The Prison Rape Elimination Act and Correctional Psychiatrists

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J Am Acad Psychiatry Law 44:9–13, 2016

Rape and sexual assault are violent crimes that exact severe and lasting emotional and functional tolls. Our society is currently grappling with the pervasiveness of sexual assault in our communities and the development of both preventive interventions and *post hoc* approaches to effective legal redress. Unlike those that occur in community settings, sexual assaults in jails and prisons have long been seen as a consequence of incarceration that society is willing to ignore and tacitly accept. That attitude is no longer prevalent. The Prison Rape Elimination Act of 2003 (PREA, Public Law 108-79),[1] signed into law by President George W. Bush on September 4, 2003, states:

> . . . inmates with mental illness are at increased risk of sexual victimization. America's jails and prisons house more mentally ill individuals than all of the Nation's psychiatric hospitals combined. As many as 16 percent of inmates in State prisons and jails and 7 percent of Federal inmates suffer from mental illness [Ref. 1, p 117].

Although this comprehensive Act addresses the role of mental health professionals only in general, this editorial briefly reviews the history and context of PREA and then proposes that psychiatrists working in jail or prison settings should assume key roles in assessment and treatment of survivors of sexual assault.

History

For years, inmate sexual assault was described by some as inevitable and "the extra punishment anyone sentenced to prison can expect."[2] Although there was some discussion of inmate welfare, no agenda or effort translated these concerns into policy until 1994. At that time, the Supreme Court ruled that prisons that fail to protect inmates from sexual assault were in violation of the Eighth Amendment, which forbids cruel and unusual punishment (*Farmer v. Brennan,* 1994).[3] Human Rights Watch[4] and Amnesty International[5] issued reports describing the extent of sexual abuse of female inmates. The advocacy group that would become Stop Prisoner Rape (SPR), cofounded by Russell Smith and prison rape survivor Stephen Donaldson, released a prisoner rape education program. The media were integral to bringing attention to prison rape, reporting findings published in academia. Public awareness grew that prison rape has downstream public health consequences. Victims can become infected with HIV/AIDS and then return to their communities of origin when released. Despite this growing attention, correctional systems made little apparent effort to address or eliminate rape. Some argue that it was the resistance of correctional systems that provided the necessary pressure for Congress to pass the Prison Rape Elimination Act (PREA) of 2003.[2] PREA in turn created the National Prison Rape Elimination Commission (NPREC), a bipartisan group that met from July 2004 through August 2009. The NPREC was charged with reporting on the nature and causes of prison rape and with recommending national standards to the U.S. Attorney General for reducing its occurrence. The NPREC released its final report in June, 2009[6] in the form of a four-volume set of standards for adult prisons and jails (with supplemental standards for immigration detainees),[7] juvenile facilities,[8] lockups,[9] and community corrections.[10]

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Disclosures of financial or other potential conflicts of interest: None.

Inmates With Mental Illness at Risk

Research has consistently found that at any given time in the United States, there are more mentally ill individuals in jails and prisons than in psychiatric facilities.[11] In the NPREC standards, inmates with mental illness were specifically identified as an at-risk group for sexual assault; consistent estimates suggest that 12 to 13 percent of prison rape allegations involve an inmate with mental illness or intellectual limitations, eight times the proportion of the general inmate population.[6] The importance of a coordinated response at the facility level was clearly described, going beyond actions taken in response to an incident of sexual abuse to include a genuine culture change intended to eliminate prison and jail sexual assault.

Although the NPREC created standards, PREA designated the National Institute of Corrections (NIC) as the agency responsible for training and technical assistance and for serving as a national information clearinghouse. The National Institute of Justice (NIJ) was similarly tasked to provide research-based evidence to improve knowledge, practice, and policy addressing sexual violence in prisons.[1]

Specialized Training

Specific to mental health professionals, the NPREC standards, NIC training, and related documents identify the need for specialized training for mental health and medical professionals in screening, prevention planning, allegation management, and investigation of prison rape. At the time of intake screening, pursuant to § 115.41,[12] if an inmate affirms experiencing or perpetrating prior sexual victimization in the community or facility, that inmate is to be offered a follow-up meeting with a medical or mental health practitioner within 14 days of intake. Although the language of the standards refers generally to "mental health practitioner," the explicit role of the psychiatrist is not identified. Psychiatrists should look at this opportunity to shape the curriculum in their facility or system to assure that it is extensive, authoritative, and effectively conveys the needed knowledge and skill base. Further, the unique role of the psychiatrist may be defined in terms of diagnosis, management, and treatment of a prison rape victim, at a minimum.

Stress Disorder Diagnoses

"Rape trauma syndrome," a term initially coined in the 1970s, is a state characterized by an acute phase of disorientation, followed by reorganization and resolution (Ref. 13, p 9). This term has been adopted formally as a nursing diagnosis.[14]

DSM-5 now devotes an entire chapter, "Trauma and Stressor Related Disorders," to these disorders (Ref. 15 pp 265–290). Although DSM-5 provides guidance, the rape victim most likely will not present as delineated in the manual. As the inmate's manifestation of symptoms is not linear, it is imperative that the correctional psychiatrist recognize that an inmate can manifest symptoms subsequent to sexual trauma at any point throughout the incarceration.[13] Moreover, an inmate with pre-existing mental illness who becomes a victim of sexual assault may present with primary illness exacerbation and additional signs and symptoms of a secondary illness. For example, the stressor criterion (Criterion A) for acute stress disorder (ASD) in DSM-5 requires specific identification of direct experience, indirect experience, or witnessed traumatic events. Individuals may now meet diagnostic criteria in DSM-5 for ASD if any 9 of 14 listed symptoms are present.[15] Although DSM-5 attempts to take into account the many ways in which an individual suffering with ASD or posttraumatic stress disorder (PTSD) may present, incarcerated patients have even more heterogeneous symptoms and functional impairment.

Increased Suicide Risk

Victims of sexual assault are at a significantly higher risk for suicide, given the common sequelae of increased fear, stress, and anxiety. The risk is especially high in men, as higher percentages of men than women experience distress about their sex-role reputations.[2,16] The research of Struckman-Johnson[16] in Midwestern prisons document suicidal ideation among inmate victims of sexual assault, both male and female. Responses affirming sexual coercion were reported by both sexes in prisons that were overcrowded, and assaults were alleged to have originated both from staff and from other inmates. When assessing a victim, psychiatrists should inquire specifically about suicidal ideation immediately after an assault, as that is the time of highest risk. However, given the potential for delayed symptom manifestation, careful

assessment of suicidal ideation should be conducted at each subsequent interaction thereafter.

Treatment

The goals of treatment for individuals with a diagnosis of ASD or PTSD include reducing the severity of ASD or PTSD symptoms, preventing or treating trauma-related comorbid conditions that may be present or emerge, improving adaptive functioning and restoring a psychological sense of safety and trust. Patients assessed within hours or days after an acute trauma may present with overwhelming physiological and emotional symptoms (e.g., insomnia, agitation, emotional pain, and dissociation). Pharmacotherapy may be the first-line intervention for acutely traumatized patients whose degree of distress prevents new verbal learning or nonpharmacological treatment strategies.

In the jail or prison system, it is not atypical that victims of sexual abuse have great difficulty in making the decision to come forward and report the incident. During this initial phase, when life has been suddenly disrupted by an external event, the victims may be left feeling confused, anxious, and upset, with a compromised sense of self and autonomy. It is while in this state that the inmate is expected to report the assault, talk to multiple officials, undergo the gathering of physical evidence, and so forth. In the community, the traumatically assaulted individual might rely on a support system, and subsequently remove himself from the location of the crime and the aggressor. Moving to a safer location has historically not been possible during incarceration. PREA now mandates that the victim be provided with a victim advocate from a rape crisis center as soon as possible. The facility has the responsibility to place the victim in a safe environment, with involuntary segregated housing as last resort (for no more than 24 hours), while finding a safe nonpunitive location for the victim. However, although the victim may now feel safe, the reality is that the inmate has been separated from any routines and support systems formed during incarceration.

As part of PREA, mental health care practitioners are to receive training in detecting signs of sexual abuse and sexual harassment, in preserving physical signs of sexual abuse, in responding effectively and professionally to victims of sexual abuse and sexual harassment, and in reporting allegations or suspicions of sexual abuse and sexual harassment. Although it is atypical, it is possible that the psychiatrist is either the first responsible individual on the scene or the person to whom the victim first discloses the assault. Hence, within the correctional setting, in addition to training on identification of signs and symptoms of sexual abuse and harassment, practitioners also have to be trained in preserving physical evidence.

Research has not consistently identified patient- or trauma-specific factors that predict the development of ASD or interventions that will alter the evolution of ASD into PTSD. Effective treatments for the symptoms of ASD or PTSD encompass psychopharmacology, psychotherapy, and psychoeducation. With an acute trauma, the timing and nature of the first mental health contact may vary. Although some individuals who have been sexually assaulted are able to benefit from supportive and psychological interventions, some victims may exhibit hysteria, sadness, anger, and hostility, whereas others may demonstrate no emotion at all. They may be numb or in shock or have difficulty expressing themselves. Others may not be comfortable expressing emotion and therefore may appear totally calm, composed, and quiet. Any of these reactions may be observed. One should not expect a sexual abuse victim to act in a particular way.[13]

Although the formal assessment may be postponed, it is imperative that the victim be assessed for dangerousness to self or others. In evaluations that occur shortly after exposure to the traumatic event, the initial clinical response generally consists of supportive psychiatric care and assessment.[17,18]

By definition, ASD occurs within four weeks of the trauma and lasts for a minimum of three days.[15] Consequently, it can be diagnosed through four weeks after the traumatic event. If symptoms meeting the criteria are present one month subsequent to the traumatic episode, PTSD is the appropriate diagnosis. Because diagnostic assessment may occur at any time after a traumatic event, the clinician must bear these essential distinctions in mind when evaluating the trauma-exposed individual. Although it has been hypothesized that pharmacological treatment soon after trauma exposure may prevent the development of ASD and PTSD, existing evidence is limited and preliminary.[19] Thus, no specific pharmacological interventions are currently recommended to prevent the development of ASD or PTSD in at-risk individuals. Further, exposure to previous trauma

may modify vulnerability to subsequent trauma. For example, a victim may have become convinced at the time of a prior traumatic incident that the best way to get over it is just to act normal; thus, showering, grooming, eating and attempting to seem "okay" may influence the development of PTSD and complicate treatment and recovery.[13,15,20]

In the short- and long-term after an incident, victims may become depressed or anxious. In someone with a preexisting mental illness, this stressor may exacerbate symptoms that had been controlled. A victim with bipolar disorder may begin to manifest symptoms of mania, including less need for sleep, an increase in goal-directed activities, and elevated or irritable mood.[15,19] An inmate with a preexisting mental illness may also exhibit signs or symptoms of a separate disorder altogether. Further, a victim with a previous diagnosis of PTSD may experience a relapse.[19] The correctional psychiatrist should identify the patient's symptoms and decide how best to treat them.

Over the weeks after the sexual abuse, victims should be followed up by the mental health team as they will most likely exhibit a range of emotions, including fear of being alone or being around others, and significant changes in pursuit of activities that they enjoyed before the abuse. They may also exhibit retraumatization in response to triggers in the environment in the form of shock, denial, humiliation, self-doubt, guilt, shame, self-blame, depression, self-hatred or anger in the form of a desire for revenge, or suicidal thoughts.[19,20,21]

Conclusion

For years, prison sexual violence was an ingrained part of correctional culture. There was no realistic recourse for inmate victims, or in general, for the individuals responsible for their care and custody. The Prison Rape Elimination Act (PREA) is the first U.S. federal law passed that addresses the right of incarcerated individuals to be safe from sexual assault. This comprehensive act requires all correctional institutions to execute and comply with PREA standards. Monitoring and evaluating PREA-related data that are reported from the nation's correctional facilities is imperative. It is clear that while new data are being gathered, specialized training for mental health practitioners should continue to evolve as well. Correctional psychiatrists should be actively engaged in curriculum development and training efforts. They have critical roles in the assessment, management, and treatment of sexual assault survivors. PREA creates an opportunity for psychiatrists to take key leadership roles in this defined area. More than that, such engagement can and should be leveraged to take an active role in shaping the nation's management of mental illness in correctional settings, working to reduce the risks and improve the conditions of incarceration while seeking to empower those in our care to lead healthier, more productive lives.

References

1. Prison Rape Elimination Act: 42 U.S.C.§§ 15602-15609 (2003). Available at http://www.gpo.gov/fdsys/pkg/PLAW-108publ79/pdf/PLAW-108publ79.pdf/. Accessed June 1, 2015
2. Struckman-Johnson C, Struckman-Johnson D: Stopping prison rape: the evolution of standards recommended by PREA's National Prison Rape Elimination Commission. Prison J 93:335–354, 2013
3. Farmer v. Brennan, 511 U.S. 825 (1994)
4. Human Rights Watch: All Too Familiar: Sexual Abuse of Women in U.S. State Prisons. New York: Human Rights Watch, 1996
5. Amnesty International: Not Part of my Sentence: Violations of the Human Rights of Women in Custody. New York: Amnesty International, 1999
6. National Prison Rape Elimination Commission: National Prison Rape Elimination Commission Report. NCJ226680. Washington, DC: National Prison Rape Elimination Commission. June 2009. Available at http://cybercemetery.unt.edu/archive/nprec/. Accessed June 8, 2015
7. National Prison Rape Elimination Commission: Standards for the prevention, detection, response, and monitoring of sexual abuse in adult prisons and jails. NCJ22682. Washington, DC: National Prison Rape Elimination Commission. 2009. Available at http://nprec.us/publication/standards/adult_prisons_and_jails/. Accessed on June 8, 2015
8. National Prison Rape Elimination Commission: Standards for the prevention detection, response, and monitoring of sexual abuse in juvenile facilities. NCJ22684, Washington, DC: National Prison Rape Elimination Commission. 2009. Available at http://nprec.us/publication/standards/juvenile_facilities/. Accessed June 8, 2015
9. National Prison Rape Elimination Commission: Standards for the prevention, detection, response, and monitoring of sexual abuse in lockups. NCJ22685. Washington, DC: National Prison Rape Elimination Commission. 2009. Available at http://nprec.us/publication/standards/lockups/. Accessed June 8, 2015
10. National Prison Rape Elimination Commission: Standards for the prevention detection, response, and monitoring of sexual abuse in community corrections. NCJ22684. Washington, DC: National Prison Rape Elimination Commission. 2009. Available at http://nprec.us/publication/standards/community_corrections/. Accessed June 8, 2015
11. Treatment Advocacy Center: More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of the States. Arlington, VA: Treatment Advocacy Center. 2010. Available at http://www.tacreports.org/storage/documents/2010-jail-study.pdf/. Accessed June 8, 2015
12. Prison Rape Elimination Act: Prisons and Jails Standards. United States Department of Justice Final Rule, 2012

13. Just Detention International: Hope For Healing: Information for Survivors of Sexual Assault in Detention. Los Angeles, CA: Just Detention International, 2009
14. Burgess AW, Holstrom L: Crisis and counseling requests of rape victims. Nurs Res 23:196–202, 1974
15. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders. Fifth Edition, Washington, DC: American Psychiatric Association, 2013
16. Struckman-Johnson C, Struckman-Johnson D: Sexual coercion rates in seven Midwestern prison facilities for men. Prison J 80: 379–390, 2000
17. Dumond RW, Dumond DA: Working with female offenders: gender specific and trauma informed programming, in Managing Special Populations in Jails and Prisons. Edited by Stojkovic S. Volume II, Part IV, Chapter 13. Kingston, NJ: Civic Research Institute. 2010
18. Fagan TJ, Augustin D: Criminal justice and mental health systems, in Correctional Mental Health: From Theory to Best Practice. Edited by Fagan TJ, Ax RK. Los Angeles: Sage, 2011 pp 7–35
19. Ursano RJ, Bell C, Eth S, *et al*: Practice guideline for the treatment of patients with acute stress disorder and posttraumatic stress disorder. Am J Psychiatry 161(11 Suppl), 3–31, 2004
20. Fleisher MS, Krienert JL: The Culture of Prison Sexual Violence. Washington, DC: National Institute of Justice. Final Report of Grant No. 2003-RP-BX-1001, 2006
21. Elliott D, Bjelajac P, Fallot RD, *et al*: Trauma-informed or trauma-denied: principles and implementation of trauma-informed services for women. J Community Psychol 33:461–477, 2005