Organization	Ethical Codes and Guidelines	Website
American Academy of Physician Assistants	**Code of Ethics** **Confidentiality-**Physician assistants should maintain confidentiality. By maintaining confidentiality, PAs respect patient privacy and help to prevent discrimination based on medical conditions. If patients are confident that their privacy is protected, they are more likely to seek medical care and more likely to discuss their problems candidly. In cases of adolescent patients, family support is important but should be balanced with the patient's need for confidentiality and the PA's obligation to respect their emerging autonomy. Adolescents may not be of age to make independent decisions about their health, but providers should respect that they soon will be. To the extent they can, PAs should allow these emerging adults to participate as fully as possible in decisions about their care. It is important that PAs be familiar with and understand the laws and regulations in their jurisdictions that relate to the confidentiality rights of adolescent patients. (See the section on ***Informed Consent***.) Any communication about a patient conducted in a manner that violates confidentiality is unethical. Because written, electronic, and verbal information may be intercepted or overheard, the PA should always be aware of anyone who might be monitoring communication about a patient. PAs should choose methods of storage and transmission of patient information that minimize the likelihood of data becoming	http://www.aapa.org/

Organization	Ethical Codes and Guidelines	Website
AAPA Cont'	available to unauthorized persons or organizations. Computerized record keeping and electronic data transmission present unique challenges that can make the maintenance of patient confidentiality difficult. Pas should advocate for policies and procedures that secure the confidentiality of patient information.	
American Counseling Association	**Code of Ethics** **B.1.c. Respect for Confidentiality:** Counselors do not share confidential information without client consent or without sound legal or ethical justification. **B.1.d. Explanation of Limitations:** At initiation and throughout the counseling process, counselors inform clients of the limitations of confidentiality and seek to identify foreseeable situations in which confidentiality must be breeched. **B.2.a. Danger and Legal Requirements:** Confidentiality does not apply when disclosure is required to protect clients or identified others from serious and foreseeable harm or when legal requirements demand that confidential information must be revealed. Counselors consult with other professionals when in doubt as to the validity of	http://www.counseling.org/

Organization	Ethical Codes and Guidelines	Website
ACA Cont'	an exception. Additional considerations apply when addressing end-of-life issues.	
American Medical Association	**Code of Medical Ethics** **E 5.505 Confidentiality**-The information disclosed to a physician during the course of the relationship between physician and patient is confidential to the greatest possible degree. The patient should feel free to make a full disclosure of information to the physician in order that the physician may most effectively provide needed services. The patient should be able to make this disclosure with the knowledge that the physician will respect the confidential nature of the communication. The physician should not reveal confidential communications or information without the express consent of the patient, unless required to do so by law. The obligation to safeguard patient confidences is subject to certain exceptions which are ethically and legally justified because of overriding social considerations. Where a patient threatens to inflict serious bodily harm to another person or to him or herself and there is a reasonable probability that the patient may carry out the threat, the physician should take reasonable precautions for the protection of the intended victim, including notification of law enforcement authorities. Also,	http://www.ama-assn.org/

Organization	Ethical Codes and Guidelines	Website
AMA Cont'	communicable diseases and gun shot and knife wounds should be reported as required by applicable statutes or ordinances.	
American Mental Health Counselors Association	**Code of Ethics** **Principle 1- Welfare of the Consumer: J. Informed Consent** Mental health counselors are responsible for making their services readily accessible to clients in a manner that facilitates the clients' abilities to make an informed choice when selecting a provider. This responsibility includes a clear description of what the client can expect in the way of tests, reports, billing, therapeutic regime and schedules, and the use of the mental health counselor's statement of professional disclosure. In the event that a client is a minor or possesses disabilities that would prohibit informed consent, the mental health counselor acts in the client's best interest. **Principle 2- Clients' Rights** The following apply to all consumers of mental health services, including both in- and out-patients and all state, county, local, and private care mental health facilities, as well as clients of mental health practitioners in private practice.	http://www.amhca.org/

Organization	Ethical Codes and Guidelines	Website
AMHCA Cont'	The client has the right: A) To be treated with dignity, consideration and respect at all times; B) To expect quality service provided by concerned, trained, professional and competent staff; C) To expect complete confidentiality within the limits of the law, and to be informed about the legal exceptions to confidentiality; and to expect that no information will be released without the client's knowledge and written consent; D) To a clear working contract in which business items, such as time of sessions, payment plans/fees, absences, access, emergency procedures, and third-party reimbursement procedures are discussed; E) To a clear statement of the purposes, goals, techniques, rules of procedure and limitations, as well as the potential dangers of the services to be performed, and all other information related to or likely to affect the ongoing mental health counseling relationship; F) To appropriate information regarding the mental health counselor's education, training, skills, license and practice	

Organization	Ethical Codes and Guidelines	Website
AMHCA Cont'	limitations and to request and receive referrals to other clinicians when appropriate; G) To full, knowledgeable, and responsible participation in the ongoing treatment plan to the maximum extent feasible; H) To obtain information about their case record and to have this information explained clearly and directly; I) To request information and/or consultation regarding the conduct and progress of their therapy; J) To refuse any recommended services and to be advised of the consequences of this action; K) To a safe environment free of emotional, physical and sexual abuse; L) To a client grievance procedure, including requests for consultation and/or mediation; and to file a complaint with the mental health counselor's supervisor, and/or the appropriate credentialing body; and	

Organization	Ethical Codes and Guidelines	Website
AMHCA Cont'	M) To a clearly defined ending process, and to discontinue therapy at any time. **Principle 3- Confidentiality** Mental health counselors have a primary obligation to safeguard information about individuals obtained in the course of practice, teaching, or research. Personal information is communicated to others only with the person's written consent or in those circumstances where there is clear and imminent danger to the client, to others or to society. Disclosure of counseling information is restricted to what is necessary, relevant and verifiable. A) At the outset of any counseling relationship, mental health counselors make their clients aware of their rights in regard to the confidential nature of the counseling relationship. They fully disclose the limits of, or exceptions to, confidentiality, and/or the existence of privileged communication, if any. B) All materials in the official record shall be shared with the client, who shall have the right to decide what information may be shared with anyone beyond the immediate provider of service and be informed of the implications of the materials to be shared. C) Confidentiality belongs to the clients. They may direct the mental	

Organization	Ethical Codes and Guidelines	Website
AMHCA Cont'	health counselor, in writing, to release information to others. The release of information without the consent of the client may only take place under the most extreme circumstances. The protection of life, as in the case of suicidal or homicidal clients, exceeds the requirements of confidentiality. The protection of a child, an elderly person, or a person not competent to care for themselves from physical or sexual abuse or neglect requires that a report be made to a legally constituted authority. The mental health counselor complies with all state and federal statutes concerning mandated reporting of suicidality, homicidality, child abuse, incompetent person abuse and elder abuse. The protection of the public or another individual from a contagious condition known to be fatal also requires action that may include reporting the willful infection of another with the condition. The mental health counselor (or staff member) does not release information by request unless accompanied by a specific release of information or a valid court order. Mental health counselors will comply with the order of a court to release information but they will inform the client of the receipt of such an order. A subpoena is insufficient to release information. In such a case, the counselor must inform his client of the situation and, if the client refuses release, coordinate between the client's attorney and the requesting	

Organization	Ethical Codes and Guidelines	Website
AMHCA Cont'	attorney so as to protect client confidentiality and one's own legal welfare. In the case of all of the above exceptions to confidentiality, the mental health counselor will release only such information as is necessary to accomplish the action required by the exception. D) The anonymity of clients served in public and other agencies is preserved, if at all possible, by withholding names and personal identifying data. If external conditions require reporting such information, the client shall be so informed. E) Information received in confidence by one agency or person shall not be forwarded to another person or agency without the client's written permission. F) Service providers have the responsibility to ensure the accuracy and to indicate the validity of data shared with their parties. G) Case reports presented in classes, professional meetings, or publications shall be so disguised that no identification is possible unless the client or responsible authority has read the report and	

Organization	Ethical Codes and Guidelines	Website
AMHCA Cont'	agreed in writing to its presentation or publication. H) Counseling reports and records are maintained under conditions of security, and provisions are made for their destruction when they have outlived their usefulness. Mental health counselors ensure that all persons in his or her employ, volunteers, and community aides maintain privacy and confidentiality. I) Mental health counselors who ask that an individual reveal personal information in the course of interviewing, testing or evaluation, or who allow such information to be divulged, do so only after making certain that the person or authorized representative is fully aware of the purposes of the interview, testing or evaluation, and of the ways in which the information will be used. J) Sessions with clients may be taped or otherwise recorded only with their written permission or the written permission of a responsible guardian. Even with a guardian's written consent, one should not record a session against the expressed wishes of a client. Such tapes shall be destroyed when they have outlived their usefulness. K) Where a child or adolescent is the primary client, or the client is	

Organization	Ethical Codes and Guidelines	Website
AMHCA Cont'	not competent to give consent, the interests of the minor or the incompetent client shall be paramount. Where appropriate, a parent(s) or guardian(s) may be included in the counseling process. The mental health counselor must still take measures to safeguard the client's confidentiality. L) In work with families, the rights of each family member should be safeguarded. The provider of service also has the responsibility to discuss the contents of the record with the parent and/or child, as appropriate, and to keep separate those parts, which should remain the property of each family member. M) In work with groups, the rights of each group member should be safeguarded. The provider of service also has the responsibility to discuss the need for each member to respect the confidentiality of each other member of the group. He must also remind the group of the limits on and risk to confidentiality inherent in the group process. N) When using a computer to store confidential information, mental health counselors take measures to control access to such information. When such information has outlived its usefulness, it should be deleted from the system.	

Organization	Ethical Codes and Guidelines	Website
American Nurses' Association	**Code of Ethics** **3.2 Confidentiality**-Associated with the right to privacy, the nurse has a duty to maintain confidentiality of all patient information. The patient's well-being could be jeopardized and the fundamental trust between patient and nurse destroyed by unnecessary access to data or by the inappropriate disclosure of identifiable patient information. The rights, well-being, and safety of the individual patient should be the primary factors in arriving at any professional judgment concerning the disposition of confidential information received from or about the patient, whether oral, written or electronic. The standard of nursing practice and the nurse's responsibility to provide quality care require that relevant data be shared with those members of the health care team who have a need to know. Only information pertinent to a patient's treatment and welfare is disclosed, and only to those directly involved with the patient's care. Duties of confidentiality, however, are not absolute and may need to be modified in order to protect the patient, other innocent parties and in circumstances of mandatory disclosure for public health reasons. Information used for peer-review, third-party payments, and other quality improvements or risk management mechanisms may be disclosed under defined policies, mandates, or protocols. These	http://www.nursingworld.org/

Organization	Ethical Codes and Guidelines	Website
ANA Cont'	written guidelines must assure that the rights, well-being, and safety of the patient are protected. In general, only that information directly relevant to a task or specific responsibility should be disclosed. When using electronic communications, special effort should be made to maintain data security.	
American Philosophical Practitioners Association	**Code of Ethics** **Part I: Fundamental Canons i.** Philosophical practitioners will, above all, endeavor to do no harm. **Part I: Fundamental Canons iv.** Philosophical practitioners will respect the dignity and autonomy of their clients, and will respect their confidentiality and protect their anonymity to the extent required by law. **Part II: Standards of Ethical Practice xii.** At all junctures in the process of providing philosophical services, the philosophical practitioner should seek to maintain the freely given and informed consent of the client. **Part II: Standards of Ethical Practice xiv.** The philosophical practitioner should safeguard a client's right to privacy by treating as	http://www.appa.edu/

Organization	Ethical Codes and Guidelines	Website
APPA Cont'	confidential all information obtained from the client, except where disclosure is required by law or is justified in order to prevent imminent, substantial harm to the client or to others. In all such exceptional cases, disclosure may be made provided that it is made to the appropriate party or authority and no more information than necessary is disclosed. The philosophical practitioner should inform the client of the pertinent limits to confidentiality upon initiating services. **Part II: Standards of Ethical Practice xv.** The philosophical practitioner who confidentially receives information establishing that his or her client has a contagious, fatal disease is justified in disclosing (necessary) information to an identifiable third party who, by his or her relation to the client, is at high risk of contracting the disease. The philosophical practitioner should, however, first confirm that neither the client nor any other party has already disclosed the information nor intends to make the disclosure in the immediate future. Prior to disclosing the information, the practitioner should inform the client of his or her intention to disclose. In proceeding with disclosure, the practitioner should act mindfully of the welfare, integrity, dignity, and autonomy of both client and third party.	

Organization	Ethical Codes and Guidelines	Website
APPA Cont'	**Part II: Standards of Ethical Practice xvi.** The philosophical practitioner should secure and treat as confidential all records and written documents obtained or produced in the course of providing services. Such documents, or the content thereof, may not be shared with other professionals without the freely given and informed consent of the client. **Part II: Standards of Ethical Practice xxiii.** Consistent with the Standards of Ethical Practice, the philosophical practitioner should comply with existing local, state or provincial, and federal laws relevant to the private practice of philosophy and should work for change of existing laws where such laws prevent or obstruct its ethical practice.	
American Public Health Association	**Code of Ethics** 12 Ethical Principles with the 10 Essential Public Health Services: **(9)** enhance physical and social environments **(10)** protect confidentiality	www.apha.org
American Society for Philosophy, Counseling and Psychotherapy	**Standards of Ethical Practice** **Code of Ethics 14.** The philosophical practitioner should safeguard a client's right to privacy by treating as confidential all information obtained from the client, except where disclosure is required by law	http://www.aspcp.org/

Organization	Ethical Codes and Guidelines	Website
ASPCA Cont'	or is justified in order to prevent imminent, substantial harm to the client or to others. In all such exceptional cases, disclosure may be made provided that it is made to the appropriate party or authority and no more information than necessary is disclosed. The philosophical practitioner should inform the client of the pertinent limits to confidentiality upon initiating services. **Code of Ethics 15.** The philosophical practitioner who confidentially receives information establishing that his or her client has a contagious, fatal disease is justified in disclosing (necessary) information to an identifiable third party who, by his or her relation to the client, is at high risk of contracting the disease. The philosophical practitioner should, however, first confirm that neither the client nor any other party has already disclosed the information nor intends to make the disclosure in the immediate future. Prior to disclosing the information, the practitioner should inform the client of his or her intention to disclose. In proceeding with disclosure, the practitioner should act mindfully of the welfare, integrity, dignity, and autonomy of both client and third party. **Code of Ethics 16.** The philosophical practitioner should secure and treat as confidential all records and written documents obtained or produced in the course of providing services. Such documents, or the	

Organization	Ethical Codes and Guidelines	Website
ASPCA Cont'	content thereof, may not be shared with other professionals without the freely given and informed consent of the client. **Code of Ethics 22.** Philosophical practitioners should keep informed about current statutes, legal precedents, social issues, etc. that are relevant to their practice and which might affect the quality of services they render. Similarly, those practicing as consultants in a specialized field, such as medical ethics, should keep informed of changes in health law and policies that may affect the quality of their services. **Code of Ethics 23.** Consistent with the Standards of Ethical Practice, the philosophical practitioner should comply with existing local, state or provincial, and federal laws relevant to the private practice of philosophy and should work for change of existing laws where such laws prevent or obstruct its ethical practice.	
Association for Addiction Professionals	**Code of Ethics** **Principle 2: Client Welfare** I understand that the ability to do good is based on an underlying concern for the well being of others. I shall act for the good of others and exercise respect, sensitivity, and insight. I understand that my primary professional responsibility and	http://naadac.org/

Organization	Ethical Codes and Guidelines	Website
AAP Cont'	loyalty is to the welfare of my clients, and I shall work for the client irrespective of who actually pays his/her fees. • I shall do everything possible to safeguard the privacy and confidentiality of client information except where the client has given specific, written, informed, and limited consent or when the client poses a risk to himself or others. • I shall provide the client his/her rights regarding confidentiality, in writing, as part of informing the client of any areas likely to affect the client's confidentiality. • I understand and support all that will assist clients to a better quality of life, greater freedom, and true independence. • I shall not do for others what they can readily do for themselves but rather, facilitate and support the doing. Likewise, I shall not insist on doing what I perceive as good without reference to what the client perceives as good and necessary. • I understand that suffering is unique to a specific individual and not of some generalized or abstract suffering, such as might be found in the understanding of the disorder. I also understand that the action taken to relieve suffering must be uniquely suited to the suffering individual and not simply some universal prescription. • I shall provide services without regard to the compensation provided by the client or by a third party and shall render equally appropriate services to individuals whether they are paying a reduced fee or a full fee. **Principle 5: Compliance with Law** I understand that laws and regulations exist for the good ordering of society and for the restraint	

Organization	Ethical Codes and Guidelines	Website
AAP Cont'	of harm and evil, and I am aware of those laws and regulations that are relevant both personally and professionally and follow them, while reserving the right to commit civil disobedience. • I understand that the determination that a law or regulation is unjust is not a matter of preference or opinion but a matter of rational investigation, deliberation, and dispute. • I willingly accept that there may be a penalty for justified civil disobedience, and I must weigh the personal harm of that penalty against the good done by civil protest. **Principle 8: Preventing Harm** I understand that every decision and action has ethical implication leading either to benefit or harm, and I shall carefully consider whether any of my decisions or actions has the potential to produce harm of a physical, psychological, financial, legal, or spiritual nature before implementing them. • I shall refrain from using any methods that could be considered coercive such as threats, negative labeling, and attempts to provoke shame or humiliation. • I shall make no requests of clients that are not necessary as part of the agreed treatment plan. • I shall terminate a counseling or consulting relationship when it is reasonably clear that the client is not benefiting from the relationship. • I understand an obligation to protect individuals, institutions, and the profession from harm that might be done by others. Consequently, I am	

Organization	Ethical Codes and Guidelines	Website
	aware that the conduct of another individual is an actual or likely source of harm to clients, colleagues, institutions, or the profession, and that I have an ethical obligation to report such conduct to competent authorities.	
National Association of Social Workers	**Code of Ethics** **Social Workers' Ethical Responsibilities to Clients** **1.01 Commitment to Clients:** Social workers' primary responsibility is to promote the well-being of clients. In general, clients' interests are primary. However, social workers' responsibility to the larger society or specific legal obligations may on limited occasions supersede the loyalty owed clients, and clients should be so advised. (Examples include when a social worker is required by law to report that a client has abused a child or has threatened to harm self or others.) **1.03 Informed Consent** (a) Social workers should provide services to clients only in the context of a professional relationship based, when appropriate, on valid informed consent. Social workers should use clear and understandable language to inform clients of the purpose of the services, risks related to the services, limits to services because of the requirements of a third-party payer, relevant costs, reasonable	http://www.socialworkers.org/

Organization	Ethical Codes and Guidelines	Website
NASW Cont'	alternatives, clients' right to refuse or withdraw consent, and the time frame covered by the consent. Social workers should provide clients with an opportunity to ask questions. (b) In instances when clients are not literate or have difficulty understanding the primary language used in the practice setting, social workers should take steps to ensure clients' comprehension. This may include providing clients with a detailed verbal explanation or arranging for a qualified interpreter or translator whenever possible. (c) In instances when clients lack the capacity to provide informed consent, social workers should protect clients' interests by seeking permission from an appropriate third party, informing clients consistent with the clients' level of understanding. In such instances social workers should seek to ensure that the third party acts in a manner consistent with clients' wishes and interests. Social workers should take reasonable steps to enhance such clients' ability to give informed consent. (d) In instances when clients are receiving services involuntarily, social workers should provide information about the nature and extent of services and about the extent of clients' right to refuse	

Organization	Ethical Codes and Guidelines	Website
NASW Cont'	service. (e) Social workers who provide services via electronic media (such as computer, telephone, radio, and television) should inform recipients of the limitations and risks associated with such services. (f) Social workers should obtain clients' informed consent before audiotaping or videotaping clients or permitting observation of services to clients by a third party. **1.07 Privacy and Confidentiality** (a) Social workers should respect clients' right to privacy. Social workers should not solicit private information from clients unless it is essential to providing services or conducting social work evaluation or research. Once private information is shared, standards of confidentiality apply. (b) Social workers may disclose confidential information when appropriate with valid consent from a client or a person legally authorized to consent on behalf of a client. (c) Social workers should protect the confidentiality of all information obtained in the course of professional service, except for	

Organization	Ethical Codes and Guidelines	Website
NASW Cont'	compelling professional reasons. The general expectation that social workers will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or other identifiable person. In all instances, social workers should disclose the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made should be revealed. (d) Social workers should inform clients, to the extent possible, about the disclosure of confidential information and the potential consequences, when feasible before the disclosure is made. This applies whether social workers disclose confidential information on the basis of a legal requirement or client consent. (e) Social workers should discuss with clients and other interested parties the nature of confidentiality and limitations of clients' right to confidentiality. Social workers should review with clients circumstances where confidential information may be requested and where disclosure of confidential information may be legally required. This discussion should occur as soon as possible in the social worker-client relationship and as needed throughout the	

Organization	Ethical Codes and Guidelines	Website
NASW Cont'	course of the relationship. (f) When social workers provide counseling services to families, couples, or groups, social workers should seek agreement among the parties involved concerning each individual's right to confidentiality and obligation to preserve the confidentiality of information shared by others. Social workers should inform participants in family, couples, or group counseling that social workers cannot guarantee that all participants will honor such agreements. (g) Social workers should inform clients involved in family, couples, marital, or group counseling of the social worker's, employer's, and agency's policy concerning the social worker's disclosure of confidential information among the parties involved in the counseling. (h) Social workers should not disclose confidential information to third-party payers unless clients have authorized such disclosure. (i) Social workers should not discuss confidential information in any setting unless privacy can be ensured. Social workers should not discuss confidential information in public or semipublic areas such	

Organization	Ethical Codes and Guidelines	Website
NASW Cont'	as hallways, waiting rooms, elevators, and restaurants. (j) Social workers should protect the confidentiality of clients during legal proceedings to the extent permitted by law. When a court of law or other legally authorized body orders social workers to disclose confidential or privileged information without a client's consent and such disclosure could cause harm to the client, social workers should request that the court withdraw the order or limit the order as narrowly as possible or maintain the records under seal, unavailable for public inspection. (k) Social workers should protect the confidentiality of clients when responding to requests from members of the media. (l) Social workers should protect the confidentiality of clients' written and electronic records and other sensitive information. Social workers should take reasonable steps to ensure that clients' records are stored in a secure location and that clients' records are not available to others who are not authorized to have access. (m) Social workers should take precautions to ensure and maintain the confidentiality of information transmitted to other parties through the use of computers, electronic mail, facsimile machines,	

Organization	Ethical Codes and Guidelines	Website
NASW Cont'	telephones and telephone answering machines, and other electronic or computer technology. Disclosure of identifying information should be avoided whenever possible. (n) Social workers should transfer or dispose of clients' records in a manner that protects clients' confidentiality and is consistent with state statutes governing records and social work licensure. (o) Social workers should take reasonable precautions to protect client confidentiality in the event of the social worker's termination of practice, incapacitation, or death. (p) Social workers should not disclose identifying information when discussing clients for teaching or training purposes unless the client has consented to disclosure of confidential information. (q) Social workers should not disclose identifying information when discussing clients with consultants unless the client has consented to disclosure of confidential information or there is a compelling need for such disclosure. (r) Social workers should protect the confidentiality of deceased	

Organization	Ethical Codes and Guidelines	Website
NASW Cont'	clients consistent with the preceding standards.	
National Commission on Correctional Healthcare	**Standards and Guidelines for Delivering Services** **Correctional Mental Health Care** **M-G-09 Procedure in the Event of a Sexual Assault** The medical and psychological trauma of a sexual assault are minimized as much as possible by prompt and appropriate health intervention. **Compliance Indicator 2d:** A report is made to the correctional authorities to effect a separation of the victim from his or her assailant in their housing assignments. **M-H-02 Confidentiality of Health Records and Information** The confidentiality of a patience written or electronic health record, as well as verbally conveyed health information, is maintained. **Compliance Indicator 3:** Access to health records and health information is controlled by the health authority.	http://www.ncchc.org/

Organization	Ethical Codes and Guidelines	Website
NCCH Cont'	**Correctional Health (Medical) Care:** **P-G-09 Procedure in the Event of Sexual Assault** The medical and psychological trauma of a sexual assault are minimized as much as possible by prompt and appropriate health intervention. **Compliance Indicator 2d:** A report is made to the correctional authorities to effect a separation of the victim from his or her assailant in their housing assignments. **P-H-02 Confidentiality of Health Records and Information** The confidentiality of a patience written or electronic health record, as well as verbally conveyed health information, is maintained. **Compliance Indicator 3:** Access to health records and health information is controlled by the health authority.	

SURVEY OF SEXUAL ASSAULT COALITIONS ON QUESTION OF OFFERING SERVICES TO PERSON IN CUSTODY

Methodology: In compiling this information, we have used information from RAINN[1] (Rape, Abuse and Incest National Network) to develop the chart below. Additionally, we have made emails to state coalitions and state and local agencies and asked four questions:

- **Do or would your services extend to incarcerated victims of sexual assault;**
- **Do or would you help victims who are now in the community (such as in halfway houses or on parole) who were sexually abused while incarcerated;**
- **Are the services that you provide to incarcerated persons dependent on status (felony vs. misdemeanor offender) or facility (prison vs. halfway house)**
- **Is Violence Against Women Act Funding used in any of your services for incarcerated or formerly incarcerated person**

The information that we are providing you is based on those emails. We have indicated with a ** those agencies that have indicated on either the state or local level that they will serve incarcerated victims. However, most rape crisis agencies have indicated that they will not serve any person who is convicted of a sex crime of any kind. The starred states that have reported that they do or would provide services to incarcerated victims have more often then not taken the position that will not provide services to sex offenders. We are conducting ongoing research in this area in connection with the development of our curriculum on inmate-inmate sexual violence and a future publication.

STATE	STATE AGENCY[2]	LOCAL AGENCIES
Alabama**	Alabama Coalition Against Rape Montgomery, AL 334-264-0123	**Daybreak Crisis Recovery** Anniston, AL 36207 Hotline Phone: 256-231-0654 **Rape Response** Birmingham, AL 35222 Hotline Phone: 205-323-7273 **Rape Response and Prevention Center of Cullman and Winston Counties** Cullman, AL 35056 Hotline Phone: 256-734-6100 **Mental Health Association**

[1] RAINN 24-hour HOTLINE: 1-800-656-4673

[2] Most of these agencies do not offer direct services just referrals to local agencies or providers.

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Decatur, AL 35602 Hotline Phone: 256-353-1160 **House of Ruth** Dothan, AL 36302 Hotline Phone: 334-793-2232 **Rape Response** Florence, AL 35630 Hotline Phone: 256-767-1100 **Crisis Services of North Alabama Rape Response** Huntsville, AL 35804 Hotline Phone: 256-716-1000 **Rape Crisis Center of Mobile** Mobile, AL 36691 Hotline Phone: 251-473-7273 **Standing Together Against Rape** Montgomery, AL 36109 Hotline Phone: 334-213-1227 **Rape Counselors of East Alabama** Opelika, AL 36801 Hotline Phone: 334-745-8634 **Safehouse of Shelby County** Pelham, AL 35124 Hotline Phone: 205-664-4357 **Crisis Center of Russell County** Phenix City, AL 36868 Hotline Phone: 334-297-4401 **The Lighthouse Rape Crisis Center** Robertsdale, AL 36567 Hotline Phone: 251-947-4393 **"SABRA Sanctuary, Inc."** Selma, AL 36702 Hotline Phone: 334-874-8711 **Turning Point**

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Tuscaloosa, AL 35403 Hotline Phone: 205-758-0808
Alaska**	Alaska Network on Domestic Violence & Sexual Assault (ANDVSA) Juneau, AK 907-586-3650	**Standing Together Against Rape** Anchorage, AK 99503 Hotline Phone: 907-276-7273 **The LeeShore Center** Kenai, AK 99611 Hotline Phone: 907-283-7257 **Women in Safe Homes** Ketchikan, AK 99901 Hotline Phone: 907-225-9474 **Kodiak Women's Resource & Crisis Center** Kodiak, AK 99615 Hotline Phone: 907-486-3625 **Bering Sea Women's Group** Nome, AK 99762 Hotline Phone: 907-443-5444 **Alaska Family Resource Center** Palmer, AK 99645 Hotline Phone: 907-746-4080 **Seward Life Action Council** Seward, AK 99664 Hotline Phone: 907-224-3027 **Sitkans Against Family Violence** Sitka, AK 99835 Hotline Phone: 907-747-6511 **USAFV** Unalaska, AK 99685 Hotline Phone: 907-581-1500 **Advocates for Victims of Violence** Valdez, AK 99686 Hotline Phone: 907-835-2999 **Arctic Women In Crisis** Barrow, AK 99723

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 907-852-0261 **Tundra Women's Coalition** Bethel, AK 99559 Hotline Phone: 907-543-3456 **Cordova Family Resource Center** Cordova, AK 99574 Hotline Phone: 907-424-4357 **Safe and Fear-Free Environment** Dillingham, AK 99576 Hotline Phone: 907-842-2316 **Emmonak Women's Shelter** Emmonak, AK 99581 Hotline Phone: 907-949-1434 **The Interior Alaska Center for Non-Violent Living** Fairbanks, AK 99701 Hotline Phone: 907-452-2293 **South Peninsula Women's Services** Homer, AK 99603 Hotline Phone: 907-235-0247 **Aiding Women from Abuse & Rape Emergencies (AWARE)** Juneau, AK 99802 Hotline Phone: 907-586-1090
Arizona	Arizona Sexual Assault Network (AzSAN) Phoenix, AZ 602-258-1195	**EMPACT-SPC** Tempe, AZ 85282 Hotline Phone: 480-736-4953 **Southern Arizona Center against Sexual Assault** Tucson, AZ 85716 Hotline Phone: 520-327-7273
Arkansas	Arkansas Coalition Against Sexual Assault Clarksville, AR 501-754-6869	**The Courage House** Arkedelphia, AR 71923 Hotline Phone: 870-246-3122 **Family Violence Prevention**

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Batesville, AR 72503 Hotline Phone: 870-793-8111 **Women's Crisis Center of South Arkansas** Camden, AR 71701 Hotline Phone: 888-836-0325 **Ozark Rape Crisis Center** Clarksville, AR 72830 Hotline Phone: 479-754-6869 **Southwest Arkansas Domestic Violence Center** DeQueen, AR 71832 Hotline Phone: 870-584-3441 **Turning Point** El Dorado, AR 71730 Hotline Phone: 888-880-0929 **Crisis Center for Women** Fort Smith, AR 72901 Hotline Phone: 479-782-4956 **Ozark Rape Crisis Center, Inc.2** Harrison, AR 72601 Hotline Phone: 870-741-4141 **Northeast Arkansas Council on Family Violence, Inc.** Jonesboro, AR 72403 Hotline Phone: 870-933-9449 **Options, Inc.** Monticello, AR 71657 Hotline Phone: 870-367-3488 **Rape Crisis: A Program of Family Service Agency** North Little Rock, AR 72114 Hotline Phone: 501-801-2700 **Northwest Arkansas Rape Crisis** Springdale, AR 72764 Hotline Phone: 479-927-1020

STATE	STATE AGENCY[2]	LOCAL AGENCIES
California**	CALCASA Rape Prevention Resource Center Sacramento, CA 916-446-2520	**Tahoe Women Services** King Beach, CA 96143 Hotline Phone: 530-546-3241 **Sutter Lakeside Community Services** Lakeport, CA 95453 Hotline Phone: 707-263-3242 **Sexual Assault Response Services** Lancaster, CA 93534 Hotline Phone: 661-723-7273 **Tri-Valley Haven for Women** Livermore, CA 94551 Hotline Phone: 925-449-5842 **N. County Rape Crisis & Child Protection** Lompoc, CA 93438 Hotline Phone: 805-736-7273 **N. County Rape Crisis & Child Protection** Lompoc, CA 93438 Hotline Phone: 805-928-3554 **Sexual Assault Crisis Agency** **Long Beach, CA 90804** Hotline Phone: 562-597-2002 Business Phone: 562-494-5046 **Rape Treatment Center at Santa Monica-UCLA Medical Center** Los Angeles, CA 90001 Hotline Phone: 310-319-4000 **Los Angeles Commission on Assaults Against Women** Los Angeles, CA 90015 Hotline Phone: 310-392-8381 **Los Angeles Commission on Assaults Against Women** Los Angeles, CA 90015 Hotline Phone: 213-626-3393

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		East Los Angeles Women's Center Los Angeles, CA 90022 Hotline Phone: 323-526-5830 **Center for the Pacific-Asian Family, Inc.** Los Angeles, CA 90036 Hotline Phone: 323-653-4042 **Rosa Parks Sexual Assault Crisis Center** Los Angeles, CA 90062 Hotline Phone: 323-854-4319 **PCIRC SAFE Program, Sierra County** Loyalton, CA 96118 Hotline Phone: 530-283-4333 **Victim Service Center** Madera, CA 93637 Hotline Phone: 559-661-7787 **Mount Crisis Service** Mariposa, CA 95338 Hotline Phone: 209-966-2350 **A Woman Place of Merced County** Merced, CA 95341 Hotline Phone: 209-722-4357 **Haven Women Center of Stanislaus/RCC** Modesto, CA 95354 Hotline Phone: 209-577-5980 **Monterey Rape Crisis Center** Monterey, CA 93942 Hotline Phone: 831-375-4357 **Community Solutions South County Rape Crisis Services** Morgan Hill, CA 95038 Hotline Phone: 408-779-2115 **Volunteer Center of Napa Valley Inc.** Napa, CA 94559 Hotline Phone: 707-258-8000

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Highland Sexual Assault Center Oakland, CA 94602 Hotline Phone: 510-534-9290 **Bay Area Women Against Rape** Oakland, CA 94621 Hotline Phone: 510-845-7273 **Women's Resource Center** Oceanside, CA 92054 Hotline Phone: 760-757-3500 **Coalition To End Domestic & Sexual Violence** Oxnard, CA 93030 Hotline Phone: 805-656-1111 **Coachella Valley Sexual Assault Services** Palm Desert, CA 92260 Hotline Phone: 760-568-9071 **LACAAW -- West San Gabriel Valley Center** Pasadena, CA 91101 Hotline Phone: 626-793-3385 **El Dorado Women's Center** Placerville, CA 95667 Hotline Phone: 530-626-1131 **Project Sister Sex Assault Crisis Services** Pomona, CA 91766 Hotline Phone: 626-966-4155 **Shasta County Women's Refuge** **Redding , CA 96099** **Hotline Phone: 530-244-0117** **Women's Center--High Desert, Inc.** Ridgecrest, CA 93555 Hotline Phone: 760-375-0745
Colorado**	Colorado Coalition Against Sexual Assault	**Alternatives to Violence**

STATE	STATE AGENCY[2]	LOCAL AGENCIES
	Denver, CO 303-861-7033	Loveland, CO 80537 Hotline Phone: 970-669-5150 **Tri-County Resource Center** Montrose, CO 81402 Hotline Phone: 970-249-2486 **Pueblo Rape Crisis Center** Pueblo, CO 81003 Hotline Phone: 719-549-0549 **Advocates Against Battering & Abuse** Steamboat Springs, CO 80477 Hotline Phone: 970-879-8888 **High Plains Sexual Assault Center** Sterling, CO 80751 Hotline Phone: 970-522-8329 **San Miguel Resource Center** Telluride, CO 81435 Hotline Phone: 970-728-5660 **Advocates Against Domestic Assault** Trinidad, CO 81082 Hotline Phone: 719-846-4357
Connecticut	Connecticut Sexual Assault Crisis Services (CONNSACS) East Hartford, CT 860-282-9881	**The Center for Women and Families** Bridgeport, CT 06604 Hotline Phone: 203-333-2233 **The Center for Women and Families** Bridgeport, CT 06604 Hotline Phone: 203-384-9559 **Women's Center of Greater Danbury** Danbury, CT 06810 Hotline Phone: 203-731-5204 **Rape Crisis Center of Milford, Inc.** Milford, CT 06460 Hotline Phone: 203-878-1212 **YWCA of New Britain Sexual Assault Crisis**

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Service New Britain, CT 06051 Hotline Phone: 800-656-HOPE **Sexual Assault Crisis Center of Eastern CT** Willimantic, CT 06226 Hotline Phone: 860-456-2789
Delaware	Contact Delaware Wilmington, DE 302-761-9800	**Contact Delaware** Milford, DE 19963 Hotline Phone: 302-761-9100 **Contact Delaware** Wilmington, DE 19809 Hotline Phone: 302-761-9100
Washington, DC**	DC Rape Crisis Center Washington, DC 202-232-0789	
Florida	Florida Council Against Sexual Violence Tallahassee, FL 850-297-2000	**Manatee Glens Rape Crisis** Bradenton, FL 34206 Hotline Phone: 941-708-6059 **Another Way, Inc.** Chiefland, FL 32644 Hotline Phone: 352-493-6742 **Rape Crisis Center** Clearwater, FL 33760 Hotline Phone: 727-530-7273 **2-1-1 Brevard** Cocoa Beach, FL 32931 Hotline Phone: 321-632-6688 **Sunrise of Pasco, Inc.** Dade City, FL 33526 Hotline Phone: 352-521-3120 **Rape Crisis** Daytona Beach, FL 32114 Hotline Phone: 386-254-4106

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		COPE Center DeFuniak Springs, FL 32433 Hotline Phone: 850-892-4357 Abuse Counseling and Treatment (ACT) Fort Myers, FL 33906 Hotline Phone: 239-939-3112 **Bridgeway Center Sexual Trauma Team Program** Fort Walton Beach, FL 32548 Hotline Phone: 850-244-9191 **Victim Services Sexual Assault Treatment Center** Ft. Lauderdale, FL 33301 Hotline Phone: 954-761-7273 **Victim Services and Rape Crisis Center** Gainesville, FL 32641 Hotline Phone: 352-264-6760 **Sexual Assault Response Center** Jacksonville, FL 32206 Hotline Phone: 904-244-7273 **North Central Florida Sexual Assault Center** Lake City, FL 32025 Hotline Phone: 386-623-1708 **Peace River Center** Lakeland, FL 33801 Hotline Phone: 863-413-2707 **Haven of Lake & Sumter Counties, Inc.** Leesburg, FL 34748 Hotline Phone: 352-753-5800 **Crisis Services of Brevard** Melbourne, FL 32941 Hotline Phone: 321-632-6688 **Roxcy Bolton Rape Treatment Center** Miami, FL 33136 Hotline Phone: 305-585-7273

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Project Help, Inc. - Rape Crisis Program Naples, FL 34102 Hotline Phone: 239-262-7227 **Rape Crisis and Spouse Abuse Center** Ocala, FL 34478 Hotline Phone: 352-622-8495 **Quiqley House** Orange Park, FL 32067 Hotline Phone: 904-284-0061 **Crisis Services of Brevard** Palm Bay, FL 32907 Hotline Phone: 321-632-6688 **Salvation Army DV & Rape Crisis Program** Panama City, FL 32401 Hotline Phone: 800-252-2597 **Rape Crisis Center of Northwest Florida** Pensacola, FL 32501 Hotline Phone: 850-438-1617 **Center for Abuse and Rape Emergencies** Punta Gorda, FL 33951 Hotline Phone: 941-627-6000 **Crisis Services of Brevard** Rockledge, FL 32956 Hotline Phone: 321-632-6688 **Safe Place and Rape Crisis Center (SPARCC)** Sarasota, FL 34237 Hotline Phone: 941-365-1976 **Crisis Services of Brevard** Satellite Beach, FL 32937 Hotline Phone: 321-632-6688 **Dawn Center of Hernando County for Sexual & Domestic Violence Assistance** Spring Hill, FL 34611

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 352-799-0657 **Betty Griffin House** St. Augustine, FL 32085 Hotline Phone: 904-824-1555 **Refuge House/Rape Crisis Center** Tallahassee, FL 32316 Hotline Phone: 850-681-2111
Georgia**	Georgia Network to End Sexual Assault (GNESA) Atlanta, GA 404-659-6482	**Sexual Assault Center of Northeast Georgia, Inc.** Athens, GA 30605 Hotline Phone: 706-353-1912 **Rape Crisis Center** Atlanta, GA 30335 Hotline Phone: 404-616-4861 **Rape Crisis and Sexual Assault Services** Augusta, GA 30901 Hotline Phone: 706-724-5200 **SAFE Inc.** Blairsville, GA 30514 Hotline Phone: 706-379-3000 **North Georgia Mountain Crisis Network** Blue Ridge, GA 30513 Hotline Phone: 706-632-8400 **Coastal Area Rape Crisis Center, Inc.** Brunswick, GA 31521 Hotline Phone: 912-230-6994 **Carroll Rape Crisis Center** Carrollton , GA 30117 Hotline Phone: 770-834-7273 **F.A.I.T.H.** Clayton, GA 30525 Hotline Phone: 706-782-1338 **Columbus Rape Crisis, Inc.** Columbus, GA 31902 Hotline Phone: 706-571-6010

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		DeKalb Rape Crisis Center Decatur, GA 30031 Hotline Phone: 404-377-1428 **Women in Need of God's Shelter, Inc.** Dublin, GA 31040 Hotline Phone: 478-272-8000 **Gwinnett Sexual Assault Center** Duluth, GA 30096 Hotline Phone: 770-476-7407 **Rape Response, Inc.** Gainesville, GA 30503 Hotline Phone: 770-503-7273 **Teem Plus of Griffin Rape Crisis Center** Griffin, GA 30224 Hotline Phone: 770-636-0088 **Southern Crescent Sexual Assault Center** Jonesboro, GA 30237 Hotline Phone: 770-477-2177 **Crisis Line of Middle Georgia** Macon, GA 31201 Hotline Phone: 478-745-9292 **YWCA of NW Georgia** Marietta, GA 30064 Hotline Phone: 770-427-3390 **The Sexual Assault Center of Northwest Georgia** Rome, GA 30162 Hotline Phone: 706-802-0580 **Rape Crisis Center of the Coastal Empure, Inc.** Savannah, GA 31412 Hotline Phone: 912-233-7273 **The Haven** Valdosta, GA 31603 Hotline Phone: 229-244-1765

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		HODAC's Victim Resource Center Warner Robins, GA 31093 Hotline Phone: 478-953-7234 **Satilla Rape Crisis Program** Waycross, GA 31501 Hotline Phone: 912-283-0987 **HODAC's Victim Resource Center** Warner Robins, GA 31093 Hotline Phone: 478-953-7234 **Satilla Rape Crisis Program** Waycross, GA 31501 Hotline Phone: 912-283-0987
Guam	Guam Healing Arts Crisis Center Tamuning, GU 671-647-5351	
Hawaii	Hawaii State Coalition for the Prevention of Sexual Assault Honolulu, HI 808-733-9038	**YWCA of Hawaii Island SAVE** Hilo, HI 96720 Hotline Phone: 808-935-0677 **Sex Abuse Treatment Center** Honolulu, HI 96813 Hotline Phone: 808-524-7273 **Child & Family Service** Kahului, HI 96732 Hotline Phone: 808-873-8624 **Kauai YWCA Sexual Assault Treatment** Lihue, HI 96766 Hotline Phone: 808-245-4144
Idaho	Idaho Coalition Against Sexual & Domestic Violence (ICASDV) Boise, ID 208-384-0419	**Bingham Crisis Center** Blackfoot, ID 83221 Hotline Phone: 208-681-8713 **YWCA Women's Crisis Center- Rape Crisis Alliance** Boise, ID 83702 Hotline Phone: 208-343-7025

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Boundary County Youth Crisis & DV Hotline Bonners Ferry, ID 83805 Hotline Phone: 208-267-5211 **Coeur d'Alene Women's Center** Coeur d'alene, ID 83814 Hotline Phone: 208-661-2522 **Family Safety Network** Driggs, ID 83422 Hotline Phone: 208-354-7233 **Advocates for Survivors of Domestic Violence** Hailey , ID 83333 Hotline Phone: 208-788-4191 **Rape Response & Crime Victim Center** Idaho Falls, ID 83402 Hotline Phone: 208-521-6018 **YWCA Lewiston/Clarkston Crisis Services** Lewiston, ID 83501 Hotline Phone: 800-669-3176 **Oneida Crisis Center** Malad, ID 83252 Hotline Phone: 208-766-3119 **Support for Women in Crisis** McCall, ID 83638 Hotline Phone: 208-382-7172 **Support for Women in Crisis** McCall, ID 83638 Hotline Phone: 208-382-6748 **New Valley Crisis Center** Nampa, ID 83653 Hotline Phone: 208-465-5011 **Family Services Alliance of Southeast Idaho** Pocatello, ID 83204 Hotline Phone: 208-251-4357

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Family Crisis Center Rexburg, ID 83440 Hotline Phone: 208-356-0065 **Lemhi County Crisis Intervention / Mahoney Family Safety Center** Salmon, ID 83467 Hotline Phone: 208-940-0600 **ROSE Advocates** Weiser, ID 83672 Hotline Phone: 208-414-0740
Illinois**	Illinois Coalition Against Sexual Assault (ICASA) Springfield, IL 217-753-4117	**Northwest Center Against Sexual Assault** Arlington Heights, IL 60005 Hotline Phone: 888-802-8890 **Mutual Ground, Inc.** Aurora, IL 60506 Hotline Phone: 630-897-8383 **YWCA Sexual Assault Program -- Stepping Stones** Bloomington, IL 61704 Hotline Phone: 309-827-4005 **Rape Crisis Services** Carbondale, IL 62901 Hotline Phone: 618-529-2324 **Rape Crisis Services** Champaign, IL 61820 Hotline Phone: 877-2-End-Rape **Sexual Assault Counseling and Information Service** Charleston, IL 61920 Hotline Phone: 217-348-5033 **YWCA Metro Chicago** Chicago, IL 60601 Hotline Phone: 888-293-2080 **YWCA -- South Suburban** Chicago Heights, IL 60411 Hotline Phone: 708-748-5672

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		YWCA Sexual Assault Crisis Services Danville, IL 61832 Hotline Phone: 217-443-5566 **Growing Strong Sexual Assault Center** Decatur, IL 62523 Hotline Phone: 217-428-0770 **Sexual Assault Abuse Services** DeKalb, IL 60115 Hotline Phone: 815-756-5228 **YWCA of the Sauk Valley** Dixon, IL 61021 Hotline Phone: 815-288-1011 **Sexual Assault Victim's Care Unit** Edgemont, IL 62203 Hotline Phone: 618-397-0975 **Community Crisis Center Inc.** Elgin, IL 60121 Hotline Phone: 847-697-2380 **Riverview Center Sexual Assault Intervention/Prevention Services** Galena, IL 61036 Hotline Phone: 888-707-8155 **YWCA of DuPage/West Surburban Area** Glen Ellyn, IL 60137 Hotline Phone: 630-971-3927 **Call for Help, Inc.** Granite City, IL 62040 Hotline Phone: 618-452-2763 **Lake County Council Against Sexual Assault** Gurnee, IL 60031 Hotline Phone: 847-872-7799 **Des Plaines Valley Community Center** Hickory Hills, IL 60457

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 708-482-9600 **Sexual Assault Service Center Guardian Angel Home** Joliet, IL 60435 Hotline Phone: 815-730-8984 **KC-CASA** Kankakee, IL 60901 Hotline Phone: 815-932-3322 **Western Illinois Regional Council Sexual Assault Program** Macomb , IL 61455 Hotline Phone: 309-837-5555 **Center for Prevention of Abuse** Peoria, IL 61612 Hotline Phone: 309-691-4111 **Freedom House** Princeton, IL 61356 Hotline Phone: 800-474-6031 **Quanada Sexual Assault Program** Quincy, IL 62301 Hotline Phone: 217-222-2873 **Counseling and Information for Sexual Assault/Abuse** Robinson, IL 62454 Hotline Phone: 618-544-9379 **Quad Cities Rape/Sexual Assault Counseling Program** Rock Island, IL 61201 Hotline Phone: 309-797-1777 **Rockford Sexual Assault Counseling, Inc.** Rockford, IL 61108 Hotline Phone: 815-636-9811 **Riverview Center** Savanna, IL 61074

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 815-273-7772 **Prairie Center Against Sexual Assault** Springfield, IL 62704 Hotline Phone: 217-753-8081 **YWCA of the Sauk Valley** Sterling, IL 61081 Hotline Phone: 815-626-7277 **ADV/SAS** Streator, IL 61364 Hotline Phone: 815-673-1555 **Sexual Assault and Family Emergencies** Vandalia, IL 62471 Hotline Phone: 618-283-1414
Indiana	Indiana Coalition Against Sexual Assault Indianapolis, IN 317-423-0233	**Alternatives, Inc. of Madison County** Anderson, IN 46015 Hotline Phone: 765-643-0200 **Middle Way House Rape Crisis Center** Bloomington, IN 47402 Hotline Phone: 812-336-0846 **Family Crisis Shelter of Montgomery County Inc.** Crawfordsville, IN 47933 Hotline Phone: 765-362-2030 **Albion Fellows Bacon Center** Evansville, IN 47731 Hotline Phone: 812-424-7273 **Rape Awareness Program of the Fort Wayne Women's Bureau, Inc.** Fort Wayne, IN 46805 Hotline Phone: 260-426-7273 **Crisis Center** Gary, IN 46403 Hotline Phone: 219-938-7509 **Crisis & Suicide Intervention** Indianapolis, IN 46205

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 317-251-7575 **Crisis Connection, Inc.** Jasper, IN 47547 Hotline Phone: 812-482-1555 **Lafayette Crisis Center** Lafayette, IN 47904 Hotline Phone: 765-742-0244 **Directions of Community Mental Health Center, Inc.** Lawrenceburg, IN 47025 Hotline Phone: 812-537-1302 **Hands of Hope** Marion, IN 46953 Hotline Phone: 765-664-0701 **A Better Way Crisis & Information Center** Muncie, IN 47308 Hotline Phone: 765-288-4357 **A Better Way Crisis & Information Center** Muncie, IN 47308 Hotline Phone: 765-747-9107 **Prevail, Inc.** Noblesville, IN 46060 Hotline Phone: 317-776-3472 **North Central Indiana Rural Crisis Center, Inc.** Rensselaer, IN 47978 Hotline Phone: 800-933-0374 **Hoosier Hills Pact DV Shelter** Salem, IN 47167 Hotline Phone: 812-883-1959 **Center for Women and Families** Sellersburg, IN 47172 Hotline Phone: 812-944-6743 **Sex Offense Services**

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		South Bend, IN 46624 Hotline Phone: 574-289-4357 **The Caring Place, Inc.** Valparaiso, IN 46383 Hotline Phone: 219-464-2128
Iowa**	Iowa Coalition Against Sexual Assault (ICASA) Des Moines, IA 515-244-7424	**Crisis Intervention & Advocacy Center** Adel, IA 50003 Hotline Phone: 800-400-4884 **ACCESS** Ames, IA 50014 Hotline Phone: 515-292-5378 **Family Crisis Support Network** Atlantic, IA 50022 Hotline Phone: 712-243-5123 **Family Crisis Support Network** Atlantic, IA 50022 Hotline Phone: 712-243-6615 **Domestic Abuse Prevention Center** Carroll, IA 51401 Hotline Phone: 712-792-6722 **Catholic Charities DV/SA Program** Council Bluffs, IA 51503 Hotline Phone: 712-328-0266 **Rural Iowa Crisis Center** Creston, IA 50801 Hotline Phone: 641-782-6632 **Quad Cities Rape/Sexual Assault Counseling Program/Family Resources Inc.** Davenport, IA 52803 Hotline Phone: 563-326-9191 **Domestic & Sexual Abuse Resource Center** Decorah, IA 52101 Hotline Phone: 563-382-2989 **Riverview Center Sexual Assault Prevention &**

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Intervention Services Dubuque, IA 52003 Hotline Phone: 563-557-0310 **Domestic/Sexual Assault Outreach Center** Ft. Dodge, IA 50501 Hotline Phone: 515-573-8000 **Seeds of Hope** Grundy Center, IA 50638 Hotline Phone: 319-824-5522 **Turning Point** Knoxville, IA 50138 Hotline Phone: 641-828-8419 **Crisis Intervention Services** Mason City, IA 50402 Hotline Phone: 641-424-9133 **Crisis Center & Women's Shelter** Ottumwa, IA 52501 Hotline Phone: 641-683-3122 **Family Crisis Center of Northwest Iowa** Sioux Center, IA 51250 Hotline Phone: 800-382-5603 **CSADV** Sioux City, IA 51102 Hotline Phone: 712-258-7233 **Cedar Valley Friends of the Family** Waverly , IA 50677 Hotline Phone: 319-352-0037
Kansas**	Kansas Coalition Against Sexual & Domestic Violence Topeka, KS 785-232-9784	**Crisis Center of Dodge City** Dodge City, KS 67801 Hotline Phone: 620-225-6510 **SOS, Inc.** Emporia, KS 66801 Hotline Phone: 620-342-1870

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Family Crisis Center Great Bend, KS 67530 Hotline Phone: 620-792-1885 **NW Kansas Family Shelter** Hays, KS 67601 Hotline Phone: 785-625-3055 **Sexual Assault And Domestic Violence Center of Reno County** Hutchinson, KS 67501 Hotline Phone: 620-663-2522 **Hope Unlimited** Iola, KS 66749 Hotline Phone: 620-365-7566 **Rape Victim's Survivor Service, Inc.** Lawrence, KS 66046 Hotline Phone: 785-841-2345 **Alliance Against Family Violence** Leavenworth, KS 66048 Hotline Phone: 913-682-9131 **Liberal Area Rape Crisis/DV Services, Inc.** Liberal, KS 67901 Hotline Phone: 620-624-8818 **The Crisis Center, Inc.** Manhattan, KS 66505 Hotline Phone: 785-539-2785 **SAFEHOME** Overland Park, KS 66204 Hotline Phone: 913-262-2868 **Crisis Resource Center of SE Kansas** Pittsburg, KS 66762 Hotline Phone: 800-794-9148 **DVACK** Salina, KS 67401 Hotline Phone: 785-827-5862

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Sexual Assault Center Topeka, KS 66601 Hotline Phone: 785-234-3300 **Wichita Area Sexual Assault Center** Wichita, KS 67202 Hotline Phone: 316-263-3002 **Safe Homes, Inc.** Winfield, KS 67156 Hotline Phone: 620-221-4357
Kentucky**	Kentucky Association of Sexual Assault Programs Frankfort, KY 502-226-2704	**Pathways Inc.** Ashland, KY 41101 Hotline Phone: 606-324-1141 **Hope Harbor** Bowling Green, KY 42101 Hotline Phone: 270-846-1100 **Cumberland River Rape Victim Services** Corbin, KY 40702 Hotline Phone: 606-523-9386 **Women's Crisis Center** Covington, KY 41011 Hotline Phone: 859-491-3335 **Advocacy & Support Center** Elizabethtown, KY 42701 Hotline Phone: 270-234-9236 **Kentucky River Community Care Rape Crisis Center** Hazard, KY 41701 Hotline Phone: 800-375-7273 **Bluegrass Rape Crisis Center** Lexington, KY 40588 Hotline Phone: 859-253-2511 **Center for Women & Families** Louisville, KY 40201 Hotline Phone: 502-581-7222

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		New Beginnings Sexual Assault Support Services Owensboro , KY 42303 Hotline Phone: 800-226-7273 **Rape Crisis Center** Paducah, KY 42002 Hotline Phone: 270-534-4422 **Mountain Comprehensive Care Center** Prestonsburg, KY 41653 Hotline Phone: 606-886-4408 **Regional Victim Services Program** Somerset, KY 42501 Hotline Phone: 606-451-9647 **Sanctuary, Inc. Crisis Intervention Center** Hopkinsville , KY 42241 Hotline Phone: 270-887-6200
Louisiana**	Louisiana Foundation Against Sexual Assault (LAFASA) Independence, LA 504-747-8815	**Family Counseling Agency Work Against Rape Program** Alexandria, LA 71301 Hotline Phone: 318-445-2022 **Tri-Parish Victim Assistance Rape Crisis** Amite, LA 70422 Hotline Phone: 985-748-6882 **Stop Rape Crisis Center** Baton Rouge, LA 70802 Hotline Phone: 225-383-7273 **Washington Parish Rape Crisis Center** Bogalusa, LA 70427 Hotline Phone: 985-732-4961 **The Haven** Houma, LA 70361 Hotline Phone: 985-872-0450 **Sexual Abuse Response Center** Lafayette, LA 70505 Hotline Phone: 337-233-7273

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Calcasien Women's Shelter Rape Crisis Outreach Program Lake Charles, LA 70602 Hotline Phone: 337-494-7273 **YWCA Rape Crisis Program** Monroe, LA 71202 Hotline Phone: 318-323-1543 **YWCA Rape Crisis Program** New Orleans, LA 70119 Hotline Phone: 504-483-8888 **St. Landry-Evangeline Sexual Assault Center** Opelousas, LA 70570 Hotline Phone: 337-585-4673 **Pine Hills Sexual Assault Center** Ruston, LA 71273 Hotline Phone: 318-255-7273 **YWCA Rape Crisis Center** Shreveport, LA 71101 Hotline Phone: 318-222-0556 **YWCA Rape Crisis Program** Slidell, LA 70458 Hotline Phone: 504-483-8888
Maine**	Maine Coalition Against Sexual Assault Augusta, ME 207-626-0034	**Sexual Assault Crisis Center** Auburn, ME 04212 Hotline Phone: 207-795-2211 **Sexual Assault Crisis & Support Center** Augusta, ME 04330 Hotline Phone: 800-871-7741 **Rape Response Services** Bangor , ME 04402 Hotline Phone: 207-989-5678 **Sexual Assault Support Services of Midcoast Maine** Brunswick, ME 04011 Hotline Phone: 800-822-5999

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Downeast Sexual Assault Services Ellsworth, ME 04605 Hotline Phone: 207-667-5304 **S.A.V.E.S.** Farmington, ME 04938 Hotline Phone: 207-778-0110 **R.E.A.C.H.** Norway, ME 04268 Hotline Phone: 207-743-3868 **Sexual Assault Response Services of Southern Maine** Portland, ME 04104 Hotline Phone: 800-313-9900 **Sexual Assault Helpline/ Emergency Services** Presque Isle, ME 04769 Hotline Phone: 207-762-4851 **Rape Crisis Assistance & Prevention** Waterville, ME 04901 Hotline Phone: 207-872-0601
Maryland	Maryland Coalition Against Sexual Assault Arnold, MD 410-974-4507	**Family Violence Unit** Baltimore City, MD 21224 Hotline Phone: 410-828-6390 **Family Violence Unit** Baltimore County, MD 21206 Hotline Phone: 410-828-6390 **Harford County Sexual Assault/Spouse Abuse Resource Center** Bel Air, MD 21014 Hotline Phone: 410-836-8430 **Prince George's County Sexual Assault Center** Cheverly, MD 20785 Hotline Phone: 301-618-3154 **The STTAR Center**

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Columbia , MD 21046 Hotline Phone: 410-997-3292 **Family Crisis Resource Center** Cumberland, MD 21502 Hotline Phone: 301-759-9244 **For All Seasons, Inc.** Easton, MD 21601 Hotline Phone: 410-820-5600 **Cecil County DV Rape Crisis Program** Elkton, MD 21922 Hotline Phone: 410-996-0333 **Heartly House, Inc.** Frederick, MD 21705 Hotline Phone: 301-662-8800 **Anne Arundel County Sexual Assault Crisis Center** Glen Burnie, MD 21061 Hotline Phone: 410-222-7273 **CASA, Inc.** Hagerstown, MD 21740 Hotline Phone: 301-739-8975 **Walden/Sierra, Inc.** Leonardtown, MD 20650 Hotline Phone: 301-863-6661 **Dove Center** Oakland, MD 21550 Hotline Phone: 301-334-9000 **Calvert County Health Department Crisis Intervention Center** Prince Frederick, MD 20678 Hotline Phone: 410-535-1121 **Calvert County Health Department Crisis Intervention Center** Prince Frederick, MD 20678 Hotline Phone: 301-855-1075

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Victim Assistance & Sexual Assault Program Rockville, MD 20850 Hotline Phone: 240-777-4247 **Life Crisis Center** Salisbury, MD 21803 Hotline Phone: 410-749-4357 **Family Violence Unit** Towson, MD 21212 Hotline Phone: 410-828-6390 **Center for Abused Persons** Waldorf, MD 20601 Hotline Phone: 301-645-3336 **Rape Crisis Intervention Service** Westminster, MD 21157 Hotline Phone: 410-857-7322
Massachusetts	Jane Doe Inc. / MCASADV Boston, MA 617-248-0922	**Everywoman's Center** Amherst, MA 01003 Hotline Phone: 413-545-0800 **North Shore Rape Crisis Center** Beverly, MA 01915 Hotline Phone: 978-922-4491 **Voices Against Violence** Framingham, MA 01702 Hotline Phone: 800-593-1125 **New England Learning Center for Women in Transition** Greenfield, MA 01301 Hotline Phone: 413-772-6507 **Independence House/Cape Cod Rape Crisis Center** Hyannis, MA 02601 Hotline Phone: 508-771-6507 **Rape Crisis Services of Greater Lowell, Inc.** Lowell, MA 01852 Hotline Phone: 978-975-1776 **Valley Rape Crisis Program**

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Milford, MA 01757 Hotline Phone: 508-478-1776 **A Safe Place** Nantucket, MA 02554 Hotline Phone: 508-228-2111 **New Bedford Women's Center, Inc. Sexual Assault Program** New Bedford, MA 02740 Hotline Phone: 508-999-2111 **Elizabeth Freeman Center** Pittsfield, MA 01201 Hotline Phone: 413-443-0089 **YWCA of Western Massachusetts Sexual Assault Program** Springfield, MA 01108 Hotline Phone: 413-733-7100 **Rape Crisis Center of Central Mass** Worcester, MA 01606 Hotline Phone: English: 800-870-5905; Spanish: 800 223-5001 **Boston Area Rape Crisis Center** Cambridge, MA 02139 Hotline Phone: 617-492-7273
Michigan	Michigan Coalition Against Domestic & Sexual Violence Okemos, MI 517-347-7000	**Catherine Cobb DV & SA Program** Adrian, MI 49221 Hotline Phone: 517-265-6776 **Sexual Assault Prevention & Awareness Center** Ann Arbor, MI 48104 Hotline Phone: 734-936-3333 **SAFE House Center** Ann Arbor, MI 48107 Hotline Phone: 734-995-5444 **Sexual Assault Services of Calhoun County** Battle Creek, MI 49015

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 269-381-4357 **Bay County Women's Center** Bay City, MI 48706 Hotline Phone: 989-686-4551 **Women's Information Service, Inc. (WISE)** Big Rapids, MI 49307 Hotline Phone: 231-796-6600 **Cadillac Area OASIS/Family Resource Center** Cadillac, MI 49601 Hotline Phone: 231-775-7233 **Branch County Shelterhouse** Coldwater, MI 49036 Hotline Phone: 517-278-7432 **Detroit Police Department Rape Counseling Center** Detroit, MI 48201 Hotline Phone: 313-833-1660 **Listening Ear Crisis Center** East Lansing, MI 48823 Hotline Phone: 517-337-1717 **Alliance Against Violence & Abuse** Escanaba, MI 49829 Hotline Phone: 906-789-1166 **YWCA Domestic Assault/Sexual Assault Services** Flint, MI 48502 Hotline Phone: 810-238-7233 **YWCA Sexual Assault Program** Grand Rapids, MI 49503 Hotline Phone: 616-776-7273 **River House Shelter** Grayling, MI 49738 Hotline Phone: 888-554-3169 **Center for Women in Transition** Holland, MI 49424

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 800-848-5991 **Dial Help Sexual Assault Crisis Center** Houghton, MI 49931 Hotline Phone: 906-482-4357 **Sexual Assault Recovery Assistance (SARA)** Howell , MI 48843 Hotline Phone: 517-548-4228 **Relief After Violent Encounter--Ionia/Montcalm** Ionia, MI 48846 Hotline Phone: 616-527-7170 **Caring House, Inc.** Iron Mountain , MI 49801 Hotline Phone: 906-774-1112 **Domestic Violence Escape, Inc.** Ironwood, MI 49938 Hotline Phone: 800-711-6744 **AWARE Inc.** Jackson , MI 49204 Hotline Phone: 517-783-2861 **YWCA Sexual Assault Program** Kalamazoo, MI 49007 Hotline Phone: 269-345-3036 **Baraga County Shelter Home** Lanse, MI 49946 Hotline Phone: 906-524-7078 **Region IV Community Services** Ludington, MI 49431 Hotline Phone: 800-950-5808 **Harbor House** Marquette, MI 49855 Hotline Phone: 906-226-6611 **Shelterhouse** Midland, MI 48641

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 989-835-6771 **Family Counseling & Shelter Services** Monroe, MI 48161 Hotline Phone: 734-243-6410 **Turning Point Inc.** Mt. Clemens, MI 48046 Hotline Phone: 586-463-6990 **Women's Aid Service, Inc.** Mt. Pleasant, MI 48804 Hotline Phone: 989-772-9168 **Every Woman's Place Crisis Center** Muskegon, MI 49441 Hotline Phone: 231-722-3333 **Women's Resource Center of Northern Michigan, Inc.** Petoskey, MI 49770 Hotline Phone: 231-347-0082 **First Step** Plymouth, MI 48148 Hotline Phone: 734-459-5900 **HAVEN** Pontiac, MI 48343 Hotline Phone: 248-334-1274 **Safe Horizons** Port Huron, MI 48061 Hotline Phone: 810-985-5538 **Sexual Assault Program of Child & Family Service of Saginaw** Saginaw, MI 48602 Hotline Phone: 989-790-9118 **Underground Railroad** Saginaw, MI 48605 Hotline Phone: 989-755-0411

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Eastern Upper Peninsula Domestic Violence Program Sault St. Marie, MI 49783 Hotline Phone: 906-635-0566 **Relief After Violent Encounter, Inc.** St. Johns, MI 48879 Hotline Phone: 989-224-7283 **Women's Resource Center - Grand Traverse Area** Traverse City, MI 49684 Hotline Phone: 231-941-1210 **Common Ground Victim Assistance** Bloomfield Hills, MI 48302 Hotline Phone: 248-456-0909
Minnesota**	Minnesota Coalition Against Sexual Assault Minneapolis, MN 612-313-2797	**Sexual Assault Services for Aitkin County** Aitkin, MN 56431 Hotline Phone: 218-828-4357 **Crime Victims' Resource Center** Austin, MN 55912 Hotline Phone: 507-437-6680 **Sexual Assault Program of Beltrami, Cass & Hubbard Counties** Bemidji, MN 56619 Hotline Phone: 218-444-9522 **Community Action Council, Inc. Sexual Assault Services - Dakota County** Burnsville, MN 55337 Hotline Phone: 651-405-1500 **Rape and Sexual Violence Center** Cottage Grove, MN 55016 Hotline Phone: 651-777-1117 **Lakes Crisis Center** Detroit Lakes, MN 56502 Hotline Phone: 218-847-7446 **Program for Aid to Victims of Sexual Assault, Inc.** Duluth, MN 55802

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 218-726-1931 **WomanSafe Center** Faribault, MN 55021 Hotline Phone: 800-607-2330 **Someplace Safe** Fergus Falls, MN 56538 Hotline Phone: 800-974-3359 **Itasca Alliance Against Sexual Assault** Grand Rapids, MN 55744 Hotline Phone: 218-326-5008 **Pathways of West Central MN, Inc.** Granite Falls , MN 56241 Hotline Phone: 320-564-4894 **WINDOW (Women in Need Depending on Other Women)** Hinckley, MN 55037 Hotline Phone: 320-384-7113 **Koochiching County Sexual Assault Program** International Falls, MN 56649 Hotline Phone: 218-283-9334 **Hands of Hope Resource Center** Little Falls, MN 56345 Hotline Phone: 320-632-4878 **Mahnomen County Victim Resource Program** Mahnomen, MN 56557 Hotline Phone: 218-766-4119 **CADA, Inc.** Mankato, MN 56002 Hotline Phone: 507-625-3966 **New Horizons Crisis Center** Marshall, MN 56258 Hotline Phone: 507-532-5764 **Rape and Sexual Abuse Center** Minneapolis, MN 55405

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 612-825-4357 **Sexual Violence Center** Minneapolis, MN 55412 Hotline Phone: 612-871-5111 **Sexual Violence Center** Minneapolis, MN 55412 Hotline Phone: 952-448-5425 **SAVES Resource Center** Olivia, MN 56277 Hotline Phone: 320-523-2096 **Women's Resource Center of Steele County** Owatonna, MN 55060 Hotline Phone: 507-451-1202 **Victim Services** Rochester, MN 55904 Hotline Phone: 507-289-0636 **Central Minnesota Sexual Assault Center** Saint Cloud, MN 56304 Hotline Phone: 320-251-4357 **Victim Services** St. James, MN 56081 Hotline Phone: 507-375-5770 **Sexual Offense Services of Ramsey County (SOS)** St. Paul, MN 55104 Hotline Phone: 651-643-3006 **Nicollet/Sibley Sexual Assault Services** St. Peter, MN 56073 Hotline Phone: 507-227-1425 **Violence Intervention Project** Thief River Falls, MN 56701 Hotline Phone: 218-681-5557 **North Shore Horizons** Two Harbors, MN 55616 Hotline Phone: 218-834-5924

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Sexual Violence and Abuse Crisis Center Willmar, MN 56201 Hotline Phone: 888-235-8001
Mississippi	Mississippi Coalition Against Sexual Assault Jackson, MS 888-987-9011	**Gulf Coast Women's Center** Biloxi, MS 39533 Hotline Phone: 228-435-1968 **Safe Haven, Inc.** Columbus, MS 39704 Hotline Phone: 662-327-2259 **Our House, Inc.** Greenville, MS 38702 Hotline Phone: 662-332-5683 **Sexual Assault Crisis Center, Inc.** Hattiesburg, MS 39406 Hotline Phone: 601-264-7777 **Catholic Charities Rape Crisis Center** Jackson , MS 39202 Hotline Phone: 601-982-7273 **Sexual Assault Crisis Services** Meridian, MS 39302 Hotline Phone: 601-482-2828 **Guardian Sexual Assault Center** Natchez, MS 39120 Hotline Phone: 601-442-0107 **Family Crisis Services of Northwest Mississippi** Oxford, MS 38655 Hotline Phone: 662-234-9929 **Safe, Inc.** Tupelo, MS 38802 Hotline Phone: 662-841-2273
Missouri**	Missouri Coalition Against Sexual Assault Jefferson City, MO	**New Way Shelter** Bonne Terre, MO 63628 Hotline Phone: 573-358-4461

STATE	STATE AGENCY[2]	LOCAL AGENCIES
	573-636-8776	**Women's Crisis Center** Branson, MO 65615 Hotline Phone: 417-561-5084 **Citizens Against Domestic Violence/Victim Outreach Center** Camdenton, MO 65020 Hotline Phone: 888-809-7233 **The Shelter** Columbia , MO 65205 Hotline Phone: 573-875-1370 **Coalition Against Rape & Domestic Violence** Fulton, MO 66251 Hotline Phone: 866-642-4422 **AVENUES** Hannibal, MO 63401 Hotline Phone: 573-221-4280 **Rape & Abuse Crisis Service** Jefferson City, MO 65102 Hotline Phone: 573-634-4911 **Lafayette House** Joplin, MO 64801 Hotline Phone: 417-782-1772 **Metropolitan Organization to Counter Sexual Assault** Kansas City, MO 64111 Hotline Phone: 816-531-0233 **Metropolitan Organization to Counter Sexual Assault** Kansas City, MO 64111 Hotline Phone: 913-642-0233 **Christian Associates of Table Rock Lake** Kimberling City, MO 65686-0398 Hotline Phone: 877-507-7233

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Victim Support Services Kirksville, MO 63501 Hotline Phone: 660-665-1617 **Safe Passage** Moberly, MO 65270 Hotline Phone: 800-616-3754 **SafeHaven -- Synergy Services** Parkville, MO 64152 Hotline Phone: 816-452-8535 **Haven House, Inc.** Poplar Bluff, MO 63901 Hotline Phone: 573-686-4873 **Phelps County Family Crisis Services, Inc.** Rolla, MO 65402 Hotline Phone: 573-364-0222 **CASA, Inc.** Sedalia, MO 65302 Hotline Phone: 660-827-5555 **House of Refuge** Sikeston, MO 63801 Hotline Phone: 877-633-3843 **The Victim Center** Springfield, MO 65806 Hotline Phone: 417-864-7233 **YWCA Rape Crisis/Sexual Assault Services** St Joseph, MO 64501 Hotline Phone: 816-232-1225 **Bridgeway Sexual Assault Center** St. Charles, MO 63302 Hotline Phone: 636-946-6894 **YWCA St. Louis Regional Sexual Assault Center** St. Louis, MO 63105 Hotline Phone: 314-531-7273 **Women's Support and Community Services**

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		St. Louis, MO 63139 Business Phone: 314-646-7500 **Warren County Council Against Domestic Violence** Warrenton , MO 63383 Hotline Phone: 636-456-1186
Montana**	Montana Coalition Against Domestic Violence and Sexual Assault Helena, MT 406-443-7794	**Anaconda PCA Family Resource Center** Anaconda, MT 59711 Hotline Phone: 406-563-7972 **Sexual Assault Services -- YWCA** Billings, MT 59101 Hotline Phone: 406-259-8100 **The Sexual Assault Center Bozeman Help Center** Bozeman, MT 59715 Hotline Phone: 406-586-3333 **The Voice Center** Bozeman, MT 59717 Hotline Phone: 406-994-7069 **Safe Space** Butte, MT 59703 Hotline Phone: 406-782-8511 **Hi-Line's Help** Conrad, MT 59425 Hotline Phone: 406-759-5170 **Women's Resource Center** Dillon, MT 59725 Hotline Phone: 406-683-3621 **Women's Resource Center** Glasgow, MT 59230 Hotline Phone: 406-228-8400 **Dawson County Domestic Violence** Glendive, MT 59330 Hotline Phone: 406-989-1318 **Voices of Hope** Great Falls, MT 59403

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 406-453-4357 **Supporters of Abuse-Free Environments** Hamilton, MT 59840 Hotline Phone: 406-363-4600 **District 4 HRDC DV Program** Havre, MT 59501 Hotline Phone: 406-265-2222 **Friendship Center** Helena, MT 59601 Hotline Phone: 406-442-6800 **Violence Free Crisis Line** Kalispell, MT 59903 Hotline Phone: 406-752-7273 **Healing Hearts** Lame Deer, MT 59043 Hotline Phone: 406-477-6412 **SAVES, Inc.** Lewistown, MT 59457 Hotline Phone: 406-538-2281 **Lincoln Co. Women's Help Line** Libby, MT 59923 Hotline Phone: 406-756-2835 **Tri-County Network Against Domestic & Sexual Violence** Livingston, MT 59047 Hotline Phone: 406-222-8154 **CNADA** Miles City, MT 59301 Hotline Phone: 406-951-0475 **YWCA of Missoula** Missoula, MT 59802 Hotline Phone: 406-542-1944 **Family Crisis & Resource Center**

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Polson, MT 59860 Hotline Phone: 406-883-3350 **Richland County Coalition Against Domestic Violence** Sidney, MT 59270 Hotline Phone: 406-433-7421 **Mineral County Helpline** Superior, MT 59872 Hotline Phone: 406-822-4202 **Sanders County Coalition for Families** Thompson Falls, MT 59873 Hotline Phone: 406-827-3218
Nebraska**	Nebraska Domestic Violence/Sexual Assault Coalition Lincoln, NE 402-476-6256	**Project Response** Auburn, NE 68305 Hotline Phone: 402-274-5092 **Family Service Domestic Abuse** Bellevue, NE 68005 Hotline Phone: 402-292-5888 **CEDARS Family Violence Services** Broken Bow, NE 68822 Hotline Phone: 308-872-5988 **Family Rescue Services** Chadron, NE 69337 Hotline Phone: 308-432-4113 **Center for Sexual Assault & Domestic Violence Survivors** Columbus, NE 68601 Hotline Phone: 402-564-2155 **Blue Valley Crisis Intervention** Fairbury, NE 68352 Hotline Phone: 402-474-3434 **Domestic Abuse/Sexual Assault Crisis Center** Fremont, NE 68026 Hotline Phone: 402-727-7777

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		DOVES Gering, NE 69341 Hotline Phone: 308-436-4357 **Crisis Center, Inc.** Grand Island, NE 68802 Hotline Phone: 308-381-0555 **Spouse Abuse/Sexual Assault Crisis Center** Hastings, NE 68901 Hotline Phone: 402-463-4677 **The S.A.F.E. Center** Kearney, NE 68847 Hotline Phone: 308-237-2599 **Dawson County Parent/Child Center** Lexington, NE 68850 Hotline Phone: 308-324-3040 **Rape/Spouse Abuse Crisis Center** Lincoln, NE 68510 Hotline Phone: 402-475-7273 **Domestic Abuse/Sexual Assault Services** McCook, NE 69001 Hotline Phone: 308-345-5534 **Bright Horizons** Norfolk, NE 68702 Hotline Phone: 402-379-3798 **Rape & Domestic Abuse Program** North Platte, NE 69103 Hotline Phone: 308-534-3495 **Sandhills Crisis Intervention Program** Ogallala, NE 69153 Hotline Phone: 308-284-6055 **Catholic Charities -- The Shelter** Omaha, NE 68104 Hotline Phone: 402-558-5700

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		YWCA Women Against Violence Omaha, NE 68131 Hotline Phone: 402-345-7273 **North Central Quad Counties DV/SA Services** Valentine, NE 69201 Hotline Phone: 402-376-2045 **Haven House Family Service Center** Wayne, NE 68787 Hotline Phone: 402-375-4633
Nevada	Nevada Coalition Against Sexual Violence Henderson, NV 702-940-2033	**SARA** Carson City, NV 89702 Hotline Phone: 775-883-7654 **Committee Against Domestic Violence** Elko, NV 89803 Hotline Phone: 775-738-9454 **Support, Inc. Family Crisis Center** Ely , NV 89301 Hotline Phone: 775-289-2270 **Support, Inc. Family Crisis Center** Ely , NV 89301 Hotline Phone: 775-962-5888 **Community Action Against Rape** Las Vegas, NV 89101 Hotline Phone: 702-366-1640 **Douglas County Family Support Council** Minden, NV 89423 Hotline Phone: 775-782-8692 **Crisis Call Center/Sexual Assault Support Services Coordinator** Reno , NV 89507 Hotline Phone: 775-784-8090
New Hampshire	New Hampshire Coalition Against Domestic & Sexual	**RESPONSE** Berlin, NH 03570

STATE	STATE AGENCY[2]	LOCAL AGENCIES
	Violence Concord, NH 603-224-8893	Hotline Phone: 800-277-5570 **Women's Supportive Services** Claremont, NH 03743 Hotline Phone: 603-543-0155 **Rape & Domestic Violence Crisis Center** Concord, NH 03302 Hotline Phone: 800-277-5570 **Starting Point** Conway, NH 03818 Hotline Phone: 603-527-7394 **SHARPP** Durham , NH 03824 Hotline Phone: 603- 862-3494 **Monadnock Center for Violence Prevention** Keene , NH 03431 Hotline Phone: 603-352-3782 **New Beginnings** Laconia, NH 03247 Hotline Phone: 800-277-5570 **Women's Information Service (WISE)** Lebanon, NH 03766 Hotline Phone: 603-448-5525 **The Support Center Against Domestic Violence and Sexual Assault** Littleton, NH 03561 Hotline Phone: 603-444-0544 **YWCA Crisis Service** Manchester, NH 03101 Hotline Phone: 603-668-2299 **Bridges** Nashua, NH 03061 Hotline Phone: 603-883-3044 **Voices Against Violence**

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Plymouth , NH 03264 Hotline Phone: 603-536-1659 **Sexual Assault Support Services** Portsmouth, NH 03801 Hotline Phone: 888-747-7070
New Jersey**	New Jersey Coalition Against Sexual Assault Trenton, NJ 609-631-4450	**Domestic Abuse and Rape Crisis Center, Inc.** Belvedere, NJ 07823 Hotline Phone: 908-475-8408 **St. Francis Sexual Abuse and Assault Program** Brant Beach, NJ 08008 Hotline Phone: 732-370-4010 **Services Empowering Rape Victims** Camden, NJ 08103 Hotline Phone: 866-295-7378 **Coalition Against Rape and Abuse** Cape May Court House, NJ 08210 Hotline Phone: 609-522-6489 **East Orange General Hospital- Crisis Intervention Unit** East Orange, NJ 07019 Hotline Phone: 973-672-9685 **East Orange General Hospital- Crisis Intervention Unit** East Orange, NJ 07019 Hotline Phone: 973-672-9686 **Rape Crisis Intervention Center of Middlesex County** Edison, NJ 08837 Hotline Phone: 732-452-5900 **Women's Crisis Service** Flemington, NJ 08822 Hotline Phone: 908-788-4044 **Services Empowering Rape Victims** Glassboro, NJ 08028

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 866-295-7378 **YWCA of Bergen County Rape Crisis Center** Hackensack, NJ 07601 Hotline Phone: 201-487-2227 **180 Turning Lives Around** Hazlet, NJ 07730 Hotline Phone: 732-264-4111 **Jersey City Medical Center** Jersey City, NJ 07304 Hotline Phone: 201-433-6161 **Cumberland County Guidance Center- Sexual Assault Program** Millville, NJ 08332 Hotline Phone: 856-293-9753 **Essex County Rape Crisis Center** Montclair, NJ 07042 Hotline Phone: 973-746-0800 **CONTACT/Burlington County -- The Rape Crisis Program** Moorestown, NJ 08057 Hotline Phone: 856-234-8888 **Morris County Sexual Assault Center** Morristown, NJ 07960 Hotline Phone: 973-829-0587 **Safe and Sound Rape Crisis Center** Newark, NJ 07103 Hotline Phone: 973-972-1325 **Sexual Trauma Resource Center** Newton, NJ 07860 Hotline Phone: 973-875-1211 **Atlantic County Women's Center** Northfield, NJ 08225 Hotline Phone: 609-646-6767

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Passaic County Women's Center Paterson, NJ 07513 Hotline Phone: 973-881-1450 **Salem County Women's Services** Salem, NJ 08079 Hotline Phone: 856-935-6655 **Women's Health & Counseling Center** Somerville, NJ 08876 Hotline Phone: 908-526-7444 **Womanspace** Trenton, NJ 08618 Hotline Phone: 609-394-9000 **Union County Rape Crisis Center** Westfield, NJ 07090 Hotline Phone: 908-233-7273
New Mexico	New Mexico Coalition of Sexual Assault Programs Albuquerque, NM 505-883-8020	**Albuquerque Rape Crisis Center** Albuquerque, NM 87108 Hotline Phone: 505-266-7711 **Artesia Counseling Center** Artesia, NM 88210 Hotline Phone: 505-365-7606 **Daybreak Center, Inc.** Aztec, NM 87410 Hotline Phone: 505-947-3645 **La Buena Vida** Bernalillo, NM 87004 Hotline Phone: 505-269-7596 **Carlsbad Mental Health** Carlsbad , NM 88220 Hotline Phone: 505-885-8888 **Border Area Mental Health Center** Deming, NM 88030 Hotline Phone: 505-388-4412 **Crisis Center of Northern New Mexico**

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Espanola, NM 87532 Hotline Phone: 505 -753-1656 **Guidance Center of Lea County** Hobbs, NM 88240 Hotline Phone: 505-393-6633 **La Pinon Sexual Assault Recovery Service of Southern New Mexico** Las Cruces, NM 88005 Hotline Phone: 505-526-3437 **Los Alamos Family Council** Los Alamos , NM 87544 Hotline Phone: 505-662-4422 **Counseling Associates, Inc.** Roswell , NM 88202 Hotline Phone: 505-623-1480 **The Counseling Center** Ruidoso Downs, NM 88346 Hotline Phone: 505-437-7404 **Santa Fe Rape Crisis Center** Santa Fe, NM 87502 Hotline Phone: 505-986-9111 **Community Against Violence** Taos, NM 87571 Hotline Phone: 505-758-9888
New York**	New York State Coalition Against Sexual Assault Albany, NY 518-482-4222 New York City Alliance Against Sexual Assault New York, NY 518-482-4222	**Albany County Rape Crisis Center** Albany, NY 12207 Hotline Phone: 518-447-7716 **Rape Crisis Service of Planned Parenthood of Orleans County** Albion, NY 14411 Hotline Phone: 800-527-1757 **Fulton Montgomery Rape Crisis Service of Planned Parenthood** Amsterdam , NY 12010

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 518-843-4367 **Rape Crisis Service of Planned Parenthood of Genesee County** Batavia, NY 14020 Hotline Phone: 800-527-1757 **Crime Victims Assistance Center, Inc.** Binghamton, NY 13904 Hotline Phone: 607-722-4256 **Safe Horizon** Brooklyn, NY 10007 Hotline Phone: 212-227-3000 **Advocate Program** Buffalo, NY 14214 Hotline Phone: 716-834-3131 **Citizens Against Violent Acts/ CAVA RCC** Canton, NY 13617 Hotline Phone: 315-386-3777 **Rape Crisis Sexual Assault Support Services** Cobleskill, NY 12043 Hotline Phone: 518-234-4949 **Rape Crisis Service of Planned Parenthood of Livingston County** Dansville, NY 14437 Hotline Phone: 800-527-1757 **Delaware Opportunities Inc., Safe Against Violence** Delhi, NY 13753 Hotline Phone: 607-746-6278 **Victims' Assistance Services** Elmsford, NY 10523 Hotline Phone: 800-726-4041 **Rape and Abuse Crisis Service of the Finger Lakes, Inc.** Geneva, NY 14456 Hotline Phone: 800-247-7273

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Rape Survivor Advocacy Program- The Mental Health Association of Orange County Goshen, NY 10924 Hotline Phone: 845-294-9355 **Victims Information Bureau of Suffolk County** Hauppauge, NY 11788 Hotline Phone: 631-360-3606 **Nassau County Coalition Against Domestic Violence** Hempstead, NY 11550 Hotline Phone: 516-222-2293 **Rape Crisis of the Southern Tier** Horseheads, NY 14845 Hotline Phone: 607-795-5713 **Sexual Trauma & Recovery Services** Hudson Falls, NY 12839 Hotline Phone: 866-677-8764 **Center for Crime Victims & Sexual Assault** Ithaca, NY 14850 Hotline Phone: 607-277-5000 **The Salvation Army Rape Crisis Program** Jamestown, NY 14702 Hotline Phone: 716-661-3897 **Ulster County CVAP** Kingston, NY 12401 Hotline Phone: 845-340-3442 **Putnam-North Westchester Women's Resource Center** Mahopac, NY 10541 Hotline Phone: 845-628-2166 **RISE -- Rape Intervention Services & Education** Monticello, NY 12701 Hotline Phone: 845-791-9595

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Lewis Co. Opportunities Domestic Violence & Rape Crisis Dept. New Bremen, NY 13367 Hotline Phone: 315-376-4357 **Rockland Family Shelter Sexual Trauma Services** New City, NY 10956 Hotline Phone: 845-634-3344 **Victim Resource Center of the Finger Lakes, Inc.** Newark, NY 14513 Hotline Phone: 315-294-5398 **Niagra County Rape Crisis Services** Niagra Falls, NY 14301 Hotline Phone: 716-285-3518 **Victims of Violence/Liberty Resources, Inc**. Oneida, NY 13421 Hotline Phone: 315-366-5000 **Violence Intervention Program** Oneonta, NY 13820 Hotline Phone: 607-432-4855 **SAF Rape Crisis Program** Oswego, NY 13126 Hotline Phone: 315-342-1600 **Family Services** Poughkeepsie, NY 12601 Hotline Phone: 845-452-7272 **Rape Crisis Service of Planned Parenthood of Monroe County** Rochester, NY 14605 Hotline Phone: 585-546-2777 **Rape Crisis Service of Planned Parenthood of Monroe County** Rochester, NY 14605 Hotline Phone: 585-343-1212 **Saratoga Rape Crisis Services**

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Saratoga Springs, NY 12866 Hotline Phone: 518-587-2336 **Rape Crisis Service of Schenectady** Schenectady, NY 12305 Hotline Phone: 518-346-2266 **SAVAR** St. Auburn, NY 13021 Hotline Phone: 315-252-2112 **Rape Crisis Center of Syracuse** Syracuse, NY 13203 Hotline Phone: 315-422-7273 **Sexual Assault Care Center for Rensselaer County** Troy, NY 12180 Hotline Phone: 518-271-3257 **YWCA of the Mohawk Valley** Utica, NY 13502 Hotline Phone: 315-797-7740 **YWCA of the Mohawk Valley** Utica, NY 13502 Hotline Phone: 315-866-4120 **Community Action of Wyoming County** Warsaw, NY 14569 Hotline Phone: 585-237-2600 **Victims Assistance Center of Jefferson County, Inc.** Watertown, NY 13601 Hotline Phone: 315-782-1855
North Carolina**	North Carolina Coalition Against Sexual Assault Raleigh NC 888-737-CASA (2272)	**Union County Rape Crisis/Child Abuse Center** Monroe, NC 28112 Hotline Phone: 704-283-7770 **Options, Inc.** Morganton, NC 28680 Hotline Phone: 828-438-9444 Business Phone: 828-438-9444

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Reach, Inc. Murphy, NC 28906 Hotline Phone: 828-837-8064 **Community Coalition Against Family Violence** New Bern, NC 28563 Hotline Phone: 252-474-4343 **Interact** Raleigh, NC 27605 Hotline Phone: 919-828-3005 **Hannah's Place, Inc./Roanoke Valley Rape Crisis** Roanoke Rapids, NC 27870 Hotline Phone: 252-535-5946 **My Sister's House** Rocky Mount, NC 27804 Hotline Phone: 252-459-3094 **Haven in Lee County** Sanford, NC 27331 Hotline Phone: 919-774-8923 **Abuse Prevention Council of Cleveland County, Inc.** Shelby, NC 28151 Hotline Phone: 704-481-0043 **Harbor, Inc** Smithfield, NC 27577 Hotline Phone: 919-934-6161 **DANA** Sparta, NC 28675 Hotline Phone: 336-372-3262 **Mirchell County Safe Place** Spruce Pine, NC 28777 Hotline Phone: 828-385-1716 **Hope Harbor Home, Inc.** Supply, NC 28462

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 910-754-5856 **Reach of Jackson County** Sylva, NC 28779 Hotline Phone: 828-586-1911 **Crisis Council** Troy, NC 27371 Hotline Phone: 910-572-3747 **Anson County Domestic Violence & Sexual Assault Coalition** Wadesboro, NC 28170 Hotline Phone: 704-690-0362 **Sarah's Refuge, Inc.** Warsaw, NC 28393 Hotline Phone: 910-293-3206 **Options to Domestic Violence & Sexual Assault, Inc.** Washington, NC 27889 Hotline Phone: 877-723-8390 **REACH of Haywood County** Waynesville, NC 28786 Hotline Phone: 828-456-7898 **Help, Incorporated: Center Against Violence** Wentworth, NC 27375 Hotline Phone: 336-342-3331 **Families First, Inc.** Whiteville, NC 28472 Hotline Phone: 910-641-0444 **SAFE, Inc.** Wilkesboro, NC 28697 Hotline Phone: 336-667-7656 **Rape Crisis Center of Coastal Horizons Center, Inc.** Wilmington, NC 28412 Hotline Phone: 910-392-7460

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Family Services, Inc. Winston Salem, NC 27106 Hotline Phone: 336-722-5153
North Dakota**	North Dakota Council on Abused Women's Services/CASAND Bismarck, ND 701-255-6240	**Mercer County Women's Action & Resource Center** Beulah, ND 58523 Hotline Phone: 701-873-2274 **Mercer County Women's Action & Resource Center** Beulah, ND 58523 Hotline Phone: 701-748-2274 **Abused Adult Resource Center** Bismarck, ND 58502 Hotline Phone: 701-222-8370 **Safe Alternatives for Abused Families** Devils Lake, ND 58301 Hotline Phone: 701-662-5050 **Domestic Violence & Rape Crisis Center** Dickinson , ND 58602 Hotline Phone: 701-225-4506 **Kedish House** Ellendale, ND 58436 Hotline Phone: 701-349-5118 **Rape & Abuse Crisis Center of Fargo ND & Moorhead MN** Fargo, ND 58108 Hotline Phone: 701-293-7273 **Spirit Lake Victim Assistance Program** Fort Totten, ND 58335 Hotline Phone: 701-766-1816 **Spirit Lake Victim Assistance Program** Fort Totten, ND 58335 Hotline Phone: 701-351-5033 **Tri-County Crisis Intervention**

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Grafton, ND 58237 Hotline Phone: 701-352-3059 **Community Violence Intervention Center** Grand Forks, ND 58201 Hotline Phone: 866-746-8900 **SAFE Shelter** Jamestown, ND 58402 Hotline Phone: 888-353-7233 **Abuse Resource Network** Lisbon, ND 58054 Hotline Phone: 701-683-5241 **Domestic Violence Crisis Center, Inc.** Minot, ND 58702 Hotline Phone: 701-857-2500 **Domestic Violence Program NW ND** Stanley, ND 58784 Hotline Phone: 701-628-3233 **Abused Persons Outreach Center, Inc.** Valley City, ND 58072 Hotline Phone: 701-845-0072 **Three Rivers Crisis Center** Wahpeton, ND 58075 Hotline Phone: 701-642-2115 **McLean Family Resource Center** Washburn, ND 58577 Hotline Phone: 701-462-8643 **Family Crisis Shelter** Williston, ND 58801 Hotline Phone: 701-572-9111
Ohio**	Ohio Coalition on Sexual Assault Columbus, OH 614-268-3322	**Rape Crisis Center of Medina and Summit Counties** Akron, OH 44303 Hotline Phone: 1-877-906-7273 **Rape Crisis Service of Ashland County**

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Ashland, OH 44805 Hotline Phone: 419-289-8085 **Homesafe Rape Crisis Center** Ashtabula, OH 44004 Hotline Phone: 440-998-2100 **Careline Survivor Advocacy** Athens, OH 45701 Hotline Phone: 740-593-3344 **YWCA Sexual Assault Program** Batavia, OH 45103 Hotline Phone: 513-753-7281 **SAAFE Program** Bowling Green, OH 43402 Hotline Phone: 419-352-1545 **American Red Cross Rape Crisis Center** Canton, OH 44709 Hotline Phone: 330-452-1111 **Rape Crisis and Abuse Center** Cincinnati, OH 45202 Hotline Phone: 513-872-9259 **Cleveland Rape Crisis Center** Cleveland, OH 44113 Hotline Phone: 216-619-6192 **Sexual Assault Response Network of Central Ohio** Columbus, OH 43212 Hotline Phone: 614-267-7020 **Women And Family Services Inc.** Defiance , OH 43512 Hotline Phone: 419-592-3577 **HelpLine of Delaware and Morrow Counties, Inc.** Delaware, OH 43015 Hotline Phone: 740-369-3316 **HelpLine of Delaware and Morrow Counties, Inc.** Delaware, OH 43015

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 419-947-2520 **Open Arms Domestic Violence Shelter** Findlay, OH 45839 Hotline Phone: 419-422-4766 **Community Assault Prevention Services** Jackson , OH 45640 Hotline Phone: 740-286-6611 **Townhall II** Kent, OH 44240 Hotline Phone: 330-678-4357 **Abuse & Rape Crisis Shelter of Warren County** Lebanon, OH 45036 Hotline Phone: 513-695-2292 **Crime Victims Services** Lima, OH 45801 Hotline Phone: 419-222-8666 **Christina House** Lisbon, OH 44432 Hotline Phone: 330-420-0036 **Lorain County Rape Crisis Center WG Nord** Lorain, OH 44053 Hotline Phone: 440-233-5747 **Sexual Assault Intervention Network/EVE, Inc.** Marietta , OH 45750 Hotline Phone: 740-374-3111 **Medina County Rape Crisis Center** Medina, OH 44256 Hotline Phone: 888-334-4064 **New Directions** Mt. Vernon, OH 43050 Hotline Phone: 740-397-4357 **Compass, Inc.** New Philadelphia, OH 44663

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 330-339-1427 **Rape Crisis Program of Community Counseling & Crisis Center** Oxford, OH 45056 Hotline Phone: 513-523-4146 **Project Woman** Springfield, OH 45505 Hotline Phone: 937-325-3707 **Women's Tri-County Help Center, Inc.** St. Clairsville, OH 43950 Hotline Phone: 740-695-5441 **YWCA Rape Crisis Center** Toledo, OH 43624 Hotline Phone: 419-241-7273 **Rape Crisis Team of Trumbull County** Warren, OH 44482 Hotline Phone: 330-393-1565 **Lake County Victim Assistance Program** Willoughby, OH 44094 Hotline Phone: 440-953-5823 **Every Woman's House, Inc.** Wooster, OH 44691 Hotline Phone: 330-263-1020 **Rape Information and Counseling Program of Family Service Agency** Youngstown, OH 44502 Hotline Phone: 330-782-3936 **Crime Victim Services** Ottawa, OH 45875 Hotline Phone: 419-523-1111
Oklahoma**	Oklahoma Coalition Against Domestic Violence and Sexual Assault Oklahoma City, OK 405-848-1815	**Family Crisis Center** Ada, OK 74820 Hotline Phone: 580-436-3504 **ACMI House**

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Altus , OK 73521 Hotline Phone: 580-482-3800 **Family Shelter of Southern Oklahoma for Victims of Domestic Violence, Inc.** Ardmore, OK 73402 Hotline Phone: 580-226-6424 **Family Crisis & Counseling Center** Bartlesville, OK 74006 Hotline Phone: 918-336-1188 **Women's Service & Family Resource Center** Chickasha, OK 73023 Hotline Phone: 405-222-1818 **Rogers County Community Services Center, Inc.** Claremore, OK 74018 Hotline Phone: 918-341-9400 **Women's Haven** Duncan, OK 73534 Hotline Phone: 580-252-4357 **Crisis Control Center** Durant, OK 74702 Hotline Phone: 580-924-3030 **YWCA Crisis Center** Enid, OK 73701 Hotline Phone: 580-234-7644 **SOS for Families** Idabel, OK 74745 Hotline Phone: 580-286-3369 **New Directions, Inc.** Lawton, OK 73502 Hotline Phone: 580-357-2500 **Community Crisis Center** Miami, OK 74354 Hotline Phone: 918-542-1001

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		WISH Muskogee, OK 74402 Hotline Phone: 918-682-7878 **Women's Resource Center** Norman, OK 73070 Hotline Phone: 405-701-5540 **YWCA Crisis Intervention Services** Oklahoma City, OK 73112 Hotline Phone: 405-943-7273 **Okmulgee Safehouse** Okmulgee, OK 74447 Hotline Phone: 918-756-2545 **Domestic Violence Program Of North Central Oklahoma** Ponca City, OK 74602 Hotline Phone: 580-762-2873 **Women's Crisis Center of LeFlore County** Poteau, OK 74953 Hotline Phone: 918-647-9800 **Family Resource Center** Seminole, OK 74868 Hotline Phone: 800-373-5608 **Project Safe** Shawnee, OK 74801 Hotline Phone: 405-273-9953 **Kibois Women's Shelter** Stigler, OK 74462 Hotline Phone: 918-967-3277 **Stillwater Domestic Violence Services** Stillwater, OK 74074 Hotline Phone: 405-624-3020 **Help in Crisis** Tahlequah, OK 74465 Hotline Phone: 918-456-4357

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Call Rape, Inc Tulsa, OK 74114 Hotline Phone: 918-744-7273 **Northwest Domestic Crisis Services, Inc.** Woodward, OK 73801 Hotline Phone: 580-256-8712
Oregon	Oregon Coalition Against Domestic and Sexual Violence Salem, OR 503-365-9644	**Clatsop County Women's Resource Center Safe Home Network** Astoria, OR 97103 Hotline Phone: 503-325-5735 **May Day, Inc. Safe Home Network** Baker City, OR 97814 Hotline Phone: 541-523-4134 **Central Oregon Battering & Rape Alliance** Bend, OR 97701 Hotline Phone: 541-389-7021 **HHOPE** Burn, OR 97720 Hotline Phone: 541-573-7176 **New Beginnings Intervention Center** Christmas Valley, OR 97641 Hotline Phone: 541-576-3051 **New Beginnings Intervention Center** Christmas Valley, OR 97641 Hotline Phone: 541-410-7036 **Center Against Rape & Domestic Violence** Corvallis, OR 97339 Hotline Phone: 541-754-0110 **Sable House** Dallas, OR 97338 Hotline Phone: 503-623-4033 **Sexual Assault Support Service** Eugene, OR 97401

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 541-343-7277 **Siuslaw Area Women's Center** Florence, OR 97439 Hotline Phone: 541-997-4444 **Women's Crisis Support Team** Grants Pass, OR 97526 Hotline Phone: 541-479-9349 **Helping Hands Against Violence, Inc.** Hood River, OR 97031 Hotline Phone: 541-386-6603 **Shelter From the Storm** La Grande, OR 97850 Hotline Phone: 541-963-9261 **Lake County Crisis Center** Lakeview, OR 97630 Hotline Phone: 541-947-2449 **Sexual Assault Victim Services** Medford, OR 97504 Hotline Phone: 541-779-4357 **Clackamas Women's Services** Milwaukie, OR 97269 Hotline Phone: 503-654-2288 **My Sister's Place** Newport, OR 97365 Hotline Phone: 800-841-8325 **Coos County Women's Crisis Service** North Bend, OR 97459 Hotline Phone: 800-793-5612 **Domestic Violence Eliminated (Project DOVE)** Ontario, OR 97914 Hotline Phone: 541-889-2000 **Domestic Violence Services** Pendleton, OR 97801

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 541-278-0241 **Sexual Assault Resource Center** Portland, OR 97225 Hotline Phone: 503-640-5311 **Portland Women's Crisis Line** Portland, OR 97242 Hotline Phone: 503-235-5333 **Battered Persons' Advocacy** Roseburg, OR 97470 Hotline Phone: 541-673-7867 **Tillamook County Women's Resource Center** Tillamook, OR 97141 Hotline Phone: 503-842-9486
Pennsylvania**	Pennsylvania Coalition Against Rape (PCAR) Enola, PA 717-728-9740	**Crime Victims' Council of the Lehigh Valley** Allentown, PA 18101 Hotline Phone: 610-437-6611 **Family Services of Blair County** Altoona, PA 16601 Hotline Phone: 814-944-3585 **Women's Center of Beaver County** Beaver, PA 15009 Hotline Phone: 724-775-0131 **Women's Center** Bloomsburg, PA 17815 Hotline Phone: 570-784-6631 **YWCA -- Victims' Resource Center** Bradford, PA 16701 Hotline Phone: 814-368-6325 **Sexual Assault/Rape Crisis Services of Cumberland County** Carlisle, PA 17013 Hotline Phone: 717-258-4324 **Women in Need, Inc.** Chambersburg, PA 17201

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 717-264-4444 **A Way Out** Coudersport, PA 16915 Hotline Phone: 814-274-0240 **Victim Outreach Intervention Center** Evans City, PA 16033 Hotline Phone: 724-776-5910 **Victims' Resource Center** Franklin, PA 16323 Hotline Phone: 814-432-5960 **Survivors, Inc.** Gettysburg, PA 17325 Hotline Phone: 717-334-9777 **Blackburn Center Against Domestic & Sexual Violence** Greensburg, PA 15601 Hotline Phone: 724-836-1122 **YWCA Rape Crisis Services** Harrisburg, PA 17103 Hotline Phone: 717-238-7273 **Victims Intervention Program** Honesdale, PA 18431 Hotline Phone: 570-253-4401 **Network of Victim Assistance** Jamison, PA 18929 Hotline Phone: 800-675-6900 **Victim Services, Inc.** Johnstown, PA 15905 Hotline Phone: 814-288-4961 **Helping All Victims in Need** Kittanning, PA 16201 Hotline Phone: 724-548-8888 **Sexual Assault Prevention and Counseling Center**

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Lancaster, PA 17602 Hotline Phone: 717-392-7273 **Sullivan County Victim Services** Laporte, PA 18626 Hotline Phone: 570-946-4215 **Lebanon Rape Crisis Center** Lebanon, PA 17042 Hotline Phone: 717-272-5308 **Susquehanna Valley Women in Transition** Lewisburg, PA 17837 Hotline Phone: 570-523-6482 Business Phone: 570-523-1134 **The Abuse Network, Inc.** Lewistown, PA 17044 Hotline Phone: 717-242-2444 **Clinton County Women's Center** Lock Haven, PA 17745 Hotline Phone: 570-748-9509 **Women's Services, Inc.** Meadville, PA 16335 Hotline Phone: 814-333-9766 **AW/ARE, Inc.** Mercer, PA 16137 Hotline Phone: 724-981-1457 **Survivors' Resources, Inc.** Milford, PA 18337 Hotline Phone: 570-296-4357 **Women's Shelter/Rape Crisis Center of Lawrence County** New Castle, PA 16101 Hotline Phone: 724-652-9036 Special Services: Disabled, Elderly, Family, GLBT, **Victim Services Center of Montgomery County, Inc.** Norristown, PA 19401 Hotline Phone: 888-521-0983

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Women Organized Against Rape Philadelphia, PA 19107 Hotline Phone: 215-985-3333 **Pittsburgh Action Against Rape** Pittsburgh, PA 15203 Hotline Phone: 866-END-RAPE **Allegheny County Center for Victims of Violent Crime** Pittsburgh, PA 15219 Hotline Phone: 412-392-8582 **Berks Women in Crisis** Reading, PA 19601 Hotline Phone: 610-372-9540 **CAPSEA, Inc.** Ridgway, PA 15853 Hotline Phone: 814-772-1227 **Women's Resource Center** Scranton, PA 18501 Hotline Phone: 570-346-4671 **Women's Resources of Monroe County, Inc.** Stroudsburg, PA 18327 Hotline Phone: 570-421-4200 **The C.A.R.E. Center STTARS Program** Washington, PA 15301 Hotline Phone: 724-229-5007 **HAVEN of Tioga County** Wellsboro, PA 16901 Hotline Phone: 570-724-3554 **Crime Victims Center of Chester County, Inc.** West Chester, PA 19382 Hotline Phone: 610-692-7273 **Victims Resource Center** Wilkes-Barre, PA 18701

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 570-823-0765 **YWCA -- Wise Options** Williamsport, PA 17701 Hotline Phone: 570-323-8167 **Victim Assistance Center** York, PA 17405 Hotline Phone: 717-854-3131 **Crime Victim Center of Erie County, Inc.** Erie , PA 16501 Hotline Phone: 814-455-9414 **Centre County Women's Resource Center** State College, PA 16801 Hotline Phone: 814-234-5050
Rhode Island**	Sexual Assault & Trauma Resource Center of Rhode Island Providence, RI 401-421-4100	**Sexual Assault & Trauma Resource Center** Providence, RI 02903 Hotline Phone: 401-723-3057
South Carolina**	South Carolina Coalition Against Domestic Violence & Sexual Assault Columbia, SC 803-256-2900	**Aiken Coalition to Assist Abused Persons** Aiken, SC 29802 Hotline Phone: 803-649-0480 **Foothills Rape Crisis Center** Anderson, SC 29621 Hotline Phone: 864-231-7273 **Barnwell County Help Line** Barnwell, SC 29812 Hotline Phone: 803-259-3333 **Hope Cottage, Inc.** Beaufort, SC 29901 Hotline Phone: 843-524-2256 **Kershaw County Sexual Assault Center** Camden, SC 29020 Hotline Phone: 803-425-4357 **Sexual Trauma Services of the Midlands** Columbia, SC 29205

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 803-771-7273 **Pee Dee Coalition Against Domestic & Sexual Assault** Florence, SC 29503 Hotline Phone: 843-669-4600 **Greenville Rape Crisis & Child Abuse Center** Greenville, SC 29611 Hotline Phone: 864-467-3633 **Sexual Trauma & Counseling Center** Greenwood , SC 29648 Hotline Phone: 864-227-1623 **Palmetto Citizens Against Sexual Assault** Lancaster , SC 29720 Hotline Phone: 803-286-5232 **Grand Strand Community Against Rape** Myrtle Beach, SC 29578 Hotline Phone: 843-448-7273 **People Against Rape** North Charleston, SC 29406 Hotline Phone: 843-745-0144 **CASA/Family Services** Orangeburg, SC 29116 Hotline Phone: 803-531-6211 **Rape Crisis Council** Pickens, SC 29671 Hotline Phone: 864-898-5575 **Sexual Assault Resource Center** Rock Hill , SC 29731 Hotline Phone: 803-327-7558 **Safe Homes** Spartanburg, SC 29306 Hotline Phone: 864-583-9803 **YWCA of the Upper Lowlands** Sumter, SC 29150

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 803-773-4357
South Dakota	South Dakota Coalition Against Domestic Violence & Sexual Assault Pierre, SD 605-945-0869	**Safe Harbor** Aberdeen, SD 57401 Hotline Phone: 888-290-2935 **Northern Hills Crisis Outreach** Belle Fourche, SD 57717 Hotline Phone: 866-874-9512 **Brookings Domestic Abuse Shelter** Brookings, SD 57006 Hotline Phone: 605-692-7233 **WEAVE** Custer, SD 57730 Hotline Phone: 605-673-4357 **Sacred Heart Women's Shelter** Eagle Butte, SD 57625 Hotline Phone: 605-964-7233 **Wiconi Wawokiya, Inc.** Ft. Thompson, SD 57339 Hotline Phone: 800-723-3039 **CAVA (Communities Against Violence & Abuse, Inc.)** Lemmon, SD 57638 Hotline Phone: 605-244-7233 **Bridges Against Domestic Violence** Mobridge, SD 57601 Hotline Phone: 605-845-2110 **Cangleska Inc.** Pine Ridge, SD 57770 Hotline Phone: 605-867-5111 **Cangleska Inc.** Pine Ridge, SD 57770 Hotline Phone: 605-455-2311 **Working Against Violence, Inc.** Rapid City, SD 57701

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 605-341-2046 **Rape & Domestic Abuse Center** Sioux Falls, SD 57103 Hotline Phone: 605-339-0116 **Artemis House** Spearfish, SD 57783 Hotline Phone: 605-642-7825 **Crisis Intervention Services** Sturgis, SD 57785 Hotline Phone: 605-347-0050 **Vermillion Coalition Against Domestic Violence** Vermillion, SD 57069 Hotline Phone: 605-624-5311
Tennessee	Tennessee Coalition Against Domestic and Sexual Violence Nashville, TN 615-386-9406	**The Hope Center, Inc.** Athens, TN 37371 Hotline Phone: 423-745-5289 **Sexual Assault Crisis & Resource Center of the Partnership for Families, Children and Adults** Chattanooga, TN 37403 Hotline Phone: 423-755-2700 **Rape & Sexual Abuse Center** Clarksville, TN 37041 Hotline Phone: 615-256-8526 **Family Resource Agency** Cleveland, TN 37311 Hotline Phone: 423-476-3886 **Genesis House, Inc.** Cookeville, TN 38503 Hotline Phone: 800-707-5197 **Avalon Center: DV and Sexual Assault Program** Crossville, TN 38557 Hotline Phone: 931-484-4642 **Women's Resource & Rape Assistance Program**

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Jackson, TN 38305 Hotline Phone: 731-668-0411 **Sexual Assault Response Center** Johnson City, TN 37601 Hotline Phone: 423-928-4710 **Sexual Assault Crisis Center** Knoxville, TN 37939 Hotline Phone: 865-522-7273 **Memphis Sexual Assault Resource Center** Memphis, TN 38112 Hotline Phone: 901-272-2020 **CEASE, Inc.** Morristown, TN 37815 Hotline Phone: 423-581-2220 **Rape Recovery and Prevention Center** Murfreesboro, TN 37129 Hotline Phone: 615-494-9262 **Domestic Violence Program, Inc.** Murfreesboro, TN 37133 Hotline Phone: 615-896-2012 **Rape & Sexual Abuse Center** Nashville, TN 37210 Hotline Phone: 615-256-8526
Texas	Texas Association Against Sexual Assault Austin, TX 512-474-7190	**Crime Victim Crisis Center** Abilene, TX 79604 Hotline Phone: 325-677-7895 **Family Crisis Center of Big Bend** Alpine, TX 79831 Hotline Phone: 432-837-2242 **Family Support Services** Amarillo, TX 79101 Hotline Phone: 806-374-5433

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Women's Center of Brazoria County, Inc. Angleton, TX 77516 Hotline Phone: 979-849-5166 **SafePlace** Austin, TX 78760 Hotline Phone: 512-267-7233 **Family Crisis Center** Bastrop, TX 78602 Hotline Phone: 512-303-7755 **Matagorda County Women's Crisis Center** Bay City , TX 77404 Hotline Phone: 979-245-9299 **New Horizons Family Center** Baytown, TX 77520 Hotline Phone: 281-422-2292 **Rape & Suicide Crisis of Southeast Texas** Beaumont , TX 77704 Hotline Phone: 409-835-3355 **Friends for Hope, Inc.** Big Lake, TX 76932 Hotline Phone: 325-884-9804 **Victim Services of Big Spring, Texas** Big Spring, TX 79721 Hotline Phone: 432-263-3312 **Fannin County Family Crisis Center** Bonham, TX 75418 Hotline Phone: 903-583-7000 **Hutchinson County Crisis Center, Inc.** Borger, TX 79007 Hotline Phone: 806-273-2313 **The Haven Family Shelter of McCulloch County** Brady, TX 76825 Hotline Phone: 325-597-7644

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Friendship of Women, Inc. Brownsville, TX 78523 Hotline Phone: 956-544-7412 **Brazos County Rape Crisis Center** Bryan, TX 77805 Hotline Phone: 979-731-1000 **Wintergarden Women's Shelter, Inc.** Carizzo Springs, TX 78834 Hotline Phone: 830-876-9441 **Johnson County Family Crisis Center** Cleburne, TX 76033 Hotline Phone: 817-641-2332 **Women's Shelter of the Corpus Christi Area** Corpus Christi, TX 78463 Hotline Phone: 361-881-8888 **Victim's Outreach** Dallas, TX 75205 Hotline Phone: 214-358-5693 **Dallas County Rape Crisis Center** Dallas, TX 75235 Hotline Phone: 214-590-0430 **Amistad Family Violence & Rape Crisis Center** Del Rio, TX 78841 Hotline Phone: 888-774-2744 **Denton County Friends of the Family** Denton, TX 76202 Hotline Phone: 940-382-7273 **Safe Place, Inc.** Dumas, TX 79029 Hotline Phone: 806-935-2828 **Eastland County Crisis Center, Inc.** Eastland, TX 76448 Hotline Phone: 254-629-3223

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		S.T.A.R.S. El Paso, TX 79902 Hotline Phone: 915-779-1800 **Rape Crisis Program** Fort Worth, TX 76110 Hotline Phone: 817-927-2737 **Cooke County Friends of the Family, Inc.** Gainesville, TX 76241 Hotline Phone: 940-665-2873 **Women's Resource and Crisis Center** Galveston, TX 77553 Hotline Phone: 409-765-7233 **Brighter Tomorrows, Inc.** Grand Prairie, TX 75053 Hotline Phone: 972-262-8383 **Rape Crisis Center of Northeast Texas** Greenville, TX 75404 Hotline Phone: 903-454-9999 **Family Crisis Center, Inc.** Harlingen, TX 78550 Hotline Phone: 956-423-9304 **Women & Children's Crisis Center** Hereford, TX 79045 Hotline Phone: 806-363-6727 **Houston Area Women's Center** Houston, TX 77019 Hotline Phone: 713-528-7273 **Family Time** Humble, TX 77347 Hotline Phone: 281-446-2615 **Walker County Family Violence Council** Huntsville, TX 77340 Hotline Phone: 936-291-3369

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Cherokee County Crisis Center of Anderson & Cherokee Counties Jacksonville, TX 75766 Hotline Phone: 903-586-9118 **Hill Country Crisis Council** Kerrville, TX 78029 Hotline Phone: 830-257-2400 **Families in Crisis, Inc./ Rape Crisis** Kileen, TX 76540 Hotline Phone: 254-634-8309 **Kilgore Community Crisis Center** Kilgore, TX 75662 Hotline Phone: 903-984-2377 **Hardin County Crime Victims' Assistance Center** Kountze, TX 77625 Hotline Phone: 409-246-4300 **Serving Children and Adolescents in Need, Inc.** Laredo, TX 78042 Hotline Phone: 956-724-3177 **Women's Center of East Texas** Longview, TX 75606 Hotline Phone: 903-295-7526 **Lubbock Rape Crisis Center, Inc.** Lubbock, TX 79457 Hotline Phone: 806-763-7273 **Family Crisis Center** Marble Falls, TX 78654 Hotline Phone: 830-693-5600 **Women Together/Mujeres Unidas** McAllen, TX 78501 Hotline Phone: 956-630-4881 **Midland Rape Crisis Center** Midland, TX 79702 Hotline Phone: 432-682-7273

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Shelter Agencies for Families in East Texas, Inc. Mt. Pleasant, TX 75455 Hotline Phone: 903-575-9999 **Women's Shelter of East Texas, Inc.** Nacogdoches, TX 75964 Hotline Phone: 936-569-1018 **Crisis Center of Comal & Guadalupe Counties** New Braunfels, TX 78131 Hotline Phone: 800-434-8013 **Center for Crisis Advocacy** Odessa, TX 79760 Hotline Phone: 432-339-2747 **Tralee Crisis Center** Pampa, TX 79065 Hotline Phone: 806-669-1788 **Family Haven Sexual Assault Services** Paris , TX 75461 Hotline Phone: 903-784-6842 **Bridge Over Troubled Waters** Pasadena, TX 77501 Hotline Phone: 713-473-2801 **Panhandle Crisis Center** Perryton, TX 79070 Hotline Phone: 806-435-5008 **Hale County Crisis Center** Plainview, TX 79073 Hotline Phone: 806-293-7273 **Turning Point** Plano, TX 75086 Hotline Phone: 972-985-0951 **Atascosa Family Crisis Center** Pleasanton, TX 78064 Hotline Phone: 830-569-2001

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		The Harbor Port Lavaca, TX 77982 Hotline Phone: 361-552-4357 **Fort Bend County Women's Center** Richmond, TX 77469 Hotline Phone: 281-342-4357 **Williamson County Crisis Center** Round Rock, TX 78664 Hotline Phone: 800-460-7233 **Concho Valley Rape Crisis Center, Inc.** San Angelo, TX 76903 Hotline Phone: 325-658-8888 **Rape Crisis Center** San Antonio, TX 78227 Hotline Phone: 210-349-7273 **Hays Caldwell Women's Center** San Marcos, TX 78667 Hotline Phone: 512-396-4357 **Cross Timbers Family Services** Stephenville, TX 76401 Hotline Phone: 254-965-4357 **Domestic Violence Prevention** Texarkana, TX 75504 Hotline Phone: 903-793-4357 **Montgomery County Women's Center** The Woodlands, TX 77387 Hotline Phone: 936-441-7273 **East Texas Crisis Center** Tyler, TX 75711 Hotline Phone: 903-595-5591 **Hope of South Texas** Victoria , TX 77901 Hotline Phone: 361-573-3600

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Advocacy Center for Crime Victims & Children Waco, TX 76701 Hotline Phone: 254-752-7233 **Freedom House** Weatherford, TX 76086 Hotline Phone: 817-596-8922 **Bay Area Turning Point** Webster, TX 77598 Hotline Phone: 281-286-2525 **First Step** Wichita Falls, TX 76310 Hotline Phone: 940-692-1993
Utah	Utah Coalition Against Sexual Assault Salt Lake City, UT 801-322-1500	**YWCA of Box Elder County** Brigham City, UT 84302 Hotline Phone: 435-723-5600 **Canyon Creek Women's Crisis Center** Cedar City, UT 84721 Hotline Phone: 435-867-6149 **Safe Harbor Crisis Center** Kaysville, UT 84037 Hotline Phone: 801-444-9161 **Community Abuse Prevention Services Agency** Logan, UT 84321 Hotline Phone: 435-753-2500 **Seekhaven Family Resource Center** Moab, UT 84532 Hotline Phone: 435-259-2229 **YCC Rape Recovery Center** Ogden, UT 84401 Hotline Phone: 801-392-7273 **Victim Assistance Program** Park City, UT 84098 Hotline Phone: 435-615-3850

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Center for Women & Children in Crisis, Inc. Provo, UT 84603 Hotline Phone: 801-377-5500 **New Horizons Crisis Center** Richfield, UT 84701 Hotline Phone: 435-896-9294 **Rape Recovery Center** Salt Lake City, UT 84105 Hotline Phone: 801-467-7273 **D.O.V.E Center** St. George, UT 84771 Hotline Phone: 435-628-0458 **Vernal Victim Advocacy Program** Vernal, UT 84078 Hotline Phone: 435-789-4222
Vermont**	Vermont Network Against Domestic Violence and Sexual Assault Montpelier, VT 802-223-1302	**Sexual Assault Crisis Team** Barre, VT 05641 Hotline Phone: 802-479-5577 **Project Against Violent Encounters** Bennington, VT 05201 Hotline Phone: 802-442-2111 **Women's Rape Crisis Center** Burlington, VT 05402 Hotline Phone: 802-863-1236 **AWARE** Hardwick, VT 05843 Hotline Phone: 802-472-6463 **WomenSafe** Middlebury , VT 05753 Hotline Phone: 802-388-4205 **Clarina Howard Nichols Center** Morrisville, VT 05661 Hotline Phone: 802-888-5256 **Safeline, Inc.** Randolph, VT 05060

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 800-NEW-SAFE **New Beginnings, Inc.** Springfield, VT 05156 Hotline Phone: 802-885-2050 **Voices Against Violence** St. Albans, VT 05478 Hotline Phone: 802-524-6575 **Umbrella** St. Johnsbury, VT 05819 Hotline Phone: 802-748-8645
Virginia	Virginians Aligned Against Sexual Assault Charlottesville, VA 804-979-9002	**Doves, Inc.** Danville, VA 24541 Hotline Phone: 888-403-6837 **Victim Assistance Network** Fairfax, VA 22306 Hotline Phone: 703-360-7273 **Piedmont Crisis Center** Farmville, VA 23901 Hotline Phone: 434-292-1076 **Rappahannock Council Against Sexual Assault** Fredericksburg, VA 22402 Hotline Phone: 540-371-1666 **Sexual Assault Crisis Center** Gloucester, VA 23061 Hotline Phone: 804-694-5890 **Response Peninsula** Hampton, VA 23666 Hotline Phone: 757-825-2591 **Citizens Against Sexual Assault (CASA)** Harrisonburg, VA 22801 Hotline Phone: 540-434-2272 **The James House** Hopewell, VA 23860 Hotline Phone: 804-458-2840 **People Incorporated of Southwest Virginia**

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Lebanon, VA 24266 Hotline Phone: 877-697-9444 **People Incorporated of Southwest Virginia** Lebanon, VA 24266 Hotline Phone: 276-935-6295 **LAWS Sexual Assault Services** Leesburg, VA 20176 Hotline Phone: 703-777-6552 **Project Horizon** Lexington, VA 24450 Hotline Phone: 540-463-2594 **Choices** Luray, VA 22835 Hotline Phone: 540-743-4414 **Sexual Assault Response Program** Lynchburg, VA 24503 Hotline Phone: 434-947-7273 **Citizens Against Family Violence, Inc.** Martinsville, VA 24114 Hotline Phone: 276-632-8701 **Response Sexual Assault Support Services of the YWCA** Norfolk, VA 23508 Hotline Phone: 757-622-4300 **FCSS, Inc.** Norton, VA 24273 Hotline Phone: 276-926-4816 **Women's Resource Center of the New River Valley** Radford, VA 24141 Hotline Phone: 540-639-1123 **YWCA of Richmond** Richmond, VA 23219 Hotline Phone: 804-643-0888

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		SARA Program Blue Ridge Behavioral Healthcare Roanoke, VA 24016 Hotline Phone: 540-981-9352 **New Directions** Staunton, VA 24402 Hotline Phone: 540-886-6800 **The Haven Shelter & Services, Inc.** Warsaw, VA 22572 Hotline Phone: 804-333-5321 **Avalon: A Center for Women and Children** Williamsburg, VA 23187 Hotline Phone: 757-258-5051 **The Shelter for Abused Women** Winchester, VA 22604 Hotline Phone: 540-667-6466 **SAVAS (Sexual Assault Victims' Advocacy Services)** Woodbridge, VA 22194 Hotline Phone: 703-368-4141 **Response** Woodstock, VA 22664 Hotline Phone: 540-459-5161 **SARA (Sexual Assault Response and Awareness)** Alexandria, VA 22314 Hotline Phone: 703-683-7273 **Violence Intervention Program** Arlington, VA 22201 Hotline Phone: 703-228-4848 **Hanover Safe Place** Ashland, VA 23005 Hotline Phone: 804-752-2702 **The Crisis Center** Bristol, VA 24201 Hotline Phone: 276-628-7731

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Project Hope at Quin Rivers Agency Charles City, VA 23030 Hotline Phone: 804-966-2520 **Sexual Assault Resource Agency** Charlottesville, VA 22906 Hotline Phone: 434-977-7273 **Safehome Systems, Inc.** Covington, VA 24426 Hotline Phone: 540-965-3237
Washington**	Washington Coalition of Sexual Assault Programs Olympia, WA 360-754-7583	**Beyond Survival** Aberdeen, WA 98520 Hotline Phone: 360-533-9752 **Domestic Violence and Sexual Assault Services of Whatcom County** Bellingham, WA 98225 Hotline Phone: 360-715-1563 **Human Response Network** Chehalis, WA 98532 Hotline Phone: 360-748-6601 **NEWA Rural Resources Development Assoc. Family Support Center** Colville, WA 99114 Hotline Phone: 509-684-6139 **Family Resource Center of Lincoln County** Davenport, WA 99122 Hotline Phone: 509-725-4357 **DVSA Services of the San Juan Islands** Eastsound, WA 98245 Hotline Phone: 360-376-1234 **ASPEN** Ellensburg, WA 98926 Hotline Phone: 509-925-9384 **Providence Sexual Assault Center** Everett, WA 98206

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 425-252-4800 **DVSA Services of the San Juan Islands** Friday Harbor, WA 98250 Hotline Phone: 360-378-2345 **Sexual Assault Response Center** Kennewick, WA 99336 Hotline Phone: 509-374-5391 **New Hope DV & SA Service** Moses Lake, WA 98837 Hotline Phone: 509-764-0215 **Safeplace Rape Relief & Women's Shelter Services** Olympia, WA 98501 Hotline Phone: 360-754-6300 **Domestic Violence/Sexual Assault Program** Port Townsend, WA 98368 Hotline Phone: 360-385-5291 **Alternative to Violence of the Palouse** Pullman, WA 99163 Hotline Phone: 509-332-4357 Business Phone: 509-332-0552 **King County Sexual Assault Resource Center** Renton, WA 98057 Hotline Phone: 888-99-VOICE **Mason County Council on Abuse & Neglect** Shelton, WA 98584 Hotline Phone: 360-490-9228 **Sexual Assault & Family Trauma and Response Center (SAFeT)** Spokane, WA 99201 Hotline Phone: 509-624-7273 **Sexual Assault Center of Pierce County** Tacoma, WA 98406 Hotline Phone: 253-474-7273

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		YWCA Clark Co. Sexual Assault Program Vancouver, WA 98663 Hotline Phone: 360-695-0501 **YWCA Domestic Violence/Sexual Assault Center** Walla Walla, WA 99362 Hotline Phone: 509-529-9922 **Phoenix Place** Wentachee, WA 98807 Hotline Phone: 509-663-7446 **Central WA Comprehensive Mental Health** Yakima, WA 98907 Hotline Phone: 509-452-9675
West Virginia**	West Virginia Foundation for Rape Information and Services Fairmont, WV 304-366-9500	**Women's Resource Center** Beckley, WV 25802 Hotline Phone: 304-255-2559 **Family Services of Kanawha Valley** Charleston, WV 25301 Hotline Phone: 304-340-3676 **Women's Aid in Crisis** Elkins, WV 26241 Hotline Phone: 304-636-8433 **HOPE, Inc.** Fairmont, WV 26554 Hotline Phone: 304-367-1100 **CONTACT Rape Crisis Center** Huntington, WV 25728 Hotline Phone: 304-399-1111 **Family Crisis Center** Keyser, WV 26726 Hotline Phone: 304-788-6061 **Family Refuge Center** Lewisburg, WV 24901 Hotline Phone: 304-645-6334 **Shenandoah Women's Center**

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Martinsburg, WV 25401 Hotline Phone: 304-263-8292 **Rape and Domestic Violence Information Center** Morgantown, WV 26505 Hotline Phone: 304-292-5102 **Sexual Assault Help Center** Wheeling, WV 26003 Hotline Phone: 304-234-8519
Wisconsin**	Wisconsin Coalition Against Sexual Assault Madison, WI 608-257-1516	**AVAIL, Inc.** Antigo, WI 54409 Hotline Phone: 715-623-5767 **Sexual Assault Crisis Center** Appleton, WI 54914 Hotline Phone: 920-832-4646 **New Day Shelter** Ashland, WI 54806 Hotline Phone: 715-682-9565 **Hope House** Baraboo, WI 53913 Hotline Phone: 608-356-7500 **People Against a Violent Environment, Inc.** Beaver Dam, WI 53916 Hotline Phone: 920-887-3786 **Sexual Assault Recovery Program of Rock County** Beloit, WI 53511 Hotline Phone: 608-365-1119 **Family Support Center** Chippewa Falls, WI 54729 Hotline Phone: 715-723-1138 **Bolton Refuge House, Inc.** Eau Claire, WI 54702 Hotline Phone: 715-834-0628 **The Association for the Prevention of Family Violence**

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Elkhorn, WI 53121 Hotline Phone: 262-723-4653 **ASTOP, Inc.** Fond Du Lac, WI 54935 Hotline Phone: 920-921-7657 **Sexual Assault Center of Door County** Green Bay, WI 54301 Hotline Phone: 920-746-8996 **Family Services Sexual Assault Center** Green Bay, WI 54305 Hotline Phone: 920-436-8899 **Sexual Assault Center of Oconto County** Green Bay, WI 54305 Hotline Phone: 920-846-2111 **Alternatives to Violence Program** Janesville, WI 53546 Hotline Phone: 608-752-2583 **Pathways of Courage** Kenosha, WI 53141 Hotline Phone: 262-657-9900 **Sexual Abuse Counseling & Support Program Gunderson Lutheran Medical Center** La Crosse, WI 54601 Hotline Phone: 608-775-5950 **Time-Out Family Shelter** Ladysmith, WI 54848 Hotline Phone: 715-532-6976 **Rape Crisis Center, Inc.** Madison, WI 53713 Hotline Phone: 608-251-7273 **Personal Development Center** Marshfield, WI 54449 Hotline Phone: 715-384-5555

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Stepping Stones, Inc. Medford, WI 54451 Hotline Phone: 715-748-5140 **Reach Counseling Services** Menasha, WI 54952 Hotline Phone: 920-722-8150 **The Bridge** Menomonie, WI 54751 Hotline Phone: 715-235-9074 **Haven, Inc.** Merrill, WI 54452 Hotline Phone: 715-536-1300 **Community Referral Agency** Milltown, WI 54858 Hotline Phone: 715-825-4404 **Milwaukee Women's Center** Milwaukee, WI 53202 Hotline Phone: 414-671-6140 **Sexual Assault Treatment Center** Milwaukee, WI 53233 Hotline Phone: 414-219-5555 **Family Advocates, Inc.** Platteville, WI 53818 Hotline Phone: 608-348-3838 **Sexual Assault Services of Lutheran Social Services** Racine, WI 53404 Hotline Phone: 262-637-7233 **Tri-County Council on DV& SA** Rhinelander, WI 54501 Hotline Phone: 715-362-6800 **Passages, Inc.** Richland Center, WI 53581 Hotline Phone: 608-647-3616

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Turningpoint River Falls, WI 54022 Hotline Phone: 715-425-6751 **Advocates of Ozaukee** Saukville, WI 53080 Hotline Phone: 262-375-4034 **Center Against Sexual and Domestic Abuse** Superior, WI 54880 Hotline Phone: 715-392-3136 **The Women's Center** Waukesha, WI 53186 Hotline Phone: 262-542-3828 **The Women's Community Inc.- Sexual Assault Victim Service** Wausau, WI 54403 Hotline Phone: 715-842-7323 **Friends of Abused Families, Inc.** West Bend, WI 53095 Hotline Phone: 262-334-7298
Wyoming**	Wyoming Coalition Against Violence & Sexual Assault Laramie, WY 307-755-5481	**Johnson County Family Crisis Center** Buffalo, WY 82834 Hotline Phone: 307-684-2233 **Women's Self Help Center** Casper, WY 82601 Hotline Phone: 307-235-2814 **Safe House/Sexual Assault Services** Cheyenne, WY 82003 Hotline Phone: 307-637-7233 **Crisis Intervention Services (CIS)** Cody , WY 82414 Hotline Phone: 307-527-7801 **Converse County Coalition Against Family Violence** Douglas, WY 82633

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hotline Phone: 307-358-4800 **Sexual Assault & Family Violence Task Force** Evanston, WY 82930 Hotline Phone: 307-789-7315 **Gillette Abuse Refuge Foundation (GARF)** Gillette, WY 82717 Hotline Phone: 307-686-8070 **Community Safety Network** Jackson, WY 83001 Hotline Phone: 307-733-7233 **Safe Project** Laramie, WY 82070 Hotline Phone: 307-745-3556 **Help Mate** Lusk, WY 82225 Hotline Phone: 307-334-2608 **FOCUS Family Crisis Center** Newcastle, WY 82701 Hotline Phone: 307-746-3630 **Sublette County SAFV Task Force** Pinedale, WY 82941 Hotline Phone: 307-367-6305 **Fremont Alliance** Riverton, WY 82501 Hotline Phone: 307-856-4734 **YWCA Support & Safe House (SASH)** Rock Springs, WY 82902 Hotline Phone: 307-352-1030 **Advocacy & Resource Center** Sheridan, WY 82801 Hotline Phone: 307-672-3222 **Sacred Shield** St. Stephens, WY 82524 Hotline Phone: 307-857-3877

STATE	STATE AGENCY[2]	LOCAL AGENCIES
		Hope Agency & Crisis Line Thermopolis, WY 82443 Hotline Phone: 307-864-4673 **Goshen County Task Force on Family Violence & Sexual Assault** Torrington , WY 82240 Hotline Phone: 307-532-2118 **Project Safe** Wheatland, WY 82201 Hotline Phone: 307-322-4794 **Victims of Violence Center** Worland, WY 82401 Hotline Phone: 307-347-4991

DRAFT

Medical/Mental Health Confidentiality in Correctional Settings

Professor Brenda V. Smith

NIC/WCL Project on Addressing Prison Rape

Developed by the NIC/WCL Project on Addressing Prison Rape under NIC Cooperative Agreement 06S20GJJ1

Guidance on Reporting Obligations

1. **The Health Insurance Portability and Accountability Act of 1996 (HIPAA)**
2. **State Laws**
3. **Case law**
4. **Health Organizations- Professional Codes of Ethics**
5. **Correctional Institution Policies and Procedures**

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

- HIPAA's "privacy rule" generally pre-empts state law when state law is not more stringent in the protection of health information.
- An "authorization" is required for disclosing "protected health information" before a disclosure can be made.

HIPAA Questions

- **Under HIPAA, can an inmate prevent a medical provider from reporting a sexual assault to prison authorities for investigation/prosecution?**

No. Although health providers cannot release personal health information of inmates without cause, many exceptions have been provided for, including releasing information to law enforcement during a sexual assault investigation.

HIPAA Questions

- **Can prisoners use HIPAA as grounds for a violation of privacy lawsuit against the correctional institution?**

No. HIPAA does not provide individuals with a private right of action. No prisoner lawsuit has successfully used HIPAA to defend their privacy claim.

HIPAA Questions

- **Can an inmate or health care provider use HIPAA to prevent disclosing information required under PREA?**

No. The information provided by prisons under PREA complies with the HIPAA privacy laws and therefore no objection by an individual is allowed.

HIPAA

- Correctional facilities can disclose health information about inmates without an inmate's authorization for:
  - Providing health care to inmates;
  - The health and safety of the inmate-victim or other inmates;
  - The health and safety of the officers, employees, or others at the correctional institution; and
  - The health and safety of inmates, officers or persons responsible for the transporting of inmates;
  - Law enforcement on the premises of the correctional institution; and
  - The administration and maintenance of the safety, security, and good order of the correctional institution.

HIPAA: So What?

- If state law is not as strict, HIPAA applies
- HIPAA does not prevent a medical provider from reporting a sexual assault to prison authorities for investigation/prosecution
- HIPAA cannot be used to prevent disclosing information for data collection as required under PREA

State Laws

- Confidentiality and Privilege Statutes
  - Physician- Patient
  - Nurse-Patient
  - Sexual Assault Counselor- Patient
  - Rape Crisis Counselor- Patient
  - Clergy
- Mandatory Reporting Statutes
- Vulnerable Adult

Confidentiality and Privilege Defined

- There are three kinds of privilege
  - Absolute
    - Complete protection against disclosure
  - Semi-Absolute
    - Confidentiality is guaranteed except in specific circumstances- harm to self or others, criminal acts committed against a minor, and/or if there is a qualified privilege provision in the confidentiality statute
  - Qualified
    - Privilege can be breached by court order when a judge finds there are countervailing interests

Physician & Patient: Privilege

- **District of Columbia** [D.C. Code § 14-307 (2006)].
  - **Physicians and mental health professionals.**
    - (a) In the Federal courts in the District of Columbia and District of Columbia courts a physician or surgeon or mental health professional as defined by § 7-1201.01(11) may not be permitted, without the consent of the client, or of his legal representative, to disclose any information, confidential in its nature, that he has acquired in attending a client in a professional capacity and that was necessary to enable him to act in that capacity, whether the information was obtained from the client or from his family or from the person or persons in charge of him.

Physician & Patient: Exception

- **District of Columbia** [D.C. Code § 14-307 (2006)].
  - **Physicians and mental health professionals.**
    - (b) This section does not apply to:
      - (1) **evidence** in criminal cases where the accused is charged with causing the death of, or inflicting injuries upon, a human being, and the disclosure is required in the interests of public justice;
      - (2) **evidence** relating to the mental competency or sanity of an accused in criminal trials where the accused raises the defense of insanity or where the court is required under prevailing law to raise the defense;

Sexual Assault Counselor & Victim: Privilege

- **California** [Cal. Evid. Code § 1035.4 (West 2006)].
  - **Confidential communication between the sexual assault counselor and the victim.**
    - As used in this article, "confidential communication between the sexual assault counselor and the victim" means information transmitted between the victim and the sexual assault counselor in the course of their relationship and in confidence by a means which, so far as the victim is aware, discloses the information to no third persons other than those who are present to further the interests of the victim in the consultation or those to whom disclosures are reasonably necessary for the transmission of the information or an accomplishment of the purposes for which the sexual assault counselor is consulted. The term includes all information regarding the facts and circumstances involving the alleged sexual assault and also includes all information regarding the victim's prior or subsequent sexual conduct, and opinions regarding the victim's sexual conduct or reputation in sexual matters.

Sexual Assault Counselor & Victim: Exception

- **California** [Cal. Evid. Code § 1035.4 (West 2006)].
  - **Confidential communication between the sexual assault counselor and the victim.**
    - The court **may compel** disclosure of information received by the sexual assault counselor which constitutes relevant evidence of the facts and circumstances involving an alleged sexual assault about which the victim is complaining and which is the subject of a criminal proceeding if the court determines that the probative value outweighs the effect on the victim, the treatment relationship, and the treatment services if disclosure is compelled.

Confidentiality/Privilege: Clergyman

- **Georgia** [Ga. Code Ann. § 24-9-22 (West 2006)].
  - **Communications to clergyman privileged.**
    - Every communication made by any person professing religious faith, seeking spiritual comfort, or seeking counseling to any Protestant minister of the Gospel, any priest of the Roman Catholic faith, any priest of the Greek Orthodox Catholic faith, any Jewish rabbi, or to any Christian or Jewish minister, by whatever name called, shall be deemed privileged.
    - No such minister, priest, or rabbi shall disclose any communications made to him by any such person professing religious faith, seeking spiritual guidance, or seeking counseling, nor shall such minister, priest, or rabbi be competent or compellable to testify with reference to any such communication in any court.

Confidentiality/Privilege: General Exceptions

- Some jurisdictions carve out exceptions to the general rule of prohibiting the unauthorized disclosure of a patient's confidential health information where prisoners are concerned
- State laws governing medical privacy extend to those treated in correctional facilities except :
  - mandatory reporting requirements for child abuse;
  - certain infectious diseases; or
  - Tarasoff duties ("Once a therapist does in fact determine, or under applicable professional standards reasonably should have determined, that a patient poses a serious danger of violence to others, [the therapist] bears a duty to exercise reasonable care to protect the foreseeable victim of that danger.") for patients who pose a danger to themselves or others

Exceptions: Texas

- Tex. Rev. Civ. Stat. art. 4495b, § 5.08(h)(9) (1999).
  - Physicians may without obtaining their patients' consent, disclose confidential information if their patient is detained in a "penal or other custodial institution".

Exceptions: California

- Cal. Penal Code § 7501(c) (1995).
  - Correctional health professionals may disclose a prisoner's HIV status to parole or probation officers when an HIV-infected inmate is released from prison.

Exceptions: Idaho

- Idaho Code §§ 39-601, 39-604(1)-39-604(5) (1996).
  - Allows the disclosure to a court of test results for any number of enumerated diseases of prisoners as well as persons charged with an offense.

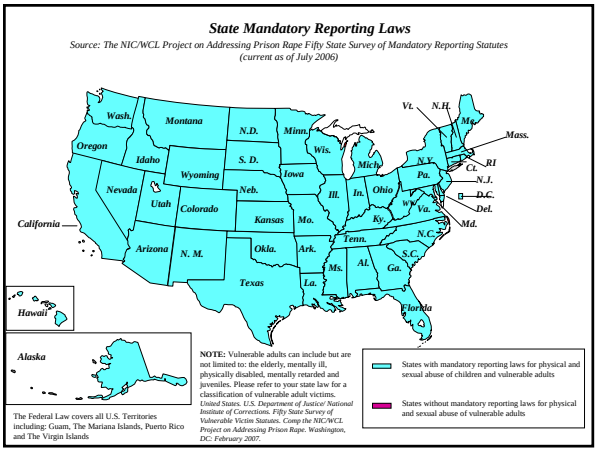
Confidentiality/Privilege--Practicalities

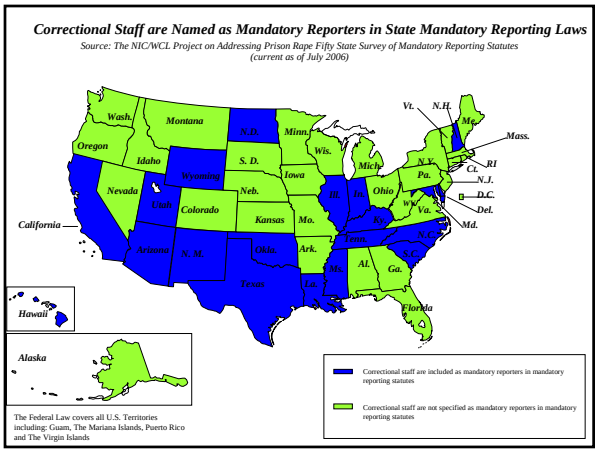
Correctional health professionals may/should fully inform patients about the limits of confidentiality so that patients can make informed decisions in consultation with the health professional, whether to divulge only that information that is necessary for effective patient care.

Jacquiline Moore, *Management & Administration of Correctional Health Care*, Civic Research Institute (2003).

Mandatory Reporting Statutes Defined

- Mandatory reporting laws require certain individuals to report cases of physical or sexual abuse committed against children and vulnerable adults.
- In 20 states correctional staff are mandatory reporters.
  - In 2 states correctional staff are explicitly named
  - In 18 states correctional staff are implicitly covered by the statute using phrases such as "any person"
- In 3 states correctional staff are required to report staff sexual misconduct.
- Often, there is a criminal penalty for the failure to report.





Mandatory Reporting: California

- **Cal. Welf. & Inst. Code § 15630 (West 2006).**
  - (b)(1) Any mandated reporter who, in his or her professional capacity, or **within the scope of his or her employment**, has observed or has knowledge of an incident that reasonably appears to be physical abuse (includes sexual assault).
- **Cal. Welf. & Inst. Code § 15610.23 (West 2006).**
  - (a) Dependent adult means any person between the ages of 18 and 64 years who resides in this state and who has **physical or mental limitations** that restrict his or her ability to carry out normal activities or to protect his or her rights, including, but not limited to, persons who have physical or developmental disabilities, or whose physical or mental abilities have diminished because of age.

Mandatory Reporting: California

- **Cal. Welf. & Inst. Code § 15630 (West 2006).**
  - (a) Any person who has assumed full or intermittent **responsibility for the care or custody** of an elder or dependent adult, whether or not he or she receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, clergy member, or employee of a county adult protective services agency **or a local law enforcement agency.**

Mandatory Reporting: Florida

- **Fla. Stat. Ann. § 944.35 (West 2006).**
  - (3)(d) Witnessing, or reasonable cause to suspect, that an **inmate or an offender** under the supervision of the department in the community has been unlawfully abused or is the subject of sexual misconduct.
- **Fla. Stat. Ann. §944.35 (West 2006).**
  - (3)(d) **Each employee** who witnesses, or has reasonable cause to suspect, that an inmate or an offender under the supervision of the department in the community has been unlawfully abused or is the subject of sexual misconduct.

Vulnerable Adult Statutes Defined

- Vulnerable adult statutes criminalize the abuse or neglect of a category of adults classified as "vulnerable"
- Vulnerable adults include but are not limited to:
  - the elderly
  - mentally ill
  - physically disabled
  - mentally retarded

Vulnerable Adult: Maryland

- **Md. Code Ann., Crim. Law § 3-604 (2006).**
  - (b) Prohibited. ----(1) A caregiver, a parent, or **other person who has permanent or temporary care or responsibility for the supervision of a vulnerable adult** may not cause abuse or neglect of the vulnerable adult that:
    - (i) results in the death of the vulnerable adult;
    - (ii) causes serious physical injury to the vulnerable adult; or
    - (iii) involves **sexual abuse** of the vulnerable adult.

Vulnerable Victims: Maryland

- **Md. Code Ann., Crim. Law § 3-604 (2006).**
  - (10) "Vulnerable adult" means an adult who lacks the physical or mental capacity to provide for the adult's daily needs.

Immunity Statutes Defined

Immunity statutes protect medical and mental health care providers from lawsuits for reporting confidential medical information.

Immunity: New York

Reporting of endangered adults; persons in need of protective services [N.Y. Soc. Serv. Law § 473-b (McKinney 2006)]

- Any person who in good faith believes that a person eighteen years of age or older may be an endangered adult or in need of protective or other services, pursuant to this article, and who, based on such belief either:
  - (a) reports or refers such person to the department, office for the aging, or any local social services district office or designated area agency on aging, law enforcement agency, or any other person, agency or organization, that such person, in good faith, believes will take appropriate action; or
  - (b) testifies in any judicial or administrative proceeding arising from such report or referral shall have immunity from any civil liability that might otherwise result by reason of the act of making such report or referral or of giving of such testimony.

Immunity: South Dakota

Immunity for reporting abuse or neglect -- Immunity of public officials in investigation of abuse and neglect -- Immunity not available for Alleged abuser [S.D. Codified Laws § 34-12-51 (2006)]

Any institution regulated pursuant to chapter 34-12 and any employee, agent or member of a medical or dental staff thereof who, in good faith, makes a report of abuse, exploitation or neglect of a disabled adult, is immune from any liability, civil or criminal, that might otherwise be incurred or imposed, and has the same immunity with respect to participation in any judicial proceeding resulting from such report. Immunity also extends in a like manner to public officials involved in the investigation of abuse, exploitation or neglect of disabled adults, or to any person or institution provided herein who in good faith cooperates with such public officials in an investigation. The provisions of this section may not be extended to any person alleged to have committed any act of abuse or neglect of a disabled adult.

State Laws: So What?

- Federal laws such as HIPAA can supersede state laws.
- Mandatory reporting laws may require that correctional staff report incidents of sexual abuse of adults in custody if they are defined as vulnerable.
- Confidentiality and privilege are NOT absolute.

Case Law

- **Ruiz v. Estelle, 503 F. Supp. 1265 (1980)**
  - The maintenance of confidential treatment records was one of the six minimum criteria established for adequate prison mental health services.

Case Law: Exceptions

- Communicable Diseases
  - See e.g.
    - Doe v. Couglin, 697 F. Supp. 1234 (1988)
    - St. Hillaire v. Arizona Dep't of Corrections, 1991 U.S. App. LEXIS 11620 (1991)
    - Harris v. Thigpen, 941 F.2d 1495 (1991)

Case Law: So What?

- Confidentiality is part of providing adequate medical and mental health treatment.
- The inmate's right to privacy will be balanced against the correctional facility's need to maintain safety and security.

Medical Health Organizations- Professional Codes of Ethics

- American Academy of Physician Assistants
- American Medical Association
- American Nurses' Association
- American Public Health Association
- National Commission on Correctional Healthcare

Mental Health Organizations- Professional Codes of Ethics

- American Counseling Association
- American Mental Health Counselors Association
- American Philosophical Practitioners Association
- American Society for Philosophy, Counseling, and Psychotherapy
- Association for Addiction Professionals
- National Association of Social workers
- National Commission on Correctional Healthcare

Medical Codes of Ethics

- Generally, confidentiality *is protected* and medical personnel in non-correctional settings are *not* required to report the sexual abuse of non-vulnerable adults.
- Generally, medical personnel *are* mandatory reporters for sexual abuse of vulnerable adults.

American Nurses' Association

- **3.2 Confidentiality**-
  - Associated with the right to privacy, the nurse has a duty to maintain confidentiality of all patient information.
  - The rights, well-being, and safety of the individual patient should be the primary factors in arriving at any professional judgment concerning the disposition of confidential information.

American Medical Association

- **E 5.505 Confidentiality**-
  - The information disclosed to a physician during the course of the relationship between physician and patient is confidential to the greatest possible degree.
  - The physician should not reveal confidential communications or information without the express consent of the patient, unless required to do so by law.

Medical But…….

- Confidentiality is not applicable in cases where the patient is a harm to himself or to another.
- Communicable diseases should be reported according to applicable statutes.
- Confidentiality may need to be modified in order to protect the patient, other innocent parties and in circumstances of mandatory disclosure for public health reasons.

Special Concerns of Medical Workers in Correctional Settings

- Communicable diseases are generally reportable, but that may go against ethical codes of confidentiality e.g. HIV
- Requires assessment of the importance of state laws, ethical codes and correctional policies and procedures for reporting.

Mental Health Codes of Ethics

- Generally, mental health providers in non-correctional settings *are not required to report* the sexual abuse of non-vulnerable adults.
- Generally, mental health providers in non-correctional settings *are protected* under confidentially and privacy laws in sexual assault situations.

American Mental Health Counselors Association

- **Principle 3- Confidentiality**
  - Mental health counselors have a primary obligation to safeguard information about individuals obtained in the course of practice, teaching, or research.
  - Personal information is communicated to others only with the person's written consent or in those circumstances where there is clear and imminent danger to the client, to others or to society.

American Counseling Association

- **B.1.c. Respect for Confidentiality:** Counselors do not share confidential information without client consent or without sound legal or ethical justification.
- **B.2.a. Danger and Legal Requirements:** Confidentiality does not apply when disclosure is required to protect clients or identified others from serious and foreseeable harm or when legal requirements demand that confidential information must be revealed.

Mental Health But…..

- Confidentiality can be breached in the free world for three reasons:
  - When the sexual abuse is committed against a minor or another vulnerable victim- then a counselor is a mandatory reporter and by law is required to report the incident;
  - If the client talks about harming themselves or another person; and
  - If a state has a qualified privilege statute and a judge feels that the benefit of the evidence outweighs the victim's privacy.

Special Concerns of Mental Health Workers in Correctional Settings

- Will reporting requirements in correctional settings deter inmates from seeking emotional and psychological assistance after a sexual assault?
- What happens when reporting would do more harm than good?

National Commission of Correctional Healthcare- (NCCH)

- Health care encounters are private, with a chaperon present when indicated, and are carried out in a manner designed to encourage the patients' subsequent use of health services.
- Clinical encounters should be conducted in private and not observed by security personnel unless the inmate poses a probable risk to the safety of the health care provider.

NCCH- Medical Standards

P-G-09 Procedure in the Event of Sexual Assault

- The medical and psychological trauma of a sexual assault are minimized as much as possible by prompt and appropriate health intervention.
- **Compliance Indicator 2d:** A report is made to the correctional authorities to effect a separation of the victim from his or her assailant in their housing assignments.

NCCH- Medical Standards

P-H-02 Confidentiality of Health Records and Information

- The confidentiality of a patient's written or electronic health record, as well as verbally conveyed health information, is maintained.
- **Compliance Indicator 3:** Access to health records and health information is controlled by the health authority.

NCCH- Mental Health Standards

M-G-09 Procedure in the Event of a Sexual Assault

- The medical and psychological trauma of a sexual assault are minimized as much as possible by prompt and appropriate health intervention.
- **Compliance Indicator 2d:** A report is made to the correctional authorities to effect a separation of the victim from his or her assailant in their housing assignments.

NCCH- Mental Health Standards

M-H-02 Confidentiality of Health Records and Information

- The confidentiality of a patience written or electronic health record, as well as verbally conveyed health information, is maintained.
- **Compliance Indicator 3:** Access to health records and health information is controlled by the health authority.

Ethical and Professional Standards: So What?

- Ethical codes do not supersede state and federal law.
- Ethical codes can provide some guidance in maintaining patient confidentiality.
- Confidentiality is NOT absolute in correctional settings.
- There are special concerns for medical and mental health providers, with regard to privacy and confidentiality of inmates.

Overarching Questions

- Does the safety and security of the institution and those living and working there outweigh the confidentiality rights of the victim?
- What is your responsibility if you believe that disclosure will affect the safety of the patient?

Overarching Questions

- Are inmates a per se vulnerable population?
- What about vulnerable adults in correctional setting?
- What about vulnerable adults in community corrections settings?

Correctional Policies– in general

- Many correctional policies require staff members including health care providers to immediately report allegations of sexual assault.
- Many correctional policies that require reporting also requires a reporter to be discreet.

Correctional Policies– in general

- Policies often don't, but should address information availability regarding post-incident care (both medical and mental health records).
- Most reporting requirements for medical and mental health staff are found in sexual assault procedure policies not in healthcare policies.

Correctional Institution Policy

- **Tennessee Department of Corrections**, Policy, Sexual Assault of Inmates (DOC 502.06)
  - **Section VI. F.1. Procedures: Reporting and Investigations:** "All allegations of sexual assault shall be reported and appropriately investigated in accordance with Policy #103.02. Such allegations shall be treated with discretion and to the extent permitted by law, confidentiality."

Correctional Institution Policy

- **Idaho Department of Corrections**, Policy, Prison Rape and Sexual Activity Elimination (325.02.01.01)
  - **Section 6 Confidentiality:** "The sharing of information regarding a sexual assault and sexual activity should be limited to those who need to know for decision making, investigation, and prosecution. Staff members should refrain from talking openly about such issues. Staff should immediately address inappropriate comments such as taunting or teasing."

Correctional Institution Policy: So What?

- The reporting and confidentiality requirements of medical and mental health staff as written into correctional policy are often contradictory, confusing and unhelpful.
- Most correctional institutions require medical and mental health staff to report sexual abuse of inmates.
- Correctional institutional policy may conflict with state law, and professional and ethical standards.

Summary

- Medical and mental health staff should consult federal and state laws regarding their responsibilities for reporting sexual abuse and maintaining the confidentiality of patient information.
- Professional codes of ethics provide good guidance for reporting and confidentiality of sexual abuse but they are neither absolute nor controlling.

Summary

- Correctional policy should not contradict or conflict with state or federal law.
- Correctional policy should integrate professional codes of ethics.
- If correctional policy deviates from law or professional standards it should articulate a justification.

Additional Resources

- United States. US Department of Justice/ Office for Victims of Crime. "Privacy of Victims' Counseling Communications." Legal Series Bulleting 8. Washington, DC. November 2002.
- United States. U.S. Department of Justice/ National Institute of Corrections. Codes of Ethics from Medical and Mental Health Organizations. Comp the NIC/WCL Project on Addressing Prison Rape Washington, DC: February 2007.
- Allen, Scott et.al. "Dual Loyalties: Our Role in Preventing Inmate Abuse." CorrectCare. Summer 2006.
- Patricia A. Furci, *The Sexual Assault Nurse Examiner: Should the Scope of the Physicial-Patient Privilege Extend That Far?*, 5 Quinnipiac Health L.J. 229 (2002).
- Anna Y. Yoo, *Broadening the Scope of Counselor-Patient Privilege to Protect the Privacy of the Sexual Assault Survivor*, 32 Harv. J. on Legis. 255 (1995).
- Euphemia B. Warren, *She's Gotta Have It Now: A Qualified Rape Crisis Counselor-Victim Privilege*, 17 Cardozo L. Rev. 141 (1995).
- Annette L. Hanson, *Confidentiality in corrections: fact or fiction?*, American Academy of Psychiatry and the Law Newsletter, Vol. 8, No. 3, p. 8 (1999).
- Jacquiline Moore, *Management & Administration of Correctional Health Care*, Civic Research Institute (2003).

U.S. Department of Justice
Office of Justice Programs

Bureau of Justice Statistics
Selected Findings

April 1999, NCJ 172879

Prior Abuse Reported by Inmates and Probationers

By Caroline Wolf Harlow, Ph.D.
BJS Statistician

In recent surveys completed by the Bureau of Justice Statistics, 19% of State prison inmates, 10% of Federal inmates, and 16% of those in local jails or on active probation told interviewers they had been physically or sexually abused before their current sentence. Just under half of the women in correctional populations and a tenth of the men indicated past abuse. The survey questions largely relied on respondents to define for themselves physical and sexual abuse.

For women, abuse as children more likely in correctional than general population

Between 6% and 14% of male offenders and between 23% and 37% of female offenders reported they had been physically or sexually abused before age 18. For the general U.S. population, prevalence estimates of child abuse vary, depending on definitions, types of questions, selection of study subjects, and response rates. A review of 16 studies estimated that for the general adult population 5% to 8% of males and 12% to 17% of females were abused as children. (See page 4 for Gorey-Leslie article reference.)

Highlights

Prior abuse of correctional populations, by sex

	Percent experiencing abuse before sentence				
		Ever		Before 18	
	Total	Male	Female	Male	Female
Ever abused before admission					
State prison inmates	18.7%	16.1%	57.2%	14.4%	36.7%
Federal prison inmates	9.5	7.2	39.9	5.8	23.0
Jail inmates	16.4	12.9	47.6	11.9	36.6
Probationers	15.7	9.3	40.4	8.8	28.2
Physically abused					
State prison inmates	15.4%	13.4%	46.5%	11.9%	25.4%
Federal prison inmates	7.9	6.0	32.3	5.0	14.7
Jail inmates	13.3	10.7	37.3	--	--
Probationers	12.8	7.4	33.5	--	--
Sexually abused					
State prison inmates	7.9%	5.8%	39.0%	5.0%	25.5%
Federal prison inmates	3.7	2.2	22.8	1.9	14.5
Jail inmates	8.8	5.6	37.2	--	--
Probationers	8.4	4.1	25.2	--	--

--Not available.

• A third of women in State prison a sixth in Federal prison, and a quarter in jail said they had been raped before their sentence. Another 3% to 6% reported that someone had tried unsuccessfully to rape them.

• Over half of the abused women said they were hurt by spouses or boyfriends, and less than a third, by parents or guardians. Over half of the abused men in correctional populations identified parents or guardians as abusers.

• Among State prison inmates 1 in 20 men and 1 in 4 women said they had been sexually abused before age 18; 1 in 10 men and 1 in 4 women, physically abused.

• For State prisoners reporting prior abuse, 89% had ever used illegal drugs: 76% of the men and 89% of the women had used them regularly. Of those not reporting prior abuse, 82% had used illegal drugs: 68% of the men and 65% of the women had used them regularly.

Sources of data In four BJS surveys — the 1997 Surveys of Inmates in State or Federal Correctional Facilities, the 1996 Survey of Inmates in Local Jails, and the 1995 Survey of Adults on Probation — offenders selected through nationally representative samples responded to questions in hour-long interviews. These offenders reported past physical or sexual abuse, offense histories, drug and alcohol use, and personal and family characteristics. See page 3 for information on obtaining the survey methodologies.

Table 1. Physical or sexual abuse before admission, by sex of inmate or probationer

Before admission	State inmates		Federal inmates		Jail inmates		Probationers	
	Male	Female	Male	Female	Male	Female	Male	Female
Ever abused	16.1%	57.2%	7.2%	39.9%	12.9%	47.6%	9.3%	40.4%
Physically[a]	13.4	46.5	6.0	32.3	10.7	37.3	7.4	33.5
Sexually[a]	5.8	39.0	2.2	22.8	5.6	37.2	4.1	25.2
Both	3.0	28.0	1.1	15.1	3.3	26.9	2.1	18.3
Age of victim at time of abuse								
17 or younger[b]	14.4%	36.7%	5.8%	23.0%	11.9%	36.6%	8.8%	28.2%
18 or older[b]	4.3	45.0	2.7	31.0	2.3	26.7	1.1	24.7
Both	2.5	24.7	1.3	14.2	1.3	15.8	0.5	12.5
Age of abuser								
Adult	15.0%	55.8%	6.9%	39.0%	12.1%	46.0%	8.5%	39.2%
Juvenile only	0.9	1.0	0.2	0.3	0.8	1.3	0.6	
Rape before admission	4.0%	37.3%	1.4%	21.4%	3.9%	33.1%	--	--
Completed	3.1	32.8	1.0	17.9	3.0	26.6	--	--
Attempted	0.8	4.3	0.3	3.2	0.7	5.6	--	--

--Not available.
[a]Includes those both physically and sexually abused.
[b]Includes those abused in both age categories.

Abused males reported being mistreated as children, but females, as both children and adults

For all correctional populations, men who reported abuse generally had been age 17 or younger when they suffered the abuse (table 1). Women, however, were abused as both juveniles and adults. Depending on the correctional population, a quarter to a third of women were abused as juveniles; a quarter to almost a half, as adults. Twenty-five percent of the female State prisoners were abused as both juveniles and adults, as were 16% of women in jail, 14% in Federal prison, and 13% on probation. If abused, almost all persons of both sexes were victimized by an adult rather than by a juvenile. Only 1% or less reported only being victimized by persons 17 or younger.

Abuse of men was by family members, but abuse of women by family members and intimates

About 9 in 10 of the surveyed persons who reported past abuse also said they had known at least 1 of their abusers (table 2). Family members were the primary abusers of the men: a parent, guardian, or other relative was identified by 57% to 70%. Wives, ex-wives, and girlfriends were identified by 3% to 7%.

Female inmates and probationers were abused by both intimates and family members. Except for women in jail, most abused women reported their abusers to have been current or prior husbands or boyfriends: 61% of abused women in State prison, 66% in Federal prison, 57% on probation, and 43% in local jails. A parent, guardian, or other relative had abused about a third to a half of the reporting women.

Prisoners' prior abuse related to their family background

Prisoners reported higher levels of abuse if they grew up in foster care rather than with parents, if their parents were heavy users of alcohol or drugs, or if a family member had been in jail or prison.

	Percent of State inmates reporting abuse	
	Male	Female
While growing up —		
Prisoners lived with		
Both parents	14.0%	54.7%
One parent	16.4	57.3
Foster/agency/other	43.6	86.7
Parent abused alcohol or drugs	29.4%	75.7%
Did not abuse	10.0	45.9
At any time —		
Family* incarcerated	20.2%	63.9%
Not incarcerated	12.3	46.9

*Includes boyfriends or girlfriends with whom the inmate had lived before admission.

Nonparental care. Forty-four percent of male prisoners and 87% of female prisoners who had spent their childhood in foster care or institutions reported abuse. Many of these inmates may have been removed

Table 2. Relationship to abuser, by the inmate or probationer reporting abuse

Relationship of victim to abuser	Percent of those persons who reported experiencing physical or sexual abuse before admission							
	State inmates		Federal inmates		Jail inmates		Probationers	
	Male	Female	Male	Female	Male	Female	Male	Female
Knew abuser	89.5%	90.6%	86.3%	95.4%	87.9%	90.2%	93.9%	93.8%
Family	66.6	40.1	56.7	34.8	64.0	50.5	69.5	50.5
Parent or guardian	54.1	27.2	49.0	24.3	52.7	33.0	62.0	31.0
Other relative	22.9	21.0	15.1	15.4	18.9	28.1	11.9	23.5
Intimate	5.8	61.3	6.5	66.3	3.1	42.8	5.7	56.7
Spouse/ex-spouse	2.2	36.5	1.9	41.0	1.8	25.1	4.9	37.6
Boyfriend/girlfriend	4.4	36.0	4.8	36.0	1.4	26.2	1.7	24.9
Friend/acquaintance	22.6	26.2	24.4	17.2	19.0	23.7	17.8	10.1
Other	17.4	15.8	18.7	10.5	15.6	13.3	11.5	14.3
Knew none of abusers	10.5%	9.4%	13.7%	4.6%	12.1%	9.8%	6.1%	6.2%

Note: Detail does not add to totals because some were abused by more than 1 person.

Table 3. Current and past violent offenses and past alcohol and drug use, by whether abused before admission to State prison, 1997

Offense history and drug and alcohol use	Percent of State prison inmates					
	Reported being abused			Reported being not abused		
	Total	Males	Females	Total	Males	Females
Current or past violent offense	70.4%	76.5%	45.0%	60.2%	61.2%	29.1%
Current violent offense	55.7%	61.0%	33.5%	45.3%	46.1%	20.9%
Homicide	15.9	16.3	13.9	12.7	12.8	7.3
Sexual assault	15.6	18.8	2.0	6.9	7.1	0.4
Robbery	12.5	13.5	7.8	14.5	14.7	6.1
Assault	9.5	9.9	7.6	9.3	9.4	5.7
Used an illegal drug						
Ever	88.6%	88.5%	88.9%	81.8%	81.9%	77.4%
Ever regularly	76.3	75.5	79.7	67.9	67.9	65.0
In month before offense	61.4	59.7	68.6	55.3	55.3	54.0
At time of offense	39.6	38.0	46.2	30.7	30.7	32.0
Drank alcohol						
Ever regularly	66.9%	69.1%	57.5%	59.0%	59.8%	38.2%
At time of offense	41.6	43.6	33.1	36.1	36.6	23.5

from abusive homes. There is little difference in the percentage of abused inmates growing up with one parent and those with two.

Parental drinking. Of those who had grown up with a parent or guardian who drank heavily or used drugs regularly, 29% of the men and 76% of the women reported prior abuse.

Incarcerated relative. Abuse was reported for about 20% of male inmates and 64% of female inmates who had a family member (including boyfriend and girlfriend) who had ever served time.

Reported past abuse associated with violent crime

Abused State prisoners were more likely than those not abused to be serving a sentence for a violent crime (table 3). Among State prisoners, 61% of abused men were serving a sentence for a violent offense, compared to 46% of those reporting no past mistreatment. Thirty-four percent of abused women and 21% of women not abused were in prison for a violent offense.

A past of abuse is specifically linked to sexual assault and homicide. Among men reporting abuse before prison, 19% were serving a sentence for sexual assault, including rape, compared to 7% of the men not abused. Higher percentages of prisoners had committed homicide if they reported abuse (men, 16%, and women, 14%) than if they reported no abuse (men, 13%, and women, 7%).

When the category of violent crime overall is broadened to include both current and past offenses, an association between abuse and violent offenses remains. Among male State prison inmates, 77% of those reporting past abuse and 61% of those without that history had ever been sentenced for a violent crime. About 45% of abused women in State prison and 29% of those not abused had served at least one sentence for a violent crime.

The reported use of illegal drugs and alcohol higher among abused

Illegal drug use and regular drinking were more common among abused State prison inmates than among those who said they were not abused. An estimated 76% of abused men and 80% of abused women had used illegal drugs regularly, compared to 68% of men and 65% of women who had not been abused. About 69% of abused men and 58% of abused women reported drinking regularly at some time in their lives, compared to 60% of men and 38% of women who were not abused.

Abused State inmates were more likely than those reporting no abuse to have been using alcohol or illegal drugs at the time of their offense. This pattern occurred especially among female inmates. Forty-six percent of the abused women committed their current offense under the influence of illegal drugs; 33% were drinking. Among women who were not abused, 32% committed their offense while on drugs and 24%, while drinking.

Inmates and probationers answered surveys about their abuse

Data for this report were taken from four BJS surveys: the Surveys of Inmates in State and Federal Correctional Facilities, 1997; the Survey of Inmates in Local Jails, 1996; and the Survey of Adults on Probation, 1995. In all four surveys nationally representative samples of inmates or probationers were interviewed about their current offense and sentence, criminal history, personal and family background, and prior drug and alcohol use and treatment.

Descriptions of methodology, sample design, and standard error calculations can be found in the following: *Substance Abuse and Treatment of State and Federal Prisoners, 1997* (NCJ 172871); *Profile of Jail Inmates, 1996* (NCJ 164620); and *Substance Abuse and Treatment of Adults on Probation, 1995* (NCJ 166611).

Appendix table. Weighted totals of persons reporting in tables 1 and 2

	Total number*	
	In population (table 1)	Reporting prior abuse (table 2)
State inmates		
Male	984,320	158,729
Female	65,425	37,391
Federal inmates		
Male	81,607	5,850
Female	6,347	2,530
Jail inmates		
Male	450,099	57,915
Female	50,298	23,777
Probationers		
Male	1,630,117	163,676
Female	428,644	176,454

*Missing data are excluded from totals.

In the probation and jail inmate surveys, past the interview's midpoint, each respondent was asked, "Have you ever been physically or sexually abused?" Inmates in the surveys in State and Federal correctional facilities were asked if "anyone ever pressured or forced you to have any sexual contact against your will, that is, touching of genitals" and for females, "breast, or buttocks, or oral, anal, or vaginal sex?" and for males "or oral or anal sex?" In a separate question they were asked if they had "ever been physically abused?"

Question wording and respondent sensitivity affect level of reported abuse

The BJS survey questions rely on respondents to define abuse within the context of their own lives, to recall their pasts, and to report what they remember. Factors can intervene so that the reported experiences do not match the actual experiences. For example, respondents may be unwilling to admit that sensitive events occurred, may be reluctant to report abuse to others, may distrust interviewers or surveys, may forget, or may purposefully misrepresent.

In contrast, most studies of abuse in the general population have used a battery of questions listing specific kinds of experiences, some of which are then classified as abuse by the analyst. These questions elicit events respondents may not recognize as abuse and impose the analysts' definitions of abuse upon respondents' experiences. These differences in definition and measurement should be taken into account when comparing the results of various surveys.

Low response rates, as well as broad definitions, have been found to produce high estimates of abuse, while high response rates and narrow definitions produce low estimates. For a discussion of the effects of question wording and response rates on estimates of abuse in the general population, see Kevin M. Gorey and Donald R. Leslie, "The Prevalence of Child Sexual Abuse: Integrative Review Adjustment for Potential Response and Measurement Biases," *Child Abuse and Neglect,* 21, pp. 391-98, 1997.

Gallop Poll estimates of abuse for the general population are based on questions similar to those asked in the correctional population surveys. See the *Sourcebook of Criminal Justice Statistics*, 1990, 1993, and 1995, for tables from the poll. The following were general adult population responses about childhood experiences: 9%, raped by an older child or an adult; 5% of men and 10% of women, kicked, punched, or choked by a parent or guardian; and 13% of men and 10% of women, physically abused by their parents.

The Bureau of Justice Statistics is the statistical agency of the U.S. Department of Justice. Jan M. Chaiken, Ph.D., is director.

BJS Selected Findings present findings from diverse data series. This report was written by Caroline Wolf Harlow under the supervision of Allen J. Beck. Thomas P. Bonczar assisted with analysis of the Survey of Adults on Probation and general statistical review. Tom Hester produced the report. Marilyn Marbrook administered final report production, assisted by Yvonne Boston.

April 1999, NCJ 172879

This report, as well as other reports and statistics, may be found at the Bureau of Justice Statistics World Wide Web site: http://www.ojp.usdoj.gov/bjs/

Data from the surveys can be obtained from the National Archive of Criminal Justice Data at the University of Michigan, 1-800-999-0960. The archive can be accessed through the BJS Web site.

U.S. Department of Justice
Office of Justice Programs

Bureau of Justice Statistics
Special Report

September 2006, NCJ 213600

Mental Health Problems of Prison and Jail Inmates

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At midyear 2005 more than half of all prison and jail inmates had a mental health problem, including 705,600 inmates in State prisons, 70,200 in Federal prisons, and 479,900 in local jails. These estimates represented 56% of State prisoners, 45% of Federal prisoners, and 64% of jail inmates. The findings in this report were based on data from personal interviews with State and Federal prisoners in 2004 and local jail inmates in 2002.

Mental health problems were defined by two measures: a recent history or symptoms of a mental health problem. They must have occurred in the 12 months prior to the interview. A recent history of mental health problems included a clinical diagnosis or treatment by a mental health professional. Symptoms of a mental disorder were based on criteria specified in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV).

	Percent of inmates in —		
Mental health problem	State prison	Federal prison	Local jail
Any mental problem	56%	45%	64%
Recent history	24	14	21
Symptoms	49	40	60

More than two-fifths of State prisoners (43%) and more than half of jail inmates (54%) reported symptoms that met the criteria for mania. About 23% of State prisoners and 30% of jail inmates reported symptoms of major depression. An estimated 15% of State prisoners and 24% of jail inmates reported symptoms that met the criteria for a psychotic disorder.

Highlights

High prevalence of mental health problems among prison and jail inmates

	Percent of inmates in —			
	State prison		Local jail	
Selected characteristics	With mental problem	Without	With mental problem	Without
Criminal record				
Current or past violent offense	61%	56%	44%	36%
3 or more prior incarcerations	25	19	26	20
Substance dependence or abuse	74%	56%	76%	53%
Drug use in month before arrest	63%	49%	62%	42%
Family background				
Homelessness in year before arrest	13%	6%	17%	9%
Past physical or sexual abuse	27	10	24	8
Parents abused alcohol or drugs	39	25	37	19
Charged with violating facility rules*	58%	43%	19%	9%
Physical or verbal assault	24	14	8	2
Injured in a fight since admission	20%	10%	9%	3%

*Includes items not shown.

- Nearly a quarter of both State prisoners and jail inmates who had a mental health problem, compared to a fifth of those without, had served 3 or more prior incarcerations.
- Female inmates had higher rates of mental health problems than male inmates (State prisons: 73% of females and 55% of males; local jails: 75% of females and 63% of males).
- About 74% of State prisoners and 76% of local jail inmates who had a mental health problem met criteria for substance dependence or abuse.
- Nearly 63% of State prisoners who had a mental health problem had used drugs in the month before their arrest, compared to 49% of those without a mental health problem.
- State prisoners who had a mental health problem were twice as likely as those without to have been homeless in the year before their arrest (13% compared to 6%).
- Jail inmates who had a mental health problem (24%) were three times as likely as jail inmates without (8%) to report being physically or sexually abused in the past.
- Over 1 in 3 State prisoners and 1 in 6 jail inmates who had a mental health problem had received treatment since admission.
- State prisoners who had a mental health problem were twice as likely as State prisoners without to have been injured in a fight since admission (20% compared to 10%).

A quarter of State prisoners had a history of mental health problems

Among all inmates, State prisoners were most likely to report a recent history of a mental health problem (table 1). About 24% of State prisoners had a recent history of a mental health problem, followed by 21% of jail inmates, and 14% of Federal prisoners.

A recent history of mental health problems was measured by several questions in the BJS' inmate surveys. Offenders were asked about whether in the past 12 months they had been told by a mental health professional that they had a mental disorder or because of a mental health problem had stayed overnight in a hospital, used prescribed medication, or received professional mental health therapy. These items were classified as indicating a recent history of a mental health problem.

State prisoners (18%), Federal prisoners (10%), and jail inmates (14%) most commonly reported that they had used prescribed medication for a mental problem in the year before arrest or since admission. They were least likely to report an overnight stay in a hospital for a mental health problem. Approximately, 5% of inmates in State prisons, 2% in Federal prisons, and 5% in local jails reported an overnight stay in a hospital for a mental health problem.

Prevalence of symptoms of mental disorders among prison and jail inmates

The Survey of Inmates in State and Federal Correctional Facilities, 2004, and the Survey of Inmates in Local Jails, 2002, included a modified structured clinical interview for the DSM-IV. The surveys collected information on experiences of inmates in the past 12 months that would indicate symptoms of major depression, mania, or psychotic disorders. The surveys did not assess the severity or duration of the symptoms, and no exclusions were made for symptoms due to medical illness, bereavement, or substance use. Inmates in mental hospitals or otherwise physically or mentally unable to complete the surveys were excluded from the sample.

Estimates of DSM-IV symptoms of mental disorder provide a baseline indication of mental health problems among inmates rather than a clinical diagnosis of mental illness. Major depression or mania symptoms covered a range of feelings and behaviors, such as persistent sadness, loss of interest in activities, insomnia or hypersomnia, psychomotor agitation, and persistent anger or irritability.

Insomnia or hypersomnia and persistent anger were the most frequently reported major depression or mania episodes with nearly half of jail inmates (49%) reporting these symptoms. Attempted suicide was the least reported symptom by State prisoners (13%), Federal prisoners (6%) and local jail inmates (13%).

A psychotic disorder was indicated by any signs of delusions or hallucinations during the 12-month period. Delusions were characterized by the offenders' belief that other people were controlling their brain or thoughts, could read their mind, or were spying on them. Hallucinations included reports of seeing things others said they did not see or hearing voices others did not hear. Approximately, 24% of jail inmates, 15% of State prisoners, and 10% of Federal prisoners reported at least one symptom of psychotic disorder (table 1).

Symptoms in past 12 months or since admission	Percent of inmates in — State prison	Federal prison	Local jail
Major depressive or mania symptoms			
Persistent sad, numb or empty mood	32.9%	23.7%	39.6%
Loss of interest or pleasure in activities	35.4	30.8	36.4
Increased or decreased appetite	32.4	25.1	42.8
Insomnia or hypersomnia	39.8	32.8	49.2
Psychomotor agitation or retardation	39.6	31.4	46.2
Feelings of worthlessness or excessive guilt	35.0	25.3	43.0
Diminished ability to concentrate or think	28.4	21.3	34.1
Ever attempted suicide	13.0	6.0	12.9
Persistent anger or irritability	37.8	30.5	49.4
Increased/decreased interest in sexual activities	34.4	29.0	29.5
Thoughts of revenge	28.4	21.3	34.1
Psychotic disorder symptoms			
Delusions	11.8%	7.8%	17.5%
Hallucinations	7.9	4.8	13.7

Number of positive responses	Percent of inmates in — State prison	Federal prison	Local jail
Major depressive disorder symptoms			
0	29.5%	38.8%	22.8%
1-2	26.1	27.9	23.8
3-4	20.5	17.1	23.0
5 or more	23.9	16.2	30.4
Mania disorder symptoms			
0	27.3%	35.6%	22.5%
1	21.5	23.3	17.0
2	20.5	17.7	20.1
3	17.7	14.0	22.0
4	13.1	9.4	18.4
Psychotic disorder symptoms			
0	84.6%	89.8%	76.0%
1	11.1	7.8	16.8
2	4.2	2.4	7.2

Note: Data are based on inmate self-report in the Survey of Inmates in State and Federal Correctional Facilities, 2004, and the Survey of Inmates in Local Jails, 2002. See *References* for sources on measuring symptoms of mental disorders based on a modified Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV).

Symptoms of mental disorder highest among jail inmates

Jail inmates had the highest rate of symptoms of a mental health disorder (60%), followed by State (49%), and Federal prisoners (40%). Symptoms of a mental health disorder were measured by a series of questions adopted from a structured clinical interview for diagnosing mental disorders based on the DSM-IV (see box on page 2 and *References* for sources on DSM-IV measures). The questions addressed behaviors or symptoms related to major depression, mania, or psychotic disorders that occurred in the 12 months before the interview.

To meet the criteria for major depression, inmates had to report a depressed mood and decreased interest or pleasure in activities, along with 3 additional symptoms of depression. In order to meet the criteria for mania, inmates had to report 3 symptoms during the 12-month period. For a psychotic disorder, 1 symptom of delusions or hallucinations met the criteria.

The high rate of symptoms of mental health disorder among jail inmates may reflect the role of local jails in the criminal justice system. Jails are locally operated correctional facilities that receive offenders after an arrest and hold them for a short period of time, pending arraignment, trial, conviction, or sentencing. Among other functions, local jails hold mentally ill persons pending their movement to appropriate mental health facilities.

While jails hold inmates sentenced to short terms (usually less than 1 year), State and Federal prisons hold offenders who typically are convicted and sentenced to serve more than 1 year. In general, because of the longer period of incarceration, prisons provide a greater opportunity for inmates to receive a clinical mental health assessment, diagnosis, and treatment by a mental health professional.[1]

[1]Persons who have been judged by a court to be *mentally incompetent to stand trial* or *not guilty by reason of insanity* are not held in these correctional facilities and are not covered by this report.

Table 1. Recent history and symptoms of mental health problems among prison and jail inmates

Mental health problem	Percent of inmates in — State prison	Federal prison	Local jail
Any mental health problem	56.2%	44.8%	64.2%
Recent history of mental health problem[a]	24.3%	13.8%	20.6%
Told had disorder by mental health professional	9.4	5.4	10.9
Had overnight hospital stay	5.4	2.1	4.9
Used prescribed medications	18.0	10.3	14.4
Had professional mental health therapy	15.1	8.3	10.3
Symptoms of mental health disorders[b]	49.2%	39.8%	60.5%
Major depressive disorder	23.5	16.0	29.7
Mania disorder	43.2	35.1	54.5
Psychotic disorder	15.4	10.2	23.9

Note: Includes inmates who reported an impairment due to a mental problem. Data are based on the Survey of Inmates in State and Federal Correctional Facilities, 2004, and the Survey of Inmates in Local Jails, 2002. See *Methodology* for details on survey sample. See *References* for sources on measuring symptoms of mental disorder based on a Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV).

[a]In year before arrest or since admission.

[b]In the 12 months prior to the interview.

Table 2. Prevalence of mental health problems among prison and jail inmates

Mental health problem	State prison inmates Number	Percent	Federal prison inmates Number	Percent	Local jail inmates Number	Percent
Any mental health problem*	705,600	56.2%	70,200	44.8%	479,900	64.2%
History and symptoms	219,700	17.5	13,900	8.9	127,800	17.1
History only	85,400	6.8	7,500	4.8	26,200	3.5
Symptoms only	396,700	31.6	48,100	30.7	322,900	43.2
No mental health problem	549,900	43.8%	86,500	55.2%	267,600	35.8%

Note: Number of inmates was estimated based on the June 30, 2005 custody population in State prisons (1,255,514), Federal prisons (156,643, excluding 19,311 inmates held in private facilities), and local jails (747,529).

*Details do not add to totals due to rounding. Includes State prisoners, Federal prisoners, and local jail inmates who reported an impairment due to a mental problem.

High proportion of inmates had symptoms of a mental health disorder without a history

Around 4 in 10 local jail inmates and 3 in 10 State and Federal prisoners were found to have symptoms of a mental disorder without a recent history (table 2). A smaller proportion of inmates had both a recent history and symptoms of mental disorder: 17% in State prisons, 9% in Federal prisons, and 17% in local jails.

An estimated 7% of State prisoners, 5% of Federal prisoners, and 3% of local jail inmates were found to have a recent history of a mental health problem and no symptoms.

About 1 in 10 persons age 18 or older in the U.S. general population met DSM-IV criteria for symptoms of a mental health disorder

• An estimated 11% of the U.S. population age 18 or older met criteria for mental health disorders, based on data in the National Epidemiologic Survey on Alcohol and Related Conditions, 2001-2002 (NESARC).

• Similar to the prison and jail inmate populations, females in the general population had higher rates of mental disorders than males (12% compared to 9%).

	Percent of U.S. population age 18 or older with symptoms of a mental disorder Total	Male	Female
Any symptom	10.6%	8.7%	12.4%
Major depression[a]	7.9	5.5	10.1
Mania disorder[a]	1.8	1.6	2.0
Psychotic disorder[b]	3.1	3.2	3.1

Note: See *Methodology* for sources on mental health disorders in the general population.

[a]In the last 12 months, not excluding symptoms due to bereavement, substance use, or a medical condition.

[b]Based on life-time occurrence.

Source: National Institute on Alcohol Abuse and Alcoholism, NESARC, 2001-2002.

Table 3. Prison and jail inmates who had a mental health problem, by selected characteristics

Characteristic	Percent of inmates in — State prison	Federal prison	Local jail
All inmates	56.2%	44.8%	64.2%
Gender			
Male	55.0%	43.6%	62.8%
Female	73.1	61.2	75.4
Race			
White[a]	62.2%	49.6%	71.2%
Black[a]	54.7	45.9	63.4
Hispanic	46.3	36.8	50.7
Other[a,b]	61.9	50.3	69.5
Age			
24 or younger	62.6%	57.8%	70.3%
25-34	57.9	48.2	64.8
35-44	55.9	40.1	62.0
45-54	51.3	41.6	52.5
55 or older	39.6	36.1	52.4

[a]Excludes persons of Hispanic origin.

[b]Includes American Indians, Alaska Natives, Asians, Native Hawaiians, other Pacific Islanders, and inmates who specified more than one race.

Mental health problems more common among female, white, and young inmates

Female inmates had much higher rates of mental health problems than male inmates. An estimated 73% of females in State prisons, compared to 55% of male inmates, had a mental health problem (table 3). In Federal prisons, the rate was 61% of females compared to 44% of males; and in local jails, 75% of females compared to 63% of male inmates.

The same percentage of females in State prisons or local jails (23%) said that in the past 12 months they had been diagnosed with a mental disorder by a mental health professional. This was almost three times the rate of male inmates (around 8%) who had been told they had a mental health problem.

Mental problem*	Percent of inmates in — State prison Male	State prison Female	Local jail Male	Local jail Female
Recent history	22%	48%	18%	40%
Diagnosed	8	23	9	23
Overnight stay	5	9	4	9
Medication	16	39	12	30
Therapy	14	32	9	23
Symptoms	48%	62%	59%	70%

*See table 1 for detailed description of categories.

Table 4. Homelessness, employment before arrest, and family background of prison and jail inmates, by mental health status

Characteristic	Percent of inmates in — State prison With mental problem	State prison Without	Federal prison With mental problem	Federal prison Without	Local jail With mental problem	Local jail Without
Homelessness in past year	13.2%	6.3%	6.6%	2.6%	17.2%	8.8%
Employed in month before arrest[a]	70.1%	75.6%	67.7%	76.2%	68.7%	75.9%
Ever physically or sexually abused before admission	27.0%	10.5%	17.0%	6.4%	24.2%	7.6%
Physically abused	22.4	8.3	13.7	5.4	20.4	5.7
Sexually abused	12.5	3.8	7.3	1.7	10.2	3.2
While growing up —						
Ever received public assistance[b]	42.5%	30.6%	33.3%	24.9%	42.6%	30.3%
Ever lived in foster home, agency or institution	18.5	9.5	9.8	6.3	14.5	6.0
Lived most of the time with —						
Both parents	41.9%	47.7%	45.4%	50.5%	40.5%	49.1%
One parent	43.8	40.8	39.8	38.8	45.4	40.4
Someone else	11.6	10.2	13.5	10.3	12.0	9.4
Parents or guardians ever abused —	39.3	25.1	33.3	20.0	37.3	18.7
Alcohol	23.6	16.9	21.7	15.4	23.2	14.1
Drugs	3.1	1.9	2.2	1.4	2.7	1.1
Both alcohol and drugs	12.7	6.2	9.4	3.2	11.5	3.4
Neither	60.7	74.9	66.7	80.0	62.7	81.3
Family member ever incarcerated —	51.7%	41.3%	44.6%	38.9%	52.1%	36.2%
Mother	7.2	4.0	5.0	3.2	9.4	3.4
Father	20.1	13.4	15.3	9.9	22.1	12.6
Brother	35.5	29.4	29.4	27.0	34.8	25.8
Sister	7.0	5.1	5.5	4.2	11.3	5.1
Child	2.7	2.3	3.4	2.8	4.0	2.6
Spouse	1.7	0.9	2.6	1.8	2.4	0.9

[a]The reference period for jail inmates was in the month before admission.

[b]Public assistance includes public housing, AFDC, food stamps, Medicaid, WIC, and other welfare programs.

The prevalence of mental health problems varied by racial or ethnic group. Among State prisoners, 62% of white inmates, compared to 55% of blacks and 46% of Hispanics, were found to have a mental health problem. Among jail inmates, whites (71%) were also more likely than blacks (63%) or Hispanics (51%) to have a mental health problem.

The rate of mental health problems also varied by the age of inmates. Inmates age 24 or younger had the highest rate of mental health problems and those age 55 or older had the lowest rate. Among State prisoners, an estimated 63% of those age 24 or younger had a mental health problem, compared to 40% of those age 55 or older. An estimated 70% of local jail inmates age 24 or younger had a mental health problem, compared to 52% of those age 55 or older.

Homelessness, foster care more common among inmates who had mental health problems

State prisoners (13%) and local jail inmates (17%) who had a mental health problem were twice as likely as inmates without a mental health problem (6% in State prisons; 9% in local jails) to have been homeless in the year before their incarceration (table 4).

About 18% of State prisoners who had a mental health problem, compared to 9% of State prisoners who did not have a mental problem, said that they had lived in a foster home, agency, or institution while growing up.

Among jail inmates, about 14% of those who had a mental health problem had lived in a foster home, agency, or institution while growing up, compared to 6% of jail inmates who did not have a mental health problem.

Low rates of employment, high rates of illegal income among inmates who had mental problems

An estimated 70% of State prisoners who had a mental health problem, compared to 76% of those without, said they were employed in the month before their arrest. Among Federal prisoners, 68% of those who had a mental health problem were employed, compared to 76% of those who did not have a mental problem.

Among jail inmates, 69% of those who had a mental health problem reported that they were employed, while 76% of those without were employed in the month before their arrest.

Of State prisoners who had a mental health problem, 65% had received income from wages or salary in the month before their arrest. This percentage was larger for inmates without a mental health problem (71%). Over a quarter (28%) of State prisoners who had a mental health problem reported income from illegal sources, compared to around a fifth (21%) of State prisoners without a mental problem.

Sources of income[a]	Percent of State prison inmates: With mental problem	Without
Wages, salary	65%	71%
Welfare	6	4
Assistance from family or friends	14	8
Illegal income	28	21
Compensation payments[b]	9	6

[a]Includes personal income in month before arrest, except for compensation which was in the month before admission.
[b]Includes Supplemental Security Income (SSI) payments and pension.

Table 5. Substance dependence or abuse among prison and jail inmates, by mental health status

Substance dependence or abuse	State prison: With mental problem	State prison: Without	Federal prison: With mental problem	Federal prison: Without	Local jail: With mental problem	Local jail: Without
	Percent of inmates in —					
Any alcohol or drugs	74.1%	55.6%	63.6%	49.5%	76.4%	53.2%
Dependence	53.9	34.5	45.1	27.3	56.3	25.4
Abuse only	20.2	21.1	18.5	22.2	20.1	27.8
Alcohol	50.8%	36.0%	43.7%	30.3%	53.4%	34.6%
Dependence	30.4	17.9	25.1	12.7	29.0	11.8
Abuse only	20.4	18.0	18.6	17.7	24.4	22.8
Drugs	61.9%	42.6%	53.2%	39.2%	63.3%	36.0%
Dependence	43.8	26.1	37.1	22.0	46.0	17.6
Abuse only	18.0	16.5	16.1	17.2	17.3	18.4
No dependence or abuse	25.9%	44.4%	36.4%	50.5%	23.6%	46.8%

Note: Substance dependence or abuse was based on criteria specified in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV). For details, see *Substance Dependence, Abuse and Treatment of Jail Inmates, 2002*, <http://www.ojp.usdoj.gov/bjs/abstract/sdatji02.htm>.

Past physical or sexual abuse more prevalent among inmates who had mental health problems

State prisoners who had a mental health problem (27%) were over two times more likely than those without (10%) to report being physically or sexually abused in the past.

Jail inmates who had a mental health problem were three times more likely than jail inmates without to have been physically or sexually abused in the past (24% compared to 8%).

Family members of inmates with mental problems had high rates of substance use and incarceration

Inmates who had a mental health problem were more likely than inmates without to have family members who abused drugs or alcohol or both. Among State prisoners, 39% of those who had a mental health problem reported that a parent or guardian had abused alcohol, drugs, or both while they were growing up. In comparison, 25% of State prisoners without a mental problem reported parental abuse of alcohol, drugs, or both.

A third (33%) of Federal prisoners who had a mental health problem, compared to a fifth (20%) of those without, reported that a parent or guardian had abused alcohol, drugs, or both while they were growing up.

An estimated 37% of jail inmates who had a mental health problem said a parent had abused alcohol, drugs, or both while they were growing up. This was almost twice the rate for jail inmates without a mental health problem (19%).

The majority of prison and jail inmates who had a mental health problem (52%) reported that they had a family member who had been incarcerated in the past. Among those without a mental health problem, about 41% of State inmates and 36% of jails inmates reported that a family member had served time.

Over a third of both State prisoners and local jail inmates who had a mental health problem (35%) had a brother who had served time in prison or jail. The rate for inmates without a mental health problem was 29% in State prisons and 26% in local jails.

High rates of both mental health problems and substance dependence or abuse among State prison and local jail inmates

• An estimated 42% of inmates in State prisons and 49% in local jails were found to have both a mental health problem and substance dependence or abuse.

• Slightly less than a quarter (24%) of State prisoners and a fifth (19%) of local jail inmates met the criteria for substance dependence or abuse only.

Mental health problems and substance dependence or abuse	Percent of inmates in — State prison	Federal prison	Local jail
Both	41.7%	28.5%	48.7%
Dependence or abuse only	24.4	27.3	18.9
Mental problems only	14.5	16.3	15.0
None	19.5	27.8	17.3

Inmates who had mental health problems had high rates of substance dependence or abuse

Among inmates who had a mental health problem, local jail inmates had the highest rate of dependence or abuse of alcohol or drugs (76%), followed by State prisoners (74%), and Federal prisoners (64%) (table 5). Substance dependence or abuse was measured as defined in the DSM-IV.[2]

Among inmates without a mental health problem, 56% in State prisons, 49% in Federal prisons, and 53% in local jails were dependent on or abused alcohol or drugs.

[2]For a detailed description of the DSM-IV measures, see *Substance Dependence, Abuse and Treatment of Jail inmates, 2002,* <http://www.ojp.usdoj.gov/bjs/abstract/sdatji02.htm.>

By specific type of substance, inmates who had a mental health problem had higher rates of dependence or abuse of drugs than alcohol. Among State prisoners who had a mental problem, 62% were dependent on or abused drugs and 51% alcohol. An estimated 63% of local jail inmates who had a mental problem were dependent on or abused drugs, while about 53% were dependent on or abused alcohol.

When dependence was estimated separately from abuse only, local jail inmates who had a mental health problem had the highest rate of drug dependence (46%). They were two and a half times more likely to be dependent on drugs than jail inmates without a mental problem (18%).

A larger percentage of State prisoners who had a mental health problem than those without were found to be dependent on drugs (44% compared to 26%). Among Federal prisoners, 37% who had a mental health problem were found to be dependent on drugs, compared to 22% of those without.

State prisoners (30%) and local jail inmates (29%) who had a mental health problem had about the same rate of alcohol dependence. A quarter of Federal prisoners (25%) who had a mental problem were dependent on alcohol.

Table 6. Substance use among prison inmates and convicted jail inmates, by mental health status

	Percent of inmates in —					
	State prison		Federal prison		Local jail	
Type of substance	With mental problem	Without	With mental problem	Without	With mental problem	Without
Alcohol or drugs						
Regular use[a]	87.1%	77.2%	82.3%	75.4%	89.9%	78.7%
In month before offense	80.3	70.4	75.8	68.1	81.6	69.6
At time of offense	53.2	42.5	41.1	30.6	53.8	42.8
Drugs						
Regular use[a]	75.5%	61.2%	71.0%	59.2%	78.1%	57.5%
In month before offense	62.8	49.1	57.1	45.2	62.1	41.7
At time of offense	37.5	25.8	31.1	23.0	34.0	19.8
Alcohol						
Regular use[a]	67.9%	58.3%	66.0%	58.2%	72.6%	61.8%
In month before offense	61.7	52.5	59.5	53.6	80.7	74.1
At time of offense	34.0	27.5	21.7	15.1	35.0	30.4
Binge drinking[b]	43.5	29.5	37.8	25.7	48.2	29.9

[a]Regular alcohol use is defined as daily or almost daily or more than once a week for more than a month. Regular drug use is defined as once a week or more for at least one month.
[b]Binge drinking is defined as having consumed a fifth of liquor in a single day, or the equivalent of 20 drinks, 3 bottles of wine, or 3 six-packs of beer.

Table 7. Drug use in the month before the offense among convicted prison and jail inmates, by mental health status

	Percent of inmates in —					
	State prison		Federal prison		Local jail	
Types of drug used in month before offense	With mental problem	Without	With mental problem	Without	With mental problem	Without
Any drug	62.8%	49.1%	57.1%	45.2%	62.1%	41.7%
Marijuana or hashish	45.7%	33.3%	41.2%	32.0%	43.4%	27.1%
Cocaine or crack	24.4	17.9	21.1	15.5	24.2	14.7
Heroin/opiates	8.9	7.2	7.2	4.7	9.6	4.6
Depressants[a]	7.3	3.0	6.7	2.7	8.5	2.0
Methamphetamines	12.6	8.8	10.9	9.6	11.7	6.2
Other stimulants[b]	5.8	2.8	4.5	2.5	5.2	2.4
Hallucinogens[c]	8.0	3.4	9.3	3.0	7.5	2.9

[a]Include barbiturates, tranquilizers, and quaaludes.
[b]Include amphetamines.
[c]Include LSD, PCP, and ecstasy.

Over a third of inmates who had mental health problems had used drugs at the time of the offense

Over a third (37%) of State prisoners who had a mental health problem said they had used drugs at the time of the offense, compared to over a quarter (26%) of State prisoners without a mental problem (table 6). Also, over a third (34%) of local jail inmates who had a mental health problem said they had used drugs at the time of the offense, compared to a fifth (20%) of jail inmates who did not have a mental problem.

Marijuana or hashish was the most common drug inmates said they had used in the month before the offense (table 7). Among inmates who had a mental health problem, more than two-fifths of those in State prisons (46%), Federal prisons (41%), or local jails (43%) reported they had used marijuana or hashish in the month before the offense.

Almost a quarter of inmates in State prisons or local jails who had a mental health problem (24%) reported they had used cocaine or crack in the month before the offense. A smaller percentage of inmates who had a mental health problem had used methamphetamines in the month before the offense — 13% of State prisoners, 11% of Federal prisoners, and 12% of jail inmates.

Binge drinking prevalent among inmates who had mental problems

Inmates who had a mental health problem were more likely than inmates without a mental problem to report a

binge drinking experience. Among State prisoners who had a mental health problem, 43% said they had participated in binge drinking in the past, compared to 29% of State prisoners without mental problems.

Similarly, jail inmates who had mental problems (48%) had a much higher rate of binge drinking than jail inmates without mental problems (30%).

Inmates who had a mental problem were more likely than inmates without to have been using alcohol at the time of the offense (State prisoners, 34% compared to 27%; Federal prisoners, 22% compared to 15%; and jail inmates, 35% compared to 30%.)

Violent offenses common among State prisoners who had a mental health problem

Among State prisoners who had a mental health problem, nearly half (49%) had a violent offense as their most serious offense, followed by property (20%) and drug offenses (19%) (table 8). Among all types of offenses, robbery was the most common offense (14%), followed by drug trafficking (13%) and homicide (12%).

An estimated 46% of State prisoners without a mental health problem were held for a violent offense, including 13% for homicide and 11% for robbery.

About 24% of State prisoners without a mental problem were held for drug offenses, particularly drug trafficking (17%).

Almost an equal percentage of jail inmates who had a mental health problem were held for violent (26%) and property (27%) offenses. About 12% were held for aggravated assault. Jail inmates who had a mental health problem were two times more likely than jail inmates without a mental problem to be held for burglary (8% compared to 4%).

Use of a weapon did not vary by mental health status

Convicted violent offenders who had a mental health problem were as likely as those without to have used a weapon during the offense (table 9). An estimated 37% of both State prisoners who had a mental problem and those without said they had used a weapon during the offense.

By specific type of weapon, among convicted violent offenders in State prisons who had a mental health problem, slightly less than a quarter (24%) had used a firearm, while a tenth (10%) had used a knife or sharp object.

Violent criminal record more prevalent among inmates who had a mental health problem

State prisoners who had a mental health problem (61%) were more likely than State prisoners without (56%) to have a current or past violent offense.

	Percent of State prison inmates with violent criminal record	
Violent criminal record	With mental problem	Without
Any violent offense	61%	56%
Current violent offense, no prior	13	17
Violent recidivist	47	39

Note: Details may not add to total due to rounding.

Among repeat offenders, an estimated 47% of State prisoners who had a mental health problem were violent recidivists, compared to 39% of State prisoners without a mental problem (table 10).

Table 8. Most serious offense among prison and jail inmates, by mental health status

	Percent of inmates in —					
	State prison		Federal prison		Local jail	
Most serious offense	With mental problem	Without	With mental problem	Without	With mental problem	Without
Total	100%	100%	100%	100%	100%	100%
Violent offenses	49.0%	46.5%	16.0%	13.2%	26.5%	23.7%
Homicide	11.6	12.9	2.5	2.3	2.6	2.5
Sexual assault*	11.0	10.4	1.1	0.7	3.4	3.6
Robbery	13.6	11.3	9.6	7.6	5.7	5.1
Assault	10.5	9.7	2.0	1.9	12.5	10.5
Property offenses	19.6%	17.7%	7.2%	6.1%	26.9%	19.7%
Burglary	8.6	7.7	0.7	0.3	7.9	4.2
Larceny/theft	4.2	3.5	0.5	0.4	7.7	5.6
Fraud	3.0	2.7	4.9	4.5	5.3	4.2
Drug offenses	19.3%	23.8%	51.3%	58.3%	23.4%	27.0%
Possession	5.7	6.3	2.0	3.8	10.1	12.3
Trafficking	12.9	17.0	47.7	52.6	11.6	12.9
Public-order offenses	11.9%	11.9%	22.3%	19.0%	22.6%	29.3%
Weapons	2.6	2.4	14.0	8.5	2.3	1.4
DWI/DUI	2.2	3.2	0.2	0.2	5.5	8.1

Note: Summary categories include offenses not shown.
*Includes rape and other sexual assault.

Table 9. Use of weapon, by mental health status of convicted violent State prison and local jail inmates

	Percent of inmates in —			
	State prison		Local jail	
Use of weapons	With mental problem	Without	With mental problem	Without
Any weapon	37.2%	36.9%	20.6%	21.2%
Firearm	24.4	27.5	12.3	13.1
Knife or sharp object	10.2	7.4	6.1	5.1
Other weapons*	3.7	2.7	2.8	4.0
No weapon	62.8%	63.1%	79.4%	78.8%
Number of violent inmates	328,670	242,524	60,787	34,305

Note: Details do not add to total because inmates may have used more than one weapon.
*Other weapons include blunt objects, stun guns, toy guns, or other specified weapons.

Nearly a third (32%) of local jail inmates who had a mental health problem were repeat violent offenders, while about a quarter (22%) of jail inmates without a mental problem were violent recidivists.

A larger proportion of inmates who had a mental health problem had served more prior sentences than inmates without a mental problem (table 11). An estimated 47% of State prisoners who had a mental health problem, compared to 39% of those without, had served 3 or more prior sentences to probation or incarceration. Among jail inmates, 42% of those with a mental health problem had served served 3 or more prior sentences to probation or incarceration, compared to 33% of jail inmates without a mental problem.

State prisoners who had mental health problems had longer sentences than prisoners without

Overall, State prisoners who had a mental health problem reported a mean maximum sentence that was 5 months longer than State prisoners without a mental problem (146 months compared to 141 months) (table 12). Among jail inmates, the mean sentence for those who had a mental problem was 5 months shorter than that for jail inmates without a mental problem (40 months compared to 45 months).

By most serious offense, excluding offenders sentenced to life or death, both violent State prisoners who had a mental health problem and those without had about the same mean sentence length. Violent State prisoners who had a mental health problem were sentenced to serve a mean maximum sentence length of 212 months and those without, 211 months.

Among prisoners sentenced to life or death, there was little variation in sentence length by mental health status (not shown in table). About 8% of State prisoners who had a mental health problem and 9% of those without were sentenced to life or death. Among Federal prisoners, 3% of both those who had a mental health problem and those without were sentenced to life or death.

Table 10. Criminal record of prison and jail inmates, by mental health status

	Percent of inmates in —					
	State prison		Federal prison		Local jail	
Criminal record	With mental problem	Without	With mental problem	Without	With mental problem	Without
No prior sentence	20.5%	27.0%	32.2%	36.9%	34.9%	43.3%
Current violent offense	13.4	16.9	5.1	4.9	12.1	13.8
Current drug offense	3.1	5.1	15.2	21.6	8.8	12.6
Current other offense	4.1	5.0	11.9	10.4	14.0	16.8
Violent recidivist	47.4%	39.2%	27.5%	23.8%	31.9%	22.4%
Current and prior violent	17.2	13.4	7.4	4.4	9.9	6.8
Current violent only	17.7	15.3	4.9	4.4	11.4	6.9
Prior violent only	12.5	10.4	15.3	15.0	10.5	8.7
Nonviolent recidivist	32.0%	33.8%	40.3%	39.2%	33.2%	34.3%
Prior drugs only	3.0	4.0	7.1	9.5	3.0	3.4
Other prior offenses	29.0	29.8	33.2	29.8	30.2	30.9

Note: Excludes inmates for whom offense and prior probation or incarceration sentences were unknown.

Table 11. Number of prior probation or incarceration sentences among prison and jail inmates, by mental health status

	Percent of inmates in —					
	State prison		Federal prison		Local jail	
Number of prior sentences	With mental problem	Without	With mental problem	Without	With mental problem	Without
0	22.1%	28.5%	34.1%	38.3%	24.5%	30.6%
1	15.3	16.1	14.9	16.5	16.8	18.9
2	15.5	16.8	15.6	14.9	16.7	17.2
3-5	26.3	24.0	21.3	20.1	22.8	20.3
6-10	13.9	10.6	10.0	7.1	12.4	8.6
11 or more	6.9	4.0	4.0	3.1	6.7	4.4

Note: Excludes inmates for whom prior probation or incarceration sentences were unknown.

Table 12. Mean maximum sentence length and mean total time expected to serve, by mental health status and offense

	Mean maximum sentence length[a]		Mean total time expected to serve until release[b]	
Most serious offense	With mental problem	Without	With mental problem	Without
State prison inmates				
All offenses[c]	146 mos	141 mos	93 mos	89 mos
Violent	212	211	139	138
Property	103	96	60	58
Drug	84	94	48	50
Public-order	81	66	51	40
Federal prison inmates				
All offenses[c]	128 mos	135 mos	99 mos	106 mos
Violent	174	202	119	131
Property	70	53	63	58
Drug	131	139	103	112
Public-order	102	100	87	83
Local jail inmates				
All offenses[c]	40 mos	45 mos	14 mos	18 mos
Violent	67	73	18	31
Property	41	36	16	14
Drug	40	59	18	25
Public-order	16	16	7	8

[a]Based on the total maximum sentence for all consecutive sentences. Excludes inmates for whom offense was unknown.
[b]Based on time served when interviewed and time to be served until the expected date of release. Excludes inmates for whom admission date or expected release date were unknown.
[c]Includes other offenses not shown.

State prisoners who had a mental health problem expected to serve 4 months longer than those without

Overall, the mean time State prisoners who had a mental health problem expected to serve was 4 months longer than State prisoners without a mental problem (93 months compared to 89 months). Among convicted jail inmates who expected to serve their time in a local jail, there was little variation by mental health status in the amount of time expected to be served. About 55% of those who had a mental problem, and 54% of those without, expected to serve 6 months or less (table 13).

Table 13. Mean time expected to be served by convicted local jail inmates sentenced to jail

	Percent of convicted local jail inmates	
Mean time expected to be served	With mental problem	Without
Less than 3 months	27.4%	26.8%
3 to 6 months	27.9	27.3
7 to 12 months	24.0	22.4
13 to 24 months	9.7	8.7
25 to 36 months	3.7	3.4
37 to 60 months	3.2	5.0
More than 5 years	4.0	6.4
Number of inmates	115,290	72,356

Note: Excludes inmates for whom admission date or expected release date were unknown.

A third of State prisoners who had mental health problems had received treatment since admission

State prisoners who had a mental health problem (34%) had the highest rate of mental health treatment since admission, followed by Federal prisoners (24%) and local jail inmates (17%) (table 14).

All Federal prisons and most State prisons and jail jurisdictions, as a matter of policy, provide mental health services to inmates, including screening inmates at intake for mental health problems, providing therapy or counseling by trained mental health professionals, and distributing psychotropic medication.[3]

[3]See *Mental Health Treatment in State Prisons, 2000,* <http://www.ojp.usdoj.gov/bjs/abstract/mhtsp00.htm> and *Census of Jails, 1999,* <http://www.ojp.usdoj.gov/bjs/abstract/cj99.htm>.

Table 14. Mental health treatment received by inmates who had a mental health problem

	Percent of inmates who had a mental problem in —		
Type of mental health treatment	State prison	Federal prison	Local jails
Ever received mental health treatment	49.3%	35.3%	42.7%
Had overnight hospital stay	20.0	9.5	18.0
Used prescribed medications	39.5	28.0	32.7
Had professional mental health therapy	35.4	25.6	31.1
Received treatment during year before arrest	22.3%	14.9%	22.6%
Had overnight hospital stay	5.8	3.2	6.6
Used prescribed medications	15.8	10.1	16.9
On prescribed medication at time of arrest	11.3	7.3	12.3
Had professional mental health therapy	11.5	8.0	12.3
Received treatment after admission	33.8%	24.0%	17.5%
Had overnight hospital stay	5.4	2.7	2.2
Used prescribed medications	26.8	19.5	14.8
Had professional mental health therapy	22.6	15.1	7.3

Note: Excludes other mental health treatment.

Table 15. Mental health treatment received by all State prison inmates, 2004 and 1997

	Percent of State prison inmates	
Type of mental health treatment	2004	1997
Ever any mental health treatment	31.2%	28.3%
Had overnight hospital stay	12.2	10.7
Used prescribed medications	23.9	18.9
Had professional mental health therapy	21.6	21.8
Had other mental health treatment	3.6	3.3
Received treatment after admission	19.3%	17.4%
Had overnight hospital stay	3.1	3.8
Used prescribed medications	15.1	12.3
Had professional mental health therapy	12.7	12.3
Had other mental health treatment	1.9	1.9
Number of inmates	1,226,171	1,059,607

More than a fifth of inmates (22%) in State prison who had a mental health problem had received mental health treatment during the year before their arrest, including 16% who had used prescribed medications, 11% who had professional therapy, and 6% who had stayed overnight in a hospital because of a mental or emotional problem.

Among jail inmates who had a mental health problem, an estimated 23% had received treatment during the year before their arrest: 17% had used medication, 12% had received professional therapy, and 7% had stayed overnight in a hospital because of a mental or emotional problem.

Taking a prescribed medication for a mental health problem was the most common type of treatment inmates who had a mental health problem had received since admission to prison or jail. About 27% of State prisoners, 19% of Federal prisoners, and 15% of jail inmates who had a mental problem had used prescribed medication for a mental problem since admission.

An overnight stay in a hospital was the least likely method of treatment inmates had received since admission. Among inmates who had a mental problem, about 5% of those in State prisons, 3% in Federal prisons, and 2% in local jails had stayed overnight in a hospital for a mental problem.

Use of medication for a mental health problem by State prisoners rose between 1997 and 2004

The proportion of State prisoners who had used prescribed medication for a mental health problem since admission to prison rose to 15% in 2004, up from 12% in 1997 (table 15). There was little change in the percentage of inmates who reported an overnight stay in a hospital since admission (around 3%), or in the percentage who had received professional mental health therapy (around 12%).

State prisoners who said they had ever used prescribed medication for a mental or emotional problem in the past rose to 24% in 2004, up from 19% in 1997. Overall, 31% of State prisoners said they had ever received mental health treatment in the past, up from 28% in 1997.

Among jail inmates, in 2002 around 30% said they had received treatment for a mental health problem in the past, up from 25% in 1996. The proportion who had received treatment since admission (11%) was unchanged.

Mental health treatment	Percent of jail inmates 2002	1996
Ever any treatment	30%	25%
Overnight stay	12	10
Medication	22	17
Therapy	22	18
Other treatment	3	3
Since admission	11%	11%
Overnight stay	1	1
Medication	9	9
Therapy	5	4
Other treatment	1	--

--Less than 0.5%.

Rule violations and injuries from a fight more common among inmates who had a mental health problem

Prison or jail inmates who had a mental health problem were more likely than those without to have been charged with breaking facility rules since admission (table 16). Among State prisoners, 58% of those who had a mental health problem, compared to 43% of those without, had been charged with rule violations.

An estimated 24% of State prisoners who had a mental health problem, compared to 14% of those without, had been charged with a physical or verbal assault on correctional staff or another inmate. Among Federal prisoners who had a mental health problem, 15% had been charged with a physical or verbal assault on correctional staff or another inmate compared to 7% of those without a mental problem.

Jail inmates who had a mental health problem were twice as likely as those without to have been charged with facility rule violations (19% compared to 9%).

Inmates in local jails who had a mental health problem were also four times as likely as those without to have been charged with a physical or verbal assault on correctional staff or another inmate (8% compared to 2%).

A larger percentage of inmates who had a mental health problem had been injured in a fight since admission than those without a mental problem (State prisoners, 20% compared to 10%; Federal prisoners, 11% compared to 6%; jail inmates, 9% compared to 3%).

Three-quarters of female inmates in State prisons who had a mental health problem met criteria for substance dependence or abuse

Female State prisoners who had a mental health problem were more likely than those without to —

- meet criteria for substance dependence or abuse (74% compared to 54%),
- have a current or past violent offense (40% compared to 32%),
- have used cocaine or crack in the month before arrest (34% compared to 24%),
- have been homeless in the year before arrest (17% compared to 9%).

They were also more likely to report —

- 3 or more prior sentences to probation or incarceration (36% compared to 29%),
- past physical or sexual abuse (68% compared to 44%),
- parental abuse of alcohol or drugs (47% compared to 29%),
- a physical or verbal assault charge since admission (17% compared to 6%).

Characteristics of females in State prison, by mental health status

Selected characteristics	Percent of female inmates With mental problem	Without
Criminal record		
Current or past violent offense	40.4%	32.2%
3 or more prior probations or incarcerations	35.9	28.7
Substance dependence or abuse	74.5%	53.6%
Alcohol	41.7	25.8
Drugs	65.5	45.6
Drug use in month before arrest*	63.7%	49.5%
Cocaine or crack	33.9	24.2
Methamphetamines	17.1	16.3
Family background		
Homeless in year before arrest	16.6%	9.5%
Past physical or sexual abuse	68.4	44.0
Parent abused alcohol or drugs	46.9	29.1
Charged with violating facility rules*	50.4%	30.6%
Physical or verbal assault	16.9	5.7
Injured in a fight since admission	10.3%	3.8%

*Includes items not shown.

Table 16. Disciplinary problems among prison and jail inmates since admission, by mental health status

Type of disciplinary problem since admission	Percent of inmates in — State prison: With mental problem	State prison: Without	Federal prison: With mental problem	Federal prison: Without	Local jail: With mental problem	Local jail: Without
Charged with rule violations*	57.7%	43.2%	40.0%	27.7%	19.0%	9.1%
Assault	24.1	13.8	15.4	6.9	8.2	2.4
Physical assault	17.6	10.4	11.0	5.4	4.7	1.6
Verbal assault	15.2	6.7	7.9	2.4	5.2	0.9
Injured in a fight	20.4%	10.1%	11.4%	5.8%	9.3%	2.9%

*Includes violations not shown (for example: possession of a weapon, stolen property or contraband, drug law violations, work slowdowns, food strikes, setting fires or rioting, being out of place, disobeying orders, abusive language, horseplay, or failing to follow sanitary regulations).

Methodology

The findings in this report are based on data in the Survey of Inmates in State and Federal Correctional Facilities, 2004, and the Survey of Inmates in Local Jails, 2002. Conducted every 5 to 6 years since 1972, the BJS' inmate surveys are the only national source of detailed information on criminal offenders, particularly special populations such as drug and alcohol users and offenders who have mental health problems.

The survey design included a stratified two-stage sample where facilities were selected in the first stage and inmates to be interviewed in the second stage. In the second sampling stage, interviewers from the Census Bureau visited each selected facility and systematically selected a sample of inmates. Computer-assisted personal interviewing (CAPI) was used to conduct the interviews.

Survey of Inmates in State and Federal Correctional Facilities, 2004

The State prison sample was selected from a universe of 1,585 facilities. A total of 287 State prisons participated in the survey; 2 refused, 11 were closed or had no inmates to survey, and 1 was erroneously included in the universe. A total of 14,499 inmates in the State facilities were interviewed; 1,653 inmates refused to participate, resulting in a second-stage nonresponse rate of 10.2%.

The Federal prison sample was selected from 148 Federal prisons and satellite facilities. Thirty-nine of the 40 prisons selected participated in the survey. After the initial sample of inmates was drawn, a secondary sample of 1 in 3 drug offenders was selected. A total of 3,686 inmates in Federal facilities were interviewed and 567 refused to participate, resulting in a second-stage nonresponse rate of 13.3%.

Survey of Inmates in Local Jails, 2002

The local jail sample was selected from a universe of 3,365. Overall, 465 jails were selected, and interviews were held in 417 jails; 39 jails refused or were excluded for administrative reasons; and 9 were closed or had no inmates. A total of 6,982 inmates were interviewed; 768 inmates refused to participate, resulting in a second-stage nonresponse rate of 9.9%.

Accuracy of survey estimates

The accuracy of the survey estimates depends on sampling and measurement errors. Sampling errors occur by chance because a sample of inmates rather than all inmates were interviewed. Measurement error can be attributed to many sources, such as nonresponse, recall difficulties, differences in the interpretation of questions among inmates, and processing errors.

The sampling error, as measured by an estimated standard error, varies by the size of the estimate and the size of the base population. These standard errors may be used to construct confidence intervals around percentages. For example, the 95% confidence interval around the percentage of jail inmates in 2002 who had a mental health problem is approximately 64.2% plus or minus 1.96 times .83% (or 62.6% to 65.8%). Standard error tables for data in this report are provided in the Appendix which is available in the electronic version of the report at <http://www.ojp.usdoj.gov/bjs/abstract/mhppji.htm>.

A detailed description of the methodology for the State and Federal Prison survey, including standard error tables and links to other reports or findings, is available on the BJS Website <http://www.ojp.usdoj.gov/bjs/abstract/sicf04.htm>. A detailed description of the methodology for the Survey of Inmates in Local Jails is available at <http://webapp.icpsr.umich.edu/cocoon/NACJD-STUDY/04359.xml>.

Measures of mental health problems in the general population

Caution should be used when making comparisons between prison and jail inmates and the general population based on the a 12-month DSM-IV structured interview. There are significant variations in the questionnaire design and data analysis. For example, questions on the severity or duration of symptoms and questions about whether symptoms are due to breavement, substance use, or a medical condition may vary from survey to survey.

For details on the methodology used in the National Epidemiologic Survey on Alcohol and Related Conditions, sponsored by the National Institute on Alcohol Abuse and Alcoholism, see the Data Reference Manual, <http://niaa.census.gov/>. For additional information on the prevalence of mental disorders in the general population, see the National Survey on Drug Use and Health, sponsored by the Substance Abuse and Mental Health Services Administration, <http://www.oas.samhsa.gpv/nsduh.htm>. Also, see the National Comorbidity Survey Replication Study, sponsored primarily by the National Institute of Mental Health, <http://www.nimh.nih.gov/healthinformation/ncs-r.cfm>.

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Contributors to the Survey of Inmates in Local Jails are listed in *Profile of Jail Inmates, 2002*, at <http://www.ojp.usdoj.gov/bjs/abstract/pji02.htm>.

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This report in portable document format and in ASCII and its related statistical data and tables— including appendix tables— are available at the BJS World Wide Web Internet site: <http://www.ojp.usdoj.gov/bjs/mhppji.htm>

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Prevalence and Severity of Lifetime Physical and Sexual Victimization Among Incarcerated Women

Angela Browne,* Brenda Miller,† and Eugene Maguin‡

Introduction

Beginning in the 1960s in the United States, a new area of interpersonal victimization—that of aggression by intimates—began receiving increased attention from researchers, mental and medical health treatment providers, and legal policy-makers. Attention to violence by family members initially focused on the physical abuse of children (Gil, 1970; Kemp, Silverman, Steele, Droegemueller, & Silver, 1962). Public awareness of physical aggression between intimates expanded in the 1970s and 1980s to include new findings on violence between marital partners, particularly violence against wives (Dobash & Dobash, 1979, 1984; Dutton, 1988; Frieze, 1980; Martin, 1976; Pagelow, 1981, 1984; Walker 1979). With the publication of Straus, Gelles, and Steinmetz's (1980) nationally representative incidence study on family violence in 1980, an area of inquiry was born that has remained a focus of extensive research, interven-

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tion, and legal policy efforts up to the present (Tjaden & Thoennes, 1996). Research on violence by intimates spans the disciplines of sociology, criminal justice, law, medicine, psychology, psychiatry, and social work, and has stimulated rapid and dramatic changes in legislation, social policy, and public awareness.

As a result of scientific inquiry, we now have an extensive body of knowledge on the incidence and prevalence of physical and sexual aggression by intimates and on potential short- and long-term effects for survivors (see Gelles & Conte, 1990 for a review). However, virtually all empirical research during this period has been based on general population studies or on mental health, medical, court, or shelter samples (Browne & Bassuk, 1997). Except for a few studies, literature on the prevalence of interpersonal violence fails to include individuals who are out of the community serving long-term sentences in correctional settings. This article begins to address this gap by presenting findings from a comprehensive study of victimization histories among incarcerated women in a maximum-security setting. Empirical information on this population is critical, given the sharp increases in the rates of incarceration in the United States over the past 15 years and the economic and human price this increased use of imprisonment exacts.

Changing Patterns of Incarceration in the United States

Although long considered too small a population to warrant extensive consideration, women now constitute the most rapidly growing segment of the prison population and the segment about which we know the least. The United States has the highest rate of incarceration in the industrialized world, even higher than that of former police states such as South Africa and the former Soviet Union (U.S. Expands its Lead in the Rate of Imprisonment, 1992). Since 1985, the nation's prison and jail populations have nearly doubled on a per capita basis, to over 1.6 million today. Nearly 30% of this population is imprisoned in three states—California, Texas, and New York (Gilliard & Beck, 1996). During 1995 alone, the number of individuals in prison grew by over 72,000, an increase of 6.8%. On December 31, 1995, 1 in every 167 U.S. residents was incarcerated (Gilliard & Beck, 1996).

The most dramatic increase over the past decade has been in the incarceration of women, which has nearly quadrupled (Beck & Gilliard, 1995). A large part of this rapid growth has been due to the increased use of prison for drug, rather than violence-related, offenses. For example, in 1986, 1 in every 8 incarcerated women was serving time for drug-related offenses; by 1991, that number had risen to 1 in 3 (Snell & Morton, 1994). Even when one considers only those individuals incarcerated in maximum security facilities (a population more likely to be serving time for crimes of violence), less than 60% of currently incarcerated women are incarcerated for violent felonies. In New York State—the state with the third largest prison population in the United States—60% of *all* women under custody on April 18, 1998 were serving time for drug-related offenses. About one quarter (26%) were incarcerated for violent felonies committed either by themselves or by a companion. Only a small minority (9%) were incarcerated for property or other offenses.

Long-Term Effects of Violence by Intimates and Reasons for the Incarceration of Women

Parallels between the literature on *long-term effects of violence by intimates* and the *predominant reasons for women's incarceration* (noted above) make a further understanding of imprisoned women's prior trauma histories particularly important. For example, empirical studies have shown a strong association between histories of family violence and development of later alcohol and drug problems in survivors, irrespective of whether samples are drawn from clinical or community populations. (e.g., Downs, Miller, Testa, & Panek, 1992; Polusny & Follete, 1995; Rohsenow, Corbett, & Devine, 1988; Singer, Petchers, & Hussey, 1989; Toray, Coughlin, Vuchinich, & Patricelli, 1991). Women victims of child sexual molestation or severe physical child abuse by parental figures are at significantly higher risk for substance abuse and addiction as teenagers and adults than women who have not had these experiences (Brown & Anderson, 1991; Miller, Downs, & Testa, 1993; Straus & Kantor, 1994; Windle et al., 1995). These findings hold even when risk factors such as the presence of alcoholic parents or sociodemographic variables are controlled. However, most research on connections between drugs and violent victimization has focused on violence related to the business of buying and selling drugs and on the drug subculture; little attention has been given to drug use as a possible *secondary* effect of earlier experiences with aggression or threat.

Girls from physically or sexually abusive homes also are more at risk of separation from their families of origin before adulthood due to out-of-home placements or running away, and then become at increased risk of involvement in drug- or prostitution-related activities. Further, in a prospective cohort study of long-term consequences of severe physical or sexual abuse or neglect in childhood (based on 908 substantiated cases in the Midwest), Widom and Ames (1994) found that children who had experienced severe child abuse or neglect were at significantly higher risk for arrest as juveniles and adults compared to a matched control group. Although the absolute percentage was low, girls who had been sexually abused (compared to girls with *other* types of victimization and to controls) were at increased risk of adult arrests for prostitution.

Finally, one of the most consistently found aftereffects of sexual molestation during childhood is a vulnerability in some survivors to later involvement with violent intimates (e.g., Beitchman et al., 1992; Browne & Finkelhor, 1986). Drug use also increases the likelihood of relationships with intimates who are violent—both to the women and to others—and who are involved in a variety of other criminal activities. Increased exposure to violent intimates increases the risk of defensive acts by women in protection of themselves or a child (e.g., Browne, 1987), as well as the likelihood that women will be present or will otherwise have "certain knowledge" when a crime is committed by an intimate and will therefore be charged with and convicted of involvement with that crime. Thus, some of the long-term effects of victimization by family members may play important roles in the events for which women today are imprisoned.

Prevalence of Lifetime Physical and Sexual Victimization Among Incarcerated Women

Questions about lifetime histories of physical and sexual victimization are just starting to be included in studies of incarcerated women. In most cases, these questions are inserted into studies on other subjects; measurement is abbreviated, question sets lack validity and reliability, and methodologies used predict that resulting prevalence levels may be low. (For example, Finkelhor, 1994 noted that, across studies, prevalence estimates of abuse seem most affected by the number of questions used to measure victimization experiences, with multiple questions yielding the highest endorsements.) The six studies in the literature using U.S. samples are reviewed below.

Findings from National Samples

Only two national studies included victimization questions in surveys with incarcerated women. In 1991, the Bureau of Justice Statistics (BJS) conducted its first nationally representative survey of women in prison, interviewing approximately 1 in every 11 women in state correctional facilities (Snell & Morton, 1994). This survey included three screening questions on lifetime experienced of victimization: (a) "*Have you ever been physically or sexually abused?*"; (b) (If yes to sexual abuse) "*In this incident did someone use force to rape you or attempt to rape you?*"; and (c) (If yes to either) "*Did you know any of the persons who abused you?*" If respondents endorsed any items, they were asked about the number of occurrences, their age, and the perpetrator(s)' age(s) at the time, and the relationship category of the perpetrator(s). Of the 38,798 women participants, 43% reported some type of assault prior to that incarceration; 33.5% reported lifetime physical abuse and 33.9% reported lifetime sexual abuse. About half of those reporting abuse had been assaulted by an intimate. More than three quarters of those reporting abuse had been sexually abused or assaulted. Over half (56%) of those who were sexually abused had experienced a completed rape (Snell & Morton, 1994).

Although the BJS sample was large and representative, the methodology used may have suppressed rates. Questions on victimization occurred near the end of the interview in a section on involvement with gangs, and only one question was used to screen for abuse histories. If respondents gave a negative response or refused to answer that questions, no further questions were asked. The BJS methodology also required respondents to *label* actions they experienced as "abuse" in order to endorse the screening item—a technique less likely to reveal experiences with physical or sexual assault by intimates than behavioral indices describing actions without labeling them as inappropriate. A revised BJS survey is currently being conducted in which questions have been reworded to include behavioral descriptors and the question set has been expanded.

The other national survey was conducted by the American Correctional Association (1990) in 1987, using similar methodology. In this sample of 1,720 women, 43% of adult respondents were white non-Hispanic, 36% were African American, and 10% were Hispanic. Respondents were asked whether

they had ever been "*the victim of physical abuse (e.g., being beaten, kicked, or tied up)*" and if they had ever been "*the victim of sexual abuse.*" If they said yes to either question, they were asked how many times incidents happened, their age at the time of the first incident, the relationship of the perpetrator, whether they disclosed the abuse to anyone, and—if they reported the incident—what happened. Based on these questions, 53% of adult respondents reported ever being physically abused—with 82% of these reporting 3 or more incidents; and 36% reported sexual abuse—with 55% reporting multiple incidents. Over one third (36%) reported physical abuse occurring before age 20, and 30% reported sexual abuse prior to that age, mostly between the ages of 5 and 14. Sexual abuse was most often perpetrated by male family members. One fourth of all respondents reported physical abused by husbands or boyfriends.

Findings from Local Samples

Only four other studies appear in the literature as being conducted in the United States and including victimization questions or obtaining information on sexual trauma. Bloom, Chesney, and Owen (1994) conducted a study of a randomly selected sample of 297 women housed in California's three women's prisons and the California Rehabilitation Center (a coed facility at that time). Women in the sample averaged 32 years of age; over one third (35%) were African American, 36% were white non-Hispanic, and 17% were Hispanic. Respondents were asked whether they had ever been "*physically abused/harmed/hit*" as a child, whether they had been "*physically abused/battered"* as an adult; if they had ever been "*sexually abused*" as a child or as an adult, and if they had ever been "*sexually assaulted (using violence)*" as a child or in adulthood. For any positive endorsements, participants were asked how often this occurred and the relationship category of the perpetrator(s). Using these questions, Bloom et al. (1994) found that 29% of California's incarcerated women reported violence by parental caretakers and 31% reported child sexual abuse. Over half (60%) reported being physically assaulted in adulthood, primarily by male partners, and 23% reported adult sexual assault.

Similar findings were obtained by Sargent, Marcus-Mendoza, and Chong (1993) and Fletcher, Rolison, and Moon (1993), in their study of 267 women at a mixed-security level prison in Oklahoma. Women in this sample also had an average age of 32; 48% were White non-Hispanic, 37% were African American, and 9% were Native American. Participants were asked four questions about victimization: if they were "*physically abused*" before age 18 or, after age 18, were "*physically abused by a mate, husband, boyfriend, lover, friend, acquaintance, or partner*"; and if they were "*raped, sexually abused, or molested*" before age 18 or, after age 18, were "*raped (forced to commit sexual acts against your will*)." Questions did not distinguish between assaults by intimates and nonintimates. Based on these questions, over one third (37.5%) reported being physically abused as children and 69% reported being physically abused as adults. Over half (55%) reported experiencing sexual assault; 40% of the sample reported sexual assault in childhood and 38% reported sexual

assault as adults. Sargent et al. (1993) noted that, in other analyses, respondents who reported physical or sexual abuse also were more likely to report problems with alcohol or other drugs.

Lake (1993) did post-hoc analyses on reported experiences of abuse by intimates and assault, sexual assault, and robbery by nonintimates among 83 women incarcerated in Washington state in 1986. The average age of these women was 29; over half were White non-Hispanic (63%), 20.5% were African American, and 8% were Hispanic. Since the study had been designed primarily to assess criminal behavior, assessments of physical and sexual victimization were quite abbreviated. Physical abuse in childhood was assessed by asking about kinds of "*punishment*" used by parental figures before the respondent's age 12. Respondents were classified as "*abused*" only if a parental figure had punched or kicked her; both design factors could sharply limit resulting prevalence levels. Sexual assault by relatives was described to respondents as someone "*using force or threats*" to make her engage in sex. Other types of sexual abuse were excluded—a potentially large omission. (Since children are socially and legally prohibited from leaving their homes, child victims are often forced to remain in an environment where inappropriate and illegal activities are perpetrated against them, regardless of whether overt threat or force is used.) Given endorsements, questions were asked about the relationship of the respondent to perpetrators, but the study did not include a way to determine whether sexual abuse occurred in childhood. Physical assaults by partners were assessed by asking if the respondent had ever been hit by a spouse or live-in partner (dating violence was not assessed). Physical and sexual assaults by strangers were measured in the same manner as those by intimates.

Using these measures, 29% of respondents reported physical abuse in childhood; 18% reported sexual abuse by relatives—a prevalence somewhat *lower* than that among women in general community-based samples (Finkelhor, 1994). However, 70% reported violence by an intimate partner and nearly half of those reported sustaining injuries severe enough to need medical treatment. Over one third (37%) reported physical assaults by strangers, and 30% reported sexual assaults; nearly three quarters reported being physically or sexually assaulted by strangers or robbed. In total, over 85% of the sample reported at least one type of victimization experience. In examining potential correlations between experiences of abuse in childhood and later assaults by partners or nonintimates, Lake reports no evidence of associations between childhood abuse and later victimization. However, this may be an artifact of the small sample size, measurement problems for childhood variables, and the resulting low endorsement—especially for childhood sexual abuse. Lake also finds family sexual assault uncorrelated with later arrest data, possibly also due to these methodological factors (see also Bonta, Pang, & Wallace-Capretta, 1995 for similar Canadian findings and similar conclusions based on unusually low endorsements of childhood abuse).

Finally, Singer, Bussey, Song, and Lunghofer (1995) interviewed 201 women randomly selected from all new admissions to the Cleveland House of Corrections from May to September 1992. (Actively violent or psychotic women were excluded.) Women were an average age of 30; most were African

American (73%) or White non-Hispanic (21%). In this municipal jail sample, half of the women were incarcerated for prostitution; 13% were incarcerated for drug offenses or drug-related loitering. Although this study did not specifically ask about intimate violence, 68% of respondents reported being forced into sexual activity as adults, and nearly half (48%) reported being sexually victimized as children.

In sum, the six studies published over the past 10 years suggest a substantial prevalence of physical or sexual assault among incarcerated women. However, these assessments used only three to six direct questions, often requiring that *respondents* decide whether actions by intimates and others qualified as abuse, molestation, battery, or rape. Studies vary widely in their ability to distinguish (a) childhood from adult experiences, (b) perpetration by intimates versus nonintimates, and (c) cumulative experiences of victimization over the lifespan. The research reported here was conducted to lay a foundation of prevalence and severity data—based on comprehensive measures with established validity for evaluating physical and sexual assault—upon which to build future inquiries on the links between later behaviors and lifetime exposure to violence. The purpose of these analyses is not to link victimization experiences to particular types of criminal behaviors, but rather to identify the prevalence of these experiences in a population of incarcerated women. In addition to the importance of establishing parallel knowledge to prevalence and severity findings on other populations, more comprehensive data on the level of prior victimization in incarcerated populations is essential to inform intervention and prevention efforts and criminal justice policy.

Method

Analyses presented here are based on data from a National Institute of Health-funded supplement to a larger National Institute on Drug Abuse (NIDA) prospective study. The NIDA study investigated the impact of family violence on women's drug use based on a sample of 600 women from four groups: shelters for partner violence, drug treatment centers, and community samples matched to these groups for geographical residence and age. Although the NIDA study was comprehensive, only women living in the community were included. This study added a sample of women (n = 150) from the societally cost-intensive and rapidly growing women's prison population, representing women who spend extended time out of the community in correctional settings.

The focus of the analyses is the aggregate experiences of incarcerated women in terms of prior victimization histories. The reported prevalence and severity of six types of violence will be discussed: (a) severe physical violence by parental figures, (b) child sexual molestation—both familial and nonfamilial, (c) severe physical aggression and (d) rape by intimate partners in adulthood, and (e) physical and (f) sexual violence by strangers or acquaintances. Data includes detailed information on reported experiences with physical and sexual victimization and threats throughout the lifespan among women serving long-term (over 6 year) prison sentences, as well as reports on resultant inju-

ries and other outcomes. Data do not include reports on victimization while incarcerated.

Setting

These data are drawn from cross-sectional interviews with 150 women entering the general population of Bedford Hills Maximum Security Correctional Facility (BHCF) in Bedford Hills, New York. BHCF, with a population of 760 to 840, is New York State's only maximum security prison for women, as well as the Reception Center for all women sentenced to prison in New York State. A maximum security facility was chosen for this research because of the assumed presence of a saturated population for inquiry into issues of drug abuse and violent victimization. The relatively longer sentences served by most maximum security inmates also offered the potential of later follow-up studies with this population.

Respondents

All women entering the general corrections population of BHCF (thus excluding women in reception who were transferred to nonmaximum security settings) for 26 consecutive months on new charges who met study criteria and had less than 1 year total time away from the community were invited to participate. A list of eligible participants was prepared monthly for the project by the Department of Correctional Services, Division of Program Planning, Research and Evaluation Unit. Because the first few weeks of incarceration can be a chaotic and potentially frightening time, women were invited to participate after they had been in the general corrections population at BHCF for at least 2 months and had had time to become familiar with prison routines and become involved in ongoing program and work activities.

The following categories were excluded from the eligible respondent pool: (a) women with severe mental illness, as determined by the Office of Mental Health Satellite Unit (OMH) at BHCF, (b) women considered a mental health risk at the time of their eligibility due to active suicidal ideation or recent incidents of self-harm (as determined by OMH), (c) women serving disciplinary time in the Segregated Housing Unit (SHU) at the time of their eligibility, and (d) women who were medically hospitalized at the time of their eligibility. For the last three categories, women were given a later opportunity to participate if they returned to the general population and were not considered at special risk. Due to human subject concerns, no women entering BHCF at ages younger than age 18 were accepted into the study.

Of the 304 women entering the general population on new charges with less than 1 year away from the community who were 18 years of age and older during the interviewing frame, 74 (24%) were excluded from the eligible subject pool for mental health ($n = 56$) or medical ($n = 5$) reasons or because they were in SHU ($n = 13$). Of the 230 women eligible for the project, 68% completed the interview, 9% refused to participate, 11% failed to appear for the call out (scheduled appointment), and 12% were absent from the facility during interview weeks due to being at court or in other facilities.

Demographic Characteristics of Sample

Respondents ranged in age from 18 to 59 years, with a mean and median age of 32 years. Ethnically, the largest group of women were African American (49%); 25% were Hispanic and 12% were White non-Hispanic. Most Hispanics in the sample were from Puerto Rico or other Caribbean countries. The majority of women reported they had never married (53%). However, 23% reported being married or in a common-law relationship at the time of the interview, while 17% were either divorced or separated. The majority of women (78%) had one or more children. Over four fifths (82%) were born in the United States. This sample is similar to recent national data on all women in state prisons in median age (31 years nationally), percent Black (45% nationally), and number who had children (78%; Snell & Morton, 1994). However, the BHCF sample has a higher proportion of Hispanics (25% vs. 14%) and married women (23% vs. 17%), and a lower proportion of White non-Hispanics (12% vs. 36%). Women at BHCF were much less likely to be divorced or separated (17% vs. 32%; Snell & Morton, 1994).

Protocol

Interviews were conducted on prison grounds 1 week each month over a 1-year period. All eligible women were sent a memo at the beginning of each interviewing week explaining the study, reassuring them that all new residents were being invited to participate and they were not being singled out in any way, and informing them that they would be called out to meet a project interviewer who would describe the study to them in more detail. Potential participants were briefed on the study individually by going through the detailed consent form with an interviewer in a private interviewing space. If they agreed to participate, they were interviewed at that time. In most cases the interview protocol took 2.5 to 3.5 hours to complete; the majority of interviews were completed in one sitting. At the conclusion of the interview, respondents were given a resource list in Spanish and English detailing mental health and family violence resources available within the prison setting and how to access those resources.

Interview questions were derived from the NIDA study. Some special considerations for prison data collection, such as time constraints on interviews, limited replication. All questions related to time periods prior to the current incarceration. Interviewers were selected for prior experience with research interviewing on sensitive topics in special settings. All interviewers were women. Interviews were conducted in either English or Spanish, depending on the preference of the interviewee. All interviews were conducted in private with just the participant and the interviewer present.

Measures

Physical Violence. The physical aggression scale of the Conflict Tactics Scales (CTS; Straus, 1979, 1990a, 1990b) was used to obtain data on physically violent actions by childhood caretakers and by intimate partners in adulthood.

Developed in the United States in 1971, the CTS has been used in two national samples of more than 8,000 respondents and employed in hundreds of studies in Western countries over the past 27 years. Alpha coefficients of reliability range from .79 to .62. Numerous indicators of concurrent validity, construct validity, and independence from social desirability effects have been demonstrated in research by Straus and others (e.g., see Straus, 1990a, pp. 40–44 and Straus, 1990b, pp. 63–70 for a review). Items give behavioral descriptions of physically aggressive acts with a yes/no or a frequency response for each item. The aggression scale is further divided into "minor" and "severe" violence indexes. The "minor" violence items are: threw something at the other; pushed, grabbed, or shoved; slapped or spanked. Severe violence items are: kicked, bit, or punched; hit or tried to hit with an object; beat up; choked (or for parent-to-child violence, burned or scalded); threatened with a knife or gun; and used a knife or gun. Only results from the "severe" violence index are reported here. Although Straus and colleagues (Straus, 1990b; Straus & Gelles, 1990) used the CTS to assess adults' behaviors toward their children, many empirical studies have since used the index as a retrospective measure of abuse in childhood (e.g., Tjaden & Thoennes, 1996).

Severe Physical Violence by Childhood and Adolescent Caretakers. Following Straus and colleagues (Straus, 1990b; Straus & Gelles, 1990), severe physical violence by childhood caretakers was defined as the occurrence of at least one of the following before age 18: being kicked, bit, or hit with a fist; hit with an object; beaten up; burned or scalded; or threatened or assaulted with a knife or gun. In addition, we incorporated the non-CTS item, "having one's life threatened in some other manner." This allowed us to elicit information about violent behaviors not captured by specific CTS items. The prevalence of severe caretaker violence in the family of origin was computed for the women's primary mother figure, primary father figure, and for other childhood caretakers combined. The primary parental figures were those with whom the women had resided the longest (until age 18 or leaving home, whichever came first) or for the longest duration prior to age 13. Other childhood or adolescent caretakers were the mothers or fathers with whom women had resided for the second-longest period of time up until their age 18 or they left home. Although this category may contain people that were not routinely (or at all) involved in caretaking, we use the term *caretakers* for brevity's sake when referring to these three categories in the aggregate.

Child Sexual Molestation. Child sexual molestation was defined as both contact and noncontact sexual experiences occurring before age 18 and involving a person at least 5 years older than the woman at the time of the incident, a relative irrespective of any age difference, or any individual who had forced the respondent to engage in sexual activities. Detailed items described experiences of sexual molestation in three categories: inappropriate exposure, sexual contact (touching), and any form of penetration. Specific sexual experiences included invitations to do something sexual; sexually oriented touching (e.g., breast, abdomen, thighs); oral sex; digital penetration ("other person inserted a finger or object into your vagina or anus"); and intercourse ("other person

inserted his penis into your vagina or anus"). Interviewers read the list of items and asked if each item had ever occurred. A measure of total sexual abuse prevalence was constructed from these items. For each endorsement, respondents were asked their age at the time of occurrence, the perpetrator's age if known, and the perpetrator's relationship to them.

This method of using multiple questions of a specific nature rather than a single, more general question, has been shown to produce more reports of sexual abuse (Briere, 1992; Finkelhor, 1994; Peters, Wyatt, & Finkelhor, 1986 Russell, 1986). Interview questions were drawn from previous works by Finkelhor (1979) and Sgroi (1982). Over the past 12 years, the indices of sexual abuse used in this study have been used with over 1400 women across community and treatment settings to help respondents identify sexual abuse experiences (Miller et al., 1993). The data for these variables were taken from a series of questions that elicited information on the first five persons involved in reported incidents of sexual abuse. Community agency involvement was measured by a question that assessed whether the police, juvenile courts, social service agencies, regular (adult) court, or any other official agency was involved with the family as a result of sexual molestation incidents.

Severe Physical Violence by Intimate Adult Partners. Severe physical violence by intimate partners was defined similarly to violence by childhood caretakers, except that—following Straus (1990a)—being "choked, strangled, or smothered" appeared in the adult violence scale. Our definition of severe violence by an adult partner differs in two ways from that of Straus and Gelles (1990). First, as with parental violence, we incorporated the non-CTS item "having one's life threatened in some other manner," enabling us to elicit information about violent behaviors not captured by specific CTS items. In addition, respondents were asked if they had been "threatened with an automobile." Respondents were asked about all "*intimate partners" (by this we mean a male or female you had a romantic or sexual relationship with for 1 month or more)*" since age 14, starting with their "*very first date or lover.*" A separate item measured whether women had been harassed, threatened, or assaulted by any expartners after an intimate relationship had ended.

Threats of Harm by Intimate Partners. Threats of harm to self or others by the women's assailants were measured by items that were asked of all women about threats by an intimate partner, irrespective of whether they reported severe partner violence. These threats included: (a) to kill themselves, (b) to kill the respondent, or (c) to kill the respondent's relatives or friends.

Medical Outcomes of Partner Violence. The prevalence of injuries sustained by women as a result of severe violence was measured by a series of questions adapted from Walker (1984), increasing in severity from "no visible injury but painful" to "permanent injury to eyes, head, joints, back, or limbs" (Browne, 1987; Walker, 1984). This set of items was asked if severe violence was reported by any intimate adult partner. The total injury prevalence was constructed of all injury items except the "no visible injury but painful" item. Thus, a positive response to the total injury prevalence indicates that the at-

tack resulted in at least minor bruises, cuts, burns, or blackened eyes. Respondents were also asked if they needed or received medical treatment as a result of partner violence.

Other Outcomes of Partner Violence. Other outcome measures of partner violence included whether the woman had moved away from an intimate partner to escape his/her violence, whether the woman or others had ever called the police related to a partner's violence, whether the woman had ever obtained a restraining order, and whether charges had ever been filed related to partner violence.

Lifetime Physical and Sexual Victimization by Strangers. Victimization by persons *other* than parental caretakers or intimate partners was assessed by five items that asked whether women had ever: (a) had something taken from them by force (e.g., been held up or mugged); (b) been beaten up or attacked with a dangerous object such as a rock or bottle; (c) been knifed, shot at, or attacked with another weapon; (d) been threatened with assault (excluding telephone threats) or threatened with a knife, gun, or some other weapon; or (e) been raped. Those reporting experiences in any of these categories were asked how many times this had occurred between their ages of 10 and 17, since they turned 18, and in the 6 months prior to this incarceration, and the number and relationship of perpetrators involved.

Results

Severe Physical Violence by Childhood and Adolescent Caretakers

Overall, results show that a substantial majority of the sample of women in the general corrections population reported having experienced sexual molestation or severe violence prior to the current incarceration. Over two thirds (70%) reported experiencing severe physical violence from a childhood or adolescent caretaker or parent. Just over half (51%) reported that their primary female caretaker had inflicted physical violence, and over one quarter (29%) reported that their primary male caretaker had severely physically attacked them. Seventeen percent reported that other caretakers had inflicted severe physical violence (Table 1).

TABLE 1
Severe Physical Violence by Childhood and Adolescent Caretakers[a]

Any caretaker/other adult in household	70%
Primary female caretaker	51%
Primarily male caretaker	29%
Other caretakers	17%

[a] $N = 150$.

Child Sexual Molestation

Over half of all respondents (59%) reported some form of sexual abuse during childhood or adolescence. Nearly half (49%) of all respondents reported experiencing exposure; 51% reported sexual touching, and 41% reported experiencing vaginal, oral, or anal penetration. Of those women reporting sexual molestation, 27% reported biological or adoptive fathers or stepfathers as the perpetrators (surprisingly, fathers were just as likely as stepfathers to be the reported perpetrators); nearly half (42%) of the sample reported sexual victimization by other male relatives (excluding foster parents). Just over half of those who reported molestation (56%) gave nonrelatives (including foster parents) as the perpetrators. Finally, a small minority (2%) of the sample reported that they had been victimized by a female relative. Over half (51%) of those reporting childhood or adolescent sexual abuse reported that their first molestation occurred between the ages of 0 and 9. For nearly half of those reporting childhood sexual abuse (42%), the duration of the abuse was estimated to exceed 1 year. Over one quarter estimated the duration as more than 3 years. Among women reporting childhood sexual abuse, only one quarter (24%) reported that their experiences of molestation had come to the attention of outside authorities. When an outside agency was reported as involved, the police or a social service agency were most often mentioned (21% and 10%, respectively). Interestingly, few women reported that either juvenile or adult courts became involved (6% and 9%, respectively) (see Table 2).

Severe Physical Violence by Intimate Adult Partners

Experiences of severe physical violence by intimate partners in adulthood were reported by three quarters (75%) of all respondents. Sixty percent reported being kicked, bitten, or hit with a fist; over half (57%) reported being beaten up; 50% reported being hit with an object able to do damage. Even when only the most *severe* sounding items are considered, 40% of all respondents reported being choked, strangled, or smothered; 36% reported being threatened with a knife or gun; and one quarter reported being cut with a knife or shot at by an intimate partner. In addition, over one third (35%) reported that they had experienced marital rape or been forced to participate in other sexual activity (Table 3).

Threats of Harm by Intimate Partners. Verbal threats of severe harm were also commonly reported: Over half of all respondents (53%) reported that a partner had threatened to kill them; over one third (36%) reported that a partner had threatened to kill himself. Homicide threats were reported as extending to the women's friends and relatives in 16% of the cases.

Medical Outcomes of Partner Violence. Nearly two thirds of all respondents (62%) reported that they had been injured by an intimate partner during adulthood. Although minor bruises were the most common form of injury mentioned (with 56% reporting this injury), over one fifth of all respondents (21%) reported suffering a concussion and 17% reported broken bones as a

TABLE 2
Child Sexual Molestation[a]

	%
Type of molestation	
Any	59
Exposure	49
Sexual touching	51
Vaginal, oral or anal penetration	41
Of those reporting molestation (any type)	(*n* = 89)
Relationship of perpetrator(s)	
Father or stepfather	27
Other male relatives	42
Female relatives	2
Nonrelatives (includes foster parents)	56
Age at first molestation experience	
0 through 9 years	51
10 through 14 years	42
15 through 17 years	8
Duration of molestation experience	
Only once or <1 month	23
1 month to 1 year	36
More than 1 year to 3 years or less	15
More than 3 years to 5 years or less	15
More than 5 years	12
Intervention by outside agency	
Any	24
Police involvement	21
Adult court involvement	9
Juvenile court involvement	6
Social service agency involvement	10

[a]*N* = 150.

result of a partner's violence. Nearly half (46%) reported that they needed medical treatment for injuries inflicted by their partner.

Other Outcomes of Partner Violence. Over one third (37%) of the total sample reported obtaining an order of protection related to partner violence, and over one quarter (28%) reported that charges had been filed. Half of all respondents who had ever *ended* a relationship with an intimate partner reported that they had been physically assaulted, threatened, or harassed after separation.

Physical and Sexual Violence by Nonintimates

The final dimension of lifetime violent victimization assessed was criminal victimization by "nonintimates": persons other than parental figures or intimate partners. Three quarters (77%) of all respondents reported that they had been the target of some form of victimization by others, which ranged from

TABLE 3
Severe Physical Violence by Intimate Adult Partners[a]

	%
Physical violence by an intimate partner	
Any	75
Kick, bit, or hit with a fist	60
Hit with an object able to do damage	50
Beat up	57
Burned or scalded	7
Choked, strangled, or smothered	40
Threatened with a knife or a gun	36
Actually used a knife or a gun	24
Threatened life with an automobile	7
Threatened life in some other manner	21
Forced sex by an intimate partner	
Threats of harm by intimate partners	
Any	56
Threatened to kill respondent	53
Threatened to kill self	36
Threatened to kill respondent's relatives or friends	16
Medical outcomes of partner violence	
Physically injured by a partner	62
Most prevalent injuries	
Minor bruises	56
Severe bruises	38
Concussion	21
Broken bones	17
Needed medical treatment	46
Other outcomes of partner violence	
Assaulted, threatened, or harassed postseparation	50
Obtained restraining order	37
Charges were filed	28

[a]*N* = 150.

threats of assaults involving weapons to physical and sexual attacks. The most common forms of criminal victimization mentioned were muggings (reported by 49% of the sample) and threats of assaults involving weapons (also reported by 49% of the sample). Only slightly less common were violent assaults, reported by 38% of respondents. Again, more than one quarter (28%) of all respondents reported being knifed or shot at. Violent sexual attacks were reported by one third of the sample. When all forms of violence are considered together, only 6% of respondents did *not* report experiencing at least one physical or sexual attack during their lifetime (Table 4).

Relationship of Childhood Victimization to Adult Victimization

Finally we examined whether women who reported different types of victimization prior to age 18 were also more likely to report physical or sexual at-

TABLE 4
Physical and Sexual Violence by Nonintimates[a]

	%
Physical or sexual violence	
Any	77
Held-up/mugged	49
Threatened to beat up/threatened with a weapon	49
Beaten up/physically attacked	38
Knifed or shot at	28
Other physical assault	2
Raped/attacked sexually	33

[a]*N* = 150.

tack in adulthood. Overall, 80% of women reporting that they experienced *severe physical violence* by parental caretakers in childhood or adolescence also reported later experiencing *severe physical violence* by an intimate partner. (In contrast, 62% of women who did not report experiencing severe assault by parental caretakers reported severe physical violence by a partner.) Similarly, women who reported being *sexually molested* before age 18 were much more likely to report *sexual assaults by nonintimates* during adulthood than women who reported no sexual intrusions during childhood (40% vs. 23%) (Table 5).

Discussion

These findings suggest that violence across the lifespan for women incarcerated in the general population of a maximum security prison is pervasive and severe. Lifetime prevalence rates of severe violence by intimates reported in this study far exceed those for *all* acts of physical abuse reported by women in

TABLE 5
Relationship of Childhood Victimization to Adult Victimization

	Childhood victimization			
	Severe violence by caretakers		Child sexual molestation	
Adult victimization	Yes (%)	No (%)	Yes (%)	No (%)
Severe partner violence (75%)	80.0*	62.2*	80.9	65.6
Sexual assaults — nonintimates (33%)	35.0	28.9	40.2*	23.0*
Physical assaults — nonintimates (72%)	75.0	64.4	76.1	65.6

*Chi-square test, $p \leq .05$.

the general female population—as identified in a recent national random sample of 8,000 U.S. women—of 40% for physical abuse by parental caretakers and 22% for violence by adult partners (Tjaden & Thoennes, 1996; Tjaden, personal communication, 1996). Similarly, the 59% lifetime prevalence rate of child sexual molestation stands in stark contrast to the 20 to 27% prevalence rates obtained in community-based samples (Finkelhor, 1994).

For these incarcerated women, experiences of physical and sexual assault began early. According to these reports, by age 11, over two thirds (66%) of those experiencing child sexual abuse had already been molested; 71% of those assaulted by caretakers had already experienced severe violence by a parental figure. Reports of childhood victimization strongly predict reported revictimization later in life. Women who reported severe physical violence by parental figures were 29% more likely to report that they later became involved with an intimate adult partner who was physically violent; women who reported childhood sexual molestation were 75% more likely to endorse violent sexual assault items than women who did not report childhood molestation.

In thinking about implications of early experiences of violence, we have primarily emphasized the parallels between long-term effects of experiences with violence and predominant reasons for women's incarceration. It is also true that there is an association between involvement in drug abuse and/or illegal activities and an increased risk of physical and sexual victimization. Since 82% of the sample reported experiencing severe parental violence and/or childhood sexual abuse before reaching adulthood, it is unlikely that victimization precipitated simply by drug use or criminal activity increased the cumulative lifetime prevalence figure significantly. However, the high rates of reported victimization by adult partners and nonintimates undoubtedly was driven, in part, by respondents' involvement in illegal drug use and other illegal activities.

This study offers several strengths. Interviews were conducted with women entering the general population of the prison facility rather than with participants in special programs or mental health interventions, thus enhancing the generalizability of findings to incarcerated women in other facilities. The study was designed to distinguish (a) childhood from adult experiences, (b) perpetration by intimates versus nonintimates, and (c) cumulative experiences of victimization over the lifespan. Measures of key domains were detailed and comprehensive, with proven validity and long histories of use in other empirical studies. All key measures were based on behavioral indices; respondents were never asked to label intimates as abusive in order to endorse a question or to respond to questions based on their personal definition of battery, abuse, or molestation. In line with Finkelhor's (1994) earlier observations, the higher prevalence rates identified in this study compared to earlier inquiries among incarcerated women underscore the importance of research utilizing comprehensive and validated measures of victimization.

The study also has several limitations. Lifetime prevalence rates of the types of violence under investigation may be underreported. For purposes of comparability and due to our concerns about strains on mental health resources within BHCF, severely and chronically mentally ill women and women considered to be mental health risks were excluded from the study. Although research with mentally ill inpatient populations and women who self-mutilate or

seriously consider suicide suggest a high prevalence rate of past physical and sexual victimization, we believe a study specifically focused on the severely mentally distressed would be most appropriate for assessing their trauma histories. Women who refused to participate in this study also may have lowered prevalence findings, due to the exclusion of their histories. A memo that accompanied each notice of call-out described the study as including questions about relationships with family and intimate partners. In informally stating their reasons for refusal at the time of call-out, many of those refusing referred to this sentence and said that they had "had things happen to them that they wanted to forget." Self-report techniques also risk underreporting of sensitive or painful information by participants due to shame or actual repression of traumatic childhood experiences (e.g., Widom & Ames, 1994). In this study, respondents sometimes asked to skip questions on sexual molestation or abuse by parents or said that responding to those questions would be disloyal to their families.

Although record data of private events such as violence by intimates severely underreport their actual occurrence in a population, self-report techniques risk both under- and overreporting. Thus, lifetime prevalence levels of violence in this study also may be overreported. For example, some participants may have felt that manufacturing stories of early abuse experiences would help justify their later incarceration. The structure of the interview and the interviewing process was designed to minimize this possibility; respondents were not asked about reasons for their current incarceration or precursors to it and knew that interviewers were blind to their criminal history and the charges for which they were serving time. Still it may have occurred. If overreporting did occur with some participants, it would not be enough to eliminate the phenomenon. For example, even if prevalence levels were overreported by 20%, this would reduce the intensity and severity, but results would still represent a phenomenon of significant magnitude and implications for policies related to incarcerated female populations.

Implications for Research

Despite these caveats, this study—along with a few others—suggests that there is a sufficiently high prevalence of severe physical and sexual assault across the lifespan among incarcerated women to warrant further inquiries on how trauma histories relate to later imprisonment. Research directions suggested by this and other studies (e.g., Widom & Ames, 1994) include investigations of: (a) mechanisms by which victimization by intimates *contribute* to women's later involvement in the criminal justice system; (b) what types of background characteristics, resiliency and support factors, and/or trauma profiles *differentiate* women with trauma histories who become involved with the criminal justice system from women with trauma histories who do not; (c) the *impact* of victimization histories on women's prison adjustment and needs for mental health and other interventions while incarcerated; and (d) what *types* of early interventions or interventions during incarceration might offset negative effects of trauma and promote a positive readjustment to the community

upon release. The pervasiveness of reported abuse experiences in this study did not suggest that victimization histories *per se* would be correlated with particular types of crimes. However, future studies that wanted to be specifically predictive could possibly look at *profiles* of abuse histories among women that might be related to specific types of criminal offenses.

Implications for Interventions and Programs

Levels of severe physical assault and sexual molestation in early childhood identified in this study are particularly troubling in their potential for long-lasting psychological and behavioral outcomes (e.g., Beitchman et al., 1991, 1992; Bryer, Nelson, Miller, & Kroll, 1987; Finkelhor, 1995; Herman, 1992). Time spent in an incarcerated setting provides an *opportunity* for targeted interventions that could markedly improve the potential for adjustment within the incarcerated setting and successful reintegration when women return to the community (e.g., Morash, Haarr, & Rucker, 1995).

For example, a study completed by the New York State Department of Correctional Services (DOCS) Division of Program Planning, Research and Evaluation (Canestrini, 1994) found evidence of specific short-term effects on recidivism for women who had participated in an on-site program for survivors of family violence. The program was comprehensive, with educational activities, support groups, and individual counseling. In addition, small groups addressed issues of survivors of child abuse, child sexual abuse/incest, and partner violence, as well as those of women who killed adult partners and women with child-related crimes. The DOCS study followed up all women (220) who had participated in the Family Violence Program at BHCF between 1988 and April 1994 and were subsequently released. Control variables for the study included type of crime, second felony offender status, ethnicity, and age at release.

After a 21-month follow-up, women with 6 to 12 months in the program had less than *half* the recidivism rate (10% vs. 24%) as women released during the same period who did not participate in the program, even when type of crime, second felony offender status, ethnicity, and age at release were controlled. Women with less than 6 months in the program had the second highest rate of return: 19%. Although the researchers did not speculate on factors affecting this outcome, this study illustrates the potential impact on recidivism of focused interventions that deal directly with histories of traumatic victimization. Beyond the humanitarian issues of providing support and intervention to individuals in our society who are suffering, addressing some of the long-term effects of violent victimization is particularly important in incarcerated populations. If left unaddressed, posttrauma effects—potentially part of the pathway leading *to* incarceration—would be expected to markedly worsen the prognosis for a successful return to life outside correctional facilities upon release.

Implications for Policy

The number of imprisoned women in the United States has nearly quadrupled over the past 15 years. An increased understanding of the precursors to

imprisonment for women is now timely and critical. Incarceration as a "solution of choice" for drug-related offenses is a radically costly alternative, both for individual taxpayers and on a state and federal level. Costs for holding one individual in jail or prison in New York City are now estimated at $58,000 per year (Singer et al., 1995). Estimates for the cost of building one prison cell range from $52,000 to $94,000 for a maximum security facility, in 1990 dollars (*America Behind Bars*, 1992; cf. Byrne, Lurigio, & Petersilia, 1992). Yet the current level of growth in the U.S. prison population would require building a 1,000-bed prison every 6 days (Beck & Gilliard, 1995; Langan, 1991). Alternative responses to substance abuse and other effects of earlier trauma would be far more cost effective than the total expenses of arrest, prosecution, incarceration, and parole.

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