AFTERNOON SESSION

HOW DOES OUR NATION CONFRONT PRISON RAPE:

THE MEDICAL, EMOTIONAL AND MENTAL HEALTH

QUESTIONS

COMMISSIONER SMITH: I actually have a question for Ms. Turner and Mr. Dumond. Both of you have talked a lot about the importance of either or both medical and mental health interventions. I know that both of you have done work with people who are in institutional settings, and I know, Mr. Dumond, you're currently working with the Massachusetts Department of Corrections.

There particular elements of a protocol or policy that you think would be helpful in addressing prisoner sexual assault, especially taking into consideration that it's not necessarily immediately reported?

MR. DUMOND: Oh, absolutely. I think that there are some models of protocols for both medical and mental health preventions that can be quite helpful. One of the --

COMISSIONER FELLNER: Excuse me, could you move your microphone a little bit closer?

MR. DUMOND: Yes, I'm sorry. There are both medical and mental health protocols which have been implemented which could be quite helpful, and certainly should help inform the commission as possible promising practices. One caveat, however, that I would like to raise which raises a troubling problem, and we heard some of it this morning from some of the survivors.

If a medical or mental health staff person is employed by a Department of Corrections, if a medical or mental health staff person is employed by the Department of Corrections, that individual -- if a prisoner comes forward and reports victimization, by statute and by protocol, that individual, that medical or mental health provider, is required to report that to the institutional security folks. And that creates sort of a disconnect for what's happening in the community practice.

In a community practice, a victim can go to a medical health provider or a hospital to get services for the victimization, and not necessarily have to report to a law enforcement agency and;

therefore, they can at least get the treatment both medically and mental health wise for their particular problem.

In a prison setting, that is actually not possible given the way prisons and jails are constructed. The prison, the correctional institution is required for the care, custody, and control of that particular prisoner. If that person presents themselves as having been violated sexually, there's a duty, as far as the correctional institution, to respond not only to the medical and mental health issues, but also to protect that person for an investigation.

So, one of the challenges that I would to propose for the commission, and I'm not sure that I even know how to answer that, I'm not sure there is a substantial answer. There needs to be alternative mechanisms not only to report, but also to get treatment and support services for those individuals because under the current model, individuals who are victimized, there has to be a reporting to the security staff, and there has to a subsequent investigation. So, that's really an

issue, I think, of concern.

COMMISSIONER SMITH: I'm aware that at least in California, California allows people to have services for -- victim services that are actually outside of the prison. So, for example, a California rape crisis center or something would be able to come in and provide some assistance.

MR. DUMOND: And I think that would be a very plausible model, however, one of the other things that I'm sure the commission is aware of, the traditional victim service community that is either prosecutor-based or that's based in the community, often does not see prisoners as victims. And even in the face of the compelling evidence that we have, they would not necessarily embrace the fact of endorsing or supporting services to that population, or even being in that position to provide for it. So, I think we need to implore a lot of education on that in the community as well.

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MS. TURNER: I don't work in education but, I do want to learn about the discharge planning for these victims. My consultant works with a nonprofit agency that provides reentry services for women, District of Columbia women who are coming out of jails and prisons. And we outreach to women while they're still in custody. We go to jails here in D.C., we go to the halfway houses to try to get the linkages with women.

But we may miss some. And if we miss some, it would be helpful to having some discharge planning coming in the other direction to try to help those inmates who are going to be released to link them to community agencies. And there could be case managers inside of the institution making phone calls and providing information and education to those inmates, talking to us, providing our names and phone numbers, so that those ex-offenders are not having to find us the best way they can

when they come out of the institution.

But those linkages, planning, and anticipation of that person's release and assisting them in making some contact with their local community would be very helpful as well.

THE CHAIRMAN: The effort you've just described, how long have you been involved with that?

MS. TURNER: This was Our Place since 2002.

THE CHAIRMAN: And how many women would you estimate you have had contact with who were reentered into the community during that period?

MS. TURNER: I'm a mental health consultant at Our Place. We see women in one-on-one counseling sessions there. And I've probably seen 70, 75.

THE CHAIRMAN: And do you routinely inquire of them whether they were the victim of any type of sexual assault?

MS. TURNER: I do. I do. It's a part of our standard assessment as a commission of doing this work to inquire. And what I find is that a

lot of people are not going to acknowledge that. They may not acknowledge that immediately, but later on as they develop a relationship with you as a clinician and they learn to trust you, then more of this information pours forth because there's a great deal of guilt and shame around this issue. And a lot of people just really need to feel like they can trust you first.

They need to be convinced that you care and that you're not stigmatizing them. And that you're really concerned about their health and welfare before you get the whole story. So after I worked with a client for, I would say, six months, nine months or a year, I know a lot more about that person than I did in my first couple of sessions with them.

THE CHAIRMAN: Do you know or can you estimate how many of those women who have said that they were sexually assaulted while incarcerated?

MS. TURNER: I would say that

approximately 25 percent have acknowledged they had an experience while incarcerated, yes, either in prison or jail or in the halfway house.

MR. DUMOND: I think one of the other things you need to consider is that unfortunately, correctional mental health as it's currently conceived, is really putting out fires, if you will. I mean it's managing a population that is extraordinarily disordered, and there are suicidal accolades that are having a whole host of major psychiatric problems. And as a result, long-term therapy is trying to described it as even not even available in many institutions because it's really a crisis-orientation mode. So that's one consideration.

The other consideration is that we need to consider that for jails, about half of the jails in the United States have 50 persons or less, so the availability of on-site medical staff is not even available. And, in fact, you would have to engage community folks for those kinds of services. And unfortunately, the linkages aren't even there

in many of those institutions to be able to be able to provide that.

And I think the other thing to consider is the availability of staff training and ongoing staff training for both medical and mental health providers really needs to be increased and improved dramatically. It has been authored by some analysts that institutional mental health folks may know more about treating sex offenders than treating sexual victimization. And I think that's something that we really need to bring all of the people that provide these services onboard, give them the adequate skill set and training to provide and deal with that.

The other issue is the addition of formularies. For psychiatric intervention, the available medication may be severely restricted by the formularies which are currently in place in the institution. And it needs to be a vehicle to identify the best intervention, the best prophylaxis in terms of psychiatric medication, and to allow formularies to be able to intricately

introduce those when and if it is appropriate for particular victims.