Clinical Indicators of Sexual Violence in Custody
Feasibility Study

1121-0324

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Clinical Indicators of Sexual Violence in Custody—Feasibility Study

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A. Justification

1. Circumstances Making the Collection of Information Necessary

On September 4, 2003, the Prison Rape Elimination Act of 2003 (PREA or the Act) was signed by President George W. Bush (Public Law 108-79). The Act requires the Bureau of Justice Statistics (BJS) to "carry out, for each calendar year, a comprehensive statistical review and analysis of the incidence and effects of prison rape." The Act further instructs BJS to collect survey data, "…the Bureau shall…use surveys and other statistical studies of current and former inmates…" The law was passed in part to overcome a shortage of available research on the incidence and prevalence of sexual violence within correctional facilities. A data collection program of this complexity and scale on such sensitive subject matter is unprecedented.

Due to the sensitive nature of violent victimization and potential reluctance to report sexual assault, BJS will collect multiple measures on the incidence and prevalence of sexual assault. To implement the Act, BJS has developed the National Prison Rape Statistics Program (NPRS), which includes five separate data collection efforts: the Survey on Sexual Violence (SSV), the National Inmate Survey (NIS), the National Survey of Youth in Custody (NSYC), the Former Prisoner Survey (FPS), and the Clinical Indicators of Sexual Violence in Custody (CISVC).

Each of these collections is independent and, while not directly comparable, will provide various measures of the prevalence and characteristics of sexual assault in correctional facilities. The SSV series (OMB No. 1121-0292) collects information about the incidents of sexual violence that are reported to and substantiated by correctional authorities. The NIS (OMB No. 1121-0311) gathers allegations of sexual assault self-reported by inmates in correctional facilities, while the NSYC (OMB No. 1121-0319) collects allegations of sexual assault self-reported by youth in juvenile facilities. Finally, the FPS (OMB No. 1121-0316) measures allegations of sexual assault experienced by former inmates on active supervision during their last incarceration.

This submission seeks clearance for a feasibility study of the CISVC, a passive surveillance system for clinical (medical, dental, and mental health) indicators of sexual violence. This feasibility study is intended to be a precursor to a full pilot of the CISVC, followed by a national surveillance system.[1] The purpose of the resulting surveillance system would be to identify and monitor clinical indicators that correlate with allegations of sexual violence in correctional facilities.

Background

In 2007, there were 1.6 million inmates in prisons and 780,000 inmates in jails in the United States (Sabol 2008a; Sabol 2008b). The incidence of rape in correctional settings is under debate, but some experts estimate that as many as 14% of U.S. inmates have been sexually assaulted in a correctional setting. As part of its efforts to monitor rape under PREA, BJS is collaborating with Centers for Disease Control Division of HIV/AIDS Prevention (CDC) to establish a passive surveillance system for clinical indicators of sexual violence in correctional facilities.

[1] If the CISVC is determined to be feasible, an OMB package will be submitted for the full pilot test.

In a review of published studies on inmate sexuality, including sexual violence, the proportion of inmates in the U.S. who reported being sexually assaulted while incarcerated ranged from less than 1% to 14% (Hensley 2002). The limitations of the reviewed studies, however, included the use of small, unrepresentative samples; low response rates; and high illiteracy rates among the survey populations. In addition, the studies were not necessarily comparable because the methods they used were inconsistent, including the definition of sexual violence, selection methods, and mode of data collection. Several of these studies examined coercive sex acts, meaning sex acts that may appear consensual but are performed under the threat of physical violence (Robertson 2003; Beck and Harrison 2007). Up to 22% of inmates reported being pressured to have sex by other inmates or staff. Inmates who are vulnerable to coercive sex include those with drug addictions or mental health issues, those who have previously been abused sexually, and those with little experience in the criminal justice system (Smith 2002).

To estimate the incidence of sexual violence in correctional setting, BJS defined sexual violence between inmates as *nonconsensual sexual acts* or *abusive sexual contacts* and sexual violence between staff and inmates as *sexual misconduct* or *sexual harassment*. BJS collected existing inmate allegation data between 2004 and 2006 (Beck and Hughes 2005; Beck and Harrison 2006; Beck, Harrison, and Adams 2007), and the rate of allegations of sexual violence in prisons was 2.46 per 1000 inmates in 2004, 2.83 per 1,000 inmates in 2005, and 2.91 per 1,000 inmates in 2006. Of these, the rate of substantiated allegations was 0.55 per 1,000 inmates in 2004, 0.40 per 1,000 inmates in 2005, and 0.43 per 1,000 inmates in 2006. Among substantiated nonconsensual sexual acts (the most serious form of inmate-on-inmate sexual violence), an injury resulted was reported in 26% of assaults in 2006 and 22% of assaults in 2005. Anal or rectal tearing was reported in 5% of assaults in 2006 and 6% of assaults in 2005. The most common types of injuries were bruises, black eye, sprains, cuts, and scratches (11% in 2005).

In addition, BJS conducted a survey of some 23,000 current prison inmates (Beck and Harrison 2007) and 40,000 jail inmates (Beck 2008) regarding sexual assault in 2007. Among prison inmates surveyed, 2.1% reported an incident involving another inmate, 2.9% reported an incident involving staff, and 0.5% reported being victimized by both other inmates and staff. Overall, 0.5% of prison inmates reported being injured during an assault by another inmate (24% of inmate-on-inmate assaults) and 0.3% of prison inmates reported being injured during an assault involving staff (10% of staff-on-inmate assaults). Among jail inmates surveyed, 1.6% reported an incident involving another inmate, 2.0% reported an incident involving staff, and 0.4% reported being victimized by other inmates and by staff. Overall, 0.6% of jail inmates reported being injured during an assault (19.5% of assaults), while among jail inmate assault victims, the most common injuries were bruises, cuts, scratches (15.8%), teeth being chipped and/or knocked out (8.9%), being knocked unconscious (7.8%), anal/rectal tearing (6.3%), internal injuries (6.3%), broken bones (3.3%), and knife or stab wounds (2.1%).

Several case studies of male sexual assault victims outside of the correctional setting in the United States have been published (Doan 1983; Lipscomb 1992; Pesola 1999; Kimerling 2002). The median age of victims varied from 19-29 years. Extra-genital trauma (e.g., abrasions, contusions, superficial lacerations) was identified in approximately 33% of patients. Although anal penetration occurred in approximately 85% of assaults, rectal trauma was identified in only 5%-15% of patients.

As part of the legally mandated PREA data collection, BJS is collaborating with CDC to establish a passive surveillance system for medical indicators of sexual violence in correctional facilities. This study will be conducted under the legal authority of the Public Law 108-79 (Attachment 1 - *Public Law 108-79.pdf*) and Title III – General Powers and Duties of Public Health Service, Section 301 (241.a) (Attachment 2 - *CDC Authority.pdf*).

As a first step in the design of this passive system, BJS is collaborating with CDC to execute a feasibility study to determine the viability of using clinical indicators to measure sexual violence. If the feasibility study yields an acceptable number of reports, a formal pilot study would be mounted to test and formalize recruitment, data collection, and analytic methods.

Privacy Impact Assessment

Overview of data collection system

The CISVC would be conducted in the medical healthcare section of the correctional system and would use information collected as part of routine medical practice in the prison or jail. The provider would complete a one-page surveillance form for male inmates aged 18 years or older who present to medical staff and either make an allegation of sexual violence or are diagnosed with any of the five clinical conditions associated with sexual violence (i.e., rectal bleeding; rectal or anal tears or fissures; bruises, scratches, or abrasions on buttocks; genital bruising; or nipple injuries). These clinical conditions would be identified either through inmate self-report or during the course of the medical examination. Providers would be instructed that they should not complete additional examinations to identify the presence of these conditions in their patients. No inmates will be interviewed or surveyed as part of the study.

Items of information to be collected

Data collected in the CISVC feasibility study will include age, height, weight, race, a general injury assessment, a mental health assessment, and follow-up information (Attachments 3 - *Original Surveillance Form.doc* & Attachment 4 - *Final Data Collection Form.doc*). The study is anonymous, in that name, social security number, and such physical identifiers as hair and eye color are not collected. Collected data will be stored both locally and at CDC. Cases will be identified by a survey identification number consisting of a four-letter facility code and a five-digit case identification.

Identification of Website(s) and Website Content Directed at Children Under 13 Years of Age

The study will not involve a web-based data collection method or refer respondents to websites. This system does not host a website.

2. Needs and Uses of the Information Collection

The purpose of this feasibility study is to develop a passive surveillance system surveillance instrument to strengthen the national capacity to monitor sexual violence in correctional settings. It will be used to determine the feasibility of conducting surveillance for sexual violence through correctional health rather than through inmate allegations to security correctional officers and is a precursor to a full pilot test. Since 2005, BJS has been exploring methods to conduct surveillance for medical indicators of sexual violence. On August 18th 2005, BJS convened a

panel of experts in correctional health to develop a protocol and identify medical ands mental health indicators of sexual violence. In 2006, BJS signed an interagency agreement with the Centers for Disease Control and Prevention to develop the passive surveillance system. Since obtaining funding in 2007, CDC has established a multicenter working group including scientists from the National Center for HIV, Hepatitis, STD, and Tuberculosis Prevention and the National Center for Injury Prevention and Control. CDC has obtained input from prison officials in California, Georgia, Kentucky, Louisiana, Pennsylvania, New Jersey, New York, and Texas, from jail officials in Chicago, Los Angeles, Philadelphia, Houston, and Washington DC, and from practitioners at national correctional conferences including the American Correctional Association (ACA) conference and the National Commission on Correctional Healthcare (NCCHC) conference.

The surveillance system resulting from the CISVC feasibility study and pilot (if feasibility is determined) will provide an important complement to current PREA data collections in that it will be used to describe the prevalence of clinical conditions associated with sexual violence, to validate the list of conditions as sensitive and specific indicators of sexual violence, and to describe basic demographic information of the victims of sexual violence. In contrast to the annual administrative record reviews and the inmate/parolee interviews, trained medical professionals will identify and report clinical conditions that are suggestive of sexual violence, *even in the absence of an inmate allegation*. The BJS administrative records data collection (SSV) may underestimate the burden of sexual violence as not all inmate who are assaulted will make an allegation. BJS inmate surveys showed that there may be up to 10 times as many assaults that occur compared with the number reported to correctional authorities. The inmate surveys interview a small sample of the more than 2 million incarcerated persons and are highly resource intensive, making them an unsustainable source of sexual violence information. The passive surveillance data could be used to triangulate results of the two other PREA data collections as well as place them in context. If the passive surveillance system is shown to be feasible without creating an undue burden on correctional health staff, the surveillance system could be a useful and sustainable source of information to monitor the existence of sexual violence in custody.

Results of the passive surveillance system may be useful to persons responsible for the safety and health of inmates and detainees, including state and local governments. The results may be useful to correctional healthcare clinicians to raise awareness of the signs and symptoms of sexual violence or to develop a rapid physical and mental health exam to identify victims. The results may be useful for researchers and practitioners to estimate the burden of sexual violence in correctional facilities. Finally, the results may inform practice guidelines related to sexual violence surveillance developed by ACA and NCCHC.

As stated above, there are currently no known national data related to sexual violence in the corrections setting as reported by medical providers. Stakeholders have expressed a need for these data as well as the ability to compare results across facilities using standard conditions, definitions, and surveillance procedures. To be sure, each medical provider may have his or her own definition of sexual violence, ranging from unwanted touching to forcible sodomy. Only the CISVC would offer stakeholders the opportunity to analyze national data on this topic, which further emphasizes the need for the CISVC feasibility study.

By law, PREA data are used by the OJP Review Panel on Prison Rape (the Panel) as well as the National Prison Rape Elimination Commission (the Commission). The Panel is responsible for conducting annual hearings to collect evidence to assist the Bureau of Justice Statistics in identifying common characteristics, not only of victims and perpetrators of prison rape, but also of prisons and prison systems with a high incidence of prison rape and those that have been successful in deterring prison rape. The Commission is charged with studying federal, state and local government policies and practices related to the prevention, detection, response and monitoring of sexual abuse in correction and detention facilities in the United States. Consistent with the Act, the Commission's recommendations will be designed to make the prevention of sexual violence a top priority in America's jails, prisons, lockups, juvenile facilities, and other detention facilities. While the CISVC pilot and resulting national collection will not be used to rank facilities, the resulting data will assist both the Panel and Commission in achieving their missions by illuminating the experiences of inmates who seek medical attention in the correctional setting.

Privacy Impact Assessment

A survey identification number will be used for the purpose of medical record review for the inmates identified by the pilot surveillance system. The survey identification number is not the same as the inmate number, the latter of which directly identifies the inmate within the facility. This being said, the survey identification number will be linked to the inmate number at the correctional facility for the purpose of locating inmates' medical records and for determining the prevalence of repeated assaults per inmate. The master crosswalk between survey identification number and inmate identification number will be stored in a secure area of the medical unit of the correctional facility. Survey forms collected through the pilot, both locally and at CDC, will be securely stored and identified only by a facility code and survey identification number.

No identifying information (e.g., name) will be collected by CDC. With the safeguards described above to protect the security and confidentiality of the data, the impact on privacy is expected to be minimal and limited. These safeguards are in place to prevent breaches of confidentiality.

3. Use of Improved Information Technology and Burden Reduction

The information will be collected using one of two methods. For correctional facilities that utilize electronic medical records, the data elements from the surveillance form will be added to the medical record system. Thus, if an inmate reports being sexually assaulted or exhibits one of the five conditions of interest, a supplemental electronic form will be completed by the provider. If the correctional facility does not use electronic medical records, a paper form will be completed by the provider. Restrictions on the use of electronic equipment in correctional facilities and resource constraints limit the ability to use electronic data collection exclusively, particularly in smaller facilities.

CDC will conduct training and site visits to provide technical assistance on how to complete the form, archive the collected data, and transfer the data. CDC will also provide training to participating correctional facilities with detailed written instructions on methods for conducting

the surveillance. CDC will require local correctional staff providing supervision on the project to monitor data collection regularly. At the conclusion of the feasibility study, CDC will convene lessons learned meetings to understand the problems that can occur with the surveillance system with the goal of refining the procedures and instrument for the pilot test.

All electronic data files will be transmitted to CDC using the Secure Data Network (SDN). Paper surveillance forms will be sent to CDC by either secure facsimile or via the U.S. Postal System.

4. Efforts to Identify Duplication and Use of Similar Information

No known department or agency maintains surveillance data for clinical indicators of sexual violence among inmates. There are no known sources for sexual violence data from inmates available within the department or agency. The CISVC is unique and therefore requires a feasibility study (and then formal pilot) to precede a national surveillance system. The CISCV working group includes investigators from the National Center for HIV, Viral Hepatitis, STD, and TB Prevention and the National Center for Injury Prevention and Control who have experience in correctional health and injury surveillance.

Data from the National Electronic Injury Surveillance System-All Injury Program (NEISS-AIP) have previously been reviewed to determine the prevalence of sexual violence in emergency departments (Saltzman 2007). This existing information collection cannot be modified, used partially, nor in aggregate format to satisfy the needs of the proposed project because it does not have a means of determining incarcerated persons.

CDC established relationships with correctional stakeholders and consultants during the conception and development of the CISVC. To promote collection of data that can be used by multiple agencies, ongoing communications with these federal and non-governmental partners will continue for the duration of this project. In addition, a review of the medical and psychological literature databases was conducted to compile a list of persons who have conducted sexual violence research in correctional populations in the United States and the nature of that research. Many of these persons attended an expert panel on clinical indicators of sexual violence in August 2005. Meetings with stakeholders and consultants who are aware of data collections relating to sexual violence ensured that duplicate or similar data collection efforts do not exist.

The August 2005 expert panel attendees included:

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5. Impact on Small Business or Other Small Entities

This research does not involve small businesses or other small entities. The respondents are medical providers in prisons and jails.

6. Consequences of Collecting the Information Less Frequently

Data collection activities are planned to occur one month after OMB approval and for the next twelve months, tentatively June 2009 through May 2010. The feasibility study will only be conducted once and will be followed by a full pilot if the study is determined to be feasible.[2]

There are no legal obstacles to reduce the burden.

7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5

This request fully complies with the guidelines of 5 CFR 1320.5.

8. Comments in Response to the Federal Register Notice and Efforts to Consult Outside the Agency

The research under this clearance is consistent with the guidelines in 5 CFR 1320.6. The 60-day notice for public commentary was published in the Federal Register Volume 73, Number 186, pages 55133 on September 24, 2008. The 30-day notice for public commentary was published in the Federal Register Volume 73, Number 231, pages 72838-72839 on December 1, 2008. No public comments were received directly in response to the 60-day notice or 30-day notices.

CDC, BJS, and NIJ met with representatives from a nonrepresentative sample of medical providers in prisons and jails on November 16, 2009. After meeting, it became evident that there were technicalities in the field that we did not fully comprehend. This led to a nonsubstantive modification of the proposed surveillance form (see Attachment 4 - *Final Data Collection Form.doc*).

The November 2009 meeting attendees included:

The proposed modifications include:

1. We received feedback that the original form was cluttered and excluded some important instructions. As a result, we decided to allow the form to be longer than one page and applied standard questionnaire design principles (e.g., the addition of white space, question numbering, question guidance, etc.)

2. Originally, the form was not meant to be stand-alone but rather was meant to be paired with a more detailed instruction manual. We learned from medical providers that the form might pass through many hands, so made the decision to add instructions at the start of the form (including when the form should be completed, who should fill it out, etc.) as

[2] A full OMB package will be submitted for a full pilot study if the CISVC is determined to be feasible.

well as brief item-level instructions (e.g., reinforcing that the form should be filled out based on observations and as part of a routine medical examination).

3. The case definition in the original protocol consisted of two components: (1) an inmate who makes an allegation of sexual violence, or (2) an inmate who presents with either rectal bleeding; rectal or anal tears or fissures; bruises, scratches, or abrasions on the buttocks; genital bruising; or nipple injuries. The case definition has been modified to include a third component. If an inmate does not make an allegation of sexual violence or present with one of the five conditions indicative of sexual violence, the form should still be completed if the clinician has a suspicion of sexual violence based on their professional expertise. This change is reflected in Item A.3 and was the result of concern raised by medical providers in recruited facilities that the former protocol did not allow their use of professional judgment.

4. A single “check if yes” box was changed to multiple “Yes/No/DK” boxes in Part A (Indicators of Sexual Violence), Part D (Behavioral Observations), and Part E (Referral). In the original form, an unchecked box could have meant “no” or that an item was skipped unintentionally. This modification was made to improve the quality of the data and reduce follow-up calls.

5. "Rectal bleeding" was changed to "unexplained rectal bleeding" at the suggestion of medical providers to rule out bleeding due to known medical causes.

6. We added “Hispanic Origin” to the title of Item B.4.

7. In Part C (General Injury Assessment), we broke the original list of injuries into two questions, one about bruises or scratches (Item C.1) and one about other injuries (Item C.2). In addition, slight modifications were made to the response options of Item C.2 for consistency and clarity.

8. In Part C (General Injury Assessment) and Part D (Behavioral Observations), questions were added to clarify the meaning of each condition. These questions were based on guidance in the original instruction manual but were included because it was felt the form would pass through many hands.

9. In Part D (Behavioral Observations), "Post traumatic stress disorder" (PTSD) was changed to "Emotionally withdrawn.” This was changed due to a concern by medical providers that PTSD can only be diagnosed by a mental health provider, while the state of being emotionally withdrawn could be observed during the course of the medical examination.

10. "Referral to another clinician" was added to Part E (Referral) at the suggestion of medical providers, since this type of referral occurs frequently.

11. A comments section was added to the end of the form in the event that a clinician could provide a more detailed portrayal of the circumstances surrounding the

injuries/allegations. This is especially important in cases in which the clinician suspects a sexual victimization but the patient did not present with the five medical indicators because the information could be used to improve the form for a larger pilot study.

12. Part F (Visit Information) was added because we learned from the medical providers that inmates present to a hierarchy of medical staff within facilities. We also felt that this information would assist in clarifying data collection procedures for the larger pilot study.

9. Explanation of Any Payment or Gift to Respondents

No gifts or incentives will be given.

10. Assurance of Confidentiality Provided to Respondents

BJS and CDC hold in confidence any information that could identify an individual according to Title 42, United States Code, Sections 3735 and 3789g. All medical providers who participate will be given written assurance that the identity of all participants,[3] victims, and perpetrators will be protected as required under Title 42 (Attachment 5 - *Title 42.doc*).

In addition to limiting the amount of personally identifying information collected, the CISVC pilot is covered by an Assurance of Confidentiality under Section 308(d) of the Public Health Act granted for HIV/AIDS surveillance data (Attachment 6 - *Assurance of Confidentiality.doc*). The Assurance provides the highest level of legal confidentiality protections to the individual persons who are the subject of this data collection, and to the individuals and organizations responsible for data collection. The terms of the Assurance of Confidentiality reflect the collective experience of CDC, health departments, and the Council of State and Territorial Epidemiologists with respect to the collection, electronic transmission, and dissemination of HIV/AIDS surveillance data. The Assurance includes established policies and procedures governing all aspects of data collection and de-identification, physical security for paper forms and records, electronic data storage and transmission, and the release of aggregate data in forms that cannot be linked back to individual respondents. The protections afforded by the Assurance of Confidentiality last forever and endure even after the respondent's death.

BJS and CDC hold in confidence any information that could identify an individual according to Title 42, United States Code, Sections 3735 and 3789g. All medical providers who participate will be given written assurance that the identity of all participants, victims, and perpetrators will be protected as required under Title 42 (Attachment 5 - *Title 42.doc*). Medical providers will be given written assurance that the conditions described on the surveillance form are not nationally notifiable and therefore medical providers are not legally compelled to report these conditions to CDC. Participation in the passive surveillance system is voluntary for each facility.

The CISVC pilot is anonymous in that name and social security number are not collected. Because inmates who are the victims of sexual assault are at risk for repeated sexual assault, a survey identification number will be used on the surveillance form that is separate from the

[3] For the purpose of the feasibility study, participants include facilities, medical staff, and inmates.

inmate identification number by the facility to identify inmates. This number will be maintained only at the correctional facility level for the purpose of identifying potential duplicate records, and a crosswalk between survey identification number and inmate identification number will be securely stored at the facility level.

Pilot data will be transmitted to CDC using either a secure facsimile system or by sending paper surveillance forms through the U.S. Postal System. Correctional facilities have limited electronic communication. Data will be entered and stored on a secured, password-protected computer drive.

While CDC will request that medical providers limit disclosure of this passive surveillance system on a need-to-know basis to their medical staff, there is a slight chance that inmates will become aware of the study. BJS/CDC does not believe that such knowledge will affect inmate behavior.

The original protocol for the collection has been reviewed and approved by CDC's Institutional Review Board (Attachment 7 - CDC IRB.pdf), and the revised protocol is under consideration. It should be noted that this collection does not require any extra examination of the inmate and no name or other identifying information will be delivered to CDC.

BJS studies of PREA to date, including post-survey debriefing sessions with administrators of participating prisons, jails, and juvenile facilities, have detected little impact on inmate behavior. A few inmates (handful) have required counseling following the survey, but this has been largely for reasons other than sexual victimization. Similarly, among juvenile facilities, debriefings in the first 56 facilities have revealed no negative impacts on youth. Approximately 1.7% of youth have requested counseling following the survey, but these requests have been wholly unrelated to sexual victimization. Based on this experience, BJS believes that the passive surveillance will not impact inmate reporting to medical staff.

Finally, the proposed collection will not lead to additional data collection on the part of the medical provider. The requested information will necessarily be recorded by medical providers in their own records given the severe nature of the injuries captured by the medical surveillance system (e.g., genital bruising, rectal tearing, etc.) Given current procedures related to PREA compliance, an allegation of sexual violence during the course of a medical examination/visit would likely be recorded in the inmate's medical record and trigger a facility-level response. Given the larger response from medical providers, BJS does not believe that the existence of a passive surveillance system will have any impact on inmate behavior.

11. Justification for Sensitive Questions

Because of the nature of the topic and the conditions of interest in the surveillance system, sensitive questions regarding the circumstances of the injuries will be discussed between the inmate and the healthcare provider. Healthcare providers are trained to ask sensitive questions during a physical examination. However, no questions will be posed systematically to inmates (e.g., as in a survey) as part of the feasibility study. Rather, providers will complete the

surveillance form after the inmate visit and only when the inmate exhibits physical signs of sexual violence (e.g., rectal bleeding) or when the inmate makes an allegation of sexual violence.

12. Estimates of Annualized Burden Hours and Costs

The goal of the feasibility study (and CISVC overall) is to capture all inmates who present any of the five conditions likely associated with sexual violence to health staff or who make an allegation of sexual violence to the health staff at the 35 participating correctional facilities. The 35 facilities have not yet been identified.

Prison inmate populations range from several hundred to more than five thousand, and jails in large cities may have an average daily inmate population of more than 10,000 inmates. We estimate that the inmate population in 10 jails with 10,000 inmates and 25 prisons with 4,000 inmates to be 200,000 inmates. Of the 100,000 jail inmates, we estimate that up to 3,200 (3.2%) may be the victim of sexual violence and about 624 (19.5%) of these victims may have been injured as a result of the assault based on published inmate self-reports (see Beck 2008). Of the 100,000 prison inmates, we estimate that up to 4,500 (4.5%) may be the victim of sexual violence and about 810 (18%) of these victims may have been injured as a result of the assault (see Beck and Harrison 2007).

The estimated average duration to complete the surveillance form is 10 minutes per inmate, and there is no cost to the participating correctional facilities other than the time of the healthcare providers. Healthcare provider wages are estimated to be $73.86 per hour according to the U.S. Department of Labor May 2007 National Occupational Employment and Wage Estimates.

Based on the aforementioned assumptions, we expect the total annualized burden to be 383 hours (see table 12.A), with a burden cost of $28,290 (see table 12.B) Note that if the form is completed by a registered nurse ($30.04 hourly wage), the total annual respondent cost is reduced to $11,505.

Table 12.A: Estimated Annualized Burden Hours

Type of Respondent	No. of Respondents	No. of Responses per Respondent	Average burden per Response (in hours)	Total Burden hours
Training				
All Providers	35	--	4	140
Surveillance Form				
Jail provider	10	63	10/60 (10 minutes)	105
Prison provider	25	33	10/60 (10 minutes)	138
TOTAL				383

Table 12.B: Estimated Annualized Burden Costs

Type of Respondent	No. of Respondents	No. of Responses per Respondent	Average burden per Response (in hours)	Total burden (in hours)	Average Hourly Wage Rate	Total Annual Respondent Cost
Training						
All Providers	35	--	4	140	$73.86	$10,341
Surveillance Form						
Jail provider	10	63	10/60	105	$73.86	$7,756
Prison provider	25	33	10/60	138	$73.86	$10,193
TOTAL				383		$28,290

In order to estimate the cost to the respondents, we used the U.S. Department of Labor May 2007 National Occupational Employment and Wage Estimates for the average hourly wage earnings of Family and General Practitioner Physicians. The proposed data collection is estimated to cost $28,290 for all respondents listed in Table 12.B. If the form is completed by a registered nurse (average annual wage=$30.04), the total annual respondent cost is reduced to $11,505.

13. Estimates of Other Total Annual Cost Burden to Respondents and Record Keepers

There are no other costs to respondents associated with this proposed collection of information.

14. Annualized Cost to the Government

The total estimated cost to the government for pretest development and implementation is $126,133 (see table 14.A).

Table 14.A. Estimated Annualized Costs to the Government

Expense Type	**Government Related Expenses**	**Annual Costs**
Direct cost to the Bureau of Justice Statistics		
	BJS Statistician (GS-13, Step 1, .25 FTE)	$20,740
	BJS Statistician (GS-13, Step 5, .10 FTE)	9,403
	BJS Supervisory Statistician (GS-15, Step 5, .10 FTE)	13,069
	Fringe (28%)	12,099
	Overhead (30%)	16,593
Direct cost to the Centers for Disease Control		
	CDC Project Officer (GS-13, .25 FTE)	$20,124
	CDC Epidemiologist (GS-13, .25 FTE)	20,124
	CDC Public Health Analyst (GS-12, .05 FTE)	3,385
	Travel	55,000
Subtotal, direct costs to the government		98,633
Contractor and other expenses		
	Data manager/analyst on-site at CDC (.25 FTE)	27,500
TOTAL COST TO THE GOVERNMENT		$296,670

Travel is related to providing training and site visits. The CISVC feasibility study is funded through a 2-year interagency agreement between the U.S. Department of Justice and the Centers for Disease Control and Prevention in the amount of $515,025. This interagency agreement includes contractor salaries, travel, equipment, and supplies.

15. Explanation for Program Changes or Adjustments

This is a new data collection.

16. Plans for Tabulation and Publication and Project Time Schedule

No identifiable data from the feasibility study will be released to the public. All such tabulations will be internal to CDC and BJS and will be used to inform the feasibility of a national surveillance program. Exploratory results may be released to inform the public on whether such a data collection effort is feasible. Any public release will be examined to prevent the identification of victims of sexual violence.

We will examine descriptive statistics for each of the following:

- Clinical indicators of sexual violence (e.g., rectal bleeding)
- Allegations of sexual violence
- Demographics (i.e., age, height, weight, race/ethnicity)
- General injuries
- Metal health assessment items
- Recommended follow-up.

In addition, the sexual violence items (i.e., clinical indicators of sexual violence and allegations of sexual violence) will be crossed with the other items to determine whether certain subgroups of inmates are more likely to report sexual violence or exhibit signs of sexual violence. These results will be compared to findings from the National Inmate Survey for external validity.

Table 16.A: Project Time Schedule

Activities	**Time Schedule**
Begin field work	1 month post OMB approval
Complete field work	12 months post OMB approval
Data management and validation	9–16 months post OMB approval
Dissemination of results	18–24 months post OMB approval

17. Reason(s) Display of OMB Expiration Date is Inappropriate

The OMB Control number and expiration date will be displayed on all forms given to respondents.

18. Exceptions to Certification for Paperwork Reduction Act (PRA) Submissions

There are no exceptions to the certification statement identified in Item 13, Paperwork Reduction Act Submission Worksheet, Part I: Information Collection Request.