Review Panel on Prison Rape
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Testimony of
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Honorable members of the Review Panel on Prison Rape, honored guests, ladies and gentlemen, I am privileged to testify before this distinguished panel and I wish to extend my sincerest thanks for the opportunity to do so.

The Review Panel on Prison Rape is a vital partner in assuring full implementation of the Prison Rape Elimination Act of 2003 (PREA) and in promoting corrections agencies' full compliance with the act's ambitious goals.

I am honored to be testifying alongside other experts, including my co-panelist Ms. Joyce Lukima, Vice President of the Pennsylvania Coalition Against Rape (PCAR). I have had the pleasure of working with PCAR, a national leader in advancing quality care to survivors of sexual assault, and have always been impressed with its commitment to addressing sexual abuse in detention.

Sexual abuse in detention has been called "the most serious and devastating of non-lethal offenses which occur in corrections" (Cotton and Groth, 1982: 47), because its impact is so profound upon survivors of such abuse, and ultimately society. The Review Panel's leadership will continue to be essential in the fight to end this grave problem.

My name is Robert W. Dumond and I am a board certified and licensed clinical mental health counselor and diplomate of clinical forensic counseling. I have provided services to crime victims and inmates in a number of settings since 1970. I have worked with juveniles and adults within the Office of the Essex County District Attorney, the Massachusetts Department of Correction, and the Merrimack County Department of Corrections. I have also had the privilege of working with the National Institute of Corrections and The Moss Group, providing training to corrections agencies nationwide, and offering consultation to a number of federal agencies , including the National Prison Rape Elimination Commission and the U.S. Department of Justice.

Today, I am representing Just Detention International, where I serve as a Senior Program Director. JDI is a health and human rights organization that seeks to end sexual abuse in all forms of detention. JDI was at the forefront of developing and advocating in favor of PREA and continues its leadership on this issue through PREA implementation efforts across the country. Having extensively researched, written, and lectured about sexual abuse in detention and treated hundreds of survivors in community and corrections settings, I believe that I can offer substantive information for the Review Panel to consider in its future deliberations.

I have been asked to provide testimony today on the challenges faced by prisoners with mental health issues and the ways in which those challenges increase this population's risk of sexual victimization while incarcerated. Through my testimony, I will be discussing four inter-related issues – (1) the epidemiology of mental illness in detention settings; (2) the challenges of inmates with developmental disabilities; (3) the specific problem of suicide; and (4) the elevated risks faced by inmates with a history of being sexually abused, particularly female inmates. I will then conclude with a set of recommendations to address each of these issues.

A. Background

1. Recent BJS Data Clarify Specific Risks for Abuse Facing Certain Inmate Populations

The recent *National Inmate Survey, 2011-2012* (Beck, Berzofsky, and Krebs, 2013) was extremely helpful in reaffirming what had been previously reported in the literature. The report documents particularly high rates of abuse of inmates with mental illness and inmates with a history of being sexually abused. The other group of inmates for whom the report documents high rates of abuse is lesbian, gay, and bisexual inmates. In order not to duplicate the testimony of Professor Giovanna Shay, who is also an expert witness at the Review Panel's hearing and is focusing on LGBT inmates, I will only briefly touch on the challenges faced by this population.

The recent BJS report included the following data on inmates with mental illness:

- Inmates with a history of mental health (MH) problems and/or who stayed overnight in a hospital or other treatment facility for MH problems had higher rates of sexual victimization;
- The rates of inmate-on-inmate sexual victimization were two to three times higher for inmates taking prescription medication for mental health problems than they were for the general population;
- Inmates with serious psychological distress (SPD) or anxiety-mood disorders reported higher overall rates of sexual victimization;
- Inmates with mental illness reported higher rates of sexual victimization than inmates without mental problems, independent of sex, race, age, sexual orientation, and most serious offense;
- Inmates with SPD who reported inmate-on-inmate victimization were more likely than inmates as a whole to be: victimized more than once; subjected to force or threats; and/or injured;
- Inmates with SPD reporting staff sexual misconduct reported being pressured and injured by staff at higher rates than other inmates suffering such abuse.

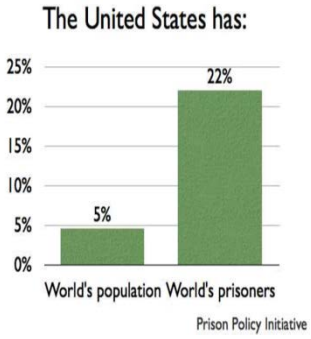
The most recent BJS *National Inmate Survey* also confirmed prior findings that inmates with a history of being sexually abused are at an extremely high risk of being sexually abused in detention. For instance:

- Among prison inmates, 12% of inmates who reported a history of being sexually abused also reported being sexually abused by another inmate in detention within the previous

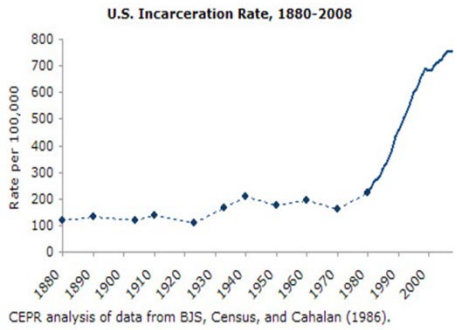
year. Compare this to inmates with no history of being sexually abused: only .6% of that population reported being abused by another inmate in detention in the previous year.

- The numbers are not as stark but are still striking when the alleged perpetrator was a prison staff member – 6.7% of prison inmates who reported a history of being sexually abused also reported this kind of abuse in detention, compared to only 1.8% of prison inmates who reported no history of being sexually abused.
- The results from jail inmates showed very similar proportions: inmates who reported a history of sexual abuse were almost 14 times more likely to be sexually abused by another inmate and 4 times more likely to be sexually abused by a jail staff member.

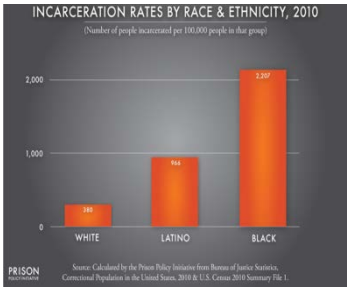
2. *U.S. Corrections in the 21st Century*



As we consider these known, identified risks for sexual abuse, it is important to consider the current state of U.S. corrections. Though the U.S. accounts for only 5% of the world's population, the U.S. currently incarcerates 22% of the world's prisoners (Prison Policy Initiative, 2011). On any given day in the U.S., there are 2.3 million people incarcerated in jails, prisons, and juvenile corrections facilities (Carson and Sabol, 2012), for a rate of 716 inmates per 100,000 people. Not surprisingly, this percentage exceeds every other nation in the world (International Centre for Prison Studies, 2012).



This percentage represents a relatively recent change in the corrections population in the U.S. (Callahan, 1986; Sabol, West, and Cooper, 2008). The rise began in the 1980s, after nearly a century of relatively stable incarceration rates, as can be seen in this graph. This increase is related to the 'War on Drugs,' the de-institutionalization movement, and the 'get tough on crime' era (Dumond and Dumond, 2010a).



Other salient facts are that U.S. jail and prison populations are disproportionately male and African-American (Wagner, 2012) – a situation that has been identified as an "epidemic of incarceration" (Rich, Wakerman, and Dickman, 2011) and that affects the general health and well-being of American society.

Finally, American corrections systems struggle with the realities of overcrowding, underfunding, understaffing, and inadequate resources. A lack of educational, vocational, medical, and mental health programs and services contribute to the crisis (Anno, 2001, 1991; Beck and Mumola, 1999; Bowker, 1982, 1980; Clark, 1994; Harrison, 2002; Harrison and Karberg, 2003). Over the last two decades, an additional combination of factors, including increased inmate populations, the aging of inmates, longer sentences, and an increase in medical and psychiatric disorders are taxing the often inadequate medical, mental health, and

programmatic resources within prisons and jails nationally (Anno, 2001, 1991; Beck and Maruschak, 2001; CDC, 2003; Dumond and Dumond, 2005; Harrison, 2002; Human Rights Watch, 2003; McDonald, 1999; NIJ/NCCHC, 2002).

Taken as a whole, these developments exacerbate the complexity of the four issues I identify as key contributors to high rates of sexual abuse in U.S. detention facilities.

B. Four Key Issues Related to Sexual Abuse in Detention

1. Mental Illness

A scandal of the 21st century is that we are now faced with more individuals being housed in corrections facilities in the U.S. than in public and private psychiatric facilities combined (Chelala, 1999; Ditton, 1999; Dumond, 2003, 2006; Harrington, 1999; Wolf-Harlow, 1999; Human Rights Watch, 2003; Kupers, 1999; Torrey, 1995, 1997, 1999; Weinstein et al., 2000).

Currently, U.S. prisons and jails have become de facto psychiatric facilities – the new "Bedlams" of the 21st century (Harrington, 1999). They serve as "the country's front-line mental health providers" (Human Rights Watch, 2003, p. 9) though are ill equipped to do so. Corrections facilities were never meant to provide the bulk of care to individuals with mental illness. Especially troubling is the recognition that jails, where inmates are held for less time than in prisons, have "the largest inpatient mental health institutions in the United States" (Drapkin, 2003, p. 1-1). Jails generally have less well-equipped facilities and fewer resources, services, and programs to offer inmates with mental disorders than do prisons.

In communities throughout the U.S., the rate of serious mental disorders clusters at the lower end of the spectrum of mental illness (National Institute of Mental Health, 2007; U.S. Department of Health and Human Services, 1999); in correctional settings, the rate of serious mental disorders is substantially higher. Well-constructed studies, using rigorous diagnostic criteria, reveal that the prevalence of severe mental disorders in corrections settings ranges from 6% to 20% (Teplin, 1994; Teplin et al., 1996; Veysey and Bichler-Robertson, 2002). Fazel and Danesh (2002), after examining 62 surveys of serious mental disorders in primarily Western countries, found that prisoners have between two and four times higher rates of psychotic illness than the overall population. Fazel and Danesh posit that, "it seems doubtful whether most prisoners with these illnesses receive appropriate care" (p. 250).

Methodologies employed by the BJS to identify the number of inmates with mental disorders have yielded even more startling results. In a recent study examining mental health problems among jail and prison inmates, James and Glaze (2006) discovered that more than half of all prison and jail inmates had a mental health problem. They found that mental health problems were more common among inmates who are female, white, and/or young. Jail inmates displayed the highest number of symptoms of serious mental disorders, including 24% of schizophrenia, 30% of major depression, and 55% of mania disorder. Even more disturbing is their finding that, despite the significant numbers of mentally ill inmates, only 22% of state prisoners and 7% of jail inmates received mental health treatment while incarcerated.

In summary, three key issues emerge in considering current epidemiological data (Dumond and Dumond, 2010; Weinstein, Kim, Mack, Malavade, and Saraiya, 2005):

(1) The prevalence of severe mental illness is significantly higher in corrections than in the community, with major depression and psychotic disorders being four to eight times more prevalent in corrections;
(2) Women in both adult and juvenile corrections facilities have higher rates of mental illness than men;
(3) Co-morbidity of substance use with mental illness is prominent.

2. Developmental Disabilities

A variety of disorders are considered to be developmental disabilities, including: cerebral palsy, epilepsy, autism, and mental retardation. Of the three, mental retardation is the most common and is characterized by a significantly below average score on a test of mental ability or intelligence and by limitations in ability to function in areas of daily life, such as communication, self-care, and managing social and school situations (DSM-IV-TR; American Psychiatric Association, 2000). Unfortunately, there is no consensus on the prevalence of mental retardation in corrections settings. It is assumed that persons with mental retardation are overrepresented in inmate populations, with prevalence rates that exceed the 3% rate found in the general population. Some research has suggested that mental retardation in corrections settings ranges from 4% to 27% (Petersilia, 1997, 2000; Santamour and West, 1997). Other research, however, has suggested that the rate of mental retardation in corrections settings is roughly the same as in the community, or 2-3% (Fazel, Xenitidis, and Powell, 2008; The New York State Commission on Quality of Care for the Mentally Disabled, 1991; Noble and Conley, 1992).

What is undeniable, however, is that prisoners with mental retardation and other developmental disabilities experience significantly higher rates of victimization and enormous challenges in adjusting to and safely coping with life in corrections facilities. The vulnerabilities of inmates with developmental disabilities include:

- *Cognitive limitations*, such as difficulty understanding and following rules;
- *Adaptive skill deficits*, including difficulty following guidelines, routines, and social norms, leading to, for example, hygiene infractions; and
- *Learned compliance*, often manifested in difficulty in asserting rights to personal space and bodily integrity.

In the community, individuals with developmental and intellectual disabilities are 4-10 times more likely to be victims of crime, and this also is true for these individuals when they are incarcerated (Petersilia, 2000). Because of their cognitive limitations, prisoners with developmental disabilities are often exploited, sexually victimized, and abused (McDermott, Hardison, and MacKenzie, 2005). They are also more likely to be manipulated and to have their property stolen (Petersilia, 1997).

People with mental, developmental, and neurological disabilities may have a decreased ability to recognize, react, and respond to threats and abuse (Tyiska, 1998; Office of Victims of Crime,

2002). They are often preferred targets, in part because they may not be able to muster adequate defenses. Even if they can defend themselves, a predator may assume that they will not receive adequate assistance and response from those who could provide protection because their pleas for help are seen as not credible (Donaldson, 1993; Dumond, 1992, 2000, 2001, 2003, 2006; Dumond and Dumond, 2002b; Human Rights Watch, 2001).

Inmates with disabilities who have lived in other institutional settings where unquestioning compliance with staff instructions is highly valued may be particularly vulnerable to abuse from staff and more powerful inmates. In such settings, residents often have little privacy and autonomy, are assisted in bathing and toileting, and are moved or touched without permission. Such high degrees of physical contact may normalize fluid personal boundaries and undermine a person's ability to recognize and assert violations of his or her rights.

Predators, in the community and in prisons and jails, want an easy conquest – someone who will submit with little resistance. Because their goal is to commit the crime and then escape undetected, assailants often choose a victim whom they perceive as weak and vulnerable. Predators hone their skills in identifying victims and assessing their potential to be exploited, coerced, intimidated, and manipulated (Samenow, 1984). The precision of an assailant's skill in evaluating vulnerability is a major factor in his or her selection of a victim.

Research on perceptions of vulnerability as manifested by body language conducted by Grayson and Stein (1981) is especially relevant here. Individuals who were targeted as vulnerable tend to emit nonverbal cues that suggest ease of victimization, cues that have been confirmed by additional studies (Gunns, Johnston, and Hudson, 2002; Sakuguchi and Hasegawa, 2006). In looking at these factors, one can easily see that the victim selection process is a complex calculus that includes a cost-benefit ratio, likelihood of success, and other characteristics

3. Suicide

A number of community studies have suggested that sexual abuse is a significant precursor for suicidal behavior, especially in women (Jenkins, Bhugra, Meltzer, Singleton, Bebbington, Brugha, Coid, Farrell, Lewis, and Paton, J., 2005; Ullman, 2002). This has also been demonstrated in adolescents. Sexual abuse is strongly associated with suicidality, both directly and indirectly as a result of hopelessness and depressive symptoms (Bergen, Richard, Allison, and Roeger, 2003; Bagley, Bolitho, and Betrand, 1995).

In the community, there is a known risk of suicide following incidents of sexual abuse. Kilpatrick, Whalley, and Edmunds (2002) have noted that "rape victims were 4.1 times more likely than non-crime victims to have contemplated suicide . . . [and] 13 times more likely than non-crime victims to have actually made a suicide attempt (13% versus 1%)."

Lesbian, gay, bisexual, and transgender (LGBT) people appear to be at increased suicide risk as well (Savin-Williams, 2001). There is considerable evidence emerging that LGBT individuals face unique risks to their well-being and mental health as a result of prejudice and discrimination from society, family, friends, and coworkers (Cochran, Sullivan, and Mays, 2003; Meyer, 2003; Omato and Kurtzman, 2006). LGBT people are also disproportionately targeted for violence and

victimization as adults (Herek, Gillis, and Cogan, 1999). Additionally, all BJS reports on sexual abuse in detention issued to date consistently show that lesbian, gay, and bisexual inmates and youth residents experience significantly higher rates of sexual abuse than other inmates. Private research has indicated even higher rates of abuse for transgender inmates. This systematic oppression can have a traumatizing effect in and of itself. It can also be one explanation for the increased rates of suicide and attempted suicide within the LGBT community.

Suicide remains among the leading non-natural causes of death in U.S. prisons and jails. Corrections facilities have made substantial improvements in preventing suicide in the 30-plus years since the release of *And Darkness Closes In...National Study of Jail Suicides* (Hayes, 1983; National Center on Institutions and Alternatives, 1981), and jail suicide rates have steadily declined since 1983 (Mumola, 2005; Noonan and Ginder, 2013). Nevertheless, a substantial risk of suicide remains in U.S. jails (Hayes, 2013). Suicide also make up 5.5% of deaths in state and federal prisons; more than drug and alcohol intoxication, homicide, and accidents combined (Noonan and Ginder, 2013; Smith, 2013). Preventing suicide in corrections facilities is the collective responsibility of administrative, custodial, and clinical staff (Daniel, 2006).

Suicide is widely believed to be the most lethal consequence of sexual abuse in detention. Some prisoners, especially those who face unrelenting, repeated physical and sexual victimization, may view suicide as the only viable option out of their intolerable circumstances. Daniel Lockwood (1980), who studied New York prisons as part of his doctoral dissertation between 1974-1975, found that "targets, however, are more than twice as likely than aggressors [sic] and more than 17 times as likely as non-targets to have made attempts on their own lives..." (p. 68). Struckman-Johnson et al. (1996), in their study of four Nebraska prisons, found that the majority of inmates targeted for sexual victimization experienced profound negative reactions – 36% reported depression and suicidal ideation. While we know that contemplating or attempting suicide is far more likely among victims of sexual violence, currently we do not know how many prisoners have attempted or completed suicide as a result of sexual violence.

4. History of Sexual Abuse

As the BJS data demonstrate, inmates with a history of being sexually abused experience high rates of sexual victimization in detention, particularly by other inmates. While this problem plagues both male and female inmates, the exceptionally high rates of previous instances of sexual abuse among women mean that it may have a disproportionate effect on female inmates.

The evidence is overwhelming that many incarcerated women have had long-term exposure to physical abuse, sexual abuse, and exploitation before arriving at a corrections facility (Browne, Miller, and Maguin, 1999; Lewis, 2003; Singer, Bussey, Songy, and Lunghofer, 1995; Zlotnick, 1997). The research shows that these experiences have devastating and debilitating effects on survivors' growth and development and have influenced their path to incarceration (Browne and Finklehor, 1986; Herman, 1992).

Multiple studies of female inmates have identified post-traumatic stress disorder (PTSD), depression, and substance abuse and dependence as the most common psychiatric disorders in women's facilities, with substantially higher rates present in incarcerated women than women in

the community (Hutton et al., 2001; Jordan, Schlenger, Fairbanks, and Cadell, 1996; Lewis, 2003, 2005; Teplin, Abram, and McLelland, 1996). In fact, PTSD in female inmates is two to three times higher than in the general population (Kessler, 1995), and women, in general, appear to be more vulnerable to PTSD (Kupers, 2005; Norris, 1992).

To meet the unique personal needs and situational and contextual issues facing women, corrections agencies have begun developing much-needed gender responsive (Berman, 2006; Bloom, 1999; Chesney-Lind 1997, 2000; Covington, 1998, 2007, 2008; Covington and Bloom, 2006) and trauma-informed treatments and programs (Elliott, Bjelajac, Fallot, Markoff, and Reed, 2005; Harris and Reed, 2001) focusing especially on the well-being of female inmates.

One particularly important tool in increasing safety for survivors of sexual abuse is early detection and treatment. The PREA regulations incorporate this tool in the adult prison and jail and juvenile facility standards (28 CFR Part 115.81 and 115.381). All PREA-compliant facilities are supposed to assess upon intake whether inmates and youth residents have a history of being sexually abused. Inmates and residents who do have such a history must be offered a follow-up meeting with appropriate mental health professionals.

Such meetings can lead to an ongoing treatment plan that can help survivors of abuse stay safe within a facility and also put them on a path to recovery that can significantly increase their likelihood of successful re-entry upon release. As noted previously, though, far too few facilities have the expertise and depth of services to be able to use this tool to its fullest potential.

C. Recommendations

1. **There must be a sufficient number of properly trained and carefully vetted corrections security staff in all facilities**. Increased numbers of staff alone will not end sexual abuse in detention. As recent BJS reports demonstrate, staff are reported as the perpetrators in more than half of alleged instances of sexual abuse. The PREA regulations outline comprehensive and ongoing education for staff. Facilities must be urged to take full advantage of this opportunity to educate their staff about the dynamics of sexual abuse and the methods of eliminating it.

2. **All corrections staff must be given adequate and appropriate medical and mental health training**. Such training will enable staff to recognize prisoners with mental illness, adequately manage them, and respond appropriately to any threats or incidents of sexual abuse. Ideally, facilities should put in place cross-training with custody staff and mental health professionals.

3. **There must be a sufficient number of credentialed mental health staff at all facilities, including psychiatrists and other prescribers, psychologists, mental health counselors, social workers, and ancillary mental health staff who are available to provide services to inmates**. The staffing goal of medical and mental health departments must be to provide access to care and treatment on both an emergency and an ongoing basis. Medical and mental health must staff have the cooperation of custody staff. Finally,

an individual clinician's caseload must be reasonable and must allow for the provision of effective services to inmates.

4. **The quality of mental health care in all corrections environments should be consistent with the community standard of care, evidence-based, consistent with current scientific practice guidelines, focused on health and resilience, and accessible to all inmates**. Mental health care should be carefully crafted to meet the needs of individual prisoners, holistic in design, and integrated with the health care and other programming being delivered within the institution. Mental health practitioners should be trained to be generalists, skilled in developing treatment plans that take into account individual needs, psychosocial histories, and rehabilitative goals of their clients.

5. **Corrections agencies should develop a full range of supportive programs and services for prisoners with mental illness and developmental and intellectual disabilities.** Community mental health centers routinely focus on enhancing knowledge, appropriate use of psychotropic medication, relapse prevention training, social skills training, coping skills, and vocational training among their clients. Such resources are also vital in assisting prisoners, helping them build skills that will serve them well within the facility and preparing them for returning to the community.

6. **Corrections mental health treatment and services for female prisoners should be trauma informed and gender-responsive**. Because of the unique pathways to incarceration and the special needs of female inmates, it is imperative that their treatment should be trauma-informed and gender-responsive. Such approaches recognize and address the ubiquitous nature of previous trauma, high rates of mental illness and addiction, and impact of gender bias within the female inmate population.

7. **Corrections facilities must provide appropriate psychiatric medications**. In order to manage prisoners with mental disorders effectively, a facility must provide the right medication in the right dosage at the right time and in the right manner. Psychiatric formularies in corrections facilities should be designed so that the care provided is consistent with community standards and current scientific practice recommendations.

8. **Corrections facilities must increase the number of specialized housing environments and units to ensure the safety of mentally compromised prisoners, especially those with serious, persistent mental illness and substantial developmental and intellectual disabilities**. Development of intermediary mental health units and therapeutic communities may ease the burden on corrections agencies in managing such inmates, while also increasing safety. Corrections officers and other staff in these environments must be carefully vetted and specially trained, so that they can supervise and support these inmates with behavioral incentive programs in an inter-disciplinary manner.

9. **Corrections agencies must provide suicide training for all staff and develop strong policies and practices for managing suicide**. Because the risk of suicide is ever present in detention, corrections agencies have to redouble their efforts to train all staff in recognizing risks of suicide, managing prisoners at risk, and providing a valid system to

respond to suicide risk. Medical and mental health staff must recognize that the traditional responses of isolation and observation, while effective for ensuring immediate safety, often is experienced as revictimizing by survivors of sexual abuse.

10. **Corrections agencies must ensure that inmates have access to adequate community re-entry and reintegration services**. As the vast majority of inmates ultimately return to the community, it is especially important that prisoners, especially those with serious, persistent mental illness and those who have experienced sexual abuse, are provided with referrals to community mental health programs. Inmates need a continuation of psychiatric medications, appropriate transfer and follow-up to community care, and assistance in securing safe housing. For many prisoners, a period of incarceration may be a rare opportunity to receive treatment, stabilize on medication, and be exposed to consistent, supportive care. Survivors of trauma, in particular, may be more amenable to reaching out for help in the community immediately after being released, reducing the likelihood that they will be arrested again.

11. **Corrections department should consider developing specialized response teams similar to the Crisis Intervention Teams (CIT) currently in operation in many jurisdictions**. The National Institute of Corrections has developed a model for crisis intervention teams that is noteworthy. Such teams can ensure that prisoners with serious mental illness are managed effectively, minimizing the use of force and maximizing the safe resolution of psychiatric crises.

12. **Agencies must create corrections environments that focus on dignity and respect for all prisoners and ensure that those who are incarcerated are afforded legal, safe, constitutional care and custody.** Staff non-compliance with standards of professional behavior can never be tolerated, and must be immediately identified and corrected by agency or facility management and supervisory staff. Corrections environments must have a zero tolerance for sexual abuse and for language or behavior that demeans inmates or staff because of their race, ethnicity, religion, sexual orientation, gender, gender identity, or disability. Staff members must also be given tools for effective communication with inmates who are culturally different from them through training, mentoring, and supervision.

13. **Continued efforts must be made to help agencies understand how the PREA standards work together.** The PREA regulations are a set of groundbreaking standards which, once fully implemented, have the potential to dramatically improve safety in U.S. corrections facilities. However, the standards for adult jails and prisons and juvenile facilities each have more than fifty provisions and run dozens of pages. All agencies must ensure that their staff understand how the various standards work together. One such tool is included at Appendix 1.

14. **We must find a way in the United States to decrease the overall number of inmates without compromising public safety**. It is economically untenable to continue to incarcerate such large numbers of individuals in America's jails, prisons, and juvenile facilities. Instead, we must employ judicial diversion alternatives like drug courts, mental

health courts, administrative home confinement, and placement in alternative and community corrections environments.

U.S. corrections agencies can, and must, together with their community partners, respond with vision and leadership to the problem of sexual violence. Just Detention International and I look forward to continuing the effort to end sexual abuse in U.S. detention once and for all. It is possible to run safe prisons, jails, and youth facilities where every person's human rights and dignity are protected and from which the most vulnerable among us can emerge stronger and healthier than they were when they went in.

I would like to thank the Review Panel for allowing me to speak today.

I swear that the above is true to the best of my knowledge, skill, and ability, submitted this fourteenth day of November, 2013, under the pains and penalty of perjury.

Respectfully submitted,

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Legal Cases

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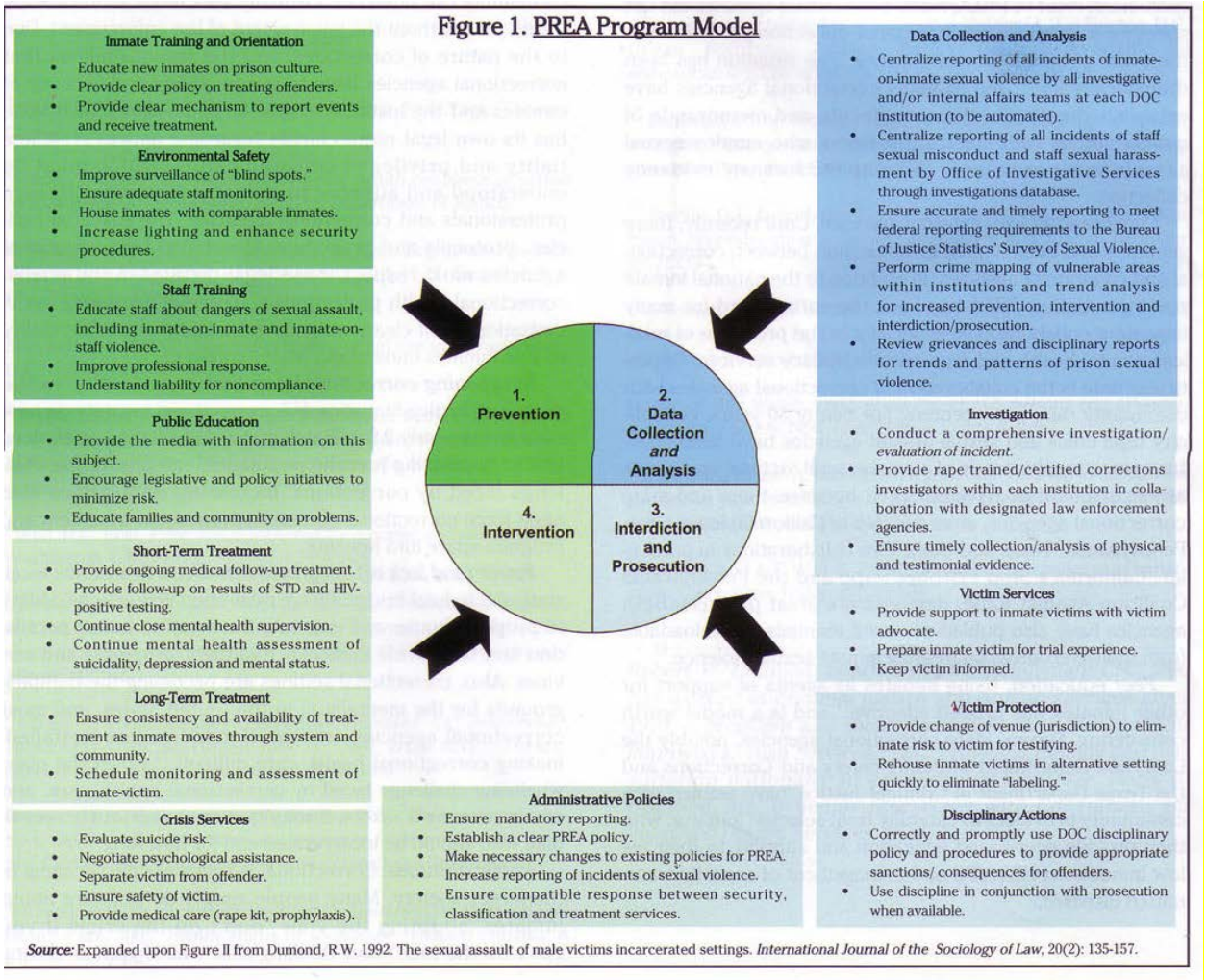
Appendix 1

In 1982, Donald Cotton and A. Nicholas Groth advanced a model program for consideration in effectively responding to prison rape, with an emphasis on three issues -- prevention, intervention, and prosecution. I reviewed and expanded this model in an early consideration of male sexual assault in corrections settings (Dumond, 1992), and expanded the model to include four dimensions: (1) Intervention; (2) Data Collection and Analysis; (3) Interdiction and Prosecution; and (4) Intervention (Dumond and Dumond, 2007). This conceptualization, which has been summarized in Figure I (Dumond and Dumond, 2007, p. 77), remains as a blueprint for all correctional agencies to respond to prisoner sexual abuse effectively.



Source: Expanded upon Figure II from Dumond, R.W. 1992. The sexual assault of male victims incarcerated settings. *International Journal of the Sociology of Law*, 20(2): 135-157.