Women may have had long histories of abuse and submission which reinforces their feelings of inadequacy, despair and unworthiness
- May become pregnant as a result

(Human Rights Watch, 2001; Ogle, 2000; Walker, 1989, 1984, 1979; Wolf Harlow, 1999;

Additional Trauma of Staff Sexual Misconduct

In cases of staff sexual misconduct, victims additionally feel the ultimate betrayal and violation by those with the duty and responsibility of their safety and security, increasing their pain & suffering

In addition – staff have absolute control over the victim's wellbeing and survival, increasing powerlessness and anguish (Dumond, 2006; Smith, 2005)

Male Sexual Victimization is Devastating & Disruptive

- Sexual assault devalues 2 primary areas of male identity: sexuality and aggression.
- Most male victims experience concern about their masculinity, competence and security, which increases their humiliation and suffering
- Men often may manifest a “controlled” response which may lead authorities to conclude the events did not occur or to minimize its impact
- Often experience > rates of fear, anxiety, suicidal thoughts & social disruption (Cotton & Groth, 1982, 1984; Donnelly & Kenyon, 1996; Dumond, 2006; Groth & Burgess, 1980; Lockwood, 1980; Kaufman, 1980)

Juveniles Face Crisis of Identity

- Sexuality is a powerful force in developing teens
- Younger males victims, there may also be considerable **confusion** regarding their **sexual identity following sexual victimization**
- **Common strategy - get victim to ejaculate**
- **Sexual arousal** can be precipitated by a variety of **emotions**, including **pain, fear, and anger**
- If occurs, precipitate considerable **confusion** & questioning particularly re. **sexual orientation**
- Juveniles may feel intense **guilt, shame** and be likely to **blame** themselves for their victimization

(Dumond, 2006; Erickson, 1968, 1950; Lockwood, 1980; Waterman, 1984)

Key Principles Which Should Guide Any Intervention

- **First - Do NO Harm!**
- **The differing responses to traumatic events and crisis are normal responses to abnormal circumstances.** (Wainrib, & Bloch,1998)
- **Staff can maximize healing/coping by validating victim's feelings and normalizing the situation.** (Kupers, 2005; Ochberg, 1991; Wainrib, & Bloch,1998)
- **Treatment undertaken should be a partnership between the victim, treating clinicians and the correctional agency.**

Avoiding the “Second Injury”

- Correctional staff must avoid the “second injury,” the perceived rejection/lack of support or conscious/unconscious projections of blame on the victim (Symonds, 1980)
- Each victim must be treated with dignity, respect and human compassion.
- Genuine concern & appropriate empathy by staff can have a palliative effect upon victims of prisoner sex violence.

Key Phases of Intervention

Victims of prisoner sexual violence have three (3) major phases of trauma, each of which has key issues which must be addressed.

- These include:
- - Crisis
- - Short-Term
- - Long-Term

Major Issues in Crisis Phase

Immediately, victims or prisoner sexual violence may experience

- a lack of control
 - physical pain & suffering
 - threat of further harm or death
- Victims often articulate shock, disbelief, panic & fright, fear
 - Victims may employ host of coping strategies w. varying success

Key Tasks to Manage Crisis

- Ensure safety for victim
- Separate victim from assailant
- Provide necessary medical care and forensic evaluation
- Evaluate suicide risk
- Negotiate psychological assistance & on-going mental health care
- Initiate classification review/develop safe, short-term placement options.

Challenge - Should We Segregate?

Correctional agencies often default to using segregation/protective custody in dealing w. victims

Protracted isolation/segregation may increase trauma & hopelessness

Consider less restrictive options when appropriate (hospital unit, protected unit) so as not to re-victimize victim

Re-evaluate placement regularly

Key Short-Term Interventions

- Provide **on-going** medical care/treatment
- Provide **follow up** for HIV/AIDS, STD & other communicable disease testing/care
- Continue close mental health supervision, esp. assessment of depression, suicidality
- Continue to ensure victim safety/security
- Assist victim to secure other necessary services to enhance coping

Long-Term Issues of Concern

Victims may negatively cope with their victimization by:

- dulling their senses with substances
- acting out their pain by re-victimizing others within the correctional institution or in the community or
- being self-destructive and even engaging in sexually promiscuous and aggressive behavior

(Dumond, 2003, 2001, 2000, 1992; Dumond & Dumond, 2002a; Fagan et al., 1996; Groth et al., 1977; Herman, 1992; Kupers, 1999; Lockwood, 1978, 1980; Scacco, 1975, 1982; Turner, 1992).

Long Term Strategies to Promote Healing

- Continue on-going medical care/follow-up
- Empower victim **not to place self at risk**
- Continue **regular, on-going mental health care, support and monitoring**
- **Support victim through prosecution**
- **Ensure continuity and consistency of medical/mental health care throughout incarceration (incl. different facilities)**
- **Make appropriate community**

Phases of Recovery

Recovery from trauma involves the victim moving through several phases:

- (1) safety,
- (2) remembering and mourning and
- (3) reconnection
- Healing/recovery cannot be “rushed”
- Victims must be allowed ample time and support. (Herman, 1992; Kupers, 2005)

Aspects of Effective Treatment

Treatment provided should be

- trauma-informed,
- trauma specific,
- gender specific,
- culturally sensitive and
- of sufficient duration to ensure adequate impact upon victims.

Characteristics of Effective Treatment

Sex (Gender) Specific - recognizes the impact of different social & cultural experiences between men and women, GLBTQ, and which promotes positive sexual identity development.

Trauma Informed - sensitive to & informed about trauma related issues in victims/survivors

Characteristics of Effective Treatment (continued)

Trauma Sensitive - treatment specifically to treat trauma of physical & sexual abuse

Culturally Sensitive - understanding of racial, ethnic, cultural diversity issues (development, attitudes, beliefs, appropriate language, etc.)

Evidence & Practice-Based Treatment

Practice-Based - treatment conforming to established clinical practice guidelines

Evidence-Based - integrates evidence from randomly controlled studies & systematic reviews

3 Evidence Based Interventions

Three evidence-based trauma interventions supported by systematic reviews and random controlled trials:

- *Trauma Focused Cognitive-Behavioral Therapies [TFCBT],*
- *Eye Movement Desensitization and Reprocessing [EMDR], and*
- *SSRI Pharmacotherapy.*

Trauma Focused Cognitive Behavioral Therapies [TFCBT]

TFCBT include variety of techniques:

- **exposure to images & real life situations;**
- **therapy to challenge distorted thoughts about the trauma, self, and world; and**
- **instruction in coping skills (stress inoculation) and cognitive restructuring.**

TFCBT have consistently been shown to be very effective in treating PTSD

(Bisson, 2002; Bisson & Andrew, 2005)

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Eye Movement Desensitization and Reprocessing [EMDR]

- **Information processing therapy** which uses an **eight phase** approach (Shapiro, 2001, 1989)
- Person is asked to **focus** on the traumatic **event**, a **negative cognition** associated with it, and the **associated emotions**.
- Individual is then asked to **follow the therapist's finger** as it moves side to side.
- One systematic review found was **likely to be beneficial** in the treatment of PTSD.

(Shepherd, Stein, & Milne, 2000)

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SSRI Pharmacotherapy

The use of anti-depressant medications known as **selective serotonin reuptake inhibitors (SSRIs)** have been shown to be effective as **first-line pharmacotherapy** and in **long-term treatment**,

SSRIs act on the core symptoms of PTSD, as well as associated depression and disability. (Stein, Ipser, & Seedat, 2006)

More study to fill in the gaps which exist.

Challenges to Implementation

- > 2.4 million currently incarcerated yearly
- Enormous annual turnover of population in Jails (12.6 million) & Prisons (606,000-625,000)
- Correctional systems face unprecedented problems: overcrowding, underfunding, understaffing, inadequate medical/mental health, program & educational resources

Challenges to Implementation (continued)

- Prisoners getting older, with substantially more medical & program issues
- Jails & prisons are the “de-facto” psychiatric facilities in the U.S.

Specific Mental Health Challenges to Implementation

- Inadequate staffing resources
- High caseloads w. difficult, complex clients
- Insufficient medication formularies/policies
- Focus on “major mental illness”

Specific Mental Health Challenges to Implementation (cont'd)

- Inability to implement recommended Treatment
- Issues related to corrections (security override, transfers, inability to impact)
- Poor/inadequate continuity of service between institutions & into community

Strategies to Improve Treatment

- Ensure sexual victimization is a clinical priority
- Build internal capacity of health care staff to provide culturally-competent, trauma informed/ specific treatment, sex (gender) specific treatment thru training, education, collaboration

Strategies to Improve Treatment (continued)

- Increase treatment staff diversity directly and/or collaterally w. community providers
- Increase ability of MH staff to impact upon administrative & security decisions (i.e.: placement, transfer, programs, services)
- Actively engage community sexual assault providers as adjunct

We Will Ensure Safety!

**Edmund Burke
(1729 - 1797) offered that**

“The only thing for evil to triumph is for good men (and women) to do nothing!”

Discussion – Where Do We Go From Here ?

- What do you think about this issue ?
- What needs to be done to improve care and treatment ?
- What do you see as the challenges toward effective intervention ?
- What else do we need ?