

Reproductive Injustice:

The State of Reproductive Health Care for Women in New York State Prisons



A report of the Women in Prison Project
of the Correctional Association of New York

Reproductive Injustice:

The State of Reproductive Health Care for Women in New York State Prisons

**A report of the Women in Prison Project of the
Correctional Association of New York**

Written by Tamar Kraft-Stolar

© 2015 Correctional Association of New York

ABOUT THE CORRECTIONAL ASSOCIATION OF NEW YORK

The Correctional Association of New York (CA) is an independent, non-profit criminal justice advocacy organization founded by concerned citizens in 1844. In 1846, the CA was granted unique authority by the New York State Legislature to inspect prisons and to report its findings and recommendations to the legislature and public. This monitoring authority has been granted to only one other organization in the country. For 170 years, the CA has worked to create a more fair and humane criminal justice system in New York and a more safe and just society for all.

Created in 1991, the CA's Women in Prison Project (WIPP) works to reduce the overuse of incarceration for women, ensure that prison conditions for women are as humane and just as possible, and create a criminal justice system that treats all people and their families with fairness, dignity and justice. The Project's work is guided by the principle that women most impacted by incarceration should be leaders in the effort to change the harmful criminal justice policies that directly affect their lives. The Project carries out an integrated and strategic program to achieve its mission, including monitoring prison conditions for women, leading policy advocacy campaigns and coordinating the Coalition for Women Prisoners, a statewide advocacy alliance. In 2003, WIPP launched ReConnect, a leadership and advocacy training program for women recently home from incarceration. WIPP also performs research, publishes reports, and conducts community organizing, coalition building, media work and public education.

For more information, please visit

www.correctionalassociation.org

www.facebook.com/correctionalassociation

www.twitter.com/CANY_1844

or contact us directly

Correctional Association of New York

2090 Adam Clayton Powell, Jr. Blvd., Suite 200

New York, NY 10027

Tel (212) 254-5700

Fax (212) 473-2807

A NOTE ON REPRODUCTIVE JUSTICE

Reproductive justice is a concept that was first developed in the mid-1990s by a group of African American women leaders who understood that the reproductive rights movement's narrow focus on "choice" did not adequately speak to the lived realities and experiences of women of color and women from low-income communities. As SisterSong Women of Color Reproductive Justice Collective explains: "Reproductive Justice analyzes how the ability of any woman to determine her own reproductive destiny is linked directly to the conditions in her community – and these conditions are not just a matter of individual choice and access."¹

Over the years, many women of color groups have worked to articulate and advance the framework of reproductive justice. One of those groups, Forward Together, developed a powerful definition of reproductive justice: "Reproductive Justice exists when all people have the social, political and economic power and resources to make healthy decisions about our gender, bodies, sexuality and families for ourselves and our communities."²

We hope that this report helps to illuminate the fundamental conflict between reproductive justice and mass incarceration. We hope it contributes to the fight for a world where women are valued, healthy, safe and able to control their own bodies, where families and communities are afforded the resources and opportunities they need to thrive, and where the basic human dignity and rights of all people are respected and upheld.

Table of Contents

FOREWORD	1
EXECUTIVE SUMMARY	3
METHODOLOGY	12
OVERVIEW OF NEW YORK STATE PRISONS HOUSING WOMEN	19
INTRODUCTION	31

SECTION 1

OVERSIGHT OF REPRODUCTIVE HEALTH CARE, DATA COLLECTION AND WRITTEN POLICIES	35
Internal oversight	35
External oversight	35
Data collection	36
Policies	37
<i>Recommendations</i>	38

SECTION 2

GENERAL REPRODUCTIVE HEALTH CARE	40
Overall assessment of GYN care	40
Accessing GYN care	41
Accessing GYN care: the official process	41
Accessing GYN care: women’s experiences	43
Reasons for delays in women’s access to GYN care	46
<i>Recommendations</i>	47

Trauma-informed health care	49
<i>Recommendations</i>	51
Quality of GYN clinical interactions	52
Common problems with sick call interactions	52
Common problems with interactions with certain GYN care providers	53
Problems with a former reception doctor at Bedford Hills	55
Physical space for GYN care	56
Thoroughness of GYN exams	56
<i>Recommendations</i>	57
Quality of medical charts	58
<i>Recommendations</i>	59
Annual GYN exams, Pap tests, breast exams and mammograms	60
Annual exams	60
Pap tests	60
Clinical and self-breast exams	61
Mammograms	61
<i>Recommendations</i>	62
GYN test results	63
<i>Recommendations</i>	63
Hysterectomies	64
<i>Recommendations</i>	65
Access to sanitary supplies	66
Sanitary napkins	66
Toilet paper supplies	68
Menstruation-related self-care items	68
<i>Recommendations</i>	68
Weight, nutrition and vitamin supplements	70
Weight	70

Nutrition and vitamin supplements	71
<i>Recommendations</i>	73
Contraception	74
Former Planned Parenthood initiative	74
Contraception for women in work release	75
Contraception for women in the Family Reunion Program	76
Contraception for health reasons unrelated to pregnancy prevention	76
Contraception for women taking medications contraindicated during pregnancy ...	77
Emergency contraception and post-exposure prophylaxis	78
<i>Recommendations</i>	78
Health education	80
Family planning and general sexual health	81
General women’s health	81
Health information priorities	82
<i>Recommendations</i>	82

SECTION 3

CARE FOR PREGNANT WOMEN	84
Overview, incidence of pregnancy and pregnancy-related policies	84
<i>Recommendations</i>	86
Pregnant women and work release	87
<i>Recommendations</i>	87
Pregnancy testing	88
<i>Recommendations</i>	88
Pregnancy options counseling and abortion	89
Pregnancy options counseling	89
Abortion	89
<i>Recommendations</i>	92

Sterilization	94
Ectopic pregnancy, miscarriage and stillbirth	95
<i>Recommendations</i>	96
Prenatal care and education	97
Access to prenatal care	97
Quality of prenatal care for women at Bedford Hills and Taconic	98
Ultrasounds	99
Prenatal supplements	100
Dental care	100
Prenatal education	101
<i>Recommendations</i>	101
Daily life in prison for pregnant women	103
Emotional support	103
Housing	103
Interactions with correction staff	105
Pat frisks and strip frisks	105
Clothing	106
Food	107
<i>Recommendations</i>	108
Having a baby: labor and delivery	110
Going into labor	110
Giving birth in the hospital	111
Cesarean births	114
<i>Recommendations</i>	115
Being in the hospital after having a baby	117
<i>Recommendations</i>	120
Postpartum care	121
<i>Recommendations</i>	122

Nursery at Bedford Hills	123
Overview.....	123
Admissions and denials.....	124
Application process and moving onto the nursery.....	126
Staffing and children’s center.....	127
Daily life on the nursery for the first six weeks.....	128
Daily life on the nursery after six weeks.....	128
Recent changes that negatively impact the nursery.....	129
Breastfeeding.....	130
Interactions with correction officers.....	131
Removals from the nursery.....	131
Pediatric care.....	131
<i>Recommendations</i>	132

SECTION 4

SHACKLING OF PREGNANT WOMEN IN DOCCS	135
Implementation of New York’s Anti-Shackling Law	136
Shackling on the way to the hospital to give birth.....	137
Shackling during recovery after giving birth.....	138
Shackling on the way back from the hospital after giving birth.....	139
Situations not covered under New York’s Anti-Shackling Law	140
Shackling during pregnancy.....	140
Shackling during trips to the pediatrician.....	142
<i>Recommendations</i>	143

SECTION 5

SPECIAL ISSUES: WOMEN IN SOLITARY CONFINEMENT, WOMEN LIVING WITH HIV AND WOMEN GROWING OLDER	145
Reproductive health care and women in solitary confinement	145
Overview.....	145

Alternative to SHU for women with mental illness	147
Women and solitary confinement	148
Accessing GYN care	150
Violations of privacy.	150
Restraints during medical interactions.	152
Sanitary supplies	153
Pregnant women in solitary	153
<i>Recommendations.</i>	158
Reproductive health care and women living with HIV.	159
Overview.	159
HIV and STD education	160
HIV and STD testing	161
Identifying women with HIV	162
Myths, stigma, discrimination and confidentiality	163
GYN care for women with HIV.	165
HIV testing for pregnant women.	166
Care for pregnant women with HIV	166
<i>Recommendations.</i>	168
Reproductive health care and women growing older	170
Overview.	170
Menopause	171
Osteoporosis.	173
Colonoscopies.	174
<i>Recommendations.</i>	174
APPENDIX: BIOGRAPHIES OF EXPERT READERS.	176
ENDNOTES	177

ACKNOWLEDGEMENTS

This report is dedicated to the incarcerated women who bravely shared, and continue to share, their lived experiences and ideas for change with us. We hope that this report accurately represents their concerns and recommendations.

This report is also dedicated to Donald Farole, who served as our expert data consultant for this project until he passed away in 2011. Don will be remembered and missed by all.

This report is part of an ongoing initiative by the Correctional Association of New York's Women in Prison Project to monitor and report on conditions for women in New York State prisons. This initiative is run by Tamar Kraft-Stolar, Director of the CA's Women in Prison Project and Jaya Vasandani, Women in Prison Project Associate Director.

Tamar Kraft-Stolar is the author of this report. Jaya Vasandani served as the primary reviewer of the report.

We are deeply indebted to Rachel Roth for serving as our expert advisor and consultant on this project, and for her editorial commentary on the report. We are enormously grateful to our expert readers whose input helped inform the report's analyses and recommendations: Jack Beck, Dr. Barbara J. Berg, Barbara Blanchard, Kathy Boudin, Judith Clark, Dr. Nereida Ferran-Hansard, Philip Genty, Donna Hylton, Sharon Katz, Rachel Roth and Maria Teresa Timoney. Bios for this distinguished group are listed in alphabetical order in the Appendix.

We thank Correctional Association Board Chair Peter v.Z. Cobb, former Board Chair William J. Dean, Executive Director Soffiyah Elijah, and former Executive Director Robert Gangi for their support of and assistance with this project.

Our gratitude goes to Amber Norris and Christina Holdredge, who assisted with research and data analysis, to Didi Charney, who proofread the report, and to Danya Henninger of Imagic Digital, who designed the report. Our gratitude also goes to Paul, Weiss, Rifkind, Wharton & Garrison LLP for their helpful research on state anti-shackling laws.

A special thank you to CA Communications Director Annette Warren-Dickerson for her feedback, and to RAPP Campaign Lead Organizer Mujahid Farid, CA Prison Visiting Project Associate Director Scott Paltrowitz, CA Associate Director of Development Sam Streed, and CA Women in Prison Project ReConnect Director Andrea B. Williams for their input on the aging, solitary, methodology and HIV sections, respectively.

We are grateful to Dr. Paula Castano, Dr. Katharine O’Connell White, Rachel Roth, Anisah Sabur, Dr. Carolyn Sufrin and Christina Voight for their input and guidance on our reproductive health survey and questionnaires.

We are also grateful to Rachael Feeney, Elisabeth Martin and Ashley Kaper for inputting survey data and to former Women in Prison Project Fellow Allison Schwartz and our many interns whose work went into various aspects of this report, including: Vanessa Bell, Isabel Brewster, Nicola Cohen, Lillian Chargin, Melissa Eells, Brooke Eliazar-Macke, Alexander Genty-Waksberg, Margaret Hurley, Rachel Isreeli, Maya Levinson, Naomi Oberman-Briendel, Rachel Silverman, Rachel Steimnitz, Grace Tan and Mariel Ramirez.

We offer heartfelt thanks to the CA prison visiting team members who joined us on visits that contributed to this report, including: Dr. Gail Allen, Jack Beck, Gina Cascino, Dr. Paula Castano, Lillian Chargin, Dr. Nancy Duggan, Caitlin Dunklee, Sarah Egan, Cindy Eigler, Dr. Lourdes Falco, Rachael Feeney, Dr. Jose Fefer, Jessica Felipe, Dr. Neredia Ferran, Robert Gangi, Dr. Jessica Ghiglione, Dr. James Gilligan, Caroline Hewitt, Avery Irons, Alicia Johnson, Shayna Kessler, Rita Khweye, Caitlin Kundrat, Dr. Bandy Lee, Serena Liguori, Marayka Lopez, Roberta Meyers-Peebles, Dr. Wendy McGahee, Teri Miller, Dr. Katharine Morrison, Jennifer Onofrio, Dr. Josephine Paredes, Edward Rosario, Jesenia Santana, Allison Schwartz, Rachel Silverman, Aileen Steiner, Dr. Carolyn Sufrin, Denise Thomas, Stacey Thompson, Maria Teresa Timoney, Jacqueline Velez, Dr. Emily Wang, Dr. Karen Wang and Lisa White.

We extend our sincere appreciation to New York State Department of Corrections and Community Supervision (DOCCS) Acting Commissioner Anthony J. Annucci and DOCCS officials for their helpful comments on a draft version of this report and for their willingness to engage in constructive dialogue about our findings and recommendations.

Finally, we express our deepest gratitude to the foundations and funders whose encouragement and generous support made this report possible (in alphabetical order): Jennifer and Jonathan Allan Soros Foundation, an anonymous donor to the Women in Prison Project, Daphne Foundation, Anne Delaney, William H. Donner Foundation, Elton John AIDS Foundation, MAC AIDS Fund, New York Women’s Foundation, NoVo Foundation, NYC AIDS Fund, Shelley and Donald Rubin Foundation, and Katrina vanden Heuvel.

Foreword

This report is an invaluable document. It reveals the problems women in New York State prisons face in getting their reproductive health care needs met. It also highlights the challenges for medical personnel, corrections officials and policymakers in meeting those needs. Women like myself, who have been incarcerated for decades, have seen how the quality of medical care available to us is a matter of life and death. Over the years, I have sat by the bedsides of women dying from cancer diagnosed too late for effective treatment and I have seen women brought back to life by new medications and dedicated professional treatment.

When I received and filled out the questionnaire the Correctional Association sent to all of us at Bedford, I was happy that we were being asked for information and opinions. Too often, we are treated as passive – often problematic – objects of expert and institutional treatment. Yet, the most effective prevention and health care work has come through our own active involvement, from the development of AIDS education, counseling and support, to peer facilitated prenatal classes to other critical health-related initiatives.

In order to address our medical needs and involve us in informed decision-making and treatment, providers have to recognize us as whole people and not merely a series of presenting symptoms and complaints. Nor can they write off our complaints as attention-seeking incarcerated women whose problems are our own fault. Our experiences of trauma are embedded in our bodies and minds. The trauma-informed care suggested in this report begins with respectful interactions and holistic understanding and care.

Health care is a human right that should not be diminished by incarceration. It is also expensive and difficult to deliver. Thus, our pursuit of adequate care can, at times, come into conflict with those in charge, be it through grievances, class-action lawsuits or critical reports such as this one. But, the truth is that providing effective, humane medical care in prisons is smart public health policy, because the problems and the people inside are connected with families, communities and institutions on the outside.

My hope is that everyone reading this report, including prison administrators, medical personnel, legislators and policymakers, recognize that the problems this report illuminates are a matter of life and death, and that the reforms suggested are both the right thing and the smart thing to do.

Judith Clark

Incarcerated at Bedford Hills Correctional Facility since 1983

Executive Summary

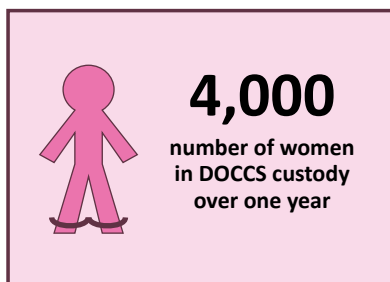
On each and every visit the Correctional Association of New York (CA) conducts to women's prisons in New York, we meet women who tell us about the serious problems they face in accessing appropriate health care and the particular challenges of securing women-specific care during their incarceration.³ The consistency and intensity of these concerns over the years led us to undertake this study, the most extensive study of reproductive health care in a state prison system to date.

Shining a light on this topic is critical because access to quality reproductive health care is a basic human right, as is a woman's ability to control her own reproductive decisions. Prison infringes on those rights, exposing women to substandard reproductive health care and denying women the right to choose when to have children and the right to be full-time parents to the children they already have.⁴ Prisons fuel social and racial injustice, undermining the conditions necessary for women to have reproductive autonomy, and to live safe and fulfilling lives.⁵

Prison infringes on women's human rights to reproductive health care and reproductive decision-making

Reproductive health also serves as an important lens onto the unique experiences of incarcerated women and the dehumanization that defines life in prison. It illuminates the specific degradation that accompanies being a woman in prison, from shackling during pregnancy to the separation of mothers from their newborns to the denial of sufficient sanitary supplies.

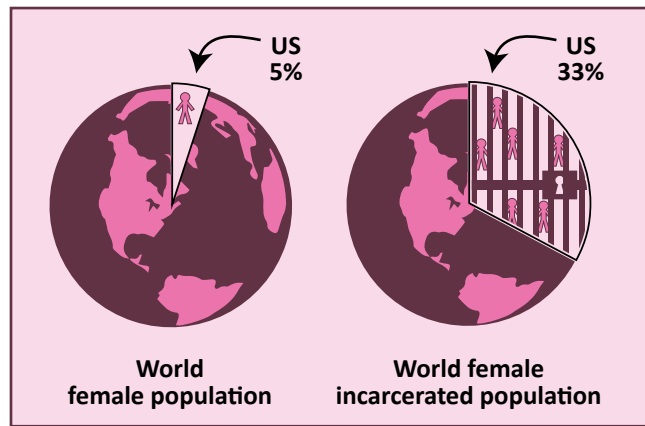
Finally, reproductive health care in prison is fundamental to the well-being of families and communities as almost everyone in prison eventually goes home.⁶ Despite this, state prison officials do not pay adequate attention to reproductive health care and neither do public health authorities when this care happens behind prison walls. The lack of oversight is alarming considering that the New York State Department of Corrections and Community Supervision (DOCCS) is responsible for providing reproductive health care to more than 2,300 women on any given day, and to nearly 4,000 women over the course of one year, about 40 of whom are pregnant.⁷



Women in prisons across the country face similar problems in accessing adequate reproductive health care and humane treatment, and the explosion in the number of incarcerated women over the past few decades has only exacerbated these problems. The U.S. women's prison population rose from about 11,200 in 1977 to about 111,300 in 2013, an increase of nearly 900% over a 36-year time span.⁸

As a result, the U.S. currently incarcerates more women per capita than any other country in the world: we have less than 5% of the world's women yet nearly 33% of the world's incarcerated women.⁹

This massive overuse of incarceration does not affect all women equally. Women in prison are overwhelmingly from low-income communities, and a vastly disproportionate number are women of color. Many have had little formal education, and many struggle with serious health conditions, including substance abuse and mental illness. Almost all have brutal histories of abuse. A majority are mothers, often of small children, and many were caring for their children on their own before prison. Most women are in prison for crimes related to addiction, poverty, mental illness, domestic violence and trauma.¹⁰



These realities reflect the criminal justice system's racism and targeting of marginalized communities, and our society's destructive overreliance on incarceration as a response to problems that are, at their root, social and economic.

Below, we list our top findings on reproductive health care in DOCCS. Some findings are positive, as DOCCS is performing well in certain areas related to women's health. Overall, however, we found that reproductive health care for women in New York State prisons is woefully substandard, with women routinely facing poor-quality care and assaults on their basic human dignity and reproductive rights.

Reproductive health care for women in New York's prisons is woefully substandard

Our findings can only be fully understood in the broader context of the prison setting. By design, prisons are isolating and oppressive environments. While incarcerated women work against this environment in a variety of ways – advocating for themselves and others, fighting to maintain relationships with children, and creating their own communities on the inside – incarceration remains a traumatizing experience.¹¹ This trauma is compounded by the lack of supportive services to help women grapple with the issues that led them to prison and the challenges they face once inside, including being separated from their families.¹² The damage the prison setting does to women's emotional well-being is profound, and women's emotional well-being is deeply connected to their physical health. Many women we spoke with talked about this connection.

Women in prison also have limited access to information and virtually no say over decisions, even basic ones like which doctor they see or whether they will see a doctor at all. Women

who stand up for themselves can be deemed troublemakers, and asking to see the doctor “too many times” or not keeping scheduled medical appointments can even result in getting a disciplinary ticket.¹³ Prison medical providers operate in an environment that promotes skepticism and mistrust of patients, and that expects loyalty to prison authorities.¹⁴ In one glaring example of this conflict, a DOCCS nurse caring for a pregnant woman the CA interviewed also served as the woman’s disciplinary hearing officer, and sentenced her to three months in solitary confinement.¹⁵

The best solution to the problems identified in this report is to stop incarcerating women

Stereotypes of women as complaining and manipulative amplify this dynamic in women’s prisons, as does medical providers’ lack of training in women’s specific experiences and health care needs.

Below, we also list our top recommendations for reform. These reforms would address the problems identified in this study and go a long way toward protecting the health and rights of incarcerated women. Chief among these recommendations is for New York’s policymakers to continue the state’s recent trend away from prison and toward alternatives to incarceration.¹⁶ This recommendation is critical because the best solution to the problems outlined in this report is to keep women, especially pregnant women and women with small children, out of prison in the first place.

KEY FINDINGS

Top 10 problems related to reproductive health care

1) Virtually no oversight of reproductive health care, substandard written policies, and inadequate data collection and analysis.

DOCCS has failed to establish any systematic review of its reproductive health services and the State Department of Health plays no role in evaluating reproductive health care in prison. Many prisons could not supply even basic information about reproductive health care and outcomes. DOCCS' written reproductive health policies are not comprehensive, fail to reference community standards and deviate from those standards in key areas.

2) Violations of New York's 2009 Anti-Shackling Law and routine shackling of women throughout all trimesters of pregnancy.

DOCCS is out of compliance with New York State law that bans the shackling of incarcerated women during childbirth: 23 of 27 women the CA surveyed who gave birth after the law went into effect said they were shackled at least once in violation of the statute. While DOCCS has made progress in curtailing the use of restraints after women arrive at the hospital until they give birth, women continue to be shackled on the way to the hospital (even when they are in labor), during recovery (even within hours after giving birth and for long periods of time), and on the way back to the prison (even with waist chains just days after having a C-section). In addition, every woman the CA heard from was shackled when she went on trips outside the prison during her pregnancy. Women described their experiences with shackling as "painful," "horrible" and "degrading."

"When I came from Albion to Bedford, I was in full restraints during the 11-hour bus ride (shackles, cuffs, waist chain, black box) at 4½ months pregnant. . . . It was an awful experience I will not forget."

3) Poor conditions of confinement for pregnant women, including insufficient food, problematic housing, officer mistreatment and few supportive services.

Women universally reported that DOCCS did not give them enough food during their pregnancies. DOCCS has a special pregnancy diet, but the supplements are minimal, some women never receive them, and they include food that pregnant women are advised to avoid. Like other women in DOCCS, many pregnant women reported inadequate heat and ventilation, too little privacy and infestations of pests in their housing areas. Women also said that correction officers' conduct ranged from fair and professional to deeply disrespectful and abusive. In terms of support, pregnant women who moved onto the

nursery unit said they received valuable assistance while women who remained in general population received virtually none, leaving them feeling depressed and ill-equipped to find stable homes for their babies.

“I remember going to bed hungry many, many nights.”

4) Negative experiences for women during childbirth, including the denial of family support and the routine separation of women from their newborns in the hospital.

Women used words like “scary,” “overwhelming” and “stressful” to describe their childbirth experiences. A main reason is that DOCCS prohibits anyone outside the prison system from providing support to women while they are in labor. Many women also said they had too little time to bond with their newborns because their babies were placed in the hospital nursery and not in their rooms, even if there was no medical reason for the separation. Some women said that officers took so long to take them to the hospital nursery that it effectively prevented them from breastfeeding.

5) Unfair rejections of women from the nursery program at Bedford Hills.

Bedford’s administration seems to be denying more and more women acceptance to the nursery, a highly valuable program that allows women to live with their babies in a separate wing of the prison for one year, or 18 months with a special extension. Many women are rejected because they were convicted of a violent crime or had prior involvement with child welfare, without a nuanced assessment of how these circumstances relate to whether participation in the nursery is in their child’s best interest. This restrictive trend unfairly deprives mothers and babies of the chance to form critical bonds and runs contrary to statutory and case law governing the nursery.

6) Inadequate access to and delays in GYN care.

A majority of women the CA heard from said they could not see a GYN when needed. The most egregious case of delays the CA learned about was a woman who waited nearly seven months for cancer treatment. She died shortly after being released. Delays in follow-up for breast abnormalities also seem to be a problem. In part, delays are the result of insufficient GYN staffing. For example, Albion, which holds about 1,000 women, has only one GYN doctor on-site 16 hours per week.

“I asked [the GYN] why I haven’t had my annual check up. She answered, ‘It’s a thousand of y’all and one of me.’ ”

7) Substandard and traumatizing treatment from certain clinicians, inadequate health education and poor quality medical charts.

Women said that while some nurses and doctors treat them well, others are rude and hurry them through appointments. Experiences ranged from older women being dismissed when

they asked for help with menopause symptoms to pregnant women being brushed off when they told nurses they were in labor. Women also said that providers often communicate poorly and that insufficient opportunities exist for them to learn about health issues outside of medical appointments. GYN care experiences were deeply traumatizing for some women, especially survivors of abuse, which nine of 10 women in prison are. That women have no choice over the gender of their GYN provider only makes the situation worse. The CA also found wide variation in the quality of medical charts, with some charts so inadequate that they likely compromise patient care.

“Your questions and concerns are ignored. . . . You are rushed in and out in minutes and treated as a child.”

8) Insufficient sanitary napkin and toilet paper supplies.

A majority of women the CA heard from said they do not receive enough sanitary napkins each month. In order to get additional supplies, prisons require women to obtain a medical permit, a process that is humiliating and unjustified. At one prison, doctors insisted that women show a bag filled with their used pads as proof they needed more. Two-thirds of women said they do not get enough toilet paper each month. Most women cannot afford to buy the sanitary supplies sold in prison commissaries. A single box of tampons, for example, can cost a woman her entire week’s earnings.

9) Severely limited access to contraception.

With few exceptions, DOCCS prohibits its doctors from prescribing contraceptives. As a result, women participating in work release and overnight trailer visits, and women preparing to return to the community cannot access birth control methods other than condoms. Even women who used hormonal contraception in the community for medical reasons other than pregnancy prevention, such as irregular periods and uterine bleeding, face serious difficulty in getting it once they are in prison.

10) Poor access to GYN care and violations of privacy for women in solitary confinement, and placement of pregnant women in solitary.

There are at least 1,600 admissions to solitary each year in DOCCS’ women’s prisons, with roughly 100 women in solitary at any given time. Women said they often had to wait weeks to see a GYN and that clinicians routinely violated their confidentiality by speaking with them through a closed cell door. Solitary is a dangerous setting for pregnant women yet the CA identified seven women who were held in solitary at some point during their pregnancy between 2009 and 2012.

One woman suffered weeks of neglect in solitary before her pregnancy was diagnosed as ectopic, a life-threatening condition

Top positive findings related to reproductive health care

1) Timely and quality prenatal care for pregnant women.

Women praised the quality of the obstetricians contracted to provide prenatal care in DOCCS. Most also said they had prenatal visits at the frequency recommended in the community and could access prenatal care when needed.

2) Annual GYN exams for most women.

Most women reported having a GYN check-up in the past year, including a pelvic exam and Pap smear.

3) Certain doctors and nurses who provide quality care.

Women described some providers at each prison as being thorough, thoughtful and professional. The Medical Directors at Bedford and Beacon, when that prison was open, stood out as particularly impressive.

4) Valuable programs for survivors of trauma.

Women praised DOCCS' Female Trauma Recovery Program, a six-month residential program at Albion and Taconic which aims to help women address unresolved trauma, particularly childhood sexual abuse. Bedford also offers an important Family Violence Program for domestic violence survivors. Unfortunately, these programs serve only about 3% of women in DOCCS custody, when the vast majority of women would benefit from them.

5) Beneficial HIV education programs.

Most women said that someone in DOCCS had spoken with them about HIV and STDs during their incarceration. This likely reflects the good work of the Criminal Justice Initiative, a joint HIV-education effort between DOCCS and the State Department of Health. Complicating this positive finding, however, were comments from women expressing reluctance to seek information and reveal their HIV status because of pervasive stigma, discrimination and a lack of confidentiality.

6) An impressive nursery program at Bedford Hills that serves as a national model.

While community-based alternative-to-incarceration programs are the ideal setting for mothers serving time and their babies, when sentencing laws do not allow for alternatives, the nursery is the next best option. Mothers who are accepted receive valuable support, and babies are able to form vital secure attachments to their mothers because they live together. Participation in the nursery is also associated with lower recidivism rates, reduced risk of babies entering foster care, and improved odds that mothers and their babies will remain together after prison.

KEY RECOMMENDATIONS

For DOCCS

- 1) Develop comprehensive written reproductive health policies that mirror and reference community standards, collect and analyze reproductive health data, and conduct regular assessments of reproductive health services at each prison.
- 2) Comply immediately with all provisions of the 2009 Anti-Shackling Law and eliminate the use of shackles on women during all trimesters of pregnancy.
- 3) Improve basic conditions for pregnant women, including providing adequate food and supportive services, and creating a separate pregnancy housing unit at Bedford Hills. For all women, maintain clean, weather-appropriate housing conditions, and enhance mechanisms to prevent and respond to abusive treatment by correction staff.
- 4) Allow women to have at least one support person of their choosing during childbirth, and place women and their newborns in the same room in the hospital.
- 5) Accept all pregnant women into Bedford's nursery program unless a determination is made, following a thorough, individualized assessment, that a woman's participation is not in the best interest of her child, as dictated by statute and case law.
- 6) Take affirmative steps to eliminate delays in access to GYN care, including increasing GYN staffing. Allow women to choose female GYN providers.
- 7) Train medical staff on women's specific health needs across the life span and on best practices for compassionate, professional and trauma-informed clinical interactions. Create a women's health education program.
- 8) Increase the monthly allotment of sanitary napkins and toilet paper for women, and give women more sanitary supplies upon request.
- 9) Offer a full range of contraceptives to women preparing for work release and trailer visits, and women returning to the community. Give women prompt access to contraception when they request it.
- 10) Eliminate the use of solitary confinement for pregnant women, women in postpartum recovery, women in the nursery program and other vulnerable groups. Strictly limit the use of solitary for all people.

For New York State Legislature and Governor

- 1) Take actions to further reduce the prison population, including increasing opportunities for early release, establishing fairer parole policies, and enacting laws that shorten sentences and allow more people to participate in alternative-to-incarceration programs.
- 2) Expand funding for gender-specific, community-based alternative-to-incarceration and reentry programs, including programs that allow mothers to live with their children.
- 3) Enact a law requiring the State Department of Health to monitor all health care in prison and allocate funds for the Department of Health to carry out this responsibility.
- 4) Enact a law that guarantees incarcerated women access to timely and quality reproductive health care.
- 5) Amend the 2009 Anti-Shackling Law to include mechanisms to ensure compliance, including requirements to post information about the law, publicly report shackling practices and violations, train staff about the law's provisions and inform pregnant women about their rights under the law.
- 6) Enact a law that bans the shackling of women during all stages of pregnancy and during trips for babies to receive medical care outside of the prison.
- 7) Enact a law that allows women who complete Bedford's nursery program to finish serving their sentences with their children in community-based programs.
- 8) Allocate funds for DOCCS to hire sufficient GYN staff, raise salaries for DOCCS clinical providers and create an electronic medical records system.
- 9) Allocate funds for DOCCS to create a women's health education program and to expand domestic violence and trauma programming, particularly the Female Trauma Recovery Program.
- 10) Enact a law that eliminates the use of solitary confinement for pregnant women, women in postpartum recovery, women in the nursery program and other vulnerable groups, and that strictly limits the use of solitary for all people.

Methodology

This study is part of the Correctional Association of New York's (CA) ongoing efforts to monitor and report on conditions of confinement for women in prisons run by the New York State Department of Corrections and Community Supervision (DOCCS). The CA gathered the bulk of the information for this study over a five-year period, from 2009 to 2013, using a range of qualitative and quantitative research methods, including site visits to women's prisons, in-person interviews and mail-in surveys with incarcerated women, reviews of women's medical charts, interviews with prison staff, data requests to individual prisons and DOCCS Central Office, Freedom of Information Law (FOIL) requests, and reviews of DOCCS' policies and relevant community standards.

While this report presents data collected from specific sources between 2009 and 2013, our analysis of this data is informed by the CA's many years of monitoring. Similarly, our understanding of the issues facing incarcerated women is informed by our ongoing collaboration with women directly affected by prison through our statewide Coalition for Women Prisoners and ReConnect, our leadership training program for women recently home from incarceration.

SITE VISITS, INTERVIEWS AND MEDICAL CHART REVIEWS

In 1846, the New York State legislature passed a law granting the CA authority to monitor conditions in New York's prisons. The CA is the only organization in the state, and one of just two in the country, with this authority.¹⁷

From 2009 to 2013, the CA conducted 19 visits to women's prisons. We conducted three visits to Bedford Hills Correctional Facility; four to Albion Correctional Facility; and four to Taconic Correctional Facility. We also visited two prisons, Bayview Correctional Facility and Beacon Correctional Facility, which were closed in 2013; we conducted four visits to Bayview and four to Beacon. Finally, in early 2014, we visited Edgecombe Correctional Facility, which began housing women on work release (a transitional work program) after Bayview and Beacon closed.

Most of our visits took place over the course of two days. Each visit involved between eight and 12 visitors. A total of 48 individuals participated in the visits, including internal medicine physicians, obstetrician-gynecologists (OB-GYNs), nurse midwives, psychiatrists, psychologists, clinical social workers, attorneys, criminal justice reform advocates, domestic violence and trauma service providers, and formerly incarcerated women. Visiting teams were composed of CA Board of Directors members and staff, and visiting committee members who were trained by CA staff prior to each trip.

During our visits, we spoke with over 950 women in one-on-one and focus group settings. We used gender-specific questionnaires tailored to each prison to guide our discussions. We spoke with women about their experiences with reproductive health care and other medical care; mental health care; academic, vocational, substance abuse and trauma programs; parenting programs and visiting services; transitional services; solitary confinement; and relations with security and civilian staff. We also spoke with over 200 civilian and security staff, including doctors and correction officers. During our tours, we visited housing units; solitary confinement units; medical and mental health units; visiting areas; academic, vocational and rehabilitative program areas; and special program areas including the nursery at Bedford Hills.

To assess the specific experiences of pregnant women, we surveyed and/or spoke with 64 women who were or had been pregnant while in DOCCS custody between 2004 and 2013.

On seven visits, we reviewed medical charts for women who informed us, either by mail or during a visit, that they were experiencing problems securing adequate medical care. We also conducted in-depth interviews with the women whose charts we reviewed. To conduct these interviews and chart reviews, a CA staff member or other experienced visitor paired with a visiting team member with medical expertise. From 2009 to 2013, we reviewed 25 medical charts focused on reproductive health issues.

PRISON DATA REQUESTS AND FOIL REQUESTS

We collected extensive data from each prison prior to our visits. Our requests covered key areas related to the prison, including population demographics; security and civilian staffing; solitary confinement; medical care; mental health care; vocational, academic and rehabilitative programming; special program areas; work release; prison jobs; transitional services; visiting services; recreation; general and law libraries; and the frequency of “unusual incidents,” which include events like deaths, incarcerated people harming themselves, and assaults between incarcerated people and between staff and incarcerated people.¹⁸ We also collected written policies related to reproductive health care from each prison and grievance reports that present an analysis of formal complaints filed by women at a particular prison.¹⁹

In spring 2012, we submitted a FOIL request to DOCCS Central Office regarding the Department’s implementation of the 2009 Anti-Shackling Law. This law prohibits the use of restraints on women during childbirth and during recovery “after giving birth,” and restricts the use of restraints on women going to the hospital for “the purpose of giving birth,” even if they are not in labor (i.e., if they are going to be induced or to have a scheduled C-section), and on women being transferred from the hospital back to the prison.²⁰

Our FOIL request asked for written policies related to the law and records of instances where shackles were used on women during labor, delivery, recovery and/or transport to or from the hospital in the first year and a half following the law’s passage. DOCCS denied the CA’s request

for written policies, citing Public Officers Law § 87(2)(f), which allows agencies to deny access to records if they believe that disclosing them would “endanger the life or safety of any person.”²¹ DOCCS stated, contrary to our findings, that no women had been shackled in instances covered by the law in the first year and a half after the law’s passage (*see Section 4, p. 135*).

SURVEYS

We created four mail-in surveys to assess women’s experiences in DOCCS: 1) general survey, 2) reproductive health survey, 3) pregnancy survey, and 4) HIV survey. We developed each survey with input from a professional statistician, formerly incarcerated women and other individuals with expertise in the various areas the surveys address. Formerly incarcerated women completed a draft copy of each survey, and we incorporated their feedback before finalizing the instruments.

With each survey we mailed, we included an explanation of the CA and the purpose of the survey. We made clear that women would not be penalized if they did or did not return the survey and explained that the CA has privileged mail status, which means that correction officers are not permitted to read mail sent between the CA and incarcerated individuals, the practice for non-privileged correspondence.²² We informed women that we would not use their names in our report and asked them to indicate whether we could use their words in the document. We also included a self-addressed, stamped return envelope with each survey.

We sent approximately 4,660 surveys and received back about 1,550, a combined return rate of 33%.

The following is a summary of each of our four surveys:

- The general survey includes questions about women’s experiences with housing conditions; relations with security staff; academic, vocational and substance abuse treatment programs; visiting services; transitional services programs; prison jobs; libraries; mental health care; and medical care. Between fall 2008 and summer 2009, the CA sent 2,480 general surveys to Bedford, Albion, Taconic, Bayview and Beacon, enough for every woman in custody. DOCCS agreed to distribute the surveys to each woman at those five prisons. We did not individually address each survey. We received back 1,068 surveys, a return rate of 43%.
- The reproductive health survey includes questions about women’s experiences with access to routine and specialty GYN care; quality of routine and specialty GYN care; quality of GYN care providers; experiences with GYN care in solitary confinement; vitamins, nutrition, exercise and weight; and experiences with care for menopause and other aging-related GYN issues. In fall 2009, we sent 1,699 reproductive health surveys to women in DOCCS. We sent the survey to all women who responded to the general survey and to most women we met during visits to Albion, Bedford, Taconic, Bayview and Beacon in 2009. Of the 1,699 surveys we sent, we received back 350, a return rate of 21%.

- The pregnancy survey asks women about their experiences with pregnancy care in DOCCS, including access to and quality of prenatal care; care for women who have abortions; care for women who have miscarriages; care during labor and delivery; postpartum care; experiences with childbirth; experiences with shackling during pregnancy, labor, delivery and postpartum recovery; experiences of pregnant women in solitary confinement; and experiences with prison nurseries. From 2009 to 2011, we sent 99 pregnancy surveys to women who were or had been pregnant in DOCCS. This pool came from women who indicated in the general survey that they were or had been pregnant in DOCCS and wanted to receive a pregnancy survey, and from women we met during prison visits (especially in the nursery units) and corresponded with from 2009 to 2011 who indicated the same. Of the 99 surveys we sent, we received back 33, a return rate of 33%. Of the women who responded, 23 had been pregnant in DOCCS between 2004 and 2011. We analyzed data only from those 23 surveys.

Specific GYN Issues

This section is about specific GYN issues you have had and your experiences trying to get the care you needed.

47) The last time you asked to see the GYN, how long did you have to wait?
_____ days/weeks/months (circle one)

48) In the past 5 years, have you had or thought you had any of these problems in a New York State prison?
(Check all that apply to you)

Lumps in your breast

Problems with your period. For example, if your period:

- comes too often or lasts too long
- doesn't come at all sometimes
- is painful/you have bad cramps
- is very heavy

Fibroids (These are tumors which do not cause cancer that grow in or around your uterus/womb and can cause bleeding, pain or other problems)

Discharge, itching or burning from your vagina, and/or a yeast infection

Bladder infection or Urinary Tract Infection (UTI)

Sexually Transmitted Diseases (STDs, for example, HIV, Hepatitis C, herpes, syphilis, gonorrhea, chlamydia, trich (trichomoniasis), HPV, genital warts)


An infection in your pelvis (called "Pelvic Inflammatory Disease/PID")

Endometriosis (when tissue grows outside of your uterus/womb and causes pain)

Serious pain in your pelvis, vagina or uterus/womb

Cancer in your:

Breasts Ovaries (Ovarian Cancer) Uterus/womb Vagina Cervix (Cervical cancer)



☞ If you did NOT check anything on the list above, please skip to the next section (OVERALL GYN CARE, Question 54)

☞ If you DID check anything on the list above, please think about the most recent time you had one of these GYN problems and answer the following questions based on that experience.

49) Did you go to sick call because of your symptoms? YES NO

☞ If no, please skip to Question 64

☞ If yes:

a) How did the sick call nurses treat you? Good Fair Poor

b) What did they say and do?

CA/Women in Prison Project - Women's Health Survey / Page 10

- The HIV survey includes questions about women's experiences with HIV and hepatitis C testing and counseling; prevention, education and support services; attitudes and stigma; and access to and quality of medical care for women living with these two illnesses. In winter 2010, we sent HIV surveys to the 386 women who indicated in the general survey that they wanted to receive an HIV survey. Living with HIV or hepatitis C was not a requirement to receive the survey. Of the 386 surveys we sent, we received back 112, a response rate of 29%.

We worked with a statistician to analyze the survey data using the statistical analysis software SPSS. We use the term "survey respondents" in this report to refer to the pool of people who responded to a particular survey and answered the specific question being referenced. For example, when we report that one-third (34%, 108 of 319) of reproductive health survey respondents rated the overall quality of GYN care since arriving in DOCCS as "poor," we mean that 319 of all reproductive health survey respondents answered the question asking them to rate the overall quality of GYN care and that 108 of those 319 respondents rated the care as "poor."

Because women self-selected to take the survey, there is a possibility that a disproportionate number of women with negative experiences returned the surveys, which would create bias in the data toward more negative responses. In addition, because the surveys were self-administered, a disproportionate number of women with higher literacy skills may have returned the surveys.

Given these possibilities, we present survey data directly rather than using survey data alone to make statistical inferences about the overall population of women in DOCCS. We also analyzed survey data in the context of our other findings and observations in a given area of investigation, and we drew conclusions based on our analysis of all this information. Where we draw conclusions, we explain the context and various contributing factors.

Below is a summary and chart outlining the demographics of our survey participants in comparison to the demographics of women in DOCCS overall at the time we collected the survey data.

The general, reproductive health and HIV survey demographic data generally mirrors DOCCS data for the women's prison population in terms of parental status (where collected), time served in current prison and whether women are serving time for their first felony conviction. The age of respondents also generally mirrors that of the overall population, although general survey respondents were slightly older (median age: 39) and HIV survey respondents were slightly younger (median age: 35) than the total women's population (median age: 37).

One characteristic where we found a difference in some of the surveys is race. While the general survey data generally mirrors DOCCS data, for the reproductive health and the HIV surveys, there was a difference between the racial profile of women who answered the surveys and the racial profile of women in DOCCS overall at the time: 43% of reproductive health survey and 41% of HIV survey respondents identified as white compared to 35% of the total women's prison population as reported by DOCCS at the time.

Demographic data for pregnancy survey respondents differed from DOCCS demographic data for age and the number reporting being parents. More pregnancy survey respondents were in the 21 to 39 age range than DOCCS general women's population (81% versus 54%). This makes sense given that pregnancy survey respondents were either pregnant or had recently given birth at the time they filled out the survey and pregnancy is less common among women 40 and over. Also, 100% of pregnancy survey respondents reported being mothers compared to 71% of all women in DOCCS at the time, also not surprising given the population being surveyed.

Similar to the reproductive health and HIV surveys, more pregnancy survey respondents identified as white (48% for the pregnancy survey compared to 35% for the total women's population). However, because we do not have data on the racial demographics of pregnant women in DOCCS, we do not know if more white women answered the pregnancy survey or if there were more white women who were pregnant in DOCCS than compared to the total population at the time.

Self-reported characteristics	General Survey	Reproductive Health Survey	HIV Survey	Pregnancy Survey	Women in DOCCS prisons in 2010 ²³
Age					
Median age ²⁴	39	38	35	28	37
16-20	1%	2%	2%	10%	4%
21-39	52%	52%	61%	81%	54%
40-59	44%	41%	35%	10%	39%
60 and over	3%	5%	2%	0%	3%
Race²⁵					
White women	37%	43%	41%	48%	35%
Women of color (total)	63%	57%	59%	52%	65%
African-American/Black	40%	35%	33%	30%	44%
Hispanic/Latina	12%	9%	10%	17%	19%
Black-Hispanic	0.4%	3%	4%	0%	DOCCS does not track
White-Hispanic	0.4%	1%	3%	0%	DOCCS does not track
Black-White	0.3%	2%	1%	0%	DOCCS does not track
Asian	0.2%	0.3%	0%	0%	0.8%
Native American	2%	3%	1%	0%	0.3%
Other	9%	3%	7%	4%	1.3%
Parent	68%	76% (estimated)	Data not collected	100%	71%
Median # of months in current prison²⁶	12	13	76% at prison for at least 12 months	Data not collected	14
Median # of years in DOCCS	2	2	51% in DOCCS for at least 3 years	Data not collected	No data available
In prison for first felony conviction²⁷	70%	69%	73%	Data not collected	66%

A NOTE ABOUT THE RECOMMENDATIONS IN THIS REPORT

Wherever we recommend DOCCS take a particular action, we also mean to imply two complementary recommendations: 1) that DOCCS codify that action into written policy, and 2) that DOCCS educate all relevant parties about the new policy. For example, when the CA writes that DOCCS should “Allow women to choose female GYN providers,” the CA is recommending not only that DOCCS give women this option but also that the Department: 1) codify the option into their written policies, and 2) educate women and train medical staff about the new policy.

Overview of New York State Prisons Housing Women

The New York State Department of Corrections and Community Supervision (DOCCS) runs all state prisons in New York. As of 2013, almost 55,000 people were in DOCCS prisons: about 2,300 women (4% of the total) and about 52,600 men (96% of the total).²⁸

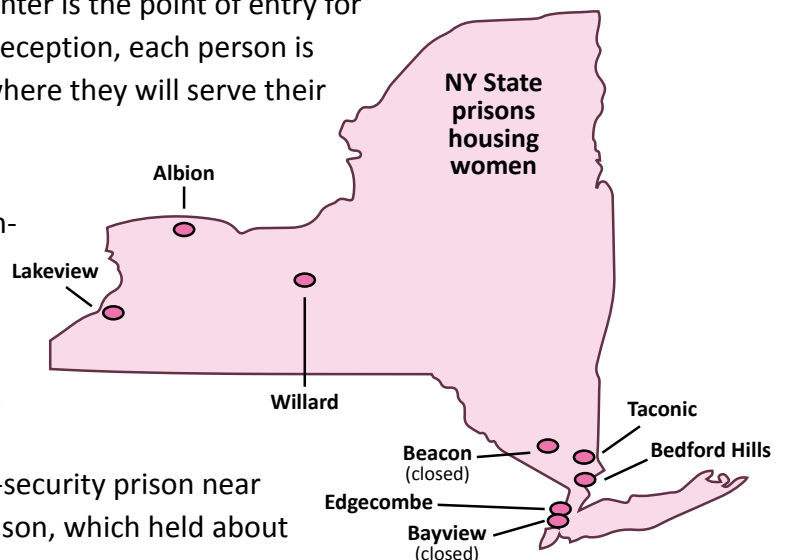
Of DOCCS' 54 prisons, 48 are all men, three are all women, and three house both men and women.²⁹

In 2011, DOCCS, which at the time was called the Department of Correctional Services, merged with the Division of Parole to become the Department of Corrections and Community Supervision.³⁰ This means that DOCCS now oversees about 37,000 people who are on parole across the state, in addition to running the prison system.³¹

DOCCS has an annual budget of nearly \$3 billion and, with a workforce of 30,000, is one of the largest employers in the state.³²

The main findings in this study are based on visits to five women's prisons. New York Governor Andrew Cuomo closed two of these prisons in 2013 to reduce excess capacity in the state prison system.³³ The three prisons we visited that remain in operation are:

- 1) Bedford Hills Correctional Facility in Westchester County, the state's only female maximum-security prison and the only reception center for women, which held about 800 women as of fall 2013. A reception center is the point of entry for people sentenced to state prison. At reception, each person is screened and assigned to the prison where they will serve their sentence.
- 2) Taconic Correctional Facility, a medium-security prison across the street from Bedford Hills Correctional Facility in Westchester County, which held about 370 women as of fall 2013.
- 3) Albion Correctional Facility, a medium-security prison near Rochester and the largest women's prison, which held about 1,000 women as of fall 2013.



The two prisons we visited that Governor Cuomo closed in 2013 are:

- 1) Bayview Correctional Facility, which was a medium-security prison in Manhattan that housed about 170 women.
- 2) Beacon Correctional Facility in Dutchess County, which was the only female general confinement minimum-security prison and housed about 200 women.

DOCCS also operates three prisons that house both men and women. One of the three, Edgecombe Correctional Facility, began housing women on work release in 2013 after Bayview and Beacon closed. We visited Edgecombe once in January 2014, and our findings are included in this report. We did not visit the two other co-ed prisons for this study. The three prisons that house both men and women are:

- 1) Edgecombe Correctional Facility, a minimum-security prison in Upper Manhattan, which housed about 15 women on work release and 100 men convicted of violating parole as of January 2014.
- 2) Willard Drug Treatment Campus, a minimum-security prison focused on substance abuse treatment for people convicted of violating parole, which houses about 60 women and 750 men.
- 3) Lakeview Shock Incarceration Facility, a minimum-security prison with a boot camp model, which houses about 110 women and 530 men.

In terms of medical services, a primary focus of this report, DOCCS prisons provide varying levels of care. DOCCS gives each prison a medical rating of 1, 2 or 3 based on the level of services offered. Medical level 1 prisons are capable of providing the most intensive services in the state prison system; they have infirmaries and medical staff on-site 24/7. Bedford Hills and Albion correctional facilities have a medical level 1 designation, along with 41 other DOCCS prisons. Medical level 2 prisons are not required to have either an infirmary or medical staff on-site 24/7 (and many do not, especially at night). These prisons are required, however, to have a physician on call at all times. Taconic Correctional Facility has a medical level 2 designation, along with eight other DOCCS prisons. Medical level 3 prisons are required to have nurses on-site eight hours per day, five days per week, and a physician either on call or available by appointment. These prisons also do not have infirmaries. Only one DOCCS prison has a medical level 3 designation. When they were open, Bayview and Beacon had medical level 1 and medical level 3 designations, respectively.³⁴

DOCCS runs infirmaries in 34 prisons and Regional Medical Units (RMUs) at five prisons. RMUs are responsible for providing inpatient treatment, skilled nursing care and specialty clinics

both for people in the prison and for people in prisons in the surrounding area. Bedford Hills houses DOCCS' only RMU specifically for women.³⁵ DOCCS also contracts with hospitals in the community to provide additional specialty care services.

In 2012, DOCCS was authorized to employ a total of just under 1,700 medical personnel, including 100 physicians, 39 physician's assistants and nurse practitioners, and almost 675 registered nurses.

DOCCS spends nearly \$339.8 million on health care for incarcerated people each year, a figure that accounts for about 11% of its total budget.³⁶ DOCCS' budget for health services has been reduced by 15% from 2010 to 2014.³⁷ Budget cuts have resulted in higher medical staff vacancy rates and fewer specialty care contract services.³⁸

Of its total health care budget, DOCCS spends about \$28.4 million (8%) on health care for incarcerated women. DOCCS reports that the per capita health care cost for men in custody is just under \$6,000, and the per capita cost for women is just over \$12,000.³⁹

Below are descriptions of the five prisons we visited to gather our main findings for this report, along with charts presenting basic data we gathered from DOCCS about each prison. For statistics on the racial composition of incarcerated women, we were able to gather information only for the entire women's prison population, not each individual facility.⁴⁰

ALBION

Albion Correctional Facility is a medium-security prison located in the town of Albion in Orleans County. The prison is equidistant between Rochester and Buffalo. As of the CA's last visit in May 2013, Albion held about 990 women, 90% of its capacity of about 1,100. Albion is New York's largest correctional facility for women, housing about 44% of the state's female prison population. Thirty-seven percent of Albion's population is from the New York City area, eight hours away from Albion by bus.

In 2009, Albion opened an intake unit where women entering DOCCS custody from upstate county jails stay for a brief time before being transferred to Bedford Hills for reception.⁴¹

Albion's housing is comprised mainly of double-bunked units in large dormitories, although the prison also has some single cells and multiple-occupancy rooms. Albion also has two solitary confinement units: a 48-bed Special Housing Unit (SHU, which DOCCS uses as punishment for more serious rule violations) and a 32-bed keeplock unit (which DOCCS uses as punishment for less serious infractions).⁴² The average SHU census at Albion is five times higher than the average census at Bedford, which is almost the same size as Albion.

Albion is one of two prisons where women can participate in work release, a transitional program where participants find jobs in the community and return to the prison either every night or on the weekend.⁴³

Albion has significantly more male correction officers and white correction officers than either Bedford or Taconic: an estimated 79% of officers at Albion are male, compared to 51% at Bedford and 39% at Taconic. An estimated 82% of Albion's officers are white, compared to 14% at Bedford and 16% at Taconic.

In 2009, Albion opened a Family Reunion Program, which allows women to stay overnight with their spouses, children and other relatives in a private trailer on prison grounds.⁴⁴ Like most medium-security prisons, Albion has visiting hours only on the weekend. Half of the women at the prison are allowed to have visits on Saturday and the other half on Sunday. The prison does not have a children's center like the one at Bedford Hills, where mothers can receive assistance in maintaining contact with their children.

Albion Correctional Facility	
Population	990
Capacity	1,100
Average age	General population: 35 Work release: 49
Race <i>(data reflects total women's population)</i>	African-American: 43% Latina: 16% White: 38% Other: 2%
Median minimum sentence	2.6 years
Median amount of time women have left to serve before their earliest release date	General population: 9.1 months Work release: 2.9 months
Women from NYC and suburbs Women from upstate NY	37% 63%
Admissions	76 per month / 912 per year
Releases	34 per month / 408 per year
Race of correction officers	African-American: 16% Latina/Latino: 1% White: 82% Other: 1%
Gender of correction officers	Male: 79% Female: 21%
Average SHU census per month	42
Average keeplock census per month	26
Average number of women in the Family Reunion Program in 2013	20
Capacity of visiting room	150

BEDFORD HILLS

Bedford Hills Correctional Facility is a maximum-security prison located in the town of Bedford Hills in Westchester County. Bedford is New York's only maximum-security prison for women and also serves as the reception facility for all women entering DOCCS custody. As of the CA's last visit in February 2013, Bedford had a population of about 780 women, 84% of its capacity of almost 930. Bedford houses about 35% of the state's female prison population. Forty-six percent of women at Bedford are from upstate New York.

Bedford's housing is comprised mainly of single cells, although it also has a few large dormitories with double-bunked units. Bedford has three "honor" units, including a unit for women participating in Puppies Behind Bars, a program where women train puppies to become service dogs, and Fiske, a free-standing honor dorm.⁴⁵

Bedford has a 24-cell Special Housing Unit (SHU) and the state's only Therapeutic Behavioral Unit (TBU), a 16-cell unit that is an alternative to SHU for women with serious mental illness whom DOCCS approves for admission.⁴⁶ Women at Bedford who live in dorms serve keeplock sentences in vacant general population cells.

Bedford is one of two prisons that houses pregnant women and is home to the state's only nursery program. Women accepted to the nursery can live there with their babies for up to one year, or 18 months if the woman is scheduled to be released in that timeframe and the prison grants a special extension. Bedford also operates the state's only Regional Medical Unit (RMU) for women, which provides skilled nursing care and specialty clinics for women at Bedford and Taconic.

Like most maximum-security prisons, Bedford has visiting hours seven days per week. The prison also runs a Family Reunion Program and has a staffed children's center, which provides visiting and parenting support for mothers.

Bedford Hills Correctional Facility	
Population	780
Capacity	930
Average age	36
Race (<i>data reflects total women's population</i>)	African-American: 43% Latina: 16% White: 38% Other: 2%
Median minimum sentence	8.5 years
Median amount of time women have left to serve before their earliest release date	3.3 years
Women from NYC and suburbs	54%
Women from upstate NY	46%
Admissions	132 per month / 1,594 per year (including reception)
Releases	25 per month / 308 per year
Race of correction officers	African-American: 66% Latina/Latino: 16% White: 14% Other: 4%
Gender of correction officers	Male: 51% Female: 49%
Average SHU census per month	8
Average keeplock census per month	25
Average number of women in the Family Reunion Program in 2013	110
Capacity of visiting room	184

TACONIC

Taconic Correctional Facility is a medium-security prison located in the town of Bedford Hills in Westchester County. Taconic is directly across the street from Bedford Hills Correctional Facility. As of the CA's last visit in April 2013, Taconic held about 310 women, 79% of its capacity of about 390. Taconic houses about 15% of the state's female prison population. Forty-one percent of women at Taconic are from upstate New York.

Women at Taconic live in single cells, multiple-occupancy rooms, and double-bunked units in large dormitories. For solitary confinement, Taconic has a 15-cell keeplock unit. Women at Taconic who are sentenced to SHU are transferred to Bedford or Albion to serve their disciplinary sentences.

Along with Bedford, Taconic houses pregnant women. In 2013, DOCCS decided to transfer pregnant women at Taconic to Bedford when they reach the third trimester. Taconic ran a nursery for many years until DOCCS closed it in 2011.

Taconic has no Family Reunion Program on-site, but women at the prison who qualify are permitted to use Bedford's trailers for overnight visits. Like most medium-security prisons, Taconic has visiting hours only on the weekend.

Taconic Correctional Facility	
Population	310
Capacity	390
Average age	38
Race <i>(data reflects total women's population)</i>	African-American: 43% Latina: 16% White: 38% Other: 2%
Median minimum sentence	3 years
Median amount of time women have left to serve before their earliest release date	8.9 months
Women from NYC and suburbs	59%
Women from upstate NY	41%
Admissions	29 per month / 348 per year
Releases	26 per month / 312 per year
Race of correction officers	African-American: 62% Latina/Latino: 21% White: 16% Other: 1%
Gender of correction officers	Male: 39% Female: 61%
Average keeplock census per month	5
Average number of women in the Family Reunion Program in 2013	29
Capacity of visiting room	206

BAYVIEW

Bayview Correctional Facility was a medium-security prison situated in two eight-story buildings on the corner of 20th Street and 11th Avenue in Manhattan. In October 2012, Bayview was evacuated because of Hurricane Sandy, and the prison remained empty until its closure in May 2013. Bayview was the only women’s prison located in New York City. Two-thirds of women at Bayview (67%) were from the New York City area.

As of April 2012, Bayview housed just under 170 women, 73% of its capacity of 229. Women at Bayview lived in either single cells or dormitories. Bayview had a work release program and a 40-bed reentry unit for women from the New York City area nearing their release date.⁴⁷ For solitary confinement, Bayview had a keeplock unit with 15 cells. Women at Bayview who were sentenced to SHU were transferred to Bedford or Albion to serve their disciplinary sentences.

Bayview allowed visiting only on the weekends and had no Family Reunion Program.

Bayview Correctional Facility	
Population	170
Capacity	229
Average age	General population: 38 years Work release: 39 years
Race (<i>data reflects total women’s population</i>)	African-American: 43% Latina: 16% White: 38% Other: 2%
Median minimum sentence	2.6 years
Median amount of time women have left to serve before their earliest release date	General population: 5.3 months Work release: 3.5 months
Women from NYC and suburbs	67%
Women from upstate NY	33%
Admissions	20 per month / 240 per year
Releases	15 per month / 180 per year
Race of correction officers	African-American: 82% Latina/Latino: 16% White: 1% Other: 1%
Gender of correction officers	Male: 41% Female: 59%
Average keeplock census per month	7
Capacity of visiting room	70

BEACON

Beacon Correctional Facility was a minimum-security prison located in the town of Beacon in Dutchess County, about 1 hour and 15 minutes from New York City by train. Along with Bayview, Beacon was closed in May 2013.

Beacon was the only general confinement prison for women with a minimum-security status, and the only women's prison with community work crews that permitted participants to perform jobs like painting and maintenance in the community. Participating in a work crew is one of only four ways incarcerated people can earn merit time off their sentences.

As of April 2012, before DOCCS began to transfer women in preparation for the prison's closure, Beacon held about 110 women, 52% of its capacity of 201. Fifty-one percent of women at Beacon were from upstate New York.

Women at Beacon lived in dormitory-style housing with single or double-bunked beds and multiple-occupancy rooms. Beacon had no solitary confinement unit. Women at Beacon who were sentenced to keeplock or SHU were transferred to Bedford or Albion to serve their disciplinary sentences.

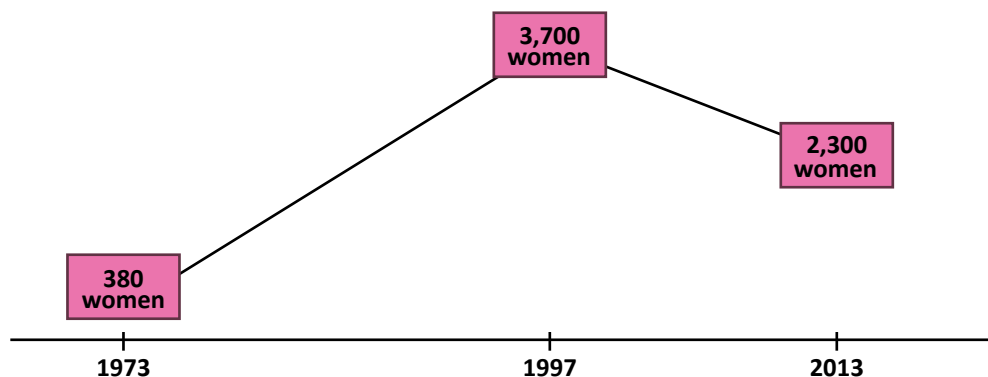
Beacon allowed visiting only on the weekends and had no Family Reunion Program.

Beacon Correctional Facility	
Population	110
Capacity	201
Average age	40 years
Race <i>(data reflects total women's population)</i>	African-American: 43% Latina: 16% White: 38% Other: 2%
Median minimum sentence	2 years
Median amount of time women have left to serve before their earliest release date	5.2 months
Women from NYC and suburbs	49%
Women from upstate NY	51%
Admissions	32 per month / 384 per year
Releases	16 per month / 192 per year
Race of correction officers	African-American: 42% Latina/Latino: 8% White: 50% Other: 0%
Gender of correction officers	Male: 41% Female: 59%
Capacity of visiting room	100

KEY FACTS ABOUT WOMEN IN NEW YORK'S PRISONS

- The median annual income of women in New York's prisons before incarceration was \$8,000.⁴⁸
- 41% were unemployed prior to their arrest, 35% received public assistance and nearly 60% were insured by Medicaid.⁴⁹
- 62% are women of color, even though women of color make up only 35% of New York's female population.⁵⁰
- 43% do not have a high school diploma.⁵¹
- 70% had a substance abuse problem prior to incarceration.⁵²
- 39% have been diagnosed with a serious mental illness.⁵³
- 90% experienced physical or sexual violence in their lifetimes, 80% were severely abused as children, and 75% suffered serious physical violence by an intimate partner as adults.⁵⁴
- 54% have a serious or chronic illness. About 12% are living with HIV, and about 17% have hepatitis C, rates significantly higher than in the general public.⁵⁵
- 70% are mothers. About 63% were living with their children before arrest, and 43% were caring for their children on their own.⁵⁶
- 15% are 50 years or older, more than double the number in this age group 10 years ago.⁵⁷

TRENDS IN NEW YORK'S FEMALE PRISON POPULATION



Introduction

When we visit women’s prisons in New York, we ask incarcerated women to identify the main problems they face at their correctional facility. Without fail, women identify difficulties with health care, including and sometimes especially women-specific health care, as one of the top problems.⁵⁸ The consistency and intensity of these concerns over the years led us to undertake this study, the most extensive study of reproductive health care in a state prison system to date.

We gathered most of the information for this study from 2009 to 2013 using a range of research methods. We conducted a total of 20 visits to prisons housing women in New York, including: three visits to Bedford Hills Correctional Facility in Westchester County, the state’s only maximum-security prison for women; four visits to Taconic Correctional Facility, a medium-security prison also in Westchester County; and four visits to Albion Correctional Facility near Rochester, a medium-security prison and the largest prison for women in New York. We also conducted four visits each to Bayview and Beacon correctional facilities, both of which were closed in 2013. In early 2014, we visited Edgecombe Correctional Facility, a minimum-security prison in Manhattan, which began housing women on work release (a transitional work program) after Bayview and Beacon closed.

We interviewed a total of 950 incarcerated women, reviewed 25 medical charts focused on reproductive health issues, and analyzed data from over 1,550 surveys on general conditions, reproductive health, pregnancy and HIV. Sixty-four of the women we spoke with or surveyed had been pregnant while in New York’s prisons between 2004 and 2013. We also reviewed extensive data collected from each prison and compared prison health policies to relevant community standards.

Over the course of our study, we found a number of areas where DOCCS has a solid track record. These areas include timely and quality prenatal care for pregnant women, annual GYN exams for most women, quality care from certain medical providers, beneficial HIV education services, valuable programs for trauma survivors, and an impressive and nationally recognized nursery program.

Much of what we found, however, is deeply troubling. Many women face serious delays in accessing GYN care, a result, in part, of insufficient GYN staffing in each prison. Women experience substandard, dismissive and sometimes traumatizing treatment from certain providers,

“Some doctors and nurses make you feel like you are lying and that you have to justify why you feel you need medical care.”

and many medical charts are sorely deficient. Women do not have access to adequate health education and are denied even basic reproductive health items like contraception and sufficient sanitary supplies. Women in 23-hour lockdown in solitary confinement – a torturous and overused penalty in DOCCS – experience myriad barriers to accessing care and repeated violations of their medical privacy.

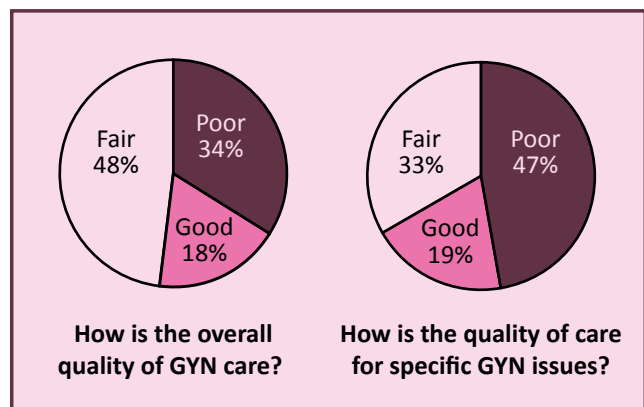
Even more disturbing are our findings related to the treatment of pregnant women. Pregnant women are routinely shackled throughout all trimesters when they leave prison grounds, and many are still subjected to the horror of being shackled during labor and recovery after childbirth, even though these practices were outlawed by New York State in 2009.

During pregnancy, women receive little support, unless they are lucky enough to be accepted to the nursery, and many women are unfairly denied admission to that program. Pregnant women do not get enough food, and, like other women, many are forced to live in poor housing conditions and to endure abusive treatment from correction officers. Pregnant women who are found guilty of violating prison rules can be, and are, held in solitary, a dangerous setting for their health and their babies' health. During childbirth, women are denied family support, and after childbirth, they are routinely separated from their newborns in the hospital.

To make matters worse, there is no external oversight and virtually no internal oversight over reproductive health care in DOCCS. DOCCS also has substandard reproductive health policies and does not adequately collect or analyze data related to reproductive health.

Overall, we found that Bedford Hills has better reproductive health care and a significantly better health services operation than either Taconic or Albion. This finding is not surprising as Bedford is home to DOCCS' only Regional Medical Unit specifically for women, which provides specialty clinics and skilled nursing care, and also because the prison improved its health care system after a class-action lawsuit filed in 1974 (the settlement agreement lasted until 2004).⁵⁹

When asked to rate the overall quality of GYN care since arriving in DOCCS, one-third (34%) of reproductive health survey respondents rated the care as "poor." About half (48%) rated the care as "fair," and about one-fifth (18%) said it was "good." When asked about care for specific GYN issues for which they sought help, women's assessments were even more negative: nearly half (47%) said the care they received was "poor." One-third (33%) said the care was "fair" and about one-fifth (19%) said the care was "good." This data suggests that DOCCS may be doing a better job with routine check-ups than with care for particular GYN complaints.



Regarding pregnancy care, about one-third (36%, 8 of 22) of pregnancy survey respondents rated the care they received while they were pregnant in DOCCS as “poor.” Less than half (41%, 9 of 22) rated the care as “fair,” and about one-quarter (23%, 5 of 22) rated the care as “good.” Many women explained that their “poor” rating was based not on the quality of prenatal care itself but on other aspects of their experience, such as not getting enough food or being shackled.

“They kept one of my ankles shackled to the bed. [They] only took it off when it was time to start pushing.”

This report presents the findings from our study in five main sections:

- 1) **Oversight, policies and data collection.** This section assesses internal and external oversight of reproductive health care in DOCCS; prison policies related to reproductive health; and DOCCS’ collection of data related to reproductive health care and outcomes.
- 2) **General reproductive health care.** This section analyzes women’s access to routine and specialty GYN care; the quality of GYN care; the quality of medical charts; annual GYN exams; Pap smears; breast exams and mammograms; hysterectomies; access to sanitary supplies; weight and nutrition; contraception; and health education.
- 3) **Care for pregnant women.** This section examines pregnancy testing; pregnancy options counseling; abortion; sterilization; pregnancy loss; pregnancy and work release; prenatal care; prenatal education; daily life in prison for pregnant women; labor and childbirth; post-partum care; and the nursery program.
- 4) **Shackling of pregnant women.** This section assesses DOCCS’ implementation of New York’s 2009 Anti-Shackling Law which bans the use of restraints on incarcerated women during childbirth, and examines the experiences of pregnant women with shackling in situations not covered by the law.
- 5) **Special issues.** This section investigates experiences with reproductive health care for three specific groups: women in solitary confinement, women growing older and women living with HIV. There is increasing national attention to the challenges facing people in these groups and our study contributes women-specific findings to the debates in these areas.

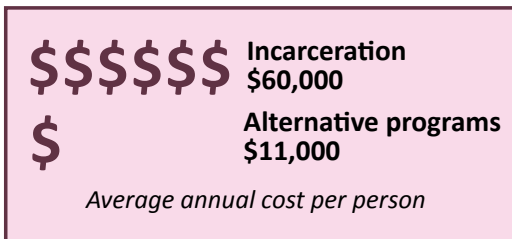
After each section in this report, we list recommendations to address the problems identified in that particular area. Among our most important recommendations for New York State policymakers are: 1) mandate better enforcement of the 2009 Anti-Shackling Law and prohibit the shackling of incarcerated women during all trimesters of pregnancy; 2) establish basic standards for reproductive health care for incarcerated women, and require robust internal and external oversight of that care; and 3) continue New York’s recent trend away from prison and toward alternatives to incarceration.

This last recommendation is critical because, ultimately, the best solution to the problems identified in this study is to not incarcerate women in the first place. As this report attests, prisons expose the people in them to significant health risks and infringe on their basic human rights and dignity. Prisons tear apart families and traumatize children by separating them from their parents. Prisons devastate communities, particularly the poor communities of color targeted by punitive criminal justice policies, fueling racial and social inequity. Prisons do little to help people overcome the issues that led to their incarceration, often making those issues worse instead of better, and they fail to provide meaningful opportunities for people to repair the harm they may have caused. Finally, prisons cost taxpayers billions of dollars,⁶⁰ yet they fail to prepare people for a successful return home or to make communities safer.⁶¹

Building healthy and safe communities requires an end to our failed policies of mass incarceration

Building people and communities that are truly safe and healthy requires an end to our failed policies of mass incarceration. Instead, we must embrace policies and programs that value human potential and offer opportunities for healing and addressing harm holistically. These approaches must tackle social injustices like poverty, racism, sexism, homophobia and transphobia, and provide treatment and support for issues like addiction, mental illness,

gender-based violence and trauma. Alternative-to-incarceration programs are one such critical service: they reduce recidivism and allow people to serve their sentences while parenting and maintaining family connections, addressing underlying issues, and making positive contributions to the community, all at a fraction of the cost of prison.⁶²



SECTION 1

Oversight of Reproductive Health Care, Data Collection & Written Policies

INTERNAL OVERSIGHT

DOCCS operates a quality improvement (QI) program in its Central Office and at individual prisons to identify and correct problems in its medical services, yet these initiatives have completely failed to establish any systematic review of the reproductive health care DOCCS provides.⁶³

None of the OB or GYN clinicians in New York's three all-women's prisons (Bedford, Albion and Taconic) are members of the prisons' QI Committees, and none of the prisons could remember the last time an OB or GYN clinician was invited to participate in a QI meeting. Instead of reviewing reproductive health care on a regular basis, the QI Committees at the women's prisons look at care only if a particular concern arises. Each prison noted that OB-GYN care had not been a specific QI review topic in the past decade.

DOCCS has inadequate reproductive health policies and data collection, and virtually no oversight of its reproductive health services

A rigorous, proactive QI program is a critical part of any quality health care operation.⁶⁴ The exclusion of reproductive health care from DOCCS' routine QI efforts undermines the Department's ability to assess and maintain quality in this basic, essential aspect of care for women in its custody.

EXTERNAL OVERSIGHT

The New York State Department of Health (DOH) oversees all hospitals and clinics providing reproductive health care in the community, yet it plays no role in monitoring this care in prison.

Until recently, DOH did not oversee any aspect of health care in DOCCS. That changed in 2009 when New York enacted a law requiring DOH to monitor HIV and hepatitis C care in prisons

and jails across the state.⁶⁵ This law represents an important step in improving prison health services and in recognizing the significant connection between prison health and public health: incarcerated people suffer disproportionately from serious and chronic illnesses, and more than 95% of people in the state's prisons will eventually be released.⁶⁶ Quality health care in prison is vital not only for incarcerated people but also for the families to which they will return and to the larger community as well.

DATA COLLECTION

Consistent and thorough data collection and analysis are necessary for DOCCS to assess and respond to the health needs of women in its custody, and to determine how best to allocate staff and resources. Nevertheless, DOCCS data collection and analysis related to reproductive health are deficient.

DOCCS maintains a written directory of codes for medical providers to use to document their patients' medical conditions. The existence of this directory indicates that prisons should have basic data about the incidence of each condition associated with a particular code. When the CA requested data related to certain conditions that have codes, however, many prisons could not supply the information, suggesting that prison staff are either not recording the codes appropriately or are not able to aggregate the data on a systemic level. Examples include:

- When the CA asked each prison for the number of pregnant women housed each year between 2004 and 2013, some prisons could not supply data for certain years, other prisons gave data that the CA found to be inaccurate after conducting medical chart reviews, and other prisons said they did not collect data on the incidence of pregnancy.
- When the CA asked for the incidence of pregnancy outcomes including abortion, miscarriage and ectopic pregnancy, some prisons did not have data for certain years, some prisons could only give vague estimates, and some could not supply any data.
- When the CA asked for figures on the frequency of abnormal mammogram and Pap smear results, and the incidence of sexually transmitted diseases (STDs) other than HIV and hepatitis C, estimates among the prisons varied widely, and some prisons could not supply any data.

There are also areas related to women's health that DOCCS does not code or track at all. Such areas include:

- Number of sick call appointments for GYN-related issues
- Reasons for hysterectomies
- Incidence of vaginal births versus C-sections

POLICIES

The health policies issued by DOCCS Central Office are contained in two main documents: the Health Services Policy Manual, which includes all Department policies related to the provision of health care, and the Women’s Health Primary Care Practice Guideline, a booklet DOCCS first published in 2000, and updated in 2008 and 2011, which discusses certain health concerns specific to women. Although this booklet is not comprehensive and does not fully reflect community standards, it is a positive addition to DOCCS’ policies and signals the Department’s recognition of the specific health issues facing women in its custody.

Two documents of particular relevance in the Health Services Policy Manual are DOCCS’ Patient Bill of Rights and DOCCS’ Professional Code of Ethics. Both documents lay out important information aimed at safeguarding patients and providing quality health care. For example, the Patient Bill of Rights includes items such as the patient’s right to “considerate and respectful care,” the right to refuse treatment, and the right to “complete information regarding your diagnosis, treatment and prognosis in terms you can understand.”⁶⁷ The Professional Code of Ethics contains an impressive list of principles, including that staff should provide services “with respect for human dignity and the uniqueness of the patient,” and establish “a professional, trusting relationship with the inmate patient as their health advocate.”⁶⁸ It seems, however, that DOCCS neither monitors adherence to these documents in a consistent fashion nor imposes any consequences for staff who deviate from them. Additionally, it seems that DOCCS does not sufficiently inform women about the Patient Bill of Rights, leaving many women unaware of the document’s existence.

Some of DOCCS’ reproductive health policies are adequate, but others are incomplete and outdated. Hardly any of the policies reference community standards and some stray from those standards in key areas. In some cases, such as the starting age for yearly GYN check-ups and the frequency of prenatal visits, the CA found that DOCCS’ practice is actually in sync with community standards even though its written policies are not. All of these areas are discussed in the relevant sections of this report.

Examples of areas where DOCCS has no written policies include:

- Pregnancy tests
- Pregnancy options counseling
- Any pregnancy outcome other than live birth, including abortion, ectopic pregnancy, miscarriage and stillbirth
- Nutrition for pregnant and nursing women
- Hysterectomies

Examples of areas where DOCCS' policies are incomplete include:

- Health care for pregnant women, women in labor and women who have recently given birth. DOCCS has no central policies on these topics; only Bedford and Taconic have written policies and these include only a basic overview of prenatal and postpartum care.
- Menopause. DOCCS' policies contain a thorough explanation of menopause but no discussion of relevant treatments.
- Vitamins. DOCCS' policies do not mention either prenatal supplements or calcium.

Examples of areas where DOCCS' policies do not comport with community standards include:

- Starting age for yearly GYN check-ups
- Frequency of breast exams
- Frequency of Pap smears
- Follow-up for abnormal Pap smears
- Frequency of prenatal visits and ultrasounds
- Time frame for postpartum check-ups for women who have C-sections
- Provision of bone density tests to check for osteoporosis

RECOMMENDATIONS

For DOCCS

- 1) Conduct regular QI assessments of reproductive health care for each prison and involve OB and GYN providers in these efforts. Survey women anonymously on a regular basis about their experiences with medical care, and review grievances and other relevant documentation to identify trends and problem areas. Incorporate this information into the QI assessment.
- 2) Create a position in Central Office for an OB-GYN to oversee facility-based reproductive health care QI efforts and to advise on evaluation tools and policies.
- 3) Enhance efforts to collect systemic data on all key health issues affecting women, including incidence (e.g., pregnancy and STDs), service delivery (e.g., the number of sick call

appointments for GYN issues), and outcomes (e.g., pregnancy outcomes and abnormal Pap smear and mammogram results). Regularly assess this data as part of efforts to understand the health needs of, and improve health services to, women in custody.

- 4) Review written policies on reproductive health care for women and make adjustments to ensure they are up-to-date, and reflect and explicitly reference community standards.
- 5) Make adjustments to the Patient Bill of Rights and Professional Code of Ethics to ensure that they mirror current best practices and include avenues for redress if patients' rights are violated. Inform women about the Patient Bill of Rights and their avenues for redress, establish mechanisms for assessing whether providers are following the Professional Code of Ethics, and work with and, where appropriate, discipline or remove staff who do not follow the code.

For New York State Legislature and Governor

- 1) Enact a law requiring the New York State Department of Health to monitor all health care, including reproductive health care, in prisons across the state.

SECTION 2

General Reproductive Health Care

OVERALL ASSESSMENT OF GYN CARE

DOCCS is responsible for providing routine and specialty GYN care for women in its custody. Routine care includes annual GYN check-ups, pelvic exams, Pap tests, breast exams and treatment for basic GYN issues such as yeast infections and vaginal discharge. Specialty care includes mammograms, more serious GYN problems such as abnormal uterine bleeding and pelvic pain, and GYN procedures such as colposcopies and biopsies. All routine GYN care is provided on-site at Bedford, Albion and Taconic. Bedford and Albion also offer some specialty GYN care on-site. For GYN procedures and surgeries, women are taken to hospitals in the surrounding area.⁶⁹

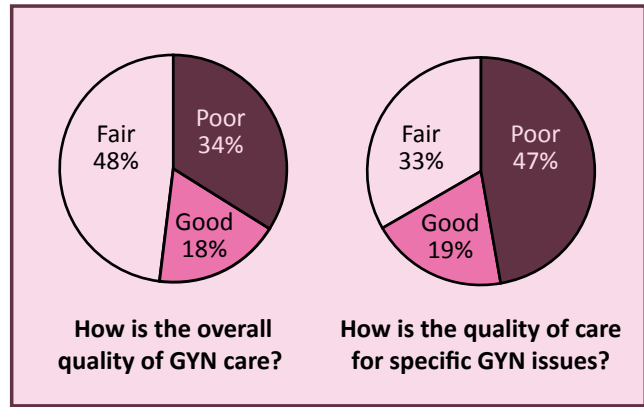
While some women in DOCCS are able to access timely, quality reproductive health care, others experience serious problems. The main problems the CA identified are: delays in GYN care, inadequate GYN staffing, certain doctors and nurses who dismiss women's concerns and rush through appointments, insufficient patient education, and the lack of a trauma-informed approach by medical staff.

Some women can access adequate reproductive health care but many others experience serious problems

When asked to rate the overall quality of GYN care since arriving in DOCCS, one-third (34%, 108 of 319) of reproductive health survey respondents rated the care as "poor." About half (48%, 153 of 319) rated the care as "fair," and about one-sixth (18%, 58 of 319) said it was "good." When asked about care for specific GYN issues for which they sought help, women had even more negative experiences, suggesting that DOCCS may be doing a better job with routine check-ups than with care for particular GYN complaints. Among reproductive health survey respondents who sought care for a specific GYN issue in the past five years, nearly half (47%, 81 of 171) said the care they received was "poor." One-third (33%, 57 of 171) said the care was "fair," and only about one-fifth (19%, 33 of 171) said the care was "good."

While problems with GYN care exist for women across the prison system, Bedford stands out as having the fewest problems. This is not surprising as Bedford offers the most comprehensive

medical services for women in DOCCS and is home to the Department's only Regional Medical Unit (RMU) specifically for women,⁷⁰ which provides specialty clinics and skilled nursing care. That Bedford's medical operation is stronger than other women's prisons is also likely the result of a class-action lawsuit, *Todaro v. Ward*, filed in 1974 by the Legal Aid Society's Prisoners' Rights Project on behalf of women at the prison.⁷¹ Until the settlement agreement ended in 2004, *Todaro* required Bedford to improve its health services in key areas including staffing, access to care, access to HIV doctors and systems for monitoring specialty care.⁷²



When it was open, Beacon also had a better track record on GYN care than other facilities, in large part because the prison's Medical Director was an OB-GYN. At Albion and Taconic, and at Bayview when it was open, the CA found more significant problems.

ACCESSING GYN CARE

Accessing GYN care: the official process

Unlike people in the community, women in prison cannot simply pick up the phone and make an appointment with a doctor or walk to the medical building and ask to be seen. Instead, there are multiple procedural hurdles a woman must overcome to access medical care in DOCCS.

The first hurdle is "sick call."⁷³ Sick call, also called nurses screening, is similar to the triage system that operates in hospital emergency rooms. Women sign up for sick call by writing their names on a list posted in their housing area and are usually called to the medical unit to see a nurse the next day. During sick call, nurses are supposed to evaluate each woman and decide on next steps, which can range from doing nothing to giving over-the-counter medication to making a doctor appointment, either for a future date or immediately. If the nurse does not schedule a doctor appointment, the woman must either deal with the problem on her own or sign up for sick call again.

At Albion and Bedford, sick call nurses can schedule appointments directly with the GYN who works on-site at the prison. At Taconic, because there is no GYN on-site, nurses can only schedule appointments for GYN issues with the facility's Medical Director, who provides routine GYN care. If Taconic's Medical Director determines that a woman needs more specialized GYN care, the Director must refer the woman to the GYN specialty clinic at Bedford.

Each prison also has emergency sick call. Emergency sick call is available for women whom nurses agree to see without their names being on the regular sick call list. To access emergency sick call, a woman must ask an officer to call the nurses' station and request approval for the woman to be seen in the medical building. Even when an officer places a call, however, nurses do not always agree to an appointment. This problem seems to be particularly acute at Albion, where women consistently report that some nurses respond to calls from officers by saying, "Tell her to sign up for sick call," even when the officer advocates for the woman to be seen. If the medical issue is serious enough, officers can either bring women directly to the medical building without calling or request that nurses come to the unit themselves.

According to estimates from each prison, there are about 1,500 regular sick call appointments and 500 emergency sick call appointments for women in DOCCS each month.⁷⁴ DOCCS does not require its prisons to track how many of these visits are for GYN issues and some prisons could not provide estimates. Bedford estimated that about 13% of its regular sick call visits each month are for GYN issues, and Taconic estimated 6%.⁷⁵ Both prisons estimated that about 2% of their monthly emergency sick call visits are GYN-related.⁷⁶

Regular sick call is available four days per week at Albion and Taconic, and five days per week at Bedford. Emergency sick call is available anytime nurses are on site: 24/7 at Bedford and Albion, and between 7am and 11pm at Taconic. All the women's prisons report that GYN emergencies are rare and that a doctor is always on call.⁷⁷ However rare, emergencies that do occur expose weaknesses in DOCCS' medical system at prisons that do not have 24/7 medical coverage. For example, if a woman at Taconic needs emergency care between 11pm and 7am, when no medical staff are on-site, she is expected to tell correction officers who call nurses at Bedford and explain the woman's medical situation.⁷⁸ Requiring correction staff to play the role of medical intermediary violates women's privacy and medical confidentiality.

Even women who see a prison doctor may face an uphill battle in getting all their needs met. At some prisons, doctors will only address the specific medical issue the nurse wrote down during sick call. This means that if the nurse does a poor job taking notes, if an issue comes up during the appointment, or if the woman develops other problems while she waits for her appointment, she will not be allowed to ask the doctor about those problems. Instead, she must sign up for sick call and begin the process all over again. Women also frequently see different doctors for each appointment and are often transferred from one prison to another, which disrupts the continuity of their care.

To access specialty care in DOCCS requires overcoming even more hurdles. The prison doctor has authority to determine whether a woman should be referred to a specialist as well as whether to follow the specialist's recommendations if the woman has an appointment. Women have little recourse if they disagree with a prison doctor's opinion. In addition, unlike doctors in the community, doctors in prison cannot make specialty care appointments at will. Instead, they must submit a request to DOCCS Central Office and wait for approval before moving

forward. This is the case even with specialty care offered on prison grounds, including the GYN specialty clinics at Bedford and Albion.

The only GYN appointment women in DOCCS do not technically have to seek out themselves is their annual GYN check-up. The process for scheduling annual check-ups begins at Bedford's reception center, where women entering custody are given a full medical evaluation, including a GYN exam.⁷⁹ The woman is then supposed to be scheduled for another appointment one year later, though some women report that they have to request these appointments themselves.

Women participating in DOCCS' work release program go through a similar process to access medical care. Work release is a transitional program where participants work in the community during the day and return to the prison in the evenings or on weekends. The program is available to individuals nearing their release date who have good disciplinary records and non-violent convictions.⁸⁰ (In 2002, New York passed a law granting work release eligibility to certain domestic violence survivors convicted of defending themselves against an abuser. Unfortunately, the law's impact has been limited, and only a few survivors have been granted work release under the exception.⁸¹)

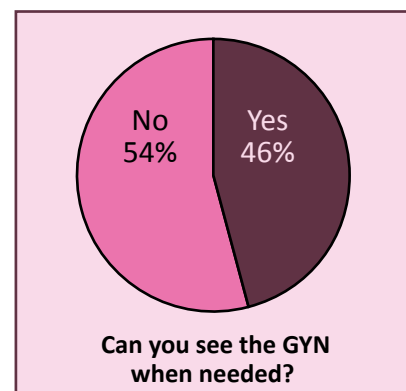
Albion and Edgecombe, a men's minimum-security prison, are the two prisons that currently house women on work release in New York. Women on work release at Albion continue to use the sick call system and see doctors at the prison for medical care, including GYN care. At Edgecombe, prison clinicians send women to a nearby community hospital for GYN services; women receive all other medical care at the prison. If an emergency arises, women on work release can go to an emergency room in the community, but they must call the prison first to get approval.

Accessing GYN care: women's experiences

The CA's research reveals significant problems with access to both routine and specialty GYN care for women in DOCCS. Delays in receiving appropriate medical care can cause irreparable harm to women's health, and postponing treatment for even common GYN problems can lead to more serious conditions.⁸²

More than half (54%, 434 of 798) of general survey respondents reported that they could not see the GYN when necessary. Among individual prisons, Bedford had the lowest percentage of women reporting inadequate access to the GYN (46%, 139 of 304), and Albion and Taconic had the highest (58%, 175 of 304, and 65%, 63 of 81, respectively).

The reproductive health survey provides more detail about women's experiences. Forty-four percent (66 of 151) of survey



respondents said it takes more than 28 days to see the GYN after requesting an appointment; the median waiting time was three weeks. Women at Albion reported longer median wait times (one month) than women at Bedford (two weeks). This finding is not surprising considering that Bedford has more GYN specialty care coverage than Albion and that Bedford's GYN sees more than twice as many patients per week as Albion's (80 versus 33), even though both are on-site the same number of hours per week.

Prison staff have a different perception of how long it takes women to access care. Staff at each prison generally estimated a waiting time for routine GYN care appointments of one to two weeks. For GYN specialty appointments, most prison staff estimates of a four- to six-week waiting period more closely matched women's experiences. Bedford reported two to three weeks, the shortest wait time for GYN specialty care.

SARA

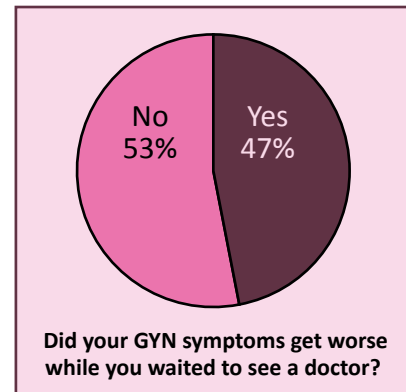
One day Sara noticed a lump in her groin area and signed up for sick call. At sick call, the nurse described the lump as "egg-size" and referred Sara to a nurse practitioner. Sara waited about a week to see the nurse practitioner and another week after that to get an ultrasound. It took another three weeks after the ultrasound for Sara to get her results. Even though the ultrasound results showed a fast-growing mass with blood circulation – a red flag for cancer – Sara's case was not fast-tracked or referred to a senior doctor at the prison.

Sara waited three more weeks after receiving the ultrasound results to get a biopsy and another two weeks to get the biopsy results. The biopsy results showed an advanced tumor yet Sara did not see an oncologist until two weeks later. Two more weeks went by after the oncology appointment before Sara met with a senior doctor at the prison. It was another month before Sara had surgery to remove the tumor and another month after that before she began chemotherapy and radiation.

One year later, Sara wrote to the CA to explain that she was no longer being treated and had received a much more grim prognosis: "[M]y body couldn't take no more, but [the cancer] was gone. Then I got tested four months later and two more lumps which was noticed months ago. Nothing done. Now it spread. . . it got bigger. Got a biopsy, but [the hospital doctor] told me I've got six months to live. . . . I was in shock, still am. No more treatment will help."

Sara died five months after her release. Whether better care would have saved or prolonged Sara's life is unclear. What is clear is that DOCCS did not act with appropriate urgency and failed to provide Sara with timely treatment for her illness. As the CA visiting team physician who reviewed Sara's chart stated: "That it took six to seven months to get this patient on treatment is shocking."

Examples abound of women who encounter delays. The most egregious case of delays the CA visiting team learned about was that of a 55-year-old woman named Sara. In-person interviews, written correspondence and a medical chart review by the CA revealed that it took DOCCS almost seven months to get Sara care for what ultimately was diagnosed as very serious and aggressive cancer.



While Sara’s case is particularly troubling, the delays Sara experienced are not unique. One woman at Albion, for example, reported waiting four months for a colposcopy the doctor ordered as follow-up to her abnormal Pap test result. Another woman at Albion, who was diagnosed with cervical cancer, reported that she had been waiting over three months for the surgery doctors recommended. Another woman at Albion wrote: “I’ve never seen the GYN. I dropped a tab [note to the doctor] explaining to them about being diagnosed with abnormal cells. . . and how I’d like to get a check-up, but no one answered. This was six months ago.”

Overall, almost half (47%, 50 of 106) of reproductive health survey respondents who said they went to sick call for a particular GYN problem reported that their symptoms became worse during the time they waited to see a doctor. One woman who went to sick call at Taconic complaining of vaginal itching, for example, wrote that during her month-and-a-half wait to see the GYN, “the symptoms went from itching to burning.” When she finally saw the GYN, she was diagnosed with chlamydia.

Other comments from women about what happened during delays include:

- “Pain increased especially during my menstrual to the point of not wanting to walk and I was told I’d have to wait – take aspirin at sick call.”
- “The bleeding got worse and the pain is bad now.”
- “I started getting very nauseated with my period, and anxiety attacks.”
- “I bled for 22 days straight.”
- “The yeast infection got worse. I would rub down there for relief until it was raw and burned when I use the bathroom.”
- “Pain using bathroom, outbreak worsened and spread.”
- “I went to sick call several times for a UTI [urinary tract infection]. I had developed pain, pressure, difficulty urinating.”
- “I started urinating in the bed uncontrollably and ended up having to go to the urologist.”

Not receiving timely follow-up for breast abnormalities seems to be a particular problem in DOCCS. A medical chart review for one woman, for example, showed a series of delays that contributed to the woman waiting four months between getting abnormal mammogram results and a needed biopsy. A chart review for another woman revealed that she had been waiting a year and a half for mammograms that she was supposed to have every six months. A chart review for a third woman indicated that she had to wait one month for a GYN appointment after she reported having a breast lump at sick call. One woman said she had to wait over one year for an MRI following an abnormal mammogram and noted that she received the MRI only after filing a grievance about the issue.⁸³

Each prison said they generally schedule follow-up appointments within one to two weeks of receiving abnormal mammogram results, but women reported significantly longer wait times.

Reasons for delays in women's access to GYN care

Many factors likely contribute to delays in women's access to GYN care. Some factors are structural and beyond the control of doctors. Such factors include insufficient staffing, the requirement that DOCCS Central Office approve requests for specialty care, labs that are slow in processing test results, the expectation that providers will keep costs to a minimum, and frequent transfers of women between prisons, which can disrupt continuity of care. These obstacles pose challenges for even DOCCS' most dedicated, resourceful clinicians.

Other delays can be attributed to doctors and nurses themselves. The lack of external oversight and public sympathy for people in prison exacerbates this problem by sending the message that inaction will not have serious consequences.

Notably, the CA's interviews and chart reviews revealed that delays were often the consequence of a combination of factors and the result not of one long holdup but a series of shorter waits at various stages which compounded each other. The previously mentioned case of Sara provides a good example: no single delay caused Sara to wait almost seven months to be treated for cancer. Instead, she experienced many shorter delays which piled up.

Inadequate staffing stands out as one of the most serious reasons for delays:⁸⁴

- **Albion, which holds about 1,000 women, has only one GYN doctor who is on-site only 16 hours per week.**

The GYN doctor at Albion sees an average of 33 women per week. Before this doctor was hired in summer 2012, Albion contracted with a GYN nurse practitioner to be on-site 30 hours per week. Because the on-site GYN hours decreased by half (from 30 to 16), Albion supplements coverage by requiring a general nurse practitioner on staff to spend two days per week doing Pap smears and annual GYN exams. This is unfortunate as Albion already has

too few clinical staff, and reducing the time this nurse practitioner devotes to other medical issues only worsens the situation. The only other GYN care at Albion is a monthly, seven-hour specialty clinic run by a contract GYN nurse practitioner. He sees 15 to 20 women at each clinic.

- **Bedford, which holds about 800 women, has only one OB-GYN doctor who is on-site 16 hours per week.**

The OB-GYN doctor at Bedford sees an estimated 30 patients per day. When needed, Bedford calls on another doctor to help with annual GYN exams and Pap smears. The only other GYN care at the facility is a three-hour specialty clinic twice per month run by two OB-GYNs for women at Bedford and Taconic. An average of eight women are seen at each clinic.

After discussing these findings with DOCCS, Department officials informed the CA that Bedford is searching for an additional part-time nurse practitioner to assist with GYN exams and Pap smears.

- **Taconic, which holds about 370 women, has no GYN on staff.**

Routine GYN care at Taconic falls to the facility's Medical Director who sees eight to 10 women per week for general GYN appointments and about eight women each week for Pap smears. This is unfortunate as triaging routine GYN care seems a poor use of the Taconic Medical Director's limited time. Until 2011, Taconic had a monthly, four-hour specialty clinic run by an OB-GYN doctor, but DOCCS ended the clinic because of budget cuts and what they determined to be a low census of women in the clinic (the average was seven). Women at Taconic who need specialty GYN care are referred to the specialty clinic at Bedford.

Deficiencies in medical staffing are not uncommon in DOCCS, especially since DOCCS' budget for health services has been reduced significantly over the past few years.⁸⁵ Even when DOCCS does have funding, the Department faces formidable challenges in filling medical positions. For example, Albion mentioned that they struggled to find a doctor willing to fill a vacant GYN position. The prison sent out 350 applications and got back one. Recruiting and retaining medical staff in DOCCS is difficult in part because the salaries for DOCCS doctors (which are governed by the state's civil service guidelines) are lower than the salaries doctors can earn practicing in the community.

RECOMMENDATIONS

For DOCCS

- 1) Increase GYN staffing at all women's prisons and hire GYN staff at Taconic.

- 2) Station at least one nurse on-site from 11pm to 7am at Taconic. As an interim measure, permit women at Taconic to speak on the phone directly with medical staff when an emergency arises instead of having correction officers act as intermediaries.
- 3) Train sick call nurses and doctors to schedule women for medical appointments appropriately according to level of urgency. Discipline or remove staff who fail to schedule appointments in a timely fashion.
- 4) Assign Central Office's Quality Improvement Committee to work with each prison-based Quality Improvement Committee to investigate delays in women's access to GYN care and to create a plan to improve women's access to care at each prison.

For New York State Legislature and Governor

- 1) Allocate funds for DOCCS to hire sufficient medical staff, including GYN staff, in women's prisons.
- 2) Raise the pay scale for medical clinicians in DOCCS.

TRAUMA-INFORMED HEALTH CARE

Being physically examined by a doctor has the potential to retraumatize women who have experienced trauma and abuse, particularly sexual violence. This is especially true for GYN exams: the focus on sensitive body parts and physical touch that often occurs during exams can trigger memories of prior abuse and cause survivors to feel violated and unsafe. Fear of being retraumatized in this way leads some survivors to avoid seeking medical care altogether.⁸⁶ These issues are central to the provision of medical care in DOCCS as the overwhelming majority of women in prison are survivors of trauma and sexual abuse.⁸⁷

Many of the reproductive health survey respondents who reported feeling “bad” after GYN appointments said they felt this way because of past experiences of abuse:

- “I don’t like to be touched ’cause I was raped.”
- “I’ve been raped numerous times, so any type of contact down there makes me feel messed up, but I know I need to be checked.”
- “I have been traumatized a great deal – GYN appointments are extremely difficult for me.”
- “Women in prison are more likely than not to be trauma victims. I don’t feel this is taken into consideration during GYN visits.”
- “It’s so uncomfortable that lately I just sign refusals [for GYN appointments] because I can’t take it.”

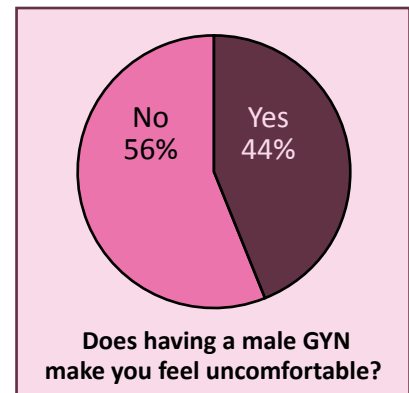
“I feel really dirty because I was raped a lot when young. So I really don’t want none of them touching me at all.”

Two issues of particular concern for survivors of trauma who answered the CA’s surveys are that DOCCS clinicians frequently fail to explain what they are doing during exams and that women are often assigned male GYNs.

On the first issue, women wrote that seeing doctors who do not explain what they are doing during exams leaves them feeling violated and powerless. One woman said: “[The GYN] just told me to take my clothes off from the waist down and to sit at the edge of the patient table. I would like to have had a warning or preparation that she was about to begin examining me with her fingers and then place the speculum inside me.” Another survivor commented that she felt “violated when I’m unprepared and not expecting to have the doctor not let me know what they are doing.” For all women, and particularly for survivors of abuse, hearing explanations during medical exams and having doctors ask permission before any touching occurs can help them feel more comfortable and safe.⁸⁸

On the second issue, many women wrote that they strongly prefer to see female GYNs and feel distressed when they are assigned to male providers. Forty-four percent (72 of 162) of general survey respondents who saw a male GYN while in DOCCS said that it made them feel uncomfortable talking about their needs.⁸⁹ The level of discomfort among women ranged from moderate anxiety to full-blown panic:

- “[I]’ve never had a male gynecologist in my life for personal reasons, and they said, ‘Tough.’ ”
- “I prefer a woman [GYN], but they tell us we don’t have the choice.”
- “I requested not to see a man GYN because I was raped and don’t feel comfortable with him.”
- “It was a male, and I get very scared because I’ve been victim to rape/molestation.”



A history of sexual abuse and having to see a male provider were the most common factors cited by women in explaining why they refused GYN appointments – which 20% (68 of 338) of reproductive health survey respondents said they did at least once during their incarceration. Some women reported that certain nurses threatened them with disciplinary tickets if they did not follow through with appointments with male providers. Such threats represent an extraordinary abuse of power on the part of medical staff, and violate DOCCS’ own Professional Code of Ethics.

“Seven times they gave me a male GYN. I was very uncomfortable, I have rape issues.”

DOCCS does not provide medical care that is “trauma informed,” meaning that its clinicians are not trained in how to recognize and understand the impact of trauma and provide care without retraumatizing their patients.⁹⁰ Outside the medical arena, DOCCS has taken some positive steps in establishing programs to help survivors of trauma and abuse. Bedford runs a Family Violence Program, and Albion and Taconic run Female Trauma Recovery Programs, six-month residential programs aimed at helping women address unresolved trauma, particularly childhood sexual violence.⁹¹ During the CA’s prison visits, women at Albion and Taconic spoke

“Since I’ve been incarcerated, [the Female Trauma Recovery Program] is the best program I’ve been in.”

very highly of their experiences in this program. Said one woman, “I never knew what was wrong with me, I never had a voice before. . . . I came in very, very angry. Two years later, I’m a completely different person.” Unfortunately, even though the need is great, the trauma program is not widely available; it serves only about 1% of the total female population in DOCCS (28 of roughly 2,300).⁹²

DOCCS also took the positive step of hosting a few trainings on trauma for staff in 2007 and 2008. Correction staff the CA interviewed who attended those trainings reported finding them “informative” and “rewarding,” and said they wished that more had been covered on vicarious trauma (trauma experienced by persons helping traumatized individuals) and the practical application of the information in a prison setting. These trainings were not mandatory and, as far as the CA knows, no medical staff attended them.

RECOMMENDATIONS

For DOCCS

- 1) Train all medical staff to provide trauma-informed care, including training them to ask for permission before touching patients and to explain what they are doing during exams.
- 2) Train all prison staff on working with survivors of trauma, and on how to handle and avoid vicarious trauma.
- 3) Allow women to choose female GYN providers.
- 4) Establish a Female Trauma Recovery Program in all prisons housing women and expand the capacity of the program at Albion and Taconic.

For New York State Legislature and Governor

- 1) Allocate funds for DOCCS to expand the Female Trauma Recovery Program.
- 2) Allocate funds for DOCCS to hold trainings for medical staff on trauma-informed care, and for security and civilian staff on working with trauma survivors and vicarious trauma.

QUALITY OF GYN CLINICAL INTERACTIONS

Women reported that the quality of interactions with medical staff varies significantly depending on which staff person they see. At each prison, women identified some clinicians who were professional and compassionate, and others who were disrespectful and inattentive. Women also commented that certain clinicians had both good and bad attributes, for example, that a doctor could be thorough but rude or kind but too rushed.

These varied experiences were reflected in women’s assessments of GYN providers, and it is important to note that women’s assessments include their experiences with both prison GYNs and other medical staff covering GYN care at their prison.

On the positive side, about three-quarters (72%, 483 of 672) of general survey respondents said the GYN at their facility was “caring and respectful,” and three-quarters said the GYN spoke to them “clearly and in a way that you can understand” during appointments (75%, 522 of 694).

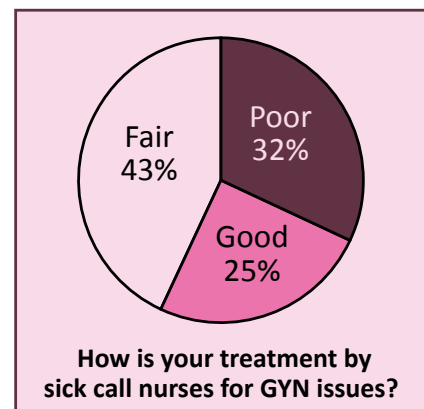
On the negative side, women identified certain sick call nurses who are dismissive and certain doctors who are insensitive, rough and hurried. More than one-quarter (28%, 79 of 285) of reproductive health survey respondents said that they felt “bad” after GYN appointments, and half (48%, 156 of 323) said they did not feel comfortable talking with the GYN at their facility.⁹³ Such experiences can fuel an overall lack of trust in prison medical care among women and can dissuade women from seeking care when they need it.⁹⁴ As one woman commented: “I’ll just wait to get out to get it dealt with because I don’t trust the doctors in here.”

The CA found the Medical Director at Bedford and, when it was open, the Medical Director at Beacon to be particularly impressive. On the other end of the spectrum was a contract doctor who, until he passed away in 2012, conducted intake physicals, including the GYN exam, at Bedford’s reception center. Women’s concerns about this doctor stood out, especially in contrast to the praise many women had for Bedford’s regular GYN.

Below is a more detailed description of common problems women identified with GYN clinical interactions.

Common problems with sick call interactions

Nearly one-third (32%, 50 of 158) of reproductive health survey respondents who went to sick call for a GYN problem rated their treatment by the nurse as “poor.” Forty-three percent (68 of 158) said the treatment was “fair,” and 25% (40 of 158) said it was “good.” Overall, Albion seems to have the most serious problem with sick call nurses who treat patients insensitively.



One woman at Albion described how she was crying in the sick call area, from pain she later learned was being caused by a kidney stone, when a nurse commented to her, “It doesn’t look like you are in that much pain.” Another woman at Albion wrote: “I told the male nurse about my problem, and he said, ‘It’s only a discharge.’ I even told him respectfully that I had a small smell coming from the discharge, and he said nothing can get done at all.”

Women at other prisons also reported poor treatment from some nurses. For example, a woman at Bedford with a history of cervical cancer, fibroids and menstrual problems said that when she went to sick call with pelvic pain, the nurse “felt around my belly and said everything is fine, no need to see a doctor yet I was still in pain.” Another woman commented: “The [sick call nurses] said that the exam from my last facility said it was nothing so it must be nothing.”

Common problems with interactions with certain GYN care providers

Some of the most frequent complaints women had about medical providers were that they had poor bedside manner, rushed through appointments and brushed off patients’ concerns. Comments include:

- “Your questions and concerns are ignored, and you are treated as if you don’t know your body. You are rushed in and out in minutes and treated as a child.”
- “[The GYN] rushes you and is intimidating which gets me nervous. . . often I forget to ask her what I need to know from the tense interaction.”
- “They don’t seem to care or have time. It’s like it’s an imposition for them to do their job. If you ask for results or tests you are a troublemaker to them.”
- “It’s basically in and out and we’ll get back to you with your results. So I find it hard to build that relationship to become that comfortable.”
- “I do not feel comfortable with most of the medical staff. . . nearly everyone is deemed a problem patient if we need more than a pat answer. . . .”
- “They do not listen about how your body feels to you. What they say goes.”
- “I’d like to be talked to and not talked at.”

“It should not matter if [medical staff] are caring for people in or out of prison. It’s truly sad to watch a person break down into tears because of the pain they are in and not being taken seriously.”

One woman summed up the general feeling when she wrote that one of the most important improvements would be to “train the physicians to be more personal and gentle. It’s hard enough dealing with being incarcerated. Kindness is essential.”

Overall, more than one-third (39%, 255 of 697) of general survey respondents said that the GYN provider did not give them enough time to talk about their needs. Many women at Bedford, in particular, reported feeling rushed during GYN appointments. One woman at Bedford wrote: “Visits are always rushed because of the amount of women that have to be seen.” Said another: “Sometimes you just feel like you’re on an assembly line.” Bedford’s GYN sees an average of 30 women on each of her two days at the prison, on top of her other responsibilities including paperwork and overseeing prenatal care. This leaves little time for each GYN appointment. One CA visitor, who is a nurse-midwife commented, “No matter how good a doctor you are, with that workload, it’s difficult not to have one hand on the speculum and the other on the doorknob.”

“She didn’t speak with me about anything. She just put the clamp in, looked, closed the clamp and said it looked okay.”

Another problem is the lack of communication and patient education from medical providers. A number of reproductive health survey respondents rated this issue as the top improvement they wanted for medical care in DOCCS. Comments include:

- “[The GYN] did not greet me nor did she introduce herself. I still don’t know her name. Only asked facts: DOB, name, age. But not how I was feeling or any risks being taken sexually.”
- “She could have talked to me more and told me why she was giving me the medicine exactly.”
- “She didn’t say anything during the whole procedure or after.”
- “They just do the test and write on the file without an explanation. I don’t feel comfortable.”
- “[The GYN] should explain more information to patients like why the specialist said I needed a sonogram. Can fibroids affect future pregnancy? Should they be removed or not? What they are doing when they examine you and if anything has changed and why I’m getting recurring yeast infections and I’m not HIV-positive.”

The CA’s chart reviews and interviews similarly revealed problems with ineffective communication from certain clinicians. For example, the CA visiting team interviewed and reviewed the charts of two women who thought they had cancer after getting abnormal Pap test results. Both women were concerned about the lack of follow-up care they were receiving. After examining the charts and speaking with the women, however, it became clear that the women did not actually have cancer but rather abnormal precancerous cells that were, in fact, being treated appropriately. The confusion and understandable anxiety the women felt stemmed from poor communication about what the Pap test results actually meant.

Finally, women identified problems with GYN providers failing to explain procedures while conducting them and being too rough during exams. Nearly one-third (32%, 76 of 241) of reproductive health survey respondents said that GYN providers did not give an explanation when conducting a pelvic exam, and about one-quarter (24%, 45 of 185) when doing a Pap smear. A lower number, 18% (21 of 118), said that GYN providers did not explain what they were doing during breast exams.

Women said that the lack of explanation left them feeling “uncomfortable,” “violated,” “nervous,” “bad and used,” and “like I didn’t have rights to know about my body because I was now in prison as an inmate.” On the issue of certain providers being too rough, one woman stated that she refused a GYN appointment in DOCCS “[b]ecause I go home in six weeks so I can go to my GYN where they are more nice doing the exam and it don’t hurt.”

Problems with a former reception doctor at Bedford Hills

A number of women commented that the GYN exam they had at Bedford’s reception center was a traumatizing experience. While the doctor conducting these exams has since died, it remains important to report these comments given their gravity and what the situation reveals about how DOCCS deals with problematic providers.

Women said that this doctor caused them pain and made them feel sexually violated during the GYN exam. In the CA’s experience, the level of concern women communicated about this provider is unusual. Comments include:

- “We were told to pull one leg out of our pants and undergarment, and lift up our shirts. Then to lay down while answering processing information questions. The doctor did a Pap smear and a breast exam, which was nothing like a proper breast exam – two fingers adding pressure in a circular path – but more like a full hand grope and then we were quickly rushed out. It was terrifying and violating.”
- “Something needs to be done about the male reception OB-GYN. He is extremely rough and scrapes you until you bleed. I bled for three days after he saw me.”
- “At reception, the GYN doctor made me feel like an object to be tolerated and groped. Felt violated and molested. So I don’t trust anything they do here.”

One woman said she left the reception exam room crying and feeling as if she had been “sexually abused.” She said that when she told a correction officer nearby, the officer commented that he had seen the same reaction in other women.

When CA staff raised this issue with DOCCS in the winter of 2010, Department officials said that they were aware of the concerns and had taken steps they considered adequate to address the problem. These steps included having Bedford's regular GYN observe the doctor's performance and conduct several sessions to re-train him on how to be gentler during exams. DOCCS said that the provider had "improved significantly" after the additional training. They also explained that a female nurse is always present if the GYN doctor is male and said the prison had spoken with nurses who chaperoned this doctor and that the nurses were "pleased with his performance." When asked if they had interviewed any patients, DOCCS responded that they had not and would not do so unless a woman filed a formal grievance against the doctor.

Physical space for GYN care

The physical space for GYN care in the various women's prisons ranged from impressive to appalling. Bedford has by far the best medical facilities; they are modern, clean and well-equipped. Bayview had by far the worst physical space for GYN examinations. Although Bayview is now closed, it is important to explain the poor condition of the prison's exam room because it indicates problems either with DOCCS' standards in this area or with the Department's awareness and oversight of medical facilities in its prisons.

Bayview's exam room was tiny, barely fitting a chair, a sink and an exam table with stirrups. Only with difficulty could the CA's visiting team fit three members in the space. The room was also in terrible condition: dingy with disheveled files and boxes piled on the floor, a broken sink and no soap, only hand sanitizer. Women expressed concern about the condition of the room, which they called a "closet," and noted their discomfort with having the stirrups face the door because they would be completely exposed if someone walked in.

Thoroughness of GYN exams

Women's reports about whether the GYN provider "examined them fully" during appointments varied by prison. Overall, 69% (473 of 682) of general survey respondents said that the GYN provider at their facility examined them thoroughly during appointments.

The CA was troubled to learn of a few particular cases where doctors treated women with recurrent symptoms of vaginal itching and discharge for yeast infections without ever physically examining them. When it was open, Bayview seemed to have particular problems in this regard. One woman at Bayview, for example, was given cream for a yeast infection without having a pelvic exam, and when she returned to the doctor after the cream did not work, she was given pills, but still no physical examination. Misdiagnosing recurring yeast infections can be dangerous as infections that are mistreated can be more painful and difficult to cure. Yeast infections also share symptoms with certain STDs (such as gonorrhea and chlamydia) which, left untreated, can lead to more serious health problems.⁹⁵

A few women reported cursory exams in other scenarios. One woman commented: “Doctor did not look at me. She said, ‘Oh, why are you here?’ She couldn’t remember I have a real issue. After explaining, she still did not touch me. She continued reading a book, never addressing I have a rash.” Wrote another woman: “A lot of the times I’ve gone to sick call the . . . nurses and sometimes the doctors generally did not want to touch you. . . .” In addition to conveying to women that their health concerns do not matter, this type of demeanor undermines the possibility of appropriate medical care.

RECOMMENDATIONS

For DOCCS

- 1) Train medical staff to: listen actively and respond to their patients’ concerns, spend adequate time explaining medical issues and test results, engage with patients to make joint decisions about treatment, and approach patient interactions with a respectful tone and a supportive bedside manner. As part of this training, adopt explicit standards for good medical practice during physical exams, including being gentle and thorough, asking patients for permission before touching them, and explaining what the exam will entail before and during the exam.
- 2) Survey women anonymously on a regular basis about their experiences with medical providers, and review grievances and other relevant documentation to identify trends and problem areas. Incorporate this information into medical staff evaluations, and use the information to acknowledge and, where possible, reward providers who excel and to monitor and work with providers identified as providing inadequate care. Replace providers who do not improve.

QUALITY OF MEDICAL CHARTS

Keeping good medical records is a critical part of any effective health care operation. Well-organized charts with thorough, clear notes help clinicians keep track of their assessments, conduct appropriate follow-up and facilitate continuity of care. These issues are particularly relevant in prison because doctors often have large caseloads and incarcerated people commonly see different providers at each medical appointment. In addition, women are frequently transferred from one prison to another and patient records are kept on paper, not on computer.⁹⁶

While the CA found examples of good medical charting at each prison, the CA also found widespread problems across the system with some charts so poor that they likely compromise patient care. These charts had missing and misplaced pages, incomplete and unclear notes from doctors and nurses, comments that were not dated, and often no indication of which provider wrote the notes, or even whether it was a nurse or doctor. Overall, medical charts at Bedford were better than at other prisons and Albion's were worse. When they were open, Beacon's medical charts were on the better end while Bayview's were even worse than Albion's.

Some medical charts had missing and misplaced pages, incomplete notes, and undated and unsigned comments

The CA visiting team was pleased to see DOCCS using a standardized form based on a documentation method commonly used in the community. This method is called SOAP, which stands for: subjective (the problem from the patient's perspective), objective (findings from a physical exam, such as vital signs), assessment (the patient's diagnosis and progress), and plan (what the doctor discussed with the patient and ordered to treat the problem).⁹⁷ This form provides a solid foundation for medical records. However, even though the CA found the form in many medical charts, DOCCS medical staff often did not use it appropriately.

On many forms the CA reviewed, entire sections were left blank, particularly the subjective, objective and assessment categories, leaving no record of the doctor's thoughts, her appraisal of the patient's condition or what she communicated to the patient. Some charts, for example, reflected that the doctor ordered prescription medication but did not indicate that the doctor ever conducted an exam. Other charts contained test results but no documentation of whether the patient was ever informed about those results.

Some providers neglected to write their name next to their notes, making it impossible to tell who treated the patient and what kind of clinician they are. Others failed to write the date and time. Sick call notations were also problematic, often with sparse, superficial notes recorded by the nurse.

In addition, many charts did not indicate whether women were taking mental health medication, even though many women in New York’s prisons do.⁹⁸ This is dangerous as doctors need this information to understand their patients’ full condition and to determine which medical medications are safe to prescribe. This process, called “medication reconciliation,” is standard practice in the community and is required by the Joint Commission on Accreditation of Healthcare Organizations (JCAHCO), the leading national organization accrediting health institutions.⁹⁹ Pharmacists in DOCCS may, in fact, carry out a reconciliation process when they fill prescriptions, but it nevertheless remains important for mental health medications to be listed in a woman’s paper medical chart for the doctor to see during each appointment.

DOCCS has a series of written policies outlining standards for medical charts, reflecting the Department’s awareness of the importance of good record keeping.¹⁰⁰ Poor medical charting violates these policies, which state that clinicians must include in each chart entry the date, their signature and “initials signifying their credential,” and that documentation in the chart should be “legible. . . specific, objective and complete” and “clearly and adequately state complaints and symptoms.”¹⁰¹

RECOMMENDATIONS

For DOCCS

- 1) Update and expand written policies regulating medical charts, including requirements that charts be properly maintained with pages filed in the appropriate section in chronological order and with a listing of all medication for each patient, including mental health medication.
- 2) Give medical providers stamps with their name and title (e.g., M.D., R.N.).
- 3) Incorporate into the quality improvement process at each prison a review of medical charts to make sure they meet appropriate standards.
- 4) Create an electronic medical charting system to facilitate effective record keeping and continuity of care.

For New York State Legislature and Governor

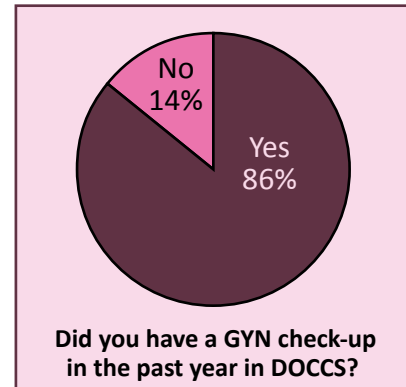
- 1) Allocate funds for DOCCS to create an electronic medical records system.

ANNUAL GYN EXAMS, PAP TESTS, BREAST EXAMS AND MAMMOGRAMS

Annual exams

DOCCS' written policy states that women over age 30 should have yearly GYN check-ups.¹⁰² In practice, women younger than 30 in DOCCS also have annual exams. This is appropriate as community standards recommend that women begin annual GYN check-ups at age 21 or earlier if they are sexually active.¹⁰³

DOCCS seems to be doing a good job ensuring that most women receive annual GYN exams: 86% (201 of 235) of reproductive health survey respondents said they had a GYN check-up in the past year. Among women who had an annual check-up, 97% (192 of 199) reported having a pelvic exam during their appointment.¹⁰⁴



One area for improvement is the timeliness of scheduling annual appointments: 30% (56 of 188) of reproductive health survey respondents who said they had a GYN check-up in the past year said they had to request the check-up themselves. Of women who had not received an annual GYN exam in the past year, some said they were well past the one-year time frame even after multiple requests. One woman, for example, reported that she had been to sick call twice in four months after passing the one-year mark but still had not seen the GYN. Another said she put in a request at sick call but still had not heard anything two months later. One woman wrote: "It's been almost two years since my last GYN, you have to request it. And it takes long."

Pap tests

DOCCS' written policy is that women should have annual Pap tests and screening for human papillomavirus (HPV), an STD that can cause cervical cancer.¹⁰⁵ Among reproductive health survey respondents who reported having an annual GYN appointment in the past year, 94% (187 of 199) reported getting a Pap smear.

DOCCS' written policy on Pap tests reflects an older community standard that is now out-of-date. Current standards call for no Pap tests or HPV screening for women under 21 or over 65, and reduced Pap- and HPV-screening frequency among women age 30 to 65, unless a woman has a history of abnormal Pap tests, HPV or cervical cancer.¹⁰⁶

DOCCS' written policy regarding follow-up for abnormal Pap tests is similarly out-of-date. For example, DOCCS' policy states that HPV screening should be performed on all abnormal Pap test

results, but guidelines from the American Society for Colposcopy and Cervical Pathology, the leading U.S. organization setting standards for cervical cancer screening, state that women under the age of 30 should never be screened for HPV.¹⁰⁷ (This is because HPV is highly prevalent among women under age 30 and typically clears up without treatment.) DOCCS' policy also states that if a woman is HPV negative and her Pap result shows a change in cells known as ASCUS (atypical squamous cells of undetermined significance), she should have another Pap test in six months, while the American Society for Colposcopy and Cervical Pathology states that women in these circumstances should not have another Pap test for three years.¹⁰⁸

Each prison reported that follow-up appointments for abnormal Pap results are generally scheduled within one to two weeks. Reports from women about the timing of follow-up appointments were mixed: some said they had an appointment within two weeks while others said they waited much longer.

DOCCS does not adequately track the incidence of abnormal Pap test results, and estimates of the frequency of such results varied widely among the prisons. Bedford and Beacon reported what seem to be reasonable estimates: Bedford, 15 to 20% and Beacon, 13%.¹⁰⁹ Albion's estimate, 6%, seems low for a population at increased risk for STDs and cervical abnormalities, and Taconic's estimate, 95%, is almost certainly too high.¹¹⁰ Bayview reported that the data was "unknown."

Clinical and self-breast exams

DOCCS' policy states that women should have a breast exam "with the initial exam and whenever clinically necessary," and notes the importance of clinical breast exams as a supplement to mammograms in detecting breast cancer early.¹¹¹ National health organizations including the American Cancer Society and American College of Obstetricians and Gynecologists (ACOG) state that women should receive clinical breast exams every one to three years at ages 20 to 39 and yearly starting at age 40. These exams should be routine and not on a case-by-case basis.¹¹²

About two-thirds (69%, 490 of 709) of general survey respondents reported that someone had spoken to them about how to do a self-breast exam since they entered DOCCS custody. Though not all health organizations agree that monthly self-breast exams are necessary to help detect cancer, many still recommend that women regularly perform the exams to increase the likelihood of identifying breast changes early on.¹¹³

Mammograms

DOCCS' policy is to provide an annual mammogram for women 40 years and older, unless a prison doctor determines that a higher frequency is needed.¹¹⁴ There is currently a debate in the medical community about the optimal frequency of mammograms. Some national health organizations recommend the same frequency outlined in DOCCS' policy: yearly screenings starting at age 40.¹¹⁵

Others recommend screenings every two years beginning at age 50 and from age 40 to 49 based on an individual assessment of a woman's medical history and risk level.¹¹⁶

However the debate gets resolved, DOCCS has a mediocre track record of adhering to its own policy: only two-thirds (67%, 85 of 127) of reproductive health survey respondents who were 40 or older reported having a mammogram in the past year in DOCCS, and about one-quarter (24%, 20 of 83) said they had to request the procedure. Some women over 40 said it had been two years since their last mammogram. A chart review by the CA for one 43-year-old woman found that she had not had a mammogram for over two years.

DOCCS' policy also states that women should begin annual mammograms at age 35 if they have first-degree relatives (such as their mother or sister) who have been diagnosed with breast cancer.¹¹⁷ Bedford reported that its clinicians screen women between age 35 and 40 at reception for a family history of breast cancer for this purpose. Only 39% (22 of 56) of reproductive health survey respondents who were between the ages of 35 and 40 when they entered DOCCS custody, however, reported that medical staff at reception asked about a family history of breast cancer.

DOCCS does not adequately track the incidence of abnormal mammogram results, and estimates of the frequency of such results varied widely among the prisons.¹¹⁸ One prison, Bayview, reported that this data was "unknown."

RECOMMENDATIONS

For DOCCS

- 1) Update written policies to reflect: 1) that women should begin annual GYN check-ups at age 21 or earlier if they are sexually active per community standards; 2) that women should be offered a clinical breast exam at every annual GYN check-up; and 3) the current community standards for frequency and follow-up of abnormal Pap tests.
- 2) Improve scheduling to make sure that no women fall through the cracks in receiving GYN check-ups every year.
- 3) Per DOCCS' policy, ensure that women are offered mammograms every year beginning at age 40. Train clinicians to inform women about the debate in the medical community regarding mammogram frequency, and to work with women to make joint decisions about when to have mammograms.
- 4) Train reception medical staff to identify women in high-risk categories for breast cancer and screen them appropriately.

GYN TEST RESULTS

Timely communication of test results and discussion of abnormal results are important dimensions of health care. Eighty-three percent of general survey respondents said it took three weeks or less to get GYN test results back. This finding is positive, especially considering that three weeks is generally consistent with the time frame in the community for basic GYN tests like Pap smears.¹¹⁹

Some women, however, particularly at Bayview when it was open and to a lesser extent at Bedford, reported longer waiting periods for GYN test results, including Paps, urine tests and biopsies. One woman, for example, reported waiting five weeks for her urine test results. When the results finally came back, she was diagnosed with a urinary tract infection and treated. A delay of this length could have resulted in a more serious problem, such as a kidney infection. A chart review for one 46-year-old woman with HPV indicated that she waited for over a month to get results from a Pap test, which were abnormal, and only received the results after going to sick call and requesting an appointment with the doctor. Other women also said they had to actively request their test results.

DOCCS' stated practice is for doctors to send normal test results by mail and to talk to patients about abnormal test results in person during appointments. More than one-third (36%, 107 of 297) of general survey respondents, however, said they got their abnormal test results by mail. One woman, for example, wrote: "I was told at Albion by mail of what I had (trich[omoniasis, an STD]). . . . I saw no doctor. . . ."

Sending abnormal results by mail is ineffective, depriving patients of the chance to learn about their medical situation and process bad news with a doctor's assistance, and it can cause extra delays in follow-up. For example, of general survey respondents who got their abnormal test results by mail, 17% (56 of 337) said it took more than two weeks to see the GYN after receiving their results.

RECOMMENDATIONS

For DOCCS

- 1) Investigate instances where women report delays in getting medical test results and take affirmative steps to ensure that women receive test results in a timely fashion.
- 2) Adopt a written policy codifying DOCCS' stated practice of sharing abnormal test results during face-to-face appointments.

HYSTERECTOMIES

A hysterectomy, surgery to remove a woman's uterus, is a serious operation that can have a negative emotional impact. Some women grapple with the inability to have children and the early onset of menopause, and some struggle with depression and feelings that their female identity had been altered.¹²⁰ One woman who had a hysterectomy in DOCCS wrote that she felt as if her "womanhood has been annihilated."

Based on data from each prison, it seems that anywhere from five to 15 women have hysterectomies each year in DOCCS. All of the women's prisons stated that the most common underlying reasons for hysterectomies are fibroids and excessive uterine bleeding. These conditions are also common reasons for hysterectomies in the community, although a hysterectomy should not always be the first course of action to address these medical problems.¹²¹

DOCCS has no written policy on hysterectomies and does not adequately track the incidence of fibroids, which makes it difficult to evaluate whether women are getting appropriate treatment.¹²² One case of concern is that of a 42-year-old woman, Andrea, who had pelvic pain and heavy bleeding during her period. Andrea's medical chart shows that she saw a prison GYN and a GYN specialist, and received a CT scan and an ultrasound which found a non-cancerous fibroid. She had a hysterectomy about one month later. Andrea said she felt disempowered and distressed because the prison doctor did not adequately explain his reasons for scheduling a hysterectomy before exploring less drastic treatment methods. "All they said was surgery," she wrote.

Andrea's experience contradicts both DOCCS' Patient Bill of Rights, which states that incarcerated people have the right to "information necessary to give informed consent prior to the start of any [non-emergency] procedure or treatment," and DOCCS' informed consent policy which states that, before obtaining consent for a major medical procedure, incarcerated people must be told why the procedure is needed.¹²³

Another woman said that the hospital doctor who performed her hysterectomy followed neither the prison doctor's recommendation nor her personal wishes: "[The doctor at the hospital] did a complete hysterectomy when I specifically told him, like [the prison doctor] advised me, to [leave my ovaries so that I would] still have estrogen. But two years later. . . [the prison doctor] checked my chart and saw a complete instead of a partial hysterectomy was done. I found out too late. . . . No other type of treatment was mentioned to me by [the hospital doctor]."

In addition to better communication about their medical condition and treatment options, women need better emotional support and follow-up care after hysterectomies. Comments from the 13 women the CA surveyed or interviewed who had a hysterectomy or one or both

ovaries removed while in DOCCS custody make this clear. For example, when asked if any staff had inquired about how she was coping after the surgery, one of the woman stated: “No. It’s always a rush in this place.” This woman also noted that even months after the hysterectomy, no doctor had explained to her why she continued to experience “burning and pain in my stomach.” Another woman reported waiting six months after her hysterectomy to see a GYN for a follow-up appointment. Community standards recommend that women who undergo hysterectomies have a follow-up appointment with a physician within six weeks after the procedure. Many women need appointments soon after their surgery to discuss issues such as physical discomfort and hormone therapy.¹²⁴

RECOMMENDATIONS

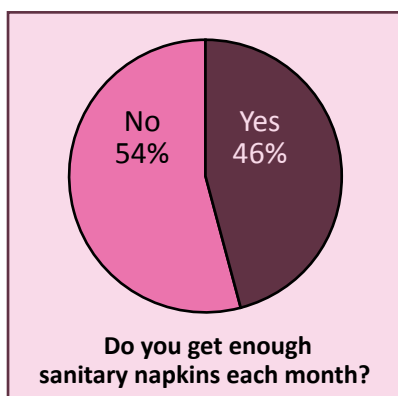
For DOCCS

- 1) Develop informed consent protocols to ensure that hysterectomies are a treatment of last resort.
- 2) Ensure that women understand why a hysterectomy is being recommended.
- 3) Provide referrals to supportive services including counseling for women who have hysterectomies.
- 4) Establish written policies for hysterectomies that comport with community standards, including scheduling follow-up appointments for women who have hysterectomies within six weeks after the surgery, and sooner if needed.

ACCESS TO SANITARY SUPPLIES

Sanitary napkins

Insufficient sanitary napkin supplies is a problem for women in DOCCS. The vast majority of women the CA interviewed reported that the monthly supply of sanitary napkins DOCCS gives them does not meet their needs. More than half (54%, 514 of 957) of general survey respondents said the same, and this figure may be an underestimate because the total pool of respondents likely includes some post-menopausal women who no longer need pads.



DOCCS distributes 24 sanitary napkins to women in general population each month.¹²⁵ Many women expressed dismay and exasperation at the inadequate supplies. As one woman wrote, “[R]eceiving only 24 sanitary napkins per month is not very sanitary during a menstrual cycle.” Other women said that the poor quality of state-issued pads exacerbated the situation: “My period lasts seven days. . . . Sometimes I have to wear four at a time because they are so thin.”

Additional pads are given only to women who obtain a special permit from the medical department. This practice is misguided given that the underlying reason many women need more pads is not a medical illness but rather DOCCS’ refusal to distribute an adequate number of sanitary napkins in the first place.

At Taconic, prison medical staff reported to the CA that only a woman who can prove she is anemic can get a permit (doctors would do a blood test). The prison’s rationale was that they wanted to “treat the underlying problem, not the symptom.” When the CA asked DOCCS for clarification, Department officials explained that Taconic’s anemia-specific policy is no longer in effect. DOCCS’ explanation did indicate, however, that a version of Taconic’s old policy still exists: “On occasion, inmates have complained that they need more sanitary napkins or heavier sanitary napkins, but many do not also want to then be assessed by medical staff for the heavier sanitary napkins, which is a precautionary health care protocol (blood counts, pelvic exams, cancer screenings, etc.), to see if they have a more serious problem that may need medical attention.”¹²⁶ While women should be treated appropriately for any illness, approving sanitary napkin medical permits only after a medical assessment makes no sense. Many women need more pads even if they do not have a serious health condition.¹²⁷

Women who need more monthly supplies must get a special medical permit, a humiliating and unjustified practice

The process for getting a permit at Bayview when it was open was even more degrading. The prison required women to bring in their used sanitary napkins to prove they needed more supplies. As explained by Bayview's former Medical Director: "We need to have evidence that a woman needs more. We need her to bring in a bag of used sanitary napkins to show that she actually has used them and needs more." Bayview was also slow to grant permits and sometimes refused to grant them at all. One woman who was at Bayview and had to use three sanitary napkins at a time said the doctor told her to fill out a chart to track her menstrual cycle before she could get a permit. Two other women who had to use multiple pads at a time said that the prison denied their request for permits outright.

Another problem at Bayview and, until recently, at Taconic, was that extra pads were not stored on the housing units for correction officers to distribute. One woman explained, "It's a huge issue. It's terrible. We're women and we need it for our menstruation. It's not the COs' fault. They don't keep it on the units." Even at Albion and Bedford, and now Taconic, which do keep extra supplies on the housing units, the practice remains less than ideal. Correction officers should not have authority to deny women extra supplies, however infrequently that may happen (reports of refusals are rare), and asking officers for pads can be an uncomfortable situation for women, especially if the officer is male.

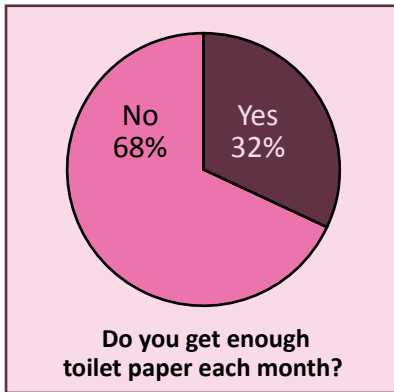
The challenges women face in obtaining additional sanitary napkins on their own only add to the problem. Prices for pads and tampons in prison commissaries vary widely and are prohibitive for women with few financial resources and outside support. It costs 12 cents for each tampon at Bedford's commissary, 17 cents at Albion and 24 cents at Taconic. Pads are also expensive, costing 22 cents at Albion and 21 cents at Taconic. Bedford sells only "panty liners," which are thinner and less absorbent than pads, for 67 cents per box. At these rates, a woman making 17 cents per hour (a common prison wage) would have to spend her entire week's earnings to buy a single 20-pack box of tampons or pads at Taconic. Even women with family support report that they are not allowed to receive pads or tampons by mail.

To buy a single 20-pack box of tampons or pads at Taconic, a woman has to spend her entire week's earnings

The CA's discussions over the past few years with DOCCS about the sanitary napkin problems have produced no improvements. Department officials express skepticism that the problem is widespread and suggest that women run out of supplies because they use pads for other purposes, for example, to quiet squeaky doors, steady uneven tables and chairs, and clean their housing area. The CA's research demonstrates that the problem of inadequate supplies is significant. In addition, DOCCS could easily provide other items for cleaning and addressing noisy doors and broken furniture instead of denying all women enough pads because some use them for other purposes. Ultimately, the cost of providing sufficient sanitary supplies is minimal while the benefit – protecting women's health and personal integrity – is great.

Toilet paper supplies

Not getting enough toilet paper is also a problem for women in DOCCS. Similar to sanitary napkins, the vast majority of women the CA interviewed report that the monthly supply of toilet paper DOCCS provides does not meet their needs. More than two-thirds of general survey respondents (68%, 694 of 1,025) reported that they do not get enough toilet paper each month.



One woman explained that she sometimes used “magazines, newspaper, lined paper and washcloths” when she ran out.

Women receive the same amount of toilet paper each month as men, even though biology dictates that women need more. Women use toilet paper each time they urinate, and many women use more toilet paper when they menstruate, including to hygienically dispose of sanitary napkins. As one woman explained: “We need more toilet paper. We do not have enough to wrap our pads in. . . .”

Women typically get six rolls of toilet paper per month at Albion, and five rolls at Bedford and Taconic. Buying more is not an option for women with few financial resources. Toilet paper costs 48 cents per roll at Albion and Bedford, and 49 cents per roll at Taconic. This means that a woman earning 17 cents per hour would have to work for three hours to make enough money for a single roll of toilet paper. As one woman wrote: “Toilet [paper rolls] are scarce and to have to buy toilet paper is not an option for those who live on state money.”

It takes a woman 3 hours of work to earn enough to buy a single roll of toilet paper

Menstruation-related self-care items

Women report difficulty obtaining basic self-care items frequently used in the community to help with cramps during their period. DOCCS does not permit nurses to distribute self-care items like hot water bottles and heating pads, though nurses can give over-the-counter medication, including Motrin, Advil and Tylenol.¹²⁸ Women also report that they are not allowed to receive self-care items like hot water bottles and heating pads by mail.

RECOMMENDATIONS

For DOCCS

- 1) Increase the number of sanitary napkins and rolls of toilet paper given to women each month, and improve the quality of pads.

- 2) Provide women each month with a choice between free pads and free tampons, or a combination of both.
- 3) Provide women with small bags or wraps that they can use to hygienically dispose of used sanitary napkins.
- 4) Quiet squeaky doors, fix furniture and provide women with adequate supplies to clean their housing areas so that sanitary napkins do not have to be used for those purposes.
- 5) Establish a written policy stating that women will receive adequate sanitary supplies each month and that women are entitled to receive more upon request without a medical permit. Until such a policy is established, remove barriers to medical permits, including eliminating any requirement that women be diagnosed with an illness or show used sanitary pads as proof of need.
- 6) Require prisons to maintain extra sanitary napkin supplies in the medical area and on the housing units, and allow women to receive sanitary napkins and tampons in packages sent from the community.
- 7) Allow nurses to distribute self-care items such as hot water bottles and heating pads to women who need them.

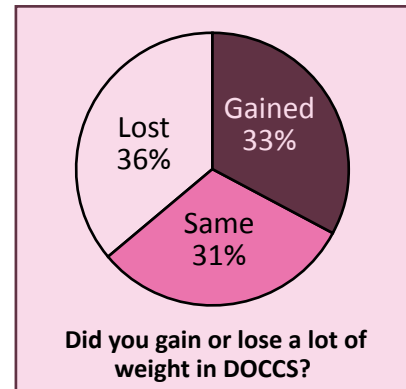
WEIGHT, NUTRITION AND VITAMIN SUPPLEMENTS

Proper weight and nutrition are vital to women’s physical and emotional health.¹²⁹ They are also essential to women’s reproductive health: poor nutrition and being underweight or overweight can negatively affect menstruation and fertility.¹³⁰ Incarceration poses significant challenges to women’s ability to get the right nutrition and maintain a healthy weight.

Weight

Women in prison are at particular risk of gaining or losing too much weight. This results in part from the fact that incarcerated women have little control over the food they eat and how much they exercise. The stress of incarceration may also fuel weight problems as many women deal with emotional distress through food, over- or under-eating as a way of coping with anxiety.¹³¹

About two-thirds of reproductive health survey respondents reported experiencing a serious weight change since their incarceration: one-third (33%, 103 of 311) said they gained a significant amount of weight, and another one-third (36%, 113 of 311) said they lost a significant amount. The most common reasons women cited were: 1) eating prison food with too much sugar and starch; 2) not eating prison food because of its poor quality; 3) eating too much or too little as a way of dealing with stress and depression; 4) weight-related side effects from mental health medication; and 5) exercising more or less frequently than before prison. Comments include:



- “[At Bedford] my weight stayed the same. Very depressed at Albion because monthly visits from children now yearly. . . .”
- “The stress. I don’t eat well when I’m nervous or sad.”
- “Lost because of not eating, nasty food.”
- “Lack of exercise and poor facility diet. Too much carbs are given to us, rice, bread, potatoes and pasta. More fruit and veggies are needed.”
- “Mental medication makes you gain weight.”
- “The [mental health] medication I was on. . . had me lose a lot of weight.”
- “I have gained 15 pounds in four months in Taconic. There is nothing to do here and at Albion I was much more active.”

Some women also said that being in solitary confinement affected their weight because of the stress and inability to move around while locked down 23 hours per day in a small cell. One woman, for example, wrote that she had gained weight “because I stay lock confined and eat all day to easy my pain.” Another woman wrote: “[E]very meal has starch and since I spent over seven months in solitude I ate bread. . . .”

Nutrition and vitamin supplements

DOCCS provides incarcerated people with three meals per day.¹³² Most food in the New York prison system is prepared at Oneida Correctional Facility’s Food Production Center, where it is partially cooked and frozen before being shipped to other facilities to be fully cooked and served.¹³³ DOCCS provides modified diets if ordered by a prison doctor, including low-salt and low-carbohydrate diets, and diets for diabetics, individuals on dialysis and individuals who observe religious dietary rules.¹³⁴ If an incarcerated person on a special diet misses more than three meals in one week, DOCCS reserves the right to discontinue the diet and discipline the individual.¹³⁵

“High-starch, low-fruit, low-vegetable diet. Commissary carries few fruits and vegetables, no healthy snacks and often runs out of fruit for months.”

According to DOCCS Office of Nutritional Services, the Department’s prison diet “exceeds RDA standards for adequate nutrition.”¹³⁶ Many women the CA surveyed and interviewed, however, reported that prison food has too many carbohydrates and does not seem well balanced or healthy. These comments are worrisome considering that a high-starch diet has been linked to diabetes and obesity, two conditions disproportionately affecting African-American and Latino/Latina people, who are overrepresented in prison.¹³⁷

Regarding vitamins, DOCCS’ policy is to provide vitamin supplements only for people who have specific illnesses or vitamin deficiencies. Prison doctors are allowed to prescribe multivitamins for people with cancer, HIV, hepatitis C, thyroid problems, liver disease and pregnancy, who have “compromised nutritional status or unintentional weight loss.”¹³⁸ This guideline comports with the findings of national health organizations that multivitamins for specific groups, such as those listed in DOCCS’ policy, can be beneficial.¹³⁹ However, given the lack of fresh food in prison and the limited control people in prison have over their diet, multivitamin supplements would likely be helpful for all incarcerated people.

About half of reproductive health survey respondents who had not been prescribed vitamins (53%, 88 of 165) said they had asked for vitamins at some point during their incarceration and were refused by the prison. Some women commented that doctors said they could not have vitamins because of budget cuts and suggested they buy vitamins at the prison commissary

instead.¹⁴⁰ Women noted that they cannot get vitamins in the mail unless a prison doctor gives them special permission and that commissary vitamins are too expensive for women with limited financial means. As one woman wrote: “Discontinued the vitamins and told me to buy it off commissary. Can’t afford it. Live off of the state pay.”

DOCCS’ vitamin practices for women with HIV is of particular concern. One woman with HIV said her request for vitamins was denied because “they said the state does not pay for vitamins for HIV people anymore.” This is contrary both to DOCCS’ own policy and to the recommendations of national health organizations that people with HIV should take multivitamins, especially if their access to fresh food is limited.¹⁴¹

Calcium, a mineral, is not mentioned in DOCCS’ written policies.¹⁴² Calcium is important to women because it can help keep bones strong and prevent osteoporosis, a condition causing bones to become brittle which disproportionately affects women, particularly older women.¹⁴³ While there is debate among national health organizations about whether all women should take calcium, there is consensus that supplements should be given to women with particular risk factors, such as decreased bone density, and women who are unlikely to get enough calcium from their daily diet.

There is also consensus that getting calcium through a healthy diet as opposed to supplements is ideal.¹⁴⁴ Most women in the community find it difficult to consume the recommended amounts of calcium each day through diet alone, and women in prison likely face even more difficulty.¹⁴⁵

Based on data from each prison, it seems that DOCCS does not give calcium supplements to many women: Bedford reported that 11% of its population was receiving calcium, Albion reported 8%, and Taconic reported 4%.

Vitamin D, also of special importance to women because it helps the body absorb calcium, is mentioned in DOCCS’ policy. The policy recommends giving vitamin D supplements to women over 50 and to other specific groups. Recently, studies have shown that vitamin D deficiency is widespread in the U.S., especially among African-American and Latino/Latina people, and that vitamin D deficiency may be linked to certain chronic diseases.¹⁴⁶ These findings make it even more important for DOCCS to screen and treat incarcerated people for vitamin D deficiency.

Some women said they were denied calcium and vitamin D even if they presented a legitimate medical need. One woman, for example, wrote that her request for calcium was rejected “even though I am over 40 with a family history of osteoporosis.” Another woman explained that it took the prison four months to check her vitamin D levels, and when they finally did, the test results showed a “severe deficiency” requiring treatment.

RECOMMENDATIONS

For DOCCS

- 1) Provide women with up-to-date and gender-specific information on nutrition, exercise and healthy eating.¹⁴⁷
- 2) Create peer support groups for women having difficulty maintaining a healthy weight and healthy eating habits.
- 3) Re-evaluate DOCCS' cook-chill menu with a particular focus on the level of carbohydrates compared to fruits and vegetables.
- 4) Provide all women with the option of calcium supplements and multivitamins. Until multivitamins are available for all women, re-train doctors on DOCCS' policy to provide multivitamins for specific groups, including women with HIV, and make sure that women in those categories are receiving appropriate supplements.
- 5) Test vitamin D levels for all women and give vitamin D supplements to women who have a deficiency.

CONTRACEPTION

Access to contraception is central to women’s health, agency and economic security.¹⁴⁸ This is true for women in the community and for women in prison. Nevertheless, access to contraception for women in DOCCS is severely limited.

With few exceptions, DOCCS prohibits its doctors from prescribing contraceptives. The exceptions are for women participating in the Family Reunion Program, who can have condoms for overnight trailer visits with their husbands, for women returning to the community, who receive condoms when they exit the prison gates, and for women enrolled in DOCCS’ hepatitis C continuity-of-care program, who can be prescribed birth control because hepatitis C medication can cause severe birth defects.¹⁴⁹

DOCCS’ prohibition on contraception negatively impacts women’s health and limits the control women have over their lives

From 2009 to 2013, DOCCS contracted with Planned Parenthood to offer contraceptives to women at Albion, Bedford and Taconic who were within two weeks of release. Unfortunately, after funding was cut, this initiative ended in all three prisons, and women no longer have access to birth control before their release.

The reasons for DOCCS’ contraception policies are unclear, although they may stem from concern that providing birth control would appear to condone sexual activity in prison. For example, when asked to state the reason for the policy, Taconic wrote: “Female offenders are not having heterosexual sex then there is no need for birth control which has many side effects.” Among the other rationales suggested by Department officials, the most perplexing was from Bayview’s former Medical Director, who said that women preparing for release should not have birth control because “there is no guarantee that women will be monitored. We can’t follow up with them and we don’t know if they are taking it correctly.” This is true of all prescription medications yet DOCCS commonly provides prescriptions to women before they leave prison.

Regardless of the rationale, DOCCS’ policy has multiple negative consequences, which are discussed below.

Former Planned Parenthood initiative

From 2009 to 2013, DOCCS contracted with Planned Parenthood to provide reproductive health education sessions and access to birth control for women preparing for release at Bedford, Albion and Taconic. Almost 680 women participated in educational sessions in 2012, and more than one-quarter (28%, 190) signed up for birth control.

While the program was similar at all three prisons, Albion's program seemed to be the most robust and effective. For example, at Albion, Planned Parenthood offered women the full range of birth control methods, including the pill,¹⁵⁰ the Depo-Provera shot (a hormonal injection),¹⁵¹ Implanon (a hormone-releasing plastic rod implanted in the arm),¹⁵² the NuvaRing (a hormone-releasing ring inserted into the vagina)¹⁵³ and the IUD (a device inserted into the uterus).¹⁵⁴ At Taconic, the program offered women only three choices (the pill, the NuvaRing and the Depo-Provera shot), and at Bedford, the program offered only two choices (the pill and Depo-Provera shot).¹⁵⁵

Albion had the highest rate of women signing up for birth control after the Planned Parenthood educational session. In 2012, 38% (170 of 453) of women who attended an educational session at Albion signed up for birth control, compared to 17% (13 of 79) of women at Bedford and 7% (10 of 146) of women at Taconic.

To conduct the educational sessions, a staff member from the regional Planned Parenthood office would travel to Bedford every two to three months and to Albion and Taconic every month to speak with women who had three months or less until their next parole board hearing or release date. The average size of each group was eight to 10 women at Bedford and Taconic, and 15 women at Albion. The sessions included information about safe sex, STDs, healthy sexual relationships, birth control methods and family planning resources. Planned Parenthood staff reported that these sessions were helpful because, although some participants were well-informed, most women were not familiar with the full range of birth control methods or STDs, and, like women in the general public, many had misconceptions and questions.

At the end of each session, women were given the opportunity to sign up for birth control, which they would receive from a Planned Parenthood clinician who came to the prison. A clinician traveled to Bedford approximately once every two months, to Taconic about once a month, and to Albion twice a month for the appointments, which were scheduled by a DOCCS nurse. Women were permitted to leave the prison with an extra prescription so they could more easily obtain a refill after returning home.

This initiative was of great benefit to women and their families, and it is a significant loss that DOCCS no longer has the funds to continue the program.¹⁵⁶

Contraception for women in work release

DOCCS does not give women in its work release program access to prescription birth control, even though women in the program spend time in the community and may have sexual partners there. Prison officials' explanation for this practice is that DOCCS doctors are not permitted to prescribe birth control, and women on work release are not allowed to obtain medication from medical providers in the community. The lack of access to birth control has significant implications because women who get pregnant while participating in work release may lose their spot in the program (*see Section 3, p. 87*).

Contraception for women in the Family Reunion Program

DOCCS' Family Reunion Program is a valuable program that allows incarcerated people to stay overnight with their spouses, children and other relatives in a private trailer on prison grounds. To be eligible, an incarcerated person must maintain a positive disciplinary record and have been in DOCCS for at least six months.¹⁵⁷ Trailers are on-site at Albion and Bedford, and women from Taconic who qualify are permitted to use the Bedford trailers. In 2013, about 160 women participated in the program (20 women at Albion, 110 at Bedford and 29 at Taconic).

DOCCS permits women participating in the Family Reunion Program to have condoms for their overnight visits. The process for accessing condoms varies from facility to facility. Albion reported that women ask for condoms from the officer on duty at the time of the trailer visit. Bedford reported that women ask their Offender Rehabilitation Counselor (ORC) for condoms. (ORCs are DOCCS civilian staff who meet with incarcerated people about once every three months for 15 to 30 minutes to record progress in meeting programmatic requirements. Their caseload is usually 50 to 100 people.) Taconic initially reported that women need to be cleared by the Medical Director but later stated that women could receive condoms directly from ORCs.

DOCCS does not allow women in the Family Reunion Program any birth control other than condoms. This is problematic for women who do not want to use condoms and for women who are concerned about asking their husbands to use a condom or who have husbands who will not agree to use a condom even if they are asked.¹⁵⁸

Contraception for health reasons unrelated to pregnancy prevention

Hormonal contraception is standard treatment for a range of conditions, including irregular periods, abnormal uterine bleeding, ovarian cysts and endometriosis (abnormal tissue growth which can cause serious pelvic pain).¹⁵⁹ Many women reported that DOCCS denied them hormonal contraception when they needed it for health reasons unrelated to pregnancy prevention. Comments include:

- "I wasn't allowed my birth control that I was taking for irregular periods."
- "I took the pill to maintain my balance of male/female hormones. DOCCS did not agree that I needed it."
- "They didn't follow my doctor's orders from outside, I was told to address the issue at my destined facility."

"I was on birth control for endometriosis before coming into prison. . . I was told here that we aren't allowed birth control."

- “They refuse to give me Yaz¹⁶⁰ for PMDD [premenstrual dysphoric disorder], and state only that I’m not allowed to have it because it’s a form of birth control.”
- “I asked [for birth control] to regulate my period. They told me no!”
- “They told me that they don’t give the birth control medication out to inmates because we will not be getting pregnant. I have explained to them that it is for my health reasons. They did not care.”

Some women explained that DOCCS doctors only renewed their birth control prescriptions after extensive advocacy. One woman, for example, said it took eight months of requests before doctors gave her a prescription. Another woman wrote, “I am supposed to take birth control to regulate my cycle. I’ve just recently, almost 12 months since I’ve requested it, have been considered for birth control.”

Some women singled out Albion as being particularly problematic in this area. For example, one woman, who was ultimately diagnosed with fibroids, wrote: “In Bedford, I was having very bad pain and no period months at a time. Then when I would get one, it would be on for a month or more. . . I was on the pill and Albion took them from me.” Another woman wrote: “When I came to Albion, they took me off birth control pills. I was bleeding a lot.”

The issue of access to hormonal contraception was recognized by the New York State Commission of Correction, an executive agency charged with overseeing conditions in the state’s correctional institutions, in a 2008 memo to jail administrators. Written in response to a New York Civil Liberties Union (NYCLU) report on reproductive health care for women in New York’s jails,¹⁶¹ the memo states that jails should permit women “to continue taking previously prescribed hormonal therapy during incarceration, i.e., in a manner no different from most other prescription medications prescribed by an offender’s primary care physician.”¹⁶²

Contraception for women taking medications contraindicated during pregnancy

Women who take medication that is contraindicated during pregnancy also seem to have limited access to contraception. For example, a chart review and interview with a woman who became pregnant while on work release at Bayview revealed that the woman was taking the blood thinner Coumadin yet was never offered birth control, even though women who take Coumadin are advised to avoid pregnancy because the medication can cause serious birth defects, miscarriage and fetal death.¹⁶³

Emergency contraception and post-exposure prophylaxis

Emergency contraception is a pill that can prevent pregnancy if taken within five days of unprotected sex.¹⁶⁴ It is available on an over-the-counter basis in the community.¹⁶⁵ Post-exposure prophylaxis (PEP) is a treatment that can reduce the risk of contracting HIV and other STDs after a person has been exposed.¹⁶⁶ Emergency contraception and PEP work best if taken immediately, and both treatments begin to lose effectiveness if taken more than three days after intercourse.¹⁶⁷

Women who participate in work release and the Family Reunion Program should have access to emergency contraception and PEP. Women who experience the horror of being raped while in custody should also have access to these treatments, which are standard in community hospitals and an important part of the range of emotional, legal and medical services that should be available to rape victims.¹⁶⁸ Timely access to both treatments is required by the Prison Rape Elimination Act (PREA), federal legislation passed in 2003 to curb rape and sexual assault in prison, a serious problem in correctional facilities across the country, including New York.¹⁶⁹ The regulations to implement PREA went into effect in the summer of 2013.¹⁷⁰

Prisons gave conflicting reports about the availability of emergency contraception and PEP. Bedford reported that DOCCS does not provide emergency contraception and indicated that doctors would not write a prescription for the medication even if a woman requested it. Albion and Taconic said that doctors could, in fact, write a prescription for emergency contraception and administer it within one day. Regarding PEP, Bedford and Taconic reported that the treatment is available in the prison medical clinic. Albion reported that it does not keep PEP on-site but that doctors could write a prescription if necessary and administer it the next day.

All three prisons said that they had not given out emergency contraception in the past 10 years. Albion and Taconic also said they had not given out PEP in the past decade. Bedford reported using PEP about once every year.

RECOMMENDATIONS

For DOCCS

- 1) Offer women participating in work release and the Family Reunion Program, and women preparing to return home, with the option to use the full range of FDA-approved birth control methods. Provide access to contraception for all women who request it.
- 2) Restart the Planned Parenthood initiative at all prisons housing women.

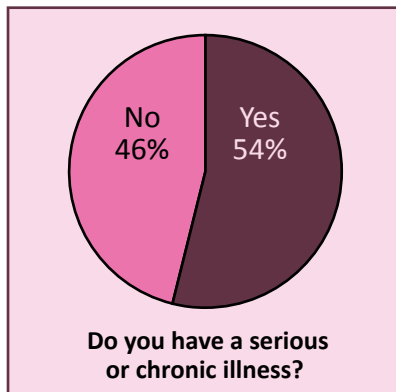
- 3) Keep emergency contraception and post-exposure prophylaxis on-site at all prisons housing women. Administer these treatments immediately upon request.
- 4) Allow women in the Family Reunion Program to obtain condoms from whichever staff they feel most comfortable asking, including medical staff, counselors (ORCs) or correction officers.
- 5) End the practice of terminating hormonal contraceptives for women entering prison if women are taking the medication for reasons other than pregnancy prevention, and eliminate delays in prescribing these medications to women who need them.
- 6) Offer women contraception if they are taking medication that is contraindicated during pregnancy.

For New York State Legislature and Governor

- 1) Enact a law guaranteeing incarcerated women timely access to contraception for reasons related to pregnancy prevention and for other medical reasons.
- 2) Allocate funds to allow DOCCS to restart the Planned Parenthood initiative at all prisons housing women.

HEALTH EDUCATION

Health education is a critical part of empowering women to feel comfortable with their health care providers and to take an active role in staying healthy.¹⁷¹ Such education also has a positive ripple effect as the more informed women are, the more likely they may be to make healthy choices for their children and to encourage loved ones to do the same.



Incarcerated women are disproportionately affected by physical illnesses.¹⁷² More than half (54%, 538 of 993) of general survey respondents reported having a serious or chronic medical condition, and, of those women, 44% (228 of 518) said they were living with at least two such conditions. This situation is the result of criminal justice policies that “criminalize rather than treat behaviors that put people at risk of contracting these diseases” and that target poor communities of color already suffering from high rates of chronic illnesses.¹⁷³ Given that most incarcerated people will be released, the quality of health

education in prison has a significant impact on families and communities on the outside.

As discussed in Section 5 (*p.159*), DOCCS seems to be doing a solid job educating women about HIV and STDs, though more work is needed to combat stigma and create conditions where women with HIV who have not revealed their status feel comfortable doing so. Also discussed in Section 5 is the additional work needed to provide adequate education on hepatitis C, which, like HIV, disproportionately affects incarcerated women.

On education related to family planning and general sexual health, DOCCS seems to be doing a mediocre job, and on education related to general women’s health issues, DOCCS seems to be doing a poor job. Better programming in these areas would empower women with vital health information. It would also allow DOCCS to provide information about heavily stigmatized illnesses like HIV and hepatitis C as part of a broader range of topics, which would allow women to learn about the illnesses without feeling exposed.

DOCCS provides solid HIV education, mediocre sexual health education and poor general women’s health education

Health information that comes from peers can be especially effective, as can education in group settings which can offer a sense of support and community, often lacking in the isolating environment of prison. DOCCS has an impressive HIV peer education program that provides one-on-one counseling as well as support groups but not much else.

Family planning and general sexual health

Before DOCCS closed its Planned Parenthood program, women who were within three months of their release had the opportunity to participate in a two-hour class about family planning and general sexual health. This class was the only formal opportunity women had to learn about family planning and general sexual health outside of the HIV peer programs, which offer more limited education on those topics. Without the Planned Parenthood session, women receive little of this important information.

Among reproductive health survey respondents who had not participated in the Planned Parenthood class, only 10% (33 of 321) reported that they were given information about family planning during their incarceration. Bayview and Beacon did not contract with Planned Parenthood, and none of the women at those prisons who were nearing release had received information about family planning when the CA interviewed them. In addition, none of the women on work release that the CA interviewed or surveyed said they were given information about birth control, safe sex or STDs before they started the program.

General women's health

DOCCS does not provide women with sufficient information about general women's health issues. Although DOCCS extols the virtues of patient education in its written policies and has taken steps to collect health materials for women, the Department falls short in making sure that women get this information and that clinicians spend time educating women during medical appointments.¹⁷⁴

In 2008, the CA was pleased to partner with DOCCS on a women's health library project where the CA donated over 200 books and brochures addressing common women's health issues to the libraries of each prison housing women. Unfortunately, many reproductive health survey respondents said they were unaware of the collection, and many others said they had not seen the materials in their library. Others said that only a small selection of the books were available.



Many women the CA surveyed and interviewed commented that doctors did not give them enough, or any, information about either their specific health concerns or common health issues facing women. DOCCS' written policies encourage doctors to distribute the Department's informational handouts which cover a range of health topics but it appears that most providers do not actually use the handouts or explain the issues they address during appointments.¹⁷⁵

Ultimately, while written material can play an important role in patient education, it is not sufficient, especially given that many women in prison have low literacy levels and that some can read only in Spanish or other languages.¹⁷⁶ DOCCS estimates that 2% of women in its custody are Spanish-speaking with no, limited or moderate English.¹⁷⁷ As one physician on the CA visiting team stated, “A handout is good, but it can’t answer your questions.”

One promising model to build on is a peer health education group that Bedford ran until 2007 and then re-opened again in early 2014. One of Bedford’s nurse administrators coordinates the sessions which cover a variety of women’s health issues. The classes are open to all women in the prison.

Health information priorities

Most women surveyed and interviewed felt that they would benefit significantly from more information about the health issues they face. When asked which issues they most wanted information about, the top 10 answers from reproductive health survey respondents were, in order of priority: HIV, hepatitis C and other STDs, especially HPV; cancer, especially breast, ovarian and cervical cancer; general GYN issues, especially menstrual issues and fibroids; nutrition and weight gain and loss; menopause; high blood pressure and heart disease; diabetes; asthma; osteoporosis and bone loss; and skin-related issues. Mental health, particularly stress and coping with death, anxiety and depression, was also a common answer, ranking 11 on the priority list.

Among reproductive health survey respondents who had used the CA-DOCCS library materials, women reported that the most useful resource was *Our Bodies, Ourselves*, a book by and for women about women’s health, sexuality and reproduction.¹⁷⁸

RECOMMENDATIONS

For DOCCS

- 1) Create a gender-specific women’s health education program that includes educational sessions, peer support groups, and one-on-one counseling in English and Spanish to provide women with information about key health issues. Hire incarcerated women to help run the groups.
- 2) Place user-friendly, up-to-date information about a wide variety of topics affecting women’s health in English and Spanish in multiple places throughout the prison, including doctors’ offices and clinic waiting areas, prison libraries and common room areas.

- 3) Train doctors and nurses to spend sufficient time educating patients about their specific medical concerns as well as health issues generally of concern to women, and expand the selection of educational handouts to cover a comprehensive list of health topics affecting women.
- 4) Inform women about the health materials provided by the CA, make those materials easily accessible to women who visit the library, and update and expand the collection as often as possible.

For New York State Legislature and Governor

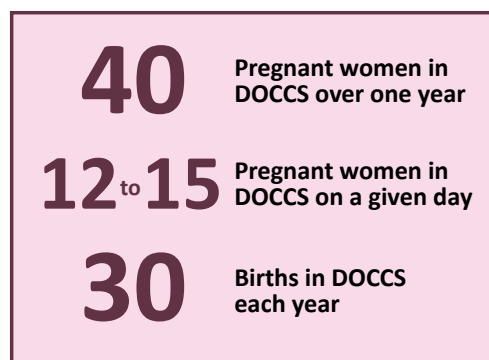
- 1) Allocate funds for DOCCS to create a women's health education program in all prisons housing women.

Care for Pregnant Women

OVERVIEW, INCIDENCE OF PREGNANCY AND PREGNANCY-RELATED POLICIES

DOCCS prisons do not adequately collect data on the incidence of pregnancy or on pregnancy outcomes.¹⁷⁹ Based on the information each prison provided, it appears that about 40 pregnant women are in DOCCS custody over the course of a year, with 12 to 15 pregnant women in custody on any given day. DOCCS handles about 30 births each year.

Bedford estimated that about 2% of women who enter reception each month are pregnant. This figure is lower than national estimates that 4% of women in state prisons are pregnant at the time of incarceration.¹⁸⁰ Bedford also reported that most newly admitted women already know if they are pregnant and estimated that fewer than 5% find out from the test given at reception. This comports with findings from the CA's pregnancy survey: of 23 respondents, 14 said they found out they were pregnant before they were arrested, six found out in county jail, and only three found out in DOCCS.



Pregnant women in DOCCS can be housed at one of two prisons, Bedford or Taconic. If a woman at another prison is pregnant, DOCCS' policy is to transfer her to Bedford. Bedford has DOCCS' only nursery program, which allows women who meet certain criteria to live in a designated unit in the prison with their babies for up to one year, or 18 months if the woman will be released within that time frame and if the prison grants a special extension. Taconic also had a nursery until DOCCS closed it in 2011.

In spring 2013, DOCCS decided that pregnant women should no longer be housed at Taconic during their third trimester. This is a positive decision as Taconic has no medical staff on-site from 11pm to 7am. Before this development, women at Taconic who went into labor at night had to rely on correction staff to call an ambulance or medical staff at Bedford. One woman at Taconic, for example, reported that she went into labor at 3am and an officer called an ambulance for her. Such situations were far from ideal as even the most well-intentioned and sensitive correction officer does not have the training to make medical judgments or deliver a baby.

Shortly after this decision, Bedford began to place most pregnant women in its custody on a “medical hold” to keep them at the prison for the duration of their pregnancies. For the reasons stated above and for other reasons detailed throughout this report, including that Bedford has a better health services operation, on-site prenatal care and the nursery program, the CA supports housing all pregnant women at Bedford from the time they enter custody through when they give birth, unless they are participating in DOCCS’ work release program.

This report includes information from women who lived at Taconic until they gave birth because the information sheds light on the experience of pregnant women overall and is relevant to women who may spend two-thirds of their pregnancies at the prison. Moreover, if DOCCS ever returns to its former practice of housing women at Taconic for the duration of their pregnancies, it is important to recognize the shortcomings in care that should be addressed.

Bedford reported that it houses between 34 and 38 pregnant women over the course of a year, with an average of 10 to 12 pregnant women at any given time. Taconic estimated having one to two pregnant women on any given day. Beacon reported having no pregnant women since 2004 and Bayview said one to three women became pregnant while in custody each year. These numbers may not be entirely accurate, however, given that Bayview reported no pregnant women in 2009 even though the CA reviewed charts of two women who became pregnant while on work release at Bayview that year. Albion reported that it does not track the number of pregnant women and estimated that three women had become pregnant while at the prison since 2004.

DOCCS’ written policies related to pregnancy care are not comprehensive. Those policies that do exist fail to reference community standards and actually stray from standards in a few key areas, such as the frequency of OB appointments and the time frame for postpartum check-ups for women who have C-sections.

DOCCS’ pregnancy care policies are not comprehensive and stray from community standards in some areas

DOCCS’ Central Office policies on pregnancy care consist mainly of a few sentences about pregnancy testing, HIV and referral to an OB for prenatal services.¹⁸¹ DOCCS also has a written policy on transporting pregnant women but will not make it available to the public, apparently because of concerns it will jeopardize prison security.¹⁸²

At the facility level, only Bedford and Taconic have policies that address pregnancy. Even those policies, however, cover only a basic overview of prenatal and postpartum care. The absence of written policies at Albion is concerning given that the prison has an intake unit, overnight trailer visits and a work release program, all of which increase the potential for pregnancy among the women there.

DOCCS has no written policies outlining the time frame within which pregnant women at prisons throughout the state should be transferred to Bedford for evaluation. Albion stated that pregnant women are transferred “within one week,” and, when Bayview and Beacon were open, Bayview stated within “one day,” and Beacon, “as quickly as possible.”

Similarly, DOCCS has no written policies on the time frame within which pregnant women at prisons other than Bedford or Taconic should be referred to an OB-GYN. As detailed in Section 5 (p. 145), interviews and chart reviews with two women revealed problems with delays in transferring pregnant women to Bedford. Both women were in solitary confinement at the time and had difficulty securing adequate prenatal care while they waited to be transferred.

RECOMMENDATIONS

For DOCCS

- 1) Establish comprehensive, centralized written policies on pregnancy care that refer to, and comport with, standards in the community, including those issued by the American College of Obstetricians and Gynecologists (ACOG).
- 2) Require prisons to collect systematic data on pregnancy, including: 1) the numbers of women who enter custody pregnant, learn they are pregnant at reception and become pregnant while in custody, and 2) the outcomes of women’s pregnancies, including abortions, ectopic pregnancies, miscarriages, stillbirths, premature births, vaginal births and C-sections.
- 3) House all pregnant women at Bedford for the duration of their pregnancies, unless they are on work release.
- 4) Transfer pregnant women at other prisons to Bedford for an initial evaluation with the OB within 72 hours, unless a more urgent assessment is needed.

PREGNANT WOMEN AND WORK RELEASE

Albion, one of two DOCCS prisons with a work release program for women, reported that it transfers women who become pregnant while on work release to Bedford. Albion follows this practice because the facility does not offer prenatal care or allow work release participants to access prenatal care in the community. While the motivation behind this decision is positive – to ensure that women can access appropriate care – it is unfair to remove a woman from work release just because she is pregnant. It is also inconsistent with past DOCCS practice: when Bayview’s work release program was running, women who became pregnant were permitted to continue working until their third trimester, when they would be transferred to Bedford.

Edgecombe, the other prison with work release for women, reported that it also transfers women who become pregnant while in the program to Bedford, but only after their first trimester. When the CA raised this issue with DOCCS and asked for clarification on Edgecombe’s policy, Department officials stated that they would develop a written policy similar to Bayview’s to allow pregnant women to remain in work release until their third trimester. This represents a positive step. Even better would be a system-wide policy that does not impose a rigid time limit, but instead allows pregnant women themselves, in partnership with their prenatal providers, to decide when they want to stop working.

As a result of state actions to limit eligibility for work release over the past two decades, the number of participants in the program has plummeted by 95%, from about 24,000 in 1994 to about 1,300 in 2011.¹⁸³ Reflecting this decline, only a small number of women participate in the program: there were 10 women on work release at Albion as of spring 2013, and 15 at Edgecombe as of winter 2014. Nevertheless, it is important to highlight this issue because work release is one of DOCCS’ most effective transitional programs, and provides a rare and important opportunity for incarcerated people to gain employment skills, build community ties and prepare for a smoother transition home.¹⁸⁴

RECOMMENDATIONS

For DOCCS

- 1) Authorize Albion and Edgecombe to contract with community prenatal providers so that work release participants who are pregnant can continue in the program until they decide, in partnership with their providers, to stop working.
- 2) Begin the nursery application process as soon as possible for pregnant women on work release who are due to give birth before their release date.

For New York State Legislature and Governor

- 1) Enact laws that open eligibility for work release to more incarcerated people, including people convicted of violent offenses.

PREGNANCY TESTING

DOCCS requires women to take pregnancy tests on two occasions: when a woman first enters custody and if a woman is removed from the work release program.¹⁸⁵ Women can ask for pregnancy tests at any other time during their incarceration, although the prisons reported that few women do.

The CA found two problems with pregnancy testing in DOCCS. First, although DOCCS gives all women a mandatory pregnancy test at reception, it does not appear that women are routinely informed about the test. More than half (61%, 38 of 62) of reproductive health survey respondents reported that medical staff had not informed them that a pregnancy test was part of the intake physical. Women the CA heard from said they would rather know about the test to prepare themselves for the possibility of learning that they are pregnant.

Second, none of DOCCS' policies outline the time frame within which medical staff are expected to respond to women who request pregnancy tests or to communicate results to them. Interviews and chart reviews by the CA reveal a great deal of variation in women's experiences accessing pregnancy tests and results. For example, one woman at Albion was given a pregnancy test the same day she asked and the results the following afternoon. For two women at Bayview, however, getting a pregnancy test and results took almost three weeks and almost two weeks, respectively, even though both women were given urine pregnancy tests, from which results can be gleaned in minutes.¹⁸⁶ Timeliness was particularly important in these two cases as the women were not only in a prison that did not provide routine prenatal care but were also in that prison's solitary confinement units while they awaited transfer to Bedford.

RECOMMENDATIONS

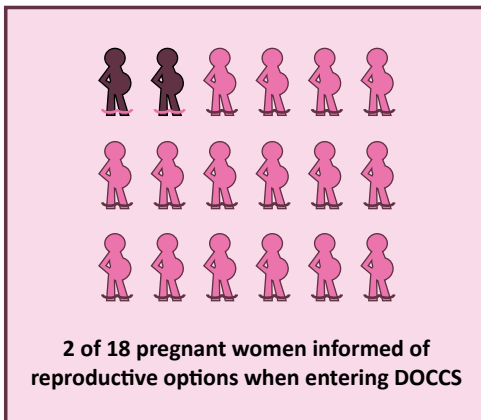
DOCCS

- 1) Inform women entering DOCCS custody about all tests they will receive as part of the intake physical at reception, including the mandatory pregnancy test, before the tests are administered.
- 2) Require medical staff to respond to women's requests for pregnancy tests by the next business day and to inform women of the results by the next business day after that. Providers should give women pregnancy tests that can provide results within minutes, and follow up, if necessary, with a confirmatory test that requires lab analysis.

PREGNANCY OPTIONS COUNSELING AND ABORTION

Pregnancy options counseling

The CA's research shows that DOCCS often fails to inform pregnant women about their reproductive rights. Only two of 18 (13%) pregnancy survey respondents who entered DOCCS custody within the legal time frame to get an abortion in New York (24 weeks) reported that someone spoke with them about their options.¹⁸⁷



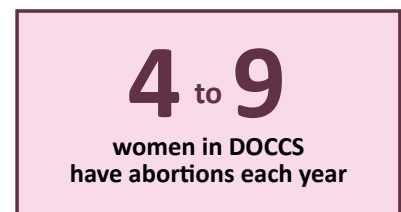
Interviews and chart reviews by the CA also indicated problems with the timeliness and quality of options counseling for those women who do receive it. For example, a chart review for one woman who became pregnant while on work release at Bayview suggests that she did not receive options counseling until one month after informing prison staff that she suspected she was pregnant. Another woman who became pregnant while on work release at Bayview said the doctor mentioned she could have an abortion but in a curt and unsupportive fashion. This woman reported being

thankful that her correction counselor took a more caring tone, saying, "It's your choice. You can have an abortion if you want."

Most concerning was the experience of one woman, in her ninth week of pregnancy, who wrote that the OB-GYN gave her only three days to make a decision about whether to have an abortion or continue the pregnancy. Medical staff should never impose a deadline that is more restrictive than what women are entitled to under the law.

Abortion

Like all women in the United States, women in prison have the legal right to obtain an abortion.¹⁸⁸ According to the U.S. Supreme Court, a woman can have an abortion for any reason until the fetus is "viable," and after that if an abortion is necessary to preserve her health or life.¹⁸⁹



New York law on abortion actually contradicts federal case law: the state's statute permits women to have abortions for any reason up until 24 weeks (as opposed to viability) and makes exceptions after that time frame only in cases where an abortion is necessary to preserve the woman's life.¹⁹⁰ New York law does not include an exception for the woman's health.¹⁹¹

DOCCS prisons do not adequately collect data on the incidence of abortion. From the estimates each prison provided, it appears that four to nine women in DOCCS custody have abortions each year.¹⁹²

DOCCS has no central written policies on abortion.¹⁹³ This is out of sync with leading health organizations such as the American College of Obstetricians and Gynecologists (ACOG) and the American Public Health Association (APHA), which include access to abortion in their recommended standards on health care for incarcerated women.¹⁹⁴

The CA's research, including feedback from clinicians contracted by DOCCS to provide abortion services, indicates that women in DOCCS are able to obtain abortions. The experience of the one pregnancy survey respondent who had an abortion, however, reveals some problems with the timeliness of scheduling these procedures. This is troubling as abortion is time-sensitive and delays can compromise not only a woman's health but also her ability to remain legally eligible for the procedure.¹⁹⁵

The pregnancy survey respondent who had an abortion, Jane, reported that it took four weeks – from week eight to week 12 – from the time she told staff she wanted to have an abortion until she actually had the procedure. This was the result of two delays: Jane waited two weeks to see the OB-GYN after arriving at Bedford and telling a nurse she was pregnant, even though Bedford's policy requires pregnant women to be seen within four days of their arrival.¹⁹⁶ "I already knew what I wanted to do," she wrote, "and I just told [the OB-GYN]." Jane waited another two weeks before going to the clinic for the procedure.

Jane was 8 weeks pregnant when she told prison staff she wanted an abortion — it took almost a month for DOCCS to schedule the procedure

Delays may also result from the requirement that, as with all medical procedures, DOCCS Central Office must process and approve requests for abortions. Although prison staff did not report any such delays or denials from Central Office, abortion should not be placed in the category of potentially deniable medical procedures because there is no circumstance under which Central Office should deny such a request, as long as it falls within the legal time frame for abortions.

Jane's experience also indicates that DOCCS' policies on outside medical appointments may prevent women from feeling free to change their mind about having an abortion. Jane wrote in her survey that the OB-GYN said that "if I changed my mind after she made the appointment, I would get a ticket."

This is likely a reference to DOCCS' policy that incarcerated people will face disciplinary action if they decline to go to a medical appointment. For many years, this policy required an

incarcerated person to sign a contract stating that if she wanted to cancel an outside medical appointment, she had to do so within five days of the appointment or face disciplinary action.¹⁹⁷ In winter 2013, DOCCS eliminated the contract-signing process and issued a new policy stating that an incarcerated person will face disciplinary action for refusing to “obey a direct order” only if she declines to go to a medical appointment on the day of the appointment itself.¹⁹⁸ This new policy seems even more punitive than the old one, as the contract process at least offered incarcerated people prior warning about the potential consequences of their actions.

Threatening women with tickets for refusing medical appointments is entirely inappropriate, especially in the case of abortion. Like women in the community, incarcerated women should be able to change their mind about having an abortion at any stage without suffering adverse consequences.

The CA does not have sufficient information to fully assess women’s experiences at the clinics that provide abortion services for women in DOCCS. However, based on Jane’s comments and conversations with community clinic staff, the CA identified three problem areas for women who have abortions while in custody: lack of emotional support, shackling and inadequate privacy.

DOCCS routinely
violates women’s privacy
and confidentiality when
women have abortions

On the first issue, Jane said she did not receive any counseling or emotional support throughout her experience. She wrote that she felt “sad and depressed” after deciding to have an abortion and that even though she wanted “somebody to talk to,” she received “no support” or “advice” from prison staff. When asked about the number one improvement that would have made her experience better, Jane wrote: “If I could have had a counseling session before and after [the abortion].”

On the second issue, the CA’s findings suggest that women who have abortions in DOCCS are routinely shackled during the trip to and from the clinic, and sometimes shackled from the time they arrive in the waiting room through when they go into the procedure room for the abortion. Jane said she was shackled during the ride to the clinic and that the shackles were removed in the waiting room and kept off until after the abortion. Clinic staff recalled that some of their incarcerated patients were, in fact, kept in shackles during the entire process leading up to the abortion, including when the patients signed the consent form, which staff noted was difficult to do in handcuffs.

On the third issue, DOCCS routinely violates women’s privacy and confidentiality when women have abortions. This is primarily because DOCCS requires women to always be within eyeshot of the correction officers who escort them on medical trips off prison grounds.¹⁹⁹ In the context of abortion, this means that officers are next to the woman throughout the whole appointment,

including when medical staff take the woman's social-medical history and discuss her feelings and concerns, and that they are within view of the woman during the abortion itself.

An exchange between DOCCS officials and staff at one of the clinics providing abortions underscores how acutely DOCCS requires adherence to the eye contact rule. When one of the prisons learned that officers frequently stood outside the operating room during abortions, staff from that prison met with clinic providers to reiterate the importance of giving officers a direct view of the woman in case she attacked medical staff or tried to escape. Clinic staff objected, noting that they had never encountered a problem in their many years of service, that their medical staff were trained to handle difficult patient interactions, and that the officers were right outside the door if an intervention was necessary. In the end, an agreement was reached that officers would remain outside the door but look through the window, allowing them to see the woman's head but not below her waist.

Jane said she was never able to have a private discussion with a counselor or doctor at the clinic because an officer was always with her. She wrote that it made her feel "uncomfortable" that the officer could hear her when she spoke with clinic staff. One clinic provider echoed these sentiments and expressed concern that an officer's presence interferes with getting a thorough medical history: "As a physician, it always gives me the heebie-jeebies. . . . I always wonder how much they are filtering because the officer is in the room."

The presence of an officer in this situation violates a woman's privacy regardless of how that officer behaves and, in fact, it seems that most officers who accompany women in DOCCS on appointments for abortions are either neutral or supportive. Jane said that her escorting officers never made disparaging comments, although she added that she would have preferred two female officers.²⁰⁰ Staff at the clinics serving DOCCS also reported that most officers were professional, although one clinic remarked that every now and then, an officer would make "very judgmental, nasty" remarks and be "difficult to manage."

With regard to follow-up medical care after abortions, Albion staff said they could not remember exactly what their practice was because it had been so long since a woman in their custody had gotten an abortion. Bedford staff said that women are generally scheduled for a GYN appointment two months after the procedure unless complications arise.

RECOMMENDATIONS

For DOCCS

- 1) Require medical staff to inform women about their reproductive rights and options (including the right to an abortion, and the right to continue with their pregnancy and apply for Bedford's nursery program) as soon as a woman receives a positive pregnancy test.

Train prison medical staff to provide options counseling in a compassionate way, without pressure, personal views or arbitrary time lines on the decision process.

- 2) Develop a written policy that affirms women’s access to timely abortions and follow-up care.
- 3) Require medical staff to schedule appointments for women requesting abortions within one week of their request, or on the next business day if the woman is nearing the 24-week legal cutoff.
- 4) Eliminate the practice of subjecting women to disciplinary action if they refuse to go on outside medical appointments. It is especially important to remove any element of coercion from reproductive decision making.
- 5) Provide women who have abortions with referrals to supportive services including counseling before and after the abortion, and offer women a private space to call toll-free, confidential hotlines such as Backline²⁰¹ to talk about pregnancy decisions and Exhale²⁰² for support after an abortion.
- 6) Maintain systemic data on how many women receive abortions each year and the time between a woman’s request for an abortion and the procedure itself.
- 7) Eliminate the requirement that prisons obtain approval from DOCCS Central Office for abortion appointments and instead adopt a policy requiring prisons to give Central Office notification of such appointments.
- 8) Implement a screening process for correction officers who accompany women on trips for abortions to protect women and clinic staff from any officer’s negative comments or anti-abortion views. This will help DOCCS adhere to its policy that officers must “maintain a cooperative and understanding demeanor at all times with members of the hospital staff.”²⁰³
- 9) Require officers to: 1) stand out of earshot so that women can have confidential discussions with medical providers in clinics and hospitals, and 2) stand outside the room without eye contact for all medical procedures where women are undressed and exposed, including abortion.

New York State Legislature and Governor

- 1) Enact a law affirming incarcerated women’s right to timely access to pregnancy options counseling and abortions.

STERILIZATION

The U.S. has a grim history of forcing poor women, and particularly poor women of color, to undergo sterilization. These programs, known as eugenics, were at their height in the 1920s and 1930s, and often targeted women in state institutions. By the 1950s, most states had ended their eugenics programs, either voluntarily or by court order, though some states continued forcing women to be sterilized throughout the 1960s and early 1970s.²⁰⁴

In 2013, disturbing information came to light about sterilization abuses in California's women's prisons. Between 2006 and 2010, nearly 150 women in California's prisons underwent sterilization procedures after giving birth in community hospitals. The sterilizations took place in violation of California state regulations, and women described being pressured into sterilization by doctors in prison and in the hospitals.²⁰⁵

Based on the CA's research, forced sterilization does not seem to be a problem in DOCCS. Of all the women the CA surveyed, only one reported a problem. What this woman experienced, however, is troubling, and signals the need for better training and oversight in this area. The woman said that hospital staff gave her a form to sign after she gave birth and, when she inquired about its purpose, they explained it was to have her "tubes tied." The woman said she was taken aback and strongly expressed that she did not want to be sterilized. This is a serious breach of medical ethics as well as public policy on sterilization, which generally requires informed consent at least 30 days in advance of the procedure.²⁰⁶

Having the choice to be sterilized can be empowering for women, as long as they are provided the information they need to make a truly informed decision and can make that decision in a non-coercive setting. There is ongoing debate about whether informed consent for sterilization can exist in prison given the coercive nature of the prison environment.²⁰⁷ For these reasons, the federal government issued regulations prohibiting the use of federal funds for sterilization procedures for incarcerated people.²⁰⁸

ECTOPIC PREGNANCY, MISCARRIAGE AND STILLBIRTH

DOCCS should be prepared to handle the full range of pregnancy outcomes yet the Department's written policies do not address any pregnancy outcome other than live birth.

DOCCS has no written guidance on ectopic pregnancies (pregnancies that occur outside the womb, usually in a fallopian tube), miscarriages (when a woman loses her pregnancy within the first 20 weeks), and stillbirths (when a woman loses her pregnancy after the 20th week).²⁰⁹ All of these situations require special attention and treatment. In fact, ectopic pregnancies can be life-threatening without proper care because a woman's fallopian tube can rupture and cause internal bleeding.²¹⁰ Stillbirth, miscarriage and ectopic pregnancy can also be difficult experiences for women emotionally and physically: pain and bleeding are common, and many women feel grief at the abrupt end of their pregnancy.²¹¹

Because DOCCS prisons do not systematically track pregnancy outcomes, no exact data exists on the frequency of ectopic pregnancy, miscarriage and stillbirth among women in custody. In the community, ectopic pregnancies and stillbirths are relatively rare, occurring in about two out of every 100 pregnancies and one in 160 pregnancies, respectively.²¹² Miscarriage is more common, occurring in an estimated 10% to 20% of pregnancies.²¹³ Based on estimates from each prison, one woman miscarries every few years, and one woman has an ectopic pregnancy every 10 to 15 years.

The CA does not have sufficient data to evaluate DOCCS' response to, and care for, ectopic pregnancies, miscarriages and stillbirths. A chart review for a woman who had an ectopic pregnancy at Bayview, however, raises some red flags (*see Section 5, p. 155*).

Reports from a woman who had a miscarriage while in custody also raise concerns about DOCCS' shackling practices for women in this situation. The woman reported being fully shackled (handcuffs, black box, waist chains and ankle shackles) while waiting to go to the hospital and said she was kept shackled the entire time except for the medical exam and procedure to treat the miscarriage. She was then re-shackled while in the hospital recovery room and during the trip back to the prison.

In addition, both the woman who had a miscarriage and the woman who had an ectopic pregnancy said they did not get any emotional support during those difficult experiences. The woman who had a miscarriage wrote that she felt as though she "had nothing" after losing her pregnancy. The other woman expressed similar sentiments, and said her feelings of sadness and isolation were made worse because she was locked in solitary confinement during and after her pregnancy.

RECOMMENDATIONS

For DOCCS

- 1) Train medical staff to identify and respond appropriately to warning signs for ectopic pregnancy, miscarriage and stillbirth.
- 2) Eliminate the shackling of women who experience ectopic pregnancy, miscarriage and stillbirth during the trip to the hospital, during treatment and recovery in the hospital, and during the trip back to prison.
- 3) Refer women who have ectopic pregnancies, miscarriages and stillbirths to supportive services, including counseling.

PRENATAL CARE AND EDUCATION

Overall, DOCCS seems to be doing a good job providing pregnant women at Bedford and Taconic with access to timely and quality prenatal care. Problems the CA identified were not with the OB care itself but with other aspects of how pregnant women are treated, including that women must sit and wait for prenatal appointments for up to five hours on hard wooden benches with no back support and that women are often not allowed to look at the screen during ultrasounds or find out the sex of their baby. Other problems include insufficient dental care and delays in seeing an OB-GYN for an initial evaluation at Bedford.

In addition, while DOCCS generally schedules prenatal visits in line with community standards, the Department's written policies do not reflect its practices and actually stray from community standards in this area.

Access to prenatal care

Pregnant women who enter DOCCS custody at reception and pregnant women who are transferred to Bedford from another prison see Bedford's OB-GYN for an initial evaluation. Bedford's written policy states that pregnant women should have this evaluation within four days of their arrival, yet Bedford frequently fails to meet this standard.²¹⁴ Half of the pregnancy survey respondents (50%, 9 of 18) said it took one week or less to have their first appointment with the OB-GYN, but almost as many (39%, 7 of 18) said getting the first appointment took more than two weeks.

After the initial evaluation, pregnant women see two high-risk OBs from Westchester Medical Center who run a prenatal clinic at Bedford. About six women attend each clinic. Like all specialty care appointments, DOCCS requires these prenatal clinic appointments to be approved by its Central Office, even though women visit the same prenatal clinic over and over again throughout their pregnancy.

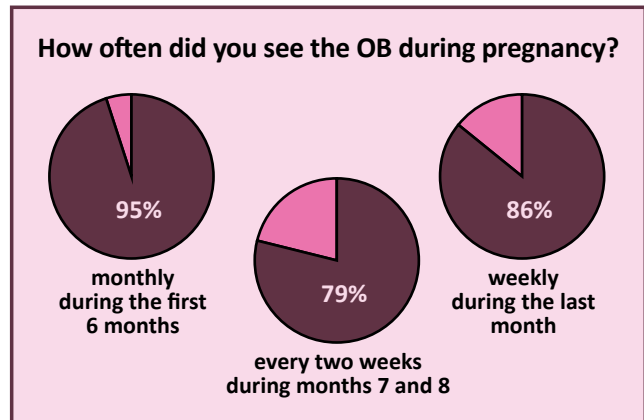
Pregnant women at Bedford also have access to the prison's OB-GYN who is on site twice per week. Pregnant women at Taconic do not have on-site access to an OB-GYN because no such doctor comes to the prison. Instead, pregnant women who need intensive or specialized care are taken to a high-risk clinic at Westchester Medical Center.

Most pregnancy survey respondents and interviewees said they could see the OB when needed, and only a small number indicated problems. Most women also reported seeing an OB at

Most pregnant women can access adequate prenatal care, but face poor dental services, long pre-appointment delays and barriers to finding out basic information about their babies

the frequency generally recommended in the community: once per month during the first six months, twice per month during the seventh and eighth months, and weekly during the last month.²¹⁵ For example:

- During the first six months of pregnancy, 19 of 20 (95%) pregnancy survey respondents said they saw an OB at least monthly. The one woman who said she did not have appointments monthly said she saw the OB every two months.



- During the seventh and eighth months, 15 of 19 (79%) pregnancy survey respondents said they saw an OB at least every two weeks. Of the four women who did not see an OB biweekly during this time period, three said they saw the OB once a month and one said she never saw the OB.

- Of pregnancy survey respondents whose pregnancies continued through their ninth month, 12 of 14 (86%) said they saw an OB every week during their last month. Of the two women who had visits less frequently, one said she never saw an OB in the two weeks before she gave birth, and the other, who delivered two weeks past her due date, said she saw the OB every two weeks during her last month and a half.

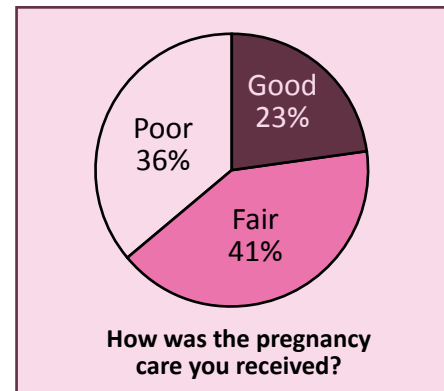
DOCCS' written policies do not reflect the Department's track record of scheduling prenatal visits in line with community standards: Bedford's policy requires pregnant women to be seen by an OB only "on a regular basis," and Taconic's policy requires women to be seen "on a monthly basis" throughout their pregnancies. Both policies state that women can have more frequent visits only with a doctor's recommendation.²¹⁶

Quality of prenatal care for women at Bedford Hills and Taconic

The vast majority of survey respondents and interviewees praised the Westchester Medical Center OBs who staff Bedford's high-risk prenatal clinic, describing them as "excellent," "caring" and "thorough."

Overall, five of 22 (23%) pregnancy survey respondents rated the care they got while they were pregnant in DOCCS as "good," nine of 22 (41%) as "fair," and eight of 22 (36%) as "poor." Many women explained that their "poor" rating was based not on the quality of OB staff but on other aspects of their experience that were negative, such as not getting enough food or being shackled while pregnant.

While most women praised the OBs, many commented that the process of waiting for prenatal appointments was an ordeal. Women reported sitting and waiting in Bedford’s medical unit for long periods of time, up to five hours, on wooden benches with no back support and no access to food. This long wait is likely the result of DOCCS’ practice of scheduling all women for the same block of time instead of giving individual women specific times for their appointments. Women commented that sitting on the benches for long stretches was “difficult,” “exhausting,” “uncomfortable” and “painful.” Some women said they were threatened with tickets if they leaned forward or back on the benches. Women transported from Taconic for prenatal appointments noted that the benches were only one bad part of an arduous, all-day process that began with waking up at 4am and ended with traveling back to Taconic at 3pm. Comments include:



- “It was awful not being able to sit back. After a while my butt would start hurting from sitting on bench. During the end of my pregnancy, it was extremely hot as well.”
- “[I]n the waiting room on the benches [for three to four hours], sometimes standing in the hallway. . . very painful for my feet and back.”
- “I got yelled at for lying down on the bench. It was very uncomfortable and hot.”
- “We usually wait three to four hours on a bench. It’s hell. Uncomfortable, you can’t stand up or you get yelled at.”
- “I waited from 11am to 2pm on the benches and I was five and a half months pregnant. I have [back problems] so that made the benches even more uncomfortable.”
- “Hard benches kills your back. My legs and feet were swollen after I had to wait over an hour. It was awful.”

Sitting for long periods of time is not only uncomfortable for pregnant women, it is also medically inadvisable. Experts recommend that pregnant women sit in chairs with back support and move frequently to ease muscle tension and prevent fluid buildup.²¹⁷

Ultrasounds

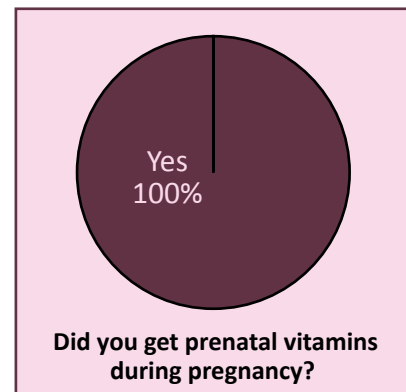
DOCCS has no written policies on ultrasounds for pregnant women. The community standard is for pregnant women to have at least one ultrasound between 16 and 20 weeks to assess fetal anatomy.²¹⁸ Women also commonly have an ultrasound in their first trimester to confirm the viability of the pregnancy, the due date and the number of fetuses. Bedford and Taconic report that their practice is to offer pregnant women an ultrasound at 20 weeks.

All pregnancy survey respondents and interviewees said that they had an ultrasound in DOCCS at some point during their pregnancy. Most women who entered DOCCS before they were 20 weeks pregnant had at least one ultrasound during their fourth or fifth month. A few women, however, reported being significantly further along. Four women, for example, who entered DOCCS between three weeks and five months of pregnancy said they did not have an ultrasound until they were at least eight months pregnant. This is troubling as the 20-week ultrasound provides critical information about fetal development and birth defects, such as heart malformations, which may influence whether a woman wants to continue with her pregnancy.

An additional concern is that the majority of women the CA interviewed and surveyed said they were not allowed to ask questions or view the screen during ultrasounds. Most women said they were also prohibited from finding out the sex of their baby. Women in the community have access to this information, and no rational basis exists for denying it to women simply because they are in prison. Viewing ultrasounds can serve both as an educational tool for women curious about their babies' development and as a source of joy and excitement.

Prenatal supplements

Although DOCCS' written policies do not mention prenatal vitamins, the Department has a solid track record of making sure that pregnant women at Bedford and Taconic receive these supplements. All women the CA interviewed and 100% (23 of 23) of pregnancy survey respondents reported being given prenatal vitamins while they were pregnant in DOCCS.



Dental care

Good oral health is important for pregnant women as gum disease and related infections are associated with preterm births and low birth weight.²¹⁹ For this reason, the American Dental Association recommends that pregnant women see a dentist and get treatment for oral infections during their pregnancies.²²⁰ Dental exams and cleanings are particularly important for incarcerated pregnant women as people in prison often have more dental care needs than people in the general population.²²¹



DOCCS fails to ensure that pregnant women receive necessary dental services during their pregnancies. Only four of 22 (18%) pregnancy survey respondents and relatively few interviewees reported seeing a dentist during their pregnancies in DOCCS. One woman said she asked to see a dentist because she had a toothache while she was pregnant but was never given an appointment.

Prenatal education

DOCCS contracts with the non-profit organization Hour Children to offer pregnant women at Bedford a six-week class about pregnancy, labor, early childhood parenting and reentry. Hour Children also runs Bedford's children's center and nursery. The prenatal class provides an important opportunity for pregnant women to receive up-to-date information and to plan for their return to the community.

Even with this class, however, it seems that not all pregnant women are getting basic information. Only about two-thirds (68%, 15 of 22) of pregnancy survey respondents said they received information about labor, birth and breastfeeding, and about half (55%, 12 of 22) received information about pumping breast milk. This may be because, prior to DOCCS' recent decision to house most pregnant women at Bedford, some pregnant women were transferred from Bedford to Taconic before completing the full six-week course. Even pregnant women who stay at Bedford may face problems accessing this information, however, because they often must begin mandated programs such as drug treatment and school before the prenatal class ends. These programs are prioritized because, unlike the prenatal class, they count toward the mandatory programming women must complete to earn early release.²²²



About half (48%, 11 of 23) of pregnancy survey respondents said they never received information from their doctors about warning signs to watch for, such as fever, pain or bleeding, which might indicate they were having a miscarriage or other problems with their pregnancy. Doctors in the community routinely convey this type of information, which pregnant women need to monitor their health and to know when to seek help.

RECOMMENDATIONS

For DOCCS

- 1) Develop a central written policy detailing standards for prenatal care, including frequency of OB appointments and ultrasounds, which mirror and reference community standards, including those promulgated by the American College of Obstetricians and Gynecologists (ACOG).
- 2) Take steps to ensure that an OB-GYN sees pregnant women for initial evaluations within the four-day time frame outlined in Bedford's policy, and allow clinicians to schedule prenatal appointments without going through the Central Office approval process.

- 3) Shorten considerably the waiting time for prenatal appointments, provide chairs with backs for pregnant women to sit in while they wait, and allow pregnant women to stretch, walk around, eat snacks and lie down on benches while they wait for appointments.
- 4) Allow pregnant women to see the monitor during ultrasounds, ask questions and find out the sex of their babies.
- 5) Offer pregnant women verbal and easy-to-read written information about pregnancy and childbirth, including labor, breastfeeding and warning signs that might indicate a miscarriage or other problems.
- 6) Schedule at least one dental appointment that includes a routine check-up and cleaning for pregnant women, and provide pregnant women with prompt treatment for oral infections and other dental problems.

For New York State Legislature and Governor

- 1) Amend the statute outlining the programs that incarcerated people must complete in order to earn merit time (time off their sentences) to include prenatal classes.

DAILY LIFE IN PRISON FOR PREGNANT WOMEN

Pregnancy is often a stressful experience, even for women who want to be pregnant and feel happiness at the prospect of becoming a mother.²²³ This stress is intensified for incarcerated women, as they live in an oppressive environment away from friends and family, and are forced to contend with uncertainty about whether they will be separated from their babies.

Some of the problems related to daily life that pregnant women experience are the same as those experienced by other women in DOCCS: inadequate emotional support services, mistreatment by correction officers, invasive pat frisks and strip frisks, and poor conditions in housing units. Other problems are unique to pregnant women, the most troubling of which is that pregnant women in DOCCS do not get enough food.

Pregnant women experience correction officer mistreatment, traumatizing strip frisks, poor housing conditions, insufficient emotional support and inadequate food

Emotional support

Like the women who experienced abortion and pregnancy loss, most women who gave birth while in custody said they did not feel supported throughout their experience, unless and until they moved onto the nursery unit.



Only three of 23 pregnancy survey respondents said they were offered counseling to talk about their feelings during pregnancy. Emotional support services are essential for pregnant women in prison, especially women who are denied admission to the nursery and experience the devastation of being separated from their babies immediately after giving birth. These services are particularly important as women in prison suffer from high rates of mental illness, and pregnancy can intensify anxiety and depression, and exacerbate mental health conditions.²²⁴

Housing

Pregnant women in DOCCS live in general population, unless they are accepted into Bedford's nursery program which is in a separate wing of the prison. Even women who are accepted to the nursery, however, often spend most of their pregnancies in general population because

they do not move onto the nursery unit until they are close to their due date. Aside from assigning bottom bunks, housing conditions for pregnant women in general population are the same as they are for everyone else.

Pregnant women reported problems with conditions in their housing units, reports the CA also frequently hears from women who are not pregnant. The most common problems at Bedford are inadequate heat, insufficient ventilation, broken showers, showers that have extremely hot water or no hot water at all, mice and bugs. At Taconic, the most common problems are inadequate heat, insufficient ventilation, mice, bugs, and too little space and privacy. Women who lived in dorm settings with double bunks also said it was difficult to share a small space with their cube-mate as they grew bigger throughout their pregnancy.

- One woman who lived in Bedford’s Building 121A before being transferred to the nursery four days before her due date said her housing unit had “no heat during the winter months and no air on hot days. Most of the time the officers wouldn’t let us turn the fan on either. Hot water in the shower was always not working.”
- One woman who lived in Taconic’s Building 81 while she was pregnant wrote: “There were bugs everywhere, and it was so hot down there. I sometimes felt like I was suffocating. I felt exposed because there was about 25 to 30 women down there and we had no curtains or walls. Everyone could see you when you undressed, and everything you did. The tiles in the ceiling were leaking and it was just disgusting.”
- One woman who lived in Taconic’s Building 71 during her pregnancy wrote that the “15 bunks on the west side [of the room]” were “all packed together.”
- Another woman who lived in Taconic’s Building 71 during her pregnancy reported that it was “horrendous, gross, small, windows were broken and it was very cold.”

A clean living space with adequate heat, ventilation and privacy is important for all people. This fact has been recognized by the American Correctional Association, an organization providing accreditation services to prisons across the country, including DOCCS. The Association’s standards require prisons to have working showers with hot water, appropriate indoor temperatures, and control of vermin and pest problems.²²⁵ Pest infestations can be particularly dangerous for pregnant women because they can cause infections that harm the fetus.²²⁶

Regarding sleeping arrangements, a few pregnancy survey respondents and interviewees said that their requests for an extra pillow and mattress were denied. Women reported these denials both at Taconic, which said it does not allow women to have the extra items, and by Bedford, which said it does. Pregnant women commonly experience insomnia, back pain and heartburn when lying down, and additional mattress and pillow support can alleviate this

“Mice, very cold, no ventilation, very noisy. [They] wouldn’t give me an extra blanket.”

discomfort.²²⁷ These bedding materials can be particularly helpful in DOCCS as the mattress and pillow women receive are often thin and uncomfortable.

Interactions with correction staff

Pregnant women reported mixed treatment from correction officers, as do women generally in DOCCS. Some officers treat women with fairness and professionalism while others are deeply disrespectful and openly hostile and abusive.

Relations between officers and incarcerated women also vary from prison to prison. The CA consistently hears the fewest complaints about officer conduct from women at Taconic, and the most from women at Bedford and Albion. Bedford seems to have a particular problem with a small group of officers who blatantly disregard the rules and make life miserable for the women they guard. One serious incident at Bedford in 2007 involved an officer who, unprovoked by any physical confrontation, punched a woman in the face with enough force to knock her to the ground. The woman, who is a survivor of horrific domestic violence and who was in a leg brace at the time, was sent to solitary confinement. The officer was not removed from his post.²²⁸ At Albion, while relations between officers and women have improved over the years – a credit to the prison’s leadership since 2006 – the CA still frequently hears reports about officers mistreating and abusing women, and retaliating if the women speak out or file a grievance.

Across all the women’s prisons, the most widespread complaints the CA hears are related to verbal abuse, threats and retaliation. Physical and sexual abuse by officers are also persistent problems.²²⁹

Most women the CA surveyed and interviewed said officers were respectful of their pregnancies and had not made negative comments to them. A few women said that certain officers made disparaging remarks. Among the comments women reported hearing were: “Why are you having a baby and you are in prison? You are selfish, get an abortion. . . .” “If you hadn’t gotten pregnant and come to prison, you wouldn’t be able to complain now, would you. . . .” “She said I should have had an abortion, so she wouldn’t have to go out of her way to do these trips.”

Pregnancy survey respondents identified better treatment from correction staff as one of the most important ways to improve the experience for pregnant women in DOCCS. One woman summed it up when she wrote that her top change would be for officers to treat pregnant women in DOCCS “like any other pregnant woman. Stop looking at the DIN# and green outfit for nine months.”

Pat frisks and strip frisks

Pregnant women in DOCCS are subject to the same search procedures as all other incarcerated women. These include pat frisks (when an officer “pats down” a person’s clothed body) and

strip frisks (when an officer searches a person's clothes and naked body, including a visual inspection of body cavities).²³⁰

“When my water broke,
I didn't want to be touched.”

Pat frisks are conducted frequently, including when officers search a housing unit or suspect a person has contraband, and before and after a person enters the visiting room or goes to programs or recreation.²³¹ Pat frisks are such a routine part of prison life that not even women in labor are exempt from being patted down before they leave for the hospital. One woman reported that she was pat-frisked after her water broke.

Most women the CA surveyed and interviewed said that being pat-frisked when pregnant felt the same as being pat-frisked when not pregnant. Some women said they were able to tolerate the searches, however uncomfortable, while others said they felt violated. That some women felt this way is not surprising. Pat frisks are physically intrusive and can be especially traumatizing for survivors of abuse, which most incarcerated women are.²³² It is also not uncommon for the CA to hear complaints from women that certain officers (male and female) touch them inappropriately during the frisks.

Strip frisks are also a fairly frequent occurrence in DOCCS. These searches are conducted by correction staff of the same gender as the incarcerated person before and after trips off prison grounds, including for medical appointments and transfers between prisons.²³³ Strip frisks are also required after every visit, even in the regular visiting room, and when correction staff suspect that a person is hiding contraband in a body cavity.

Most women say that strip frisks are considerably more distressing than pat frisks. Many women the CA surveyed and interviewed commented that strip frisks were worse during their pregnancy because they felt extra humiliation and discomfort when officers made them bend over, squat and cough.

Clothing

DOCCS is doing a good job providing pregnant women with maternity clothes. Most women interviewed and 21 of 23 (91%) pregnancy survey respondents reported having adequate clothing from DOCCS during their pregnancies. Some women who did not receive sufficient maternity wear explained that they were given only three pairs of pants and two shirts, and that they had trouble keeping their clothes clean because of limitations on access to the washing machine.



Women the CA surveyed and interviewed described two problems related to clothing: 1) DOCCS does not permit women to wear weather-appropriate attire during medical trips outside the prison, and 2) DOCCS often requires women to wear poor-quality state boots for large portions of the day. These issues are also perennial problems for women who are not pregnant. The CA has raised both items with Department officials multiple times but practices have not changed in either area.

On the issue of medical trips, about one-quarter (26%, 5 of 19) of pregnancy survey respondents and many women interviewed said they were not allowed to wear seasonally appropriate clothing. Comments include:

- “I wasn’t allowed to have a jacket, sweatshirt or undershirt. I was cold. It was snowing outside.”
- “It was hot and I had to wear pants and I was shackled.”
- “[W]earing sweatpants (the state’s attire for pregnant women) in 100-degree weather is not pleasant.”
- “The pregnant women were not ‘allowed’ to wear shorts, so the entire summer we had to wear hot sweatpants.”

“I was freezing [on outside trips]. I had no hat, no gloves, no coat, no thermals.”

Regarding the state boots, women the CA surveyed and interviewed commented that the boots are particularly uncomfortable during pregnancy, when a woman’s feet often swell and expand.²³⁴ One woman wrote that she had to wear “boots only. No sneakers, even if feet were swollen.” Wrote another woman: “We are required to be completely stated down [in state-issued clothing] including heavy black work books that did not fit my swollen feet.”

Food

Food is a basic human need, and pregnant women have higher caloric, protein, vitamin and mineral requirements than women who are not pregnant. Proper nutrition is also vital to the healthy development of a fetus.²³⁵

Women universally reported they did not get enough food during pregnancy

Nevertheless, across the board, women the CA surveyed and interviewed said that they were not given enough food during their pregnancies. For example, every woman (12 of 12) interviewed by the CA in 2013 who either was pregnant or had recently been pregnant said that she got too little food during her pregnancy. Some women said that more food was the number one change they would make to improve the experience for pregnant women in DOCCS. Comments include:

- “I think all pregnant women should be allowed to get two food trays. . . . I remember

going to bed hungry many, many nights. Those pregnancy snacks don't do much for a pregnant woman. . . ."

- "We don't get enough food at meals and we can't get food sent in for 30 days when we first get here. Some people can't afford to buy food in commissary. We eat at 7am, 1pm and 5pm and I'm starving by the time I go to bed. They give a snack but it's not enough."
- "At [Bedford] reception, you starve if you're pregnant. Breakfast is at 6am and lunch at 1pm. . . . After dinner you get a baloney sandwich and milk. I'm lactose intolerant."
- "Extra food, not a sandwich."
- "Better food and more of it!"
- "[Pregnant] women should get double meals."
- "They should feed the girls more. Some don't have family to take care of them and they don't get anything good for a snack."

Even the food that pregnant women do receive is inadequate. Many women told the CA that the meals provided by DOCCS have too many sugars and starches, and too few fresh fruits and vegetables, which are particularly important for pregnant women.

DOCCS has no written policies on nutrition for pregnant women. Bedford and Taconic reported that pregnant women receive a special diet with extra food but the CA found problems with the content and implementation of this diet. The extra food is minimal, consisting only of a "snack" given out at dinner of an 8 oz carton of milk, a piece of fruit and a sandwich with cold cuts. In addition, about half (48%, 11 of 23) of pregnancy survey respondents reported that they never received even this minimal supplement. Those who did wrote that certain components, usually milk or fruit, were often missing. The choice of cold cuts as part of the snack is puzzling given that pregnant women in the community are advised to avoid deli meats because they can cause infections that are life-threatening to a fetus.²³⁶

RECOMMENDATIONS

For DOCCS

- 1) Provide pregnant women with referrals to supportive services including counseling, and establish peer support groups for pregnant women in general population.
- 2) Offer pregnant women healthy meals and a variety of healthy supplemental snacks, along with information about how to maintain a healthy diet during pregnancy.

- 3) Allow women, including pregnant women, to wear weather-appropriate clothing during trips for medical appointments off prison grounds.
- 4) Give women better-quality boots and eliminate the requirement for pregnant women to wear state boots during their pregnancies.
- 5) Equip all housing units with appropriate ventilation, heat and privacy, and make sure they are clean and rodent- and bug-free.
- 6) Designate a separate housing unit with specialized programs at Bedford for pregnant women who are not living on the nursery unit, and train officers assigned to the area on the specific experiences and needs of pregnant women.
- 7) Allow pregnant women to have an extra mattress and pillows upon request, and update written policy to reflect the current practice of providing pregnant women with a bottom bunk.²³⁷
- 8) Take proactive steps to respond to, and prevent, poor treatment of women by correction staff, including enhancing mechanisms for disciplining and removing staff who behave unprofessionally; acknowledging and, where possible, rewarding staff who exceed professional standards; and creating structured mentoring relationships between staff who excel and staff identified as problematic.
- 9) Eliminate strip frisks for pregnant women, and eliminate both pat frisks and strip frisks for women in labor.

HAVING A BABY: LABOR AND DELIVERY

Women in DOCCS are sent to one of two hospitals to give birth: Westchester Medical Center for routine deliveries and Northern Westchester Hospital for emergencies. At Northern Westchester Hospital, women stay on the same floor as all other maternity patients. At Westchester Medical Center, women are placed in a separate secure unit called Ward 29 which has 14 beds specifically for people in custody. Women in this unit are not allowed to keep their babies with them in their rooms.

While a majority of women said they received adequate medical care at the prison and hospital when they were in labor, most also described having negative overall birth experiences while in DOCCS custody. Women said they felt this way mainly because DOCCS denied them support from their family and forbid them from having anyone from outside the prison system be present during childbirth.

Not being allowed to have family support was also a main reason that half of pregnancy survey respondents (48%, 10 of 21) said their delivery did not “go the way they wanted.”

Scary
Lonely
Overwhelming
Stressful
Confusing
Embarrassing
Depressing

Words women used to describe their childbirth experiences in DOCCS

Going into labor

Overall, women said they received adequate care from prison staff during labor. One-third (33%, 6 of 18) of pregnancy survey respondents said the care they received during labor was “good,” one-third said “fair,” and one-third said “poor.” In general, women at Bedford reported having a better experience with labor than women at Taconic.

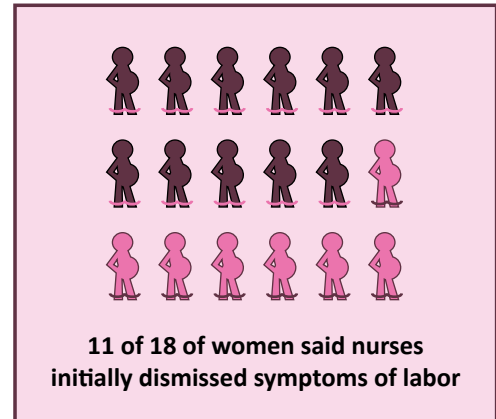
The main problem appears to be that some nurses disregard women when they first say that they are in labor. More than half (61%, 11 of 18) of pregnancy survey respondents said that nurses dismissed their symptoms and conducted superficial exams when they initially reported being in labor. One woman at Bedford wrote: “Went to RMU [medical unit] two or more times stating my water had been leaking and was sent back to my unit.”

Women at Taconic seemed to have particular difficulty with nurses in this area. Comments include:

- “[T]he [prison] nurse said my contractions were two and a half minutes apart and left saying to notify him when they are one minute apart.” This woman wrote that she “barely” got to the hospital in time to have her baby: “I was fully dilated by the time I arrived at the hospital; we arrived a little after 11pm and I had her at 11:20pm.”

- “I went [to the clinic] and seen the nurse who wanted to send me back to the unit. . . . She felt my stomach, said I wasn’t contracting. . .but she called the doctor and was told to send me to the hospital because not my first baby.”
- “The nurse on staff. . .said it was just fake labor and I needed to go back and lay down.”

Dismissing women who report labor symptoms is dangerous for women and their babies. The most egregious case the CA identified was of a woman, Barbara, who went into premature labor with twins at Taconic. An interview and medical chart review for Barbara revealed that it took more than 25 hours for the Taconic nursing staff to call a doctor and send Barbara to the hospital for a proper evaluation and safe childbirth after she informed them that she thought she was in labor.



Some women reported experiencing other delays after they went into labor in prison. Six of 14 (43%) pregnancy survey respondents said it took 30 minutes or more to see medical staff after telling someone they were in labor. Seven of 15 (47%) said it took more than 40 minutes to get them into an ambulance or van after medical staff said they should go to the hospital, including three women who said it took one hour, two who said it took two hours, and one who said it took four hours. Another survey respondent said that even though medical staff called an ambulance immediately because her blood pressure was very high, it took an hour for the ambulance to come and for staff to get her into the ambulance after it arrived.

Once they actually left the prison, a majority of women said the trip to the hospital was relatively short, 30 minutes or less. This makes sense as the two hospitals DOCCS uses for women to give birth are 30 minutes and 15 minutes away, respectively.

Giving birth in the hospital

About three-quarters (71%, 15 of 21) of pregnant survey respondents rated the medical care they got at the hospital as either “good” or “fair.” Of the women who said the care they got was poor, some said the reason was poor treatment from hospital staff. A few women described being denied pain medication, including one woman who wrote that she “wanted a C-section or an epidural but I ended up with 25 stitches from an episiotomy,” and another woman who wrote that hospital doctors “cut me open without putting me to sleep. When I started screaming they put me to sleep.”

Despite rating the medical care as “good” or “fair,” most women surveyed said their overall

BARBARA

Barbara was seven months pregnant with twins at Taconic when she began to leak fluid. Barbara had experienced this when she went into labor during a previous pregnancy and thought she might be in labor this time as well. She waited five hours and then told a correction officer who took her to see a nurse. The nurse examined Barbara but sent her back to her housing unit, saying that her twins were probably just “pressing on [her] bladder.”

Three hours later nothing had changed and Barbara asked to see the nurse again. This time, the nurse recorded that Barbara had changed three sanitary pads because of the fluid. The nurse took Barbara’s blood pressure but did not check her temperature, measure other vitals, check her cervix to see whether she was dilated, or test the pH balance of Barbara’s discharge to determine whether it was amniotic fluid, which would signify that Barbara’s water had broken. The nurse did not refer Barbara to a doctor either. Instead, the nurse again sent Barbara back to her housing unit, telling her to return only if the situation worsened.

Later that evening, Barbara asked an officer to call the medical clinic because she was still leaking fluid. The officer called but the nurse told him Barbara should just stay on her unit and “take it easy.” The next day, Barbara went to see a nurse. This nurse recorded abdominal tightness (which can indicate contractions), and, for the first time, measured the pH balance of Barbara’s fluid. The fluid measured 7.5 on the pH scale – an outcome that, along with the other signs, suggested that Barbara was in preterm labor. The nurse took Barbara’s vitals and found that her temperature was 101°, indicating a possible infection.

Barbara said the nurse looked concerned: “Nothing was explained to me. The nurse’s expression really said it all. I assumed what was happening due to my last pregnancy.” After the exam, the nurse phoned the doctor on call. Barbara heard the doctor tell the nurse, “She should have been taken out [to the hospital] yesterday.”

After this phone conversation, Barbara was finally sent to the hospital in an ambulance. Thankfully, Barbara delivered at the hospital, and both her twins were born without medical complications.

A nurse midwife on the CA’s visiting team explained: “Because Barbara was in preterm labor, and because her water broke so early, she and her twins faced serious complications. Women in this situation should receive IV antibiotics to stave off infection as well as medication to slow their contractions so doctors can administer medicine to strengthen the babies’ lungs before delivery. Denying this type of intervention can have drastic consequences.”

experiences giving birth in the hospital were negative. Women said a main reason they felt this way is that DOCCS forbids women from having anyone outside the prison system support them while they are in labor at the hospital.

DOCCS maintains this policy even though, in years past, Bedford's administration allowed an approved family member to be in the labor and delivery room, without incident. This practice was medically sound as research and experience confirm that births are easier and safer when women have someone they trust to support them through the process, particularly if the women are survivors of trauma.²³⁸ Some women said that the prohibition on outside support during childbirth was the number one thing they would change to improve the experience for pregnant women in DOCCS. That only a small number of women had met the person who delivered their baby before giving birth only made the situation worse. Comments include:

*“[Giving birth] was the worst.
I wanted my family or a
familiar face while in labor.”*

- “It was horrible. The officer did her best but it was not the same as having my mom there.”
- “It was painful to be alone and away from the ones I love.”
- “[I wanted] my mother just to hold my hand. I was scared.”
- “[I wanted] my family. I felt very alone and scared.”
- “Just a scary, unfamiliar situation to be in with nobody by your side. Very emotional situation. Alone.”

Prison staff also often neglect to call a woman's family members to let them know the woman is in labor or delay calling until after the woman has given birth. Wrote one pregnancy survey respondent, “Nobody would call home to my mother and nobody was my support.” Some women said that officers refused to give information when family members called. One woman explained, “It was horrible. [My husband] called to see if [my son] was born and they wouldn't tell him.”

Finally, while DOCCS says they permit family members with prior approval to visit the hospital after the baby has been born, many women reported problems with their families visiting.²³⁹ Some pregnancy survey respondents, for example, said that their family members came to the hospital but were not allowed in. One woman wrote that the officer “made my son's father leave. Also his mother who drove all the way from Philly.” Other women were told that family members could visit the hospital only if they had previously visited the prison, a problem for women whose family members had not visited because it was too far, too expensive or too burdensome. Of 23 pregnancy survey respondents, only two said their family members were able to visit at the hospital.

For some women, the presence of correction officers made the lack of outside support better while for other women, it made the experience worse. As with all outside hospital trips, DOCCS requires women to be within eyeshot of officers at all times during childbirth. Comments from women who had positive experiences with officers include:

- “I was okay with it. She was very supportive.”
- “I didn’t mind the female officer because this is my first child and she helped me out with breathing exercises and was really kind.”
- “The officers that were with me when I was being induced made me feel like a civilian, they held my hand, joked with me, and were extremely down to earth. . . I’m glad I had people with genuine hearts on my side.”

Women who had negative experiences with officers said that the officers’ presence during childbirth made them feel “uncomfortable,” “embarrassed” and “humiliated.” Comments include:

- “[I felt] like I was on show. I had a C-section and they were right there with all of my body exposed.”
- “[W]hen I was in labor the officer was very rude and said, ‘Just breathe, what’s wrong with you? Don’t forget you’re in prison!’ ”
- “I felt very uncomfortable. I’m having my baby and. . .officers are standing right there like I’m going to try and escape during contractions. It was ridiculous. . .very painful and frustrating. . . .”
- “[The officer was] watching my vagina the whole time. . . . [I was] nervous and scared.”

Requiring officers to be present during childbirth makes little sense as women giving birth are not an escape risk: labor is physically demanding and involves a tremendous amount of pain and concentration. Women who have epidurals and women undergoing C-sections are immobilized from the waist down from the anesthesia.

Cesarean births

DOCCS does not require its prisons to collect data on the number of vaginal births and C-sections. Based on the CA’s research, women in DOCCS appear to have about the same chance of delivering by C-section as women in the community. The rate of C-sections among pregnancy survey respondents, for example, was just over one-third (9 of 23, 39%) and the rate in the U.S. overall is 33% and in New York is 34%.²⁴⁰

The CA found that the majority of women who had C-sections knew why they had the procedure. For example, six of the nine pregnancy survey respondents who had C-sections gave reasons that are typical in the community, including a previous Cesarean birth, a breach (upside-down) baby, lack of progress in dilating and high blood pressure.²⁴¹ Three of the nine respondents, however, said that no one told them why they needed a C-section.

Women in DOCCS who want a vaginal birth after a previous C-section seem to be supported in trying for this outcome. The two pregnancy survey respondents who said they wanted a vaginal birth after a prior C-section reported that the doctors allowed them to try. One wrote that the prison doctor encouraged her to do so.

A main problem in this area seems to be inadequate follow-up care for women who have C-sections (*see p. 121*).

RECOMMENDATIONS

For DOCCS

- 1) Develop written policies that conform to community standards on how medical staff should evaluate and respond to pregnant women who report being in labor.
- 2) Train nursing staff on the appropriate response to pregnant women who report that their water has broken, that they are in labor, or that they are experiencing symptoms like bleeding or lack of fetal movement, and arrange for women in these circumstances to be evaluated immediately by an OB.
- 3) If a pregnant woman is housed at Taconic, have at least one appropriately trained nurse on-site at the prison at all times.
- 4) Allow women giving birth to have at least one support person of their choosing from outside the prison system, including a family member, a loved one or a licensed doula²⁴² with them during childbirth. Remove from the clearance process the requirement that the person must have visited the prison before the birth, and give pregnant women information about how to obtain hospital visiting clearance for their loved ones.
- 5) Train officers to follow DOCCS' practice of allowing family members to visit the hospital after women give birth, and to inform family members and loved ones when women go into labor and when they give birth, per the woman's request.
- 6) Permit officers to wait outside the delivery room, and let women choose if they want officers outside the room or with them during childbirth.

For hospitals contracting with DOCCS to deliver babies

- 1) Inform incarcerated women about their progress throughout labor and, where doctors recommend a Cesarean delivery, provide women with a clear explanation of the reasons for this recommendation.
- 2) Unless it is medically unsound, follow the wishes of incarcerated women about how they want to deliver their babies.

BEING IN THE HOSPITAL AFTER HAVING A BABY

DOCCS permits women to stay in the hospital for up to three days after giving birth, depending on the recommendations of hospital and prison doctors. All but one of the pregnancy survey respondents and interviewees said they stayed at the hospital for about two days.²⁴³ The one exception was a woman who stayed in the hospital for about a day and a half.

Most women surveyed reported having a negative experience during their time in the hospital after giving birth. Women said they felt this way because they were separated from their newborns, and denied sufficient time and adequate conditions to bond with and, for some, breastfeed their babies.

A primary factor is that Westchester Medical Center, the main hospital providing delivery services for DOCCS, places most babies of incarcerated women in the hospital nursery and not in their mothers' rooms on the secure ward, even if there is no medical reason for the separation. Most women on the secure ward are allowed only infrequent visits with their newborns, and some officers take a long time to escort women to the nursery and can cut visits short if they choose.

When asked whether the practice of separating women from their newborns originated with DOCCS or Westchester Medical Center, Bedford responded that it was the hospital's policy. This seems plausible as many women who gave birth at Northern Westchester Hospital, the hospital DOCCS uses less frequently for deliveries, said their babies were allowed to be in their rooms.

Women who were separated from their newborns in the hospital felt devastated, and some said that more time with their babies in the hospital was the top improvement they wanted for pregnant women in DOCCS. One woman wrote: "Westchester hospital needs to admit the prison mother to stay on same unit together [with her baby]. Words can't explain, you're on one end and your child somewhere else." Another wrote: "The policy at Westchester Medical Center should be looked at to allow mothers to be in the same room with the babies instead of suffering on the ward." Other comments include:

"Was at the hospital for 4 days.
. . . [I saw my baby] 2 to 3 times
a day. . .20 minutes to 2 hours,
depending on officer."

- "I was given one hour [with my baby]. . . two times a day. . ."
- "[I saw my son] for one to three hours. . . roughly two times a day, whenever it was convenient for the hospital escort [correction officer] to come."

- “I was on one side of the hospital and my baby on the other end. COs took forever to take me to her.”
- “[I saw my baby] two to three times daily depending on the officer. . .only when the officers wanted to take me downstairs to the nursery.” This woman said she was allowed to stay only “until the officers got tired of sitting there.”

Many women reported that the limited interaction with their newborns effectively prevented them from breastfeeding in the hospital:

- “Transporting me from the prison ward to see my son took about one and a half to two hours every time, and by then, the nurse had gotten impatient and fed him.”
- “Was told on numerous occasions to wait for officer. . . . By the time I arrived to feed him, it was too late. Already ate.”
- “I had to pump breast milk and take it to him. . . . [It was] degrading because I couldn’t stay with my baby which made it difficult to breastfeed.”

“The [officer] always took so long the nurses would end up feeding her formula because I was never there in time to breastfeed her.”

One woman, who could not breastfeed because the officers took such a long time to take her to the hospital nursery, said she was unable even to provide breast milk because the prison ward did not have a breast pump. Another said she was given only 20 minutes twice per day to nurse. She also said that during other feeding times, nurses gave her baby formula and that she was given no choice in the matter.

On top of limited time with their babies, many women said they had to feed their babies in a small, cramped room in the hospital that resembled a storage closet: “To feed our baby they put us in a room full of supplies away from other people.”

The presence of correction officers also had a negative impact on some women. As one woman wrote: “Some of the officers were great with me, helping me out, holding and feeding him because I’m a first-time mom. Other officers, I wanted to go back to my room because of the way their eyes burned holes in me.” Another woman wrote that the presence of male officers influenced her decision not to nurse: “The officer asked if I wanted to breastfeed but I said no because there were too many male officers there.”

Allowing mothers who want to breastfeed to do so is vital not only because all mothers deserve to have such choices respected but also because breastfeeding provides significant benefits. Nursing strengthens babies’ immune system, brain development and vision, and helps

mothers physically recover from childbirth while lowering their risk of cancer, heart disease, hypertension, diabetes and high cholesterol. It also helps mothers and babies form critical early bonds.²⁴⁴ Establishing breastfeeding as soon as possible is important because it lays a foundation for successful breastfeeding and because mothers only produce colostrum – the first stage of breast milk that contains essential nutrients and antibodies – for a few days after delivery.²⁴⁵

Current practices also contradict New York State law that requires hospitals to adopt policies that respect the “Breastfeeding Mothers’ Bill of Rights.” This document includes the rights to “have your baby stay with you right after birth” and to “begin breastfeeding within one hour after birth.” It also includes the rights to “have your baby in your room with you 24 hours a day,” “breastfeed your baby at any time day or night,” “have your baby not receive any bottle feeding,” and, if nursing is not possible, to have “every attempt” made for the baby to receive pumped breast milk.²⁴⁶

“I was also handcuffed at the ankles when taken to feed my baby and the COs kept them on. A few times, I almost fell with the baby in my arms I could’ve hurt the baby and I wouldn’t have been at fault but I also could’ve lost my baby to child welfare.”

As described in Section 4 (*p.* 135), shackling made women’s experiences in the hospital even worse. Some of the instances women told the CA about took place before the 2009 Anti-Shackling Law which bans shackling during childbirth, and others took place after the statute went into effect, in direct violation of the law. Women said that being shackled was not only painful and degrading but also dangerous as the restraints made it difficult for women to safely hold and feed their babies. Comments include:

- “I had a huge problem being restrained while visiting my baby. Had to stay in wheelchair with leg irons on. Made for a very difficult time for changing and moving around comfortably while trying/learning to breastfeed.”
- “When I was feeding my baby, I couldn’t change her or feed her good, because I was always in handcuffs and ankle shackles. I was feeling uncomfortable. It was horrible to be like that, while you in pain having your baby or feeding you newborn child.”
- “[W]hile I went to go see my baby I had ankle shackles and handcuffs until they put the baby in my arms. Then they only took off the handcuffs.”
- “One time they kept me in shackles for seven hours because I was going up and down to breastfeed.”

RECOMMENDATIONS

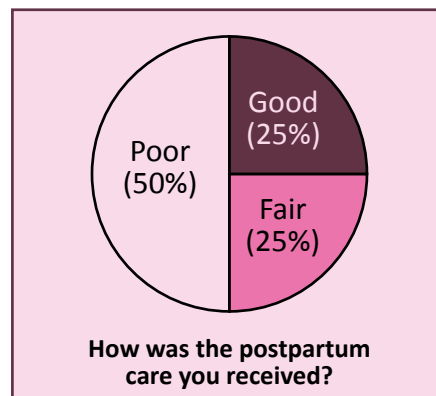
For DOCCS and hospitals contracting with DOCCS to deliver babies

- 1) Permit women to be in the same room with their babies in the hospital regardless of whether they are in a secure ward or a regular maternity ward.
- 2) If a baby must be in the hospital nursery or neonatal intensive care unit for medical reasons, require officers to escort incarcerated women to the unit promptly and for as long and as often as hospital policy allows, depending on the woman's request.
- 3) Follow state law requiring hospitals to adopt policies in line with the "Breastfeeding Mothers' Bill of Rights" by removing barriers to breastfeeding, including offering incarcerated women the choice to be with and breastfeed their babies immediately after birth and to stay in the same room with their babies throughout their hospital stay. Women should be offered hospital-grade breast pumps, receive breastfeeding support from hospital staff, and have the option of breastfeeding without male officers present. If a mother needs to be outside her room to feed her baby, provide her with an appropriate, clean space.
- 4) As recommended in Section 4 (*p. 135*), immediately comply with the 2009 Anti-Shackling Law, which prohibits shackling women during recovery after giving birth, including when they are interacting with their babies at the hospital.

POSTPARTUM CARE

DOCCS has a mixed record on postpartum care. One-quarter of pregnancy survey respondents (25%, 5 of 20) rated the postpartum care they received as “good,” one-quarter (25%, 5 of 20) as “fair,” and half (50%, 10 of 20) as “poor.” Among the women who gave a “poor” rating, many cited a lack of support as a main factor in their ranking.

One problem area is that DOCCS does not allow women to keep basic self-care items that they get at the hospital. About half of pregnancy survey respondents (47%, 7 of 15) and a majority of women the CA interviewed who received self-care items said they were not allowed to keep them when they returned to prison. The items included sanitary napkins, breast pads, calamine lotion and spray bottles, all of which can ease discomfort after childbirth and all of which are difficult for women in DOCCS to obtain on their own.²⁴⁷ DOCCS does not provide these items, commissaries do not sell them, and women are not allowed to receive most of them in packages.



Self-care items and treatments are also in short supply for women who choose not to breastfeed or who stop breastfeeding early on. For example, only two of 15 (13%) pregnancy survey respondents who did not breastfeed said that medical staff gave them something to help with the discomfort they experienced. One woman was given ibuprofen, the other “warm cloths.” One woman who was not given anything wrote that it was “[v]ery uncomfortable and it hurt when my breasts were engorged.” Two others described their experience as “painful.”

In terms of postpartum medical care, DOCCS seems to be doing a good job ensuring that women who give birth vaginally have a check-up within the six-week time frame recommended in the community.²⁴⁸ Most women the CA surveyed and interviewed who gave birth vaginally reported that they had a postpartum appointment within six to eight weeks of giving birth, though one woman said it took 12 weeks even after she went to sick call. A few women said they never had a postpartum check-up at all.

DOCCS has a worse track record in ensuring that women who have C-sections see a doctor after two weeks, which is the community standard and the stated practice at Bedford and Taconic.²⁴⁹ For example, of the five pregnancy survey respondents who had C-sections, four said they did not have a check-up until six weeks later, and one not until eight weeks later.²⁵⁰

DOCCS also maintains certain practices that actively harm women’s ability to recover from C-sections. A C-section is a major surgery, and women who give birth this way are advised to take special care of the incision and avoid strenuous activity as they heal.²⁵¹ However, as discussed in Section 4 (*p.* 135), women who have C-sections are frequently put in waist chains on the way

back from the hospital, which can irritate their incision and cause pain. In addition, some women who had C-sections said prison staff made them do physical activity before they were ready. One woman wrote that her staples “busted” one week after she gave birth because she was “made to go up and down stairs.” Another woman said she was made to walk up a large hill to her housing unit three days after having a C-section. Other women on the nursery said that they had to resume doing chores, some of which are physically strenuous, two weeks after their surgery. Finally, one woman said she was denied pain medication for three weeks after having a C-section, even though the hospital gave her medicine to continue taking when she returned to the prison.

In terms of postpartum emotional support, women’s experiences vary dramatically depending on whether they have been accepted to the nursery. Women on the nursery generally reported that the counseling and support they received from nursery staff and other women on the unit played a big role in their ability to recover and handle the stresses of motherhood in prison. The experience for women who were denied admission to the nursery and separated from their babies was virtually the opposite, with no formal counseling or support offered. Women in this situation reported feeling alone and depressed.

RECOMMENDATIONS

For DOCCS

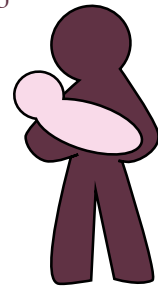
- 1) Revise written policies to require postpartum medical check-ups that follow community standards of six weeks for vaginal births and two weeks for C-sections.
- 2) Give women who have C-sections at least eight weeks, the standard in the community, to heal and recover before they return to daily activities and programs.
- 3) Permit women who give birth to keep self-care items that hospital staff provide, including sanitary napkins, breast pads, creams and spray bottles.
- 4) Provide women who do not breastfeed with cool and warm compresses, ibuprofen, supportive bras and other items that help relieve discomfort.
- 5) Enhance supportive services for women who give birth and are not in the nursery program, and refer all women who experience anxiety or depression after giving birth to supportive services including counseling.

For hospitals contracting with DOCCS to delivery babies

- 1) Provide incarcerated women who give birth with verbal and easy-to-read written information about warning signs they should watch for after delivering, such as fever, pain, heavy bleeding and blood clots.

NURSERY AT BEDFORD HILLS

Women facing sentencing should be sent to community-based alternatives to incarceration instead of to prison. These programs prevent the trauma and suffering that mothers and children experience when they are separated, cost less than prison, and are more effective in reducing recidivism and helping women rebuild their lives and contribute to the community.²⁵²



When such sentencing alternatives are not possible, the CA believes that as many women as possible should have access to the nursery at Bedford Hills.²⁵³

Overview

Bedford Hills is home to the first and longest-running prison nursery in the country.²⁵⁴ The nursery opened in 1901 and New York enacted a statute in 1930 to govern admission to the program.²⁵⁵ Prison nurseries operate in only seven other states.²⁵⁶ DOCCS opened a second nursery at Taconic in 1990 but closed it in 2011, citing budget cuts and a low census.²⁵⁷

Bedford's nursery is part of the prison's children's center, which provides visiting and parenting support for all mothers at the prison. Women on the nursery can live with their babies until the baby turns one, or 18 months if the mother is scheduled to go home or start work release within that time frame. Mothers who enter prison while nursing a child under one year are also eligible for the nursery, though prison staff could not remember the last time a woman was admitted to the nursery under this circumstance.²⁵⁸

Bedford's nursery is a highly valuable and impressive program that yields significant benefits to women and their babies as well as to taxpayers and the community at large. First, the program provides mothers with support and affords them the opportunity to care for their babies and to change patterns of unhealthy parenting that may have existed in the past.²⁵⁹

Second, because babies on the nursery are being cared for by their mothers, they are able to form critical secure attachments to their mothers. Research conducted by Dr. Mary Byrne at the Columbia University School of Nursing with 97 women and 100 babies in the Bedford and Taconic nurseries from 2003 to 2006 shows that the vast majority of babies formed secure attachments to their mothers.²⁶⁰ These attachments boost babies' development and lay the foundation for healthy relationships later in life.²⁶¹

Third, participation in the nursery program is associated with lower recidivism rates. Of the 97 women in Dr. Byrne's study, not a single woman returned to prison for a new crime in the year

after release and only 10% returned on technical parole violations.²⁶² This research affirms earlier findings by DOCCS that mothers who lived on the nursery in 1997 and 1998 had lower rates of recidivism than other women.²⁶³

Finally, the nursery reduces the risk of babies going into foster care and improves the odds that a mother and her child will remain together after prison. This is very significant as children benefit tremendously when they can remain in a stable living situation with their primary caregiver.²⁶⁴

Women the CA surveyed and interviewed who lived on the nursery felt deeply fortunate to have the opportunity to be with their babies and participate in the program:

- “I couldn’t ask for anything better in jail. As long as I got my baby and she’s safe, that’s all that matters.”
- “It’s difficult emotionally to be with your baby in prison but it’s a huge blessing.”
- “I’m extremely grateful to be in the nursery. I get to work on my parenting skills and work on myself. It has made all the difference in my life.”

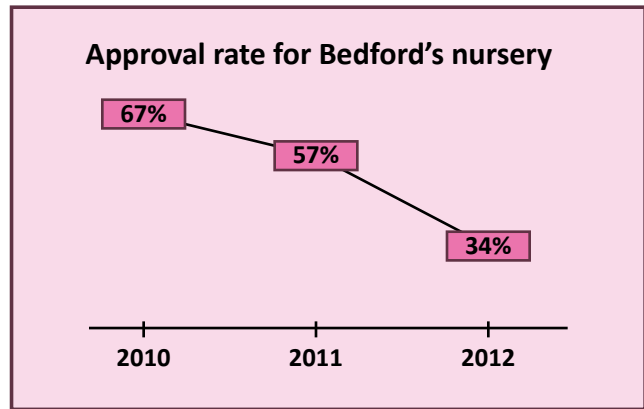
In evaluating the nursery, the CA found both positive features and areas of concern. In addition to the overall benefits of the nursery described above, the CA’s main positive findings are: 1) dedicated and widely praised civilian and peer staff; 2) an effective program model including individual and group support to help women care for their babies, work through personal issues and plan for reentry; 3) support for breastfeeding mothers; and 4) the opportunity for incarcerated women to serve as peer educators and caregivers for babies.

The most pressing areas of concern the CA identified are: 1) unfair denials of nursery applicants by Bedford’s administration; 2) delays in processing applications; 3) failure to count parenting classes as programming that women must complete in order to earn release; 4) policies prohibiting women convicted of violent crimes from working as nursery caregivers; and 5) several changes instituted by Bedford’s administration that make life more difficult for nursery participants and staff, including requiring officers to escort volunteers around the prison, prohibiting women who previously worked as caregivers from filling in when extra assistance is needed, no longer allowing women on the nursery to access the gym or to do chores or use the bathroom while their babies sleep, and eliminating overtime pay for caregivers to provide child care at night, which limits the ability of mothers on the nursery to participate in evening programming, including certain parenting and college classes.

Admissions and denials

Bedford’s nursery can hold up to 27 mother-baby pairs, yet the average census in spring 2013 was only eight. This census is nearly half of what it was in 2009 (15) and one-third of what it was in the 1990s (30).

The overall decline in prison population, driven in part by sentencing reforms, the work of alternative-to-incarceration programs, and trends in policing, may be contributing to the lower numbers of women in Bedford's nursery.²⁶⁵ Similarly, the number of women and babies in the nursery at Rikers Island (New York City's main jail) has declined, limiting the smooth transition of eligible mothers to the state nursery.²⁶⁶ Most relevant to this report is the apparent trend of more women being denied admission to Bedford's nursery. For example, while the approval rate for women applying to the nursery was 67% in 2010, the rate fell to 34% in 2012. Bedford reported that 24 women applied to the nursery in 2010, and 16 were accepted; 30 women applied in 2011, and 17 were accepted; and 35 women applied in 2012, and only 12 were accepted.



Bedford's administration also dropped the practice of putting nursery candidates they are unsure about on "probation" so staff can evaluate whether they should stay in the program. Instead, women in this category are rejected outright.

It makes sense to assess each nursery applicant on a case-by-case basis, and the criteria for admission articulated in Bedford's nursery manual reflect that view.²⁶⁷ This type of assessment, however, does not appear to be the Bedford administration's current practice. Instead, the administration seems to deny women because of issues like violent convictions and prior child welfare involvement without a nuanced assessment of how these circumstances relate to whether participation in the nursery is in their children's best interest. In 2013, Bedford reported that the most common reasons for denying women admission were an offense involving violence and a prior child welfare history.

These practices are misguided and contrary to the statute governing the nursery and to case law interpreting that statute. The law contains only two bars to admission: 1) if the mother is "physically unfit" to care for her child, and 2) if staying in the nursery would not be "desirable for the welfare" of the child.²⁶⁸ State courts have repeatedly interpreted this second factor to mean that corrections officials must determine whether placement in the nursery is in the "best interest of the child,"²⁶⁹ a standard that does not automatically exclude women with violent convictions and child welfare histories.²⁷⁰ Recently, a number of women who were denied admission to the nursery successfully sued the prison to gain entry to the program.²⁷¹

For women convicted of violent crimes, the shift in admissions is a departure from past practice as both Bedford and Taconic spent years admitting women with violent convictions to the nursery, all without incident. A 2002 DOCCS study, the most recent available, shows that 15% of mothers in the nurseries in 1997 and 1998 (26 of 179 women) were serving time for a violent crime.²⁷²

As for child welfare history, it is exactly those mothers who have made mistakes in parenting in the past who the nursery should prioritize. The program gives mothers a second chance, or sometimes the first in their lives, to learn how to parent in a healthy way, and to build the relationships and solid foundation with their children that will continue when they leave prison.

Denying admission to the nursery prevents mothers and babies from forming critical bonds and increases the risk of mothers losing their parental rights forever

Being denied admission to the nursery has significant consequences even beyond the pain of separation: a mother must make arrangements for someone in the community to take her baby or her baby will go into foster care.²⁷³ When this happens, mothers risk losing their parental rights forever because of the Adoption and Safe Families Act (ASFA), a law that speeds up the deadline by which foster care agencies must move to terminate parental rights when a child is in foster care.²⁷⁴ This risk has been mitigated for incarcerated parents in New York as a result of a law passed in 2010 that grants foster care agencies discretion to delay or forgo filing termination proceedings if a parent is in prison.²⁷⁵ The law does not, however, prevent agencies from initiating the termination process, and incarcerated parents may still lose their rights if they cannot quickly find homes for their children outside the foster care system.

Knowing the risks, staff at Bedford's children's center try to help women in this situation identify caregivers in the community. Sometimes Hour Children (the nonprofit agency that runs the children's center and nursery) is able to care for the baby in one of its community residences until the mother comes home. Otherwise, regardless of where the mother is from, the baby goes into foster care in Westchester County.

Application process and moving onto the nursery

Bedford seems to be doing a good job informing pregnant women about the nursery. Most women the CA surveyed and interviewed said they first learned about the nursery either while in county jail or shortly after arriving in DOCCS. Most women also said they received sufficient assistance with their applications, a written two-page form. A few women said that more support with the application would have been helpful.

The main problem with applications seems to be the length of time it takes for Bedford's administration to process them. A majority of women the CA surveyed and interviewed said it took months for them to learn about the decision on their applications. Many women did not find out they were accepted until the very end of their pregnancies, and some were told while they were in the hospital giving birth. One woman wrote that her number one improvement for pregnant women in DOCCS would be: "To know in a timely fashion if they are accepted in a

nursery program. . .so they do not spend their entire pregnancy worrying about if they have to find living arrangements for their baby.”

Because the process took so long, many women reported that they did not move onto the nursery unit until they were close to their due date or had already given birth. These experiences are reinforced by data from Dr. Mary Byrne’s research on the nurseries at Bedford and Taconic: only 58% of the 97 women Dr. Byrne surveyed lived on the nursery unit prior to giving birth, and, of those women, their average stay before childbirth was only three weeks. The other 42% of women were admitted to the nursery from the hospital where they delivered.²⁷⁶ This data contrasts with reports from Bedford that women generally begin living on the nursery unit in their 7th month. Delayed entry to the nursery is unfortunate given that the program provides a more supportive setting for pregnant women and can help women prepare for motherhood and acclimate to daily life on the unit.

Staffing and children’s center

DOCCS contracts with Hour Children, a community-based non-profit, to staff Bedford’s nursery and the prison’s children’s center. The center runs parenting classes, helps mothers stay connected with their children, provides assistance during family visits, and holds special events and activities including an annual holiday party, a Mother’s Day celebration, and a summer visiting program where children live with families in the local community and visit their mothers on a regular basis. Hour Children also provides reentry support services and manages several residences in Queens where mothers can live with their children after they come home from prison.²⁷⁷

Staffing for the nursery program consists of one children’s center director, one nursery manager, one infant center manager, and three social workers (all partially paid for by Hour Children’s own funding). A group of volunteers also works in the nursery providing support to women and their babies. A few years ago, DOCCS’ funding was cut for the children’s center and nursery, eliminating four staff positions.

The nursery also employs incarcerated women, 10 as of winter 2013, who are trained and supervised by Hour Children staff. Caregivers help with prenatal and parenting classes, and take care of babies when mothers are off the unit participating in required programs. To be eligible for the position, a woman must have a GED and positive disciplinary record, and pass a screening that includes an assessment of her crime and mental health status. Caregivers can stay in the position indefinitely and are paid 25 cents per hour, a wage higher than most other prison jobs.

Unfortunately, in 2010, the State Department of Labor closed the Early Childhood Associate training program it offered to nursery caregivers. This training was valuable both because it provided a rigorous learning opportunity and sense of accomplishment for women and because

women could use the certificate they received to help earn parole and build credibility with employers, especially important as jobs in the child care field are difficult for people with felony convictions to secure after prison.

Women the CA surveyed and interviewed praised the nursery staff and peer caregivers. Regarding the staff, women commented: “Very helpful and caring, most of all understanding,” “Wonderful, very caring and sensitive to your needs;” “We love them.” Regarding the caregivers, women commented: “Great;” “Excellent;” “They were a blessing, very beautiful women with big hearts;” “Very happy and positive people to have our kids around.”

Daily life on the nursery for the first six weeks

Mothers are allowed to spend full days in the nursery with their babies for six weeks before they have to resume required programming. After six weeks, women rejoin drug treatment, school and vocational training programs, which run in the morning from 8am to 11am and in the afternoon from 1pm to 3:40pm.

While some women may look forward to the break from caregiving duties that these programs provide, other women may want to spend more than six weeks with their babies and in parenting classes. Even these women, however, often readily resume programs because the quicker they finish the programs, the quicker they can earn release and go home with their babies.

Mothers in the nursery can take a specialized eight-week parenting class run by Hour Children that covers infant care, parenting skills, and early childhood health and development. Some women on the nursery, however, cannot finish the class, or even start it, because they must begin mandated programs, and parenting classes do not count toward the programming women must complete to earn early release.²⁷⁸ Adding to this problem, while the children’s center offers other parenting classes, as explained below, DOCCS no longer pays peer caregivers for child care at night when some of the classes are offered, making it difficult for women on the nursery to participate. Women on the nursery who were able to participate in parenting classes said they offered important help and information.

Daily life on the nursery after six weeks

Overall, the nursery provides important support for the women and babies who live there. Women on the unit have weekly community meetings, weekly individual sessions with a social worker, and access to staff for emotional support, parenting issues and reentry planning. Women the CA interviewed and surveyed spoke highly of the support they received in the program.

The nursery unit has child-friendly murals on the walls, a playroom for babies and a common area with carpeting (a rare feature in prison). Mothers live together with their babies in rooms

on the unit, and two mothers frequently share a room for the first four months so that they can support each other.²⁷⁹ Unlike women in the rest of the prison, women on the nursery are never locked in their rooms.²⁸⁰

A typical day in the nursery starts with mothers feeding their babies and completing their chores on the unit. Mothers then bring their children to the caregivers in the infant center and leave for required morning programs. They come back for lunch and then leave again for afternoon programs, returning their babies to the caregivers. In the early evening, mothers return to the unit and generally stay there for the rest of the night. Nursery staff describe the daily routine as a “working mother model” aimed at preparing women for life after release.

Recent changes that negatively impact the nursery

The CA found that several new policies undermine the nursery’s supportive environment and make life more difficult for nursery participants. First, DOCCS no longer pays caregivers overtime to provide child care at night, even though caregivers earn only 25 cents per hour. This practice limits the ability of mothers on the nursery to participate in evening programming, including certain parenting and college classes. Women can ask other mothers to watch their children but this strategy is unreliable as mothers are not always available and many mothers are tired from a full day and understandably want to focus their attention on their own children.

In addition, women on the nursery are no longer allowed to eat meals in the mess hall and cannot leave the nursery unit to exercise in the gym unless they find another mother to watch their children. The sole outside activity women are permitted is 30 minutes in the baby recreation yard, but only if the timing works with the women’s program schedules, which it almost never does. Even this time is not particularly joyful as the yard is not suitable for crawling so babies must be either held or kept in strollers. These policies give women on the nursery virtually no outside outlet, which is particularly problematic for women living in a confined space with a small group of other women, all dealing with the stresses of prison and motherhood.

In another departure from past practice, Bedford no longer allows women on the nursery to do their required chores while their babies are sleeping unless they can find another mother to keep watch. Everyone agrees that babies on the nursery should be safe at all times, but this policy is unrealistic and results in mothers having to wake their babies so that they can clean. Said one woman, “I had to wake my son and put him in a stroller while I buffed the floor. It’s very loud when you buff the floor and there is all sorts of dust.” Said another, “I had to put my baby in a stroller while I cleaned. . .I didn’t want my baby near all those chemicals but there was nothing I could do.” One woman reported that she was even required to wake her baby from a nap and take him with her when she went to the bathroom.

Before Bedford imposed this policy, a woman on the nursery could ask a staff member to listen for her baby and alert her if the baby woke up. Doing chores or other activities while a baby sleeps is common practice for mothers in the community, and, as long as it is done safely, there is no reason why it should be any different in prison.

The CA also found several other new policies implemented by Bedford's administration that negatively impact the nursery operation. One is a policy requiring correction staff to escort volunteers wherever they go in the prison, even volunteers who have worked at Bedford for decades. This creates delays with volunteers routinely waiting up to 30 minutes or more to traverse even short distances in the prison.

Another policy prohibits women who previously worked as nursery caregivers from helping on the unit if a substitute or extra assistance is needed on occasions like holidays and special events. A third policy prohibits women convicted of violent crimes from being hired as nursery caregivers, even though Bedford employed women convicted of violent crimes in those positions for many years without incident. In addition, some women convicted of violent crimes hired before this policy took effect continue to work successfully on the unit. These women, as the women before them, were appropriately screened, and their abilities should not be judged solely on the crime for which they are in prison. This practice also limits the pool of women with long sentences who can serve as caregivers, which is unfortunate as the position is best suited to women who can make a longer-term commitment to the program and the intensive training it requires.

Breastfeeding

Breastfeeding can be positive and yet also anxiety producing and demanding for new mothers, and these stresses are likely even more pronounced for mothers operating in the inherently stressful environment of prison.²⁸¹

Nursery staff encourage mothers to breastfeed, and one nursery volunteer is trained in providing lactation support. Staff also recently purchased a hospital-grade breast pump to make pumping more efficient for breastfeeding mothers.

Women the CA surveyed and interviewed who breastfed on the nursery said that they had enough time and privacy to pump and nurse, and that nursery staff and other mothers were supportive and helpful. One woman wrote: "I breastfed everywhere whenever for how ever long. The COs never minded as long as I was covered." Another wrote: "I was [given enough time] and officer was present the whole time, but I did it, my baby had to eat!" A few women said breastfeeding with certain officers who were substitutes for the regular nursery officers was not a pleasant experience. One woman wrote that the substitute officers "acted like it disgusted them."

DOCCS has a positive record of prescribing vitamin supplements for mothers who breastfeed, as recommended in the community.²⁸² Of the 10 survey respondents who said they were breastfeeding, eight said they were given vitamins during this time. This practice may be changing, however, as a number of women interviewed in 2013 reported that their vitamin prescriptions had been discontinued while they were still breastfeeding.

Interactions with correction officers

One officer is assigned to the nursery at all times. Generally, the same set of officers work on the nursery but sometimes a substitute fills in if the regular officer is not available. Most women said that the regular officers were “fair” and “understanding,” but that the substitute officers were frequently problematic. As one woman put it: “We often have irregular officers who don’t know or care to know the special rules, they say we’re spoiled and should not have our babies with us.” Said another woman, “Most of the COs are pretty good. Occasionally, you get some bad apples. There is a problem with consistency.”

Having officers who do not understand or follow the specific nursery rules can have serious consequences. If a woman on the nursery gets a disciplinary ticket, she faces the possibility of being expelled from the program entirely.²⁸³

Removals from the nursery

Any mother who is removed from the nursery must immediately find a guardian in the community to take her baby, and, if she cannot, her baby will go into foster care in Westchester County.

Bedford reports that women are rarely removed from the nursery. In her research with 97 women in the Bedford and Taconic nurseries, Dr. Mary Byrne found that 14 (14%) of the women were removed from the nursery for disciplinary infractions. Of these cases, Dr. Byrne comments that “the children were arguably not in danger, but the mother was being punished for repeated prison infractions such as refusing to immediately comply with a corrections officer’s direct command.” Three of the children went into foster care.²⁸⁴

Pediatric care

The nursery at Bedford is a “well baby” nursery, which means that only babies who are healthy are allowed to live there. If a baby develops a serious health condition, the prison transfers the baby to Westchester Medical Center for treatment. If the baby’s condition does not improve, the mother must make arrangements for a guardian in the community to care for her baby.

Bedford’s Medical Director oversees the nursery’s medical operation, and DOCCS contracts with a pediatrician from Westchester Medical Center to provide care for the babies. The pediatrician

holds a clinic twice per month at the prison where she meets with the mothers and babies for routine check-ups and immunizations. If there is a pediatric emergency, the correction officer on the nursery contacts medical staff who come to the unit and, if necessary, contact the pediatrician, who is on call 24/7. Bedford's Medical Director noted that they always err on the side of caution when dealing with babies' health: "It's never a waste of time to call."

DOCCS nurses also check in with nursery staff daily about babies' well-being and to make sure refrigerator temperatures are appropriate for vaccines and food.²⁸⁵

In addition to pediatric care, a nurse from the Westchester County Department of Health conducts monthly developmental evaluations of nursery babies, an ongoing practice since the early 1990s. If a baby shows signs of developmental delays, the nurse refers the baby to a county-run early intervention program which provides special services and support.

A majority of women the CA surveyed and interviewed gave the pediatrician positive reviews and felt that they could access adequate medical care for their children. Women's main concern was the length of time it took for certain nurses to arrive on the nursery unit after an officer called them with an urgent situation.

RECOMMENDATIONS

For DOCCS

- 1) Accept all pregnant women into the nursery program unless a determination is made, following a thorough, individualized assessment, that a woman's participation is not in the best interest of her child, as dictated by statute and case law. Reinstate the practices of consulting with nursery staff about candidates and accepting nursery candidates about whom Bedford's administration is unsure by putting them on "probation."
- 2) Accelerate the processing of nursery applications and give women the option of moving onto the nursery unit shortly after they have been accepted.
- 3) Reinstate overtime pay for caregivers to provide child care for mothers on the nursery who want to participate in evening programs like college and parenting classes or go outside or to the gym for physical activity.
- 4) Return to the previous practice of considering women for nursery caregiver positions regardless of the nature of their crime.

- 5) Reinstate policies that allow women who previously worked on the nursery to cover for caregivers when needed, and allow civilian volunteers to move within the prison without correction staff escorts or with civilian staff escorts, if an escort is truly necessary.
- 6) Give women the option of spending 12 weeks full-time with their babies and in nursery parenting classes, and allow nursery parenting classes to count toward mandatory programs women must complete to earn early release.
- 7) Fix the baby recreation yard so that mothers and caregivers can take babies out of their strollers and have a suitable place to play.
- 8) Allow women to perform their chores and engage in personal tasks like going to the bathroom on the nursery unit while their babies are sleeping. To facilitate this, return to the former practice of allowing women to ask staff to listen for their babies or purchase baby monitors for all rooms in the nursery.
- 9) Train correction officers who substitute for regular nursery officers on specific nursery rules.
- 10) Dismiss women from the nursery only in exceptional circumstances if they are found to be a danger to their own baby or other babies and women on the unit.

For New York State Department of Labor

- 1) Reinstate the training program for caregivers on the nursery.

For New York State Governor and Legislature

- 1) Enact laws that allow more people to serve their sentences in community-based, gender-specific alternative-to-incarceration programs instead of prison, especially pregnant women and primary caregivers of children, and expand funding for these programs.
- 2) Enact a law that allows nursery participants to leave prison with their babies at the end of one year or 18 months and to finish serving their sentences in community-based programs where they can live with their children.
- 3) Amend the statute outlining the programs incarcerated people must complete in order to earn merit time (time off their sentences) to include parenting and prenatal classes.

For Judges

- 1) Make use of community-based alternative-to-incarceration programs whenever possible, especially for pregnant women and primary caregivers for children.
- 2) Inform pregnant women and nursing mothers with infants younger than one year sentenced to state prison about the nursery at Bedford, and provide them with an application upon sentencing.

SECTION 4

Shackling of Pregnant Women in DOCCS

Handcuffs are cuffs that go around an incarcerated person's wrists and are connected to each other by chain. The black box is a metal rectangular box which clamps down on the chain between the handcuffs to further restrict hand movement. A waist chain is a chain that goes around an incarcerated person's waist and is attached to the handcuffs by another chain to restrict arm movement. Ankle shackles are cuffs put around an incarcerated person's ankles which are connected to each other by chain to restrict leg movement.



Shackling pregnant women is a dangerous and degrading practice that causes suffering, endangers the health and safety of women and their babies, and violates basic standards of human rights and decency. The practice is also unnecessary as security can be effectively maintained by correction staff when pregnant women are off prison grounds.²⁸⁶

Shackling causes pregnant women physical and psychological pain. It heightens the risk of blood clots, limits the mobility needed for a safe pregnancy and delivery, and increases the risk of falling, which can cause serious injury and even death to the fetus.²⁸⁷ Shackles can also interfere with doctors' ability to care for their patients and delay access to medical services during emergencies.²⁸⁸ Shackling during postpartum recovery prevents women from healing and bonding with their newborns.²⁸⁹

Shackling pregnant women is a dangerous and degrading practice that violates basic standards of human rights

There is widespread opposition to shackling women during childbirth, and a number of federal courts have ruled that it violates the Eighth Amendment's prohibition against cruel and unusual punishment.²⁹⁰ Among those who condemn the practice are dozens of women's and human rights groups across the country, and the nation's leading experts on women's health, including: the American College of Obstetricians and Gynecologists (ACOG),²⁹¹ the American College of Nurse Midwives,²⁹² the National Perinatal Association,²⁹³ the American Medical Women's Association,²⁹⁴ the American Public Health Association,²⁹⁵ the American Medical Association (AMA),²⁹⁶ and the

Based on surveys and interviews with 27 women who gave birth in DOCCS custody after the Anti-Shackling Law went into effect, the CA concludes that DOCCS is out of compliance with the law. Twenty-three of the 27 women (85%) who gave birth between 2009 and 2013 were shackled at least once in violation of the law. In addition, in the medical chart of one of the 27 women, the CA uncovered an official prison form documenting that the woman had been shackled shortly after the law went into effect while she recovered after giving birth in the hospital.³⁰⁹



Many women reported being shackled on multiple occasions expressly prohibited by the statute. One of the most troubling cases the CA identified is a woman who explained her experience this way:

“My ankles were shackled during the whole trip to the hospital when I was in labor. They pushed me in a wheelchair from the van to the hospital and at one point the wheelchair almost tipped over. I would not have been able to catch myself very well. . . . I was shackled until I got to the delivery room, but even then they kept one of my ankles shackled to the bed. [They] only took it off when it was time to start pushing. . . . I couldn’t rotate the way I needed to and I had to sit in one spot the whole time I was in labor. The baby was pushing and I was going through contractions and I wanted to lie on my side but I couldn’t because I couldn’t move my leg.”

Most of the other instances where women were shackled in violation of the law occurred while the women were going to the hospital, recovering after giving birth and being transferred from the hospital back to the prison.

The CA’s findings conflict with DOCCS’ official position on its shackling practices. The CA submitted a FOIL request for documentation of instances in which women were shackled during or after childbirth over the first year and a half after the Anti-Shackling Law went into effect. DOCCS’ response to this request states, “A diligent search was conducted and there were no instances, as described, being reported at any of the facilities listed on your request. . . .”³¹⁰ When the CA sent DOCCS the aforementioned official form from the woman’s medical chart documenting that she had, in fact, been shackled in violation of the law, the Department acknowledged the incident and stated that the prison took “corrective action” to make sure the officer “understood the law, so that it would not occur again.”

Shackling on the way to the hospital to give birth

- About **half of the women (46%, 12 of 26)** reported being shackled during the trip to the hospital to give birth, including nine women who were in labor at the time.

- Two women were cuffed to the stretcher in the ambulance while they were in labor, and another was put in handcuffs and the black box during the trip to the hospital.
- One of the women who went to the hospital twice while she was in labor said that during her first trip, she was in serious pain yet was handcuffed the whole time. During her second trip, one officer wanted to use handcuffs again but ultimately was stopped by the EMS worker and the other escorting officer.
- Of the two women who were not in labor when they were shackled, one was two weeks past her due date when she was taken to the hospital to be induced and the other was transferred for a scheduled C-section. Both women were handcuffed, one for over an hour.
- One other woman said that her escorting officers tried to put cuffs on her ankles but decided not to only because they were so swollen.

“While I was in the ambulance and being cuffed, I was surprised because the EMT told the officer that restraints aren’t used. . . .”

Shackling during recovery after giving birth

- About **half of the women (55%, 11 of 20)** reported being shackled while they were recovering in the hospital, some right after they gave birth and for long periods of time.
- One woman was put in restraints for a “long time” immediately after she delivered.
- One woman was kept in handcuffs and ankle shackles for over five hours shortly after she delivered. She wrote, “I shouldn’t have been shackled right after giving birth. I was way too sore to run.”
- One woman was shackled “four hours after giving birth. . . .” She commented, “Where would a woman go after giving birth? Being shackled and being told to walk to a wheelchair – then escorted to a secure ward.”
- Six women were handcuffed and shackled at the ankles when they visited their babies in the nursery or neonatal ICU, and were kept in ankle shackles when they held and fed their babies. One woman wrote, “I had to breastfeed my baby while shackled. . . . I remember

“[I was shackled] going to the bathroom. . . . had to sleep with shackles on my feet. . . . The only time they were off is when I had to take a shower.”

my vagina hurt very bad sitting there. . . I was devastated to go visit him. I had to sit in a wheelchair for hours at a time shackled in pain. . . .”

Shackling on the way back from the hospital after giving birth

- **Two-thirds of the women (67%, 18 of 27)** said they were shackled during the trip from the hospital back to the prison, including 12 women who were put in full shackles (handcuffs, black box, ankle shackles and waist chain). Three of the 12 women had given birth by C-section just days earlier.
- One of the women who had a C-section three days earlier wrote that the shackles caused her to be “in pain, a lot of pain.” This is not surprising as women who have C-sections often experience severe soreness in their abdominal region and are advised not to rub or put pressure on the incision, which is exactly the area where waist chains are applied.³¹¹
- One of the women reported that officers would not remove her handcuffs and ankle shackles until after she walked up the stairs to the nursery unit at the prison.

Many women commented that it was particularly upsetting to be in handcuffs and the black box during the ride back to the prison because the shackles prevented them from comforting their newborns. Wrote one woman, “[M]y son was screaming and I couldn’t do anything about it.”

DOCCS has made better progress in curtailing the use of restraints on pregnant women after they arrive at the hospital through when they give birth. For example, while nine of 10 pregnancy survey respondents who gave birth before the law’s passage reported being shackled in the hospital waiting room, five of 10 while being examined by medical staff, and four of 10 just before giving birth, only four of the 27 women told the CA that they were shackled on any of those occasions after the law went into effect.

Of the four women who were shackled after arriving at the hospital, one was shackled by her ankle to the delivery bed until medical staff told her to start pushing. The second woman had one wrist cuffed to the stretcher in the hospital when she went to be induced. The cuff was removed only after she unexpectedly went into labor. The third woman was in handcuffs for a short time in the waiting room after being admitted to the hospital, and the fourth woman was in handcuffs for two hours in the hospital waiting room while waiting to be induced.

DOCCS denied the CA’s FOIL request for written policies related to the Anti-Shackling Law, citing Public Officers Law § 87(2)(f), which allows agencies to deny access to records if they believe that disclosing them would “endanger the life or safety of any person.”³¹² As a result, the CA cannot determine whether DOCCS’ written policies comply with the Anti-Shackling Law.

SITUATIONS NOT COVERED UNDER NEW YORK'S ANTI-SHACKLING LAW

Shackling during pregnancy

DOCCS denied the CA's FOIL request for Central Office policies on shackling pregnant women prior to labor and delivery, when the Anti-Shackling Law does not apply.³¹³ DOCCS did provide a copy of Bedford's and Taconic's facility policies on this issue. Although these policies limit the use of restraints, they do not go far enough to protect women's safety, and both still permit shackling to some degree throughout all trimesters.

Bedford's policy forbids waist chains but allows all other restraints throughout pregnancy (handcuffs, black box, ankle shackles). It states that handcuffs are "generally" sufficient for pregnant women, urges staff not to use restraints that affect "balance and ambulation," and requires that "[e]xtra precautions must be taken not to jeopardize the health and well-being of a pregnant inmate or the fetus while on an outside trip."³¹⁴ Taconic's policy allows any type of restraint for the first two trimesters but prohibits "shackles" and "leg irons" on women in their third trimester.³¹⁵ When Taconic was still housing pregnant women through childbirth, the prison stated that they would allow handcuffs during the third trimester but that their use depended "on the size of the abdomen."

"I would pick the chain up and walk to be examined. It was terrible. . . . When I was 9 months pregnant, the handcuffs hurt. They were so tight, my wrists had marks on them for 2 days."

The CA's research reveals that women in DOCCS are routinely shackled throughout their pregnancies, often in direct violation of Bedford's and Taconic's own policies. The most common words women used to describe their experiences were "painful," "uncomfortable," "horrible" and "degrading." Many women the CA interviewed and surveyed stated that eliminating the use of restraints was the top improvement they wanted for pregnant women in DOCCS.

Two of the most common situations involving shackling are trips for medical appointments, which can happen weekly as a pregnant woman nears her due date, and trips between prisons, which can take more than 10 hours from Albion to Bedford.

Every woman the CA interviewed or surveyed was shackled, some in full restraints, during trips outside the prison. This includes the woman who had an abortion, the woman who had a miscarriage, and the many women who went on trips for prenatal care, even during their last trimester when trips occurred biweekly or weekly. Being shackled during medical trips was a

particularly common experience for pregnant women living at Taconic because DOCCS' prenatal clinic is held at Bedford. Even though Bedford and Taconic are separated by only 0.3 miles, and even though the trip is between two secure prison settings, DOCCS still required pregnant women to be shackled. Examples include:

- Four women were put in full shackles during trips to the hospital for medical care, including in the last trimester. Some of the women were kept in restraints for nearly an hour. One of the women experienced this on a monthly basis.
- Another woman wrote that it was “very uncomfortable to have waist chains on while six-plus months pregnant. . . .”
- Five women were handcuffed for one to three hours during multiple trips to the hospital for prenatal care. One woman was kept in handcuffs when she was five and a half months pregnant for over three hours, save for a 20-minute period when the hospital staff did an ultrasound.
- Eight women were put in ankle shackles, handcuffs and sometimes the black box during multiple trips from Taconic to Bedford, including during their eighth and ninth months. One woman wrote that on at least one occasion, “they tried to put waist chains on me.” Another woman commented, “A couple of times when I was shackled, I would be shoved into the bus/van if I wasn't going fast enough. Every time I had handcuffs on, there would be bruises and marks on my wrists from them.”

“When I came from Albion to Bedford, I was in full restraints during the 11-hour bus ride (shackles, cuffs, waist chain, black box) at 4½ months pregnant. . . . It was an awful experience I will not forget. The pressure of the chain on my growing belly was so uncomfortable. . . .”

All three women the CA interviewed and surveyed who were transferred from Albion to Bedford while they were pregnant reported being shackled. One of the women, who was about three months pregnant at the time, said she was put in full restraints and shackled to another pregnant woman, also about three months along and also in full restraints, for the 10-hour ride between Albion and Bedford. She commented that it was extremely uncomfortable to be shackled and said that the woman she was chained to experienced swelling in her wrists as a result of the handcuffs. Another woman, who was two and a half months pregnant at the time, wrote that it was “very hard and uncomfortable” to be in handcuffs and the black box for the 12½-hour bus trip from Albion to Bedford.

None of these women were serious security risks: two entered the nursery program after being transferred to Bedford, and the other was sent to a minimum-security prison after giving birth.

In addition to being shackled, all three women reported that the bus never stopped to let them stretch and walk around, and that they had to remain in full restraints even when using the bus bathroom. The woman who was four and a half months pregnant wrote that she went to the bathroom “by myself, wiggling, trying to pull up and down my pants without falling while the bus was moving. My wrists were bruised afterward. It took at least 10 minutes to pee and dress myself. . . . [It was] very difficult trying to maneuver down the crowded aisle as well as trying to pull my pants up and down fully shackled. . . . It’s something that I hope no other woman pregnant or not has to go through.”

The woman who was chained to another pregnant woman during the trip said that they remained shackled to each other when they used the bathroom. “It was especially difficult to move your hands with the black box on,” she said. “We had to pull each other’s pants down.”

Many women also described being shackled during trips from local jails to DOCCS prisons. One woman, for example, reported that she was put in handcuffs and a waist chain when she was eight and a half months pregnant during the hour-long trip from Rikers Island to Bedford. Another woman wrote that she was kept in full restraints during the three-hour trip between a county jail and Bedford when she was eight months pregnant. This woman also reported being shackled for five and a half hours on an earlier trip between a prison in another state and a county jail in New York when she was six and a half months pregnant.

Sitting in shackles for long periods of time is uncomfortable for any person and particularly so for pregnant women. These conditions are also dangerous as pregnant women are advised to stretch and walk periodically to reduce swelling and improve blood flow.³¹⁶ ACOG states that “limited mobility caused by shackling” can increase the risk of blood clots, a leading cause of maternal death in the U.S.³¹⁷ Using the bathroom on a moving bus while fully shackled is simply not safe for pregnant women.³¹⁸

Two of the three women who made the long trip from Albion to Bedford said they did not get enough food. One woman said that the lunch she got left her hungry, and the other wrote that she received a bag lunch at 7am and “had to wait until breakfast the next day to eat again.” She commented that she was “very hungry and thirsty the entire time,” and that the experience overall was “exhausting and overwhelming.”

Shackling during trips to the pediatrician

Another situation not covered by the Anti-Shackling Law occurs when mothers in Bedford’s nursery program accompany their babies to pediatric appointments outside the prison. Bedford’s policy is to shackle women during these trips, even though women in the nursery have passed a rigorous screening process and are not considered serious security risks.³¹⁹

Many women expressed frustration and sadness about this policy because the shackles prevented them from tending to their babies who rode next to them in a car seat. One woman said she was devastated that she could not comfort her baby because of the shackles during trips to the pediatrician. She commented that when her daughter would scream, the officer in the van would respond by turning up the radio. Another woman wrote: “The black box is the biggest problem. . . . They pull it real tight so that you can’t use your hands, even with the baby. . . . There should be no shackling and no black box. Where are you going to run to?”

“I was shackled and handcuffed with a chain and box. [My son] was in his car seat crying, and I couldn’t do anything, not feed him a bottle or give him a pacifier.”

RECOMMENDATIONS

For DOCCS

- 1) Comply immediately with the 2009 Anti-Shackling Law and ensure that no woman is shackled in violation of the law.
- 2) Train security staff and medical staff on the Anti-Shackling Law. Discipline staff who violate the law’s requirements.
- 3) Inform pregnant women about their rights under the Anti-Shackling Law and give them information outlining the law’s provisions in an easy-to-read written format. Post this information in multiple places throughout the prison, including housing areas, the nursery unit, medical area and libraries.
- 4) Prohibit the use of shackles on women during all stages of pregnancy, including when women are being transferred between prisons and taken for outside appointments, and during the full postpartum period (six weeks for vaginal deliveries and eight weeks for C-sections).
- 5) Eliminate the use of shackles on women who accompany their babies on trips for pediatric care outside the prison.
- 6) Require buses transporting pregnant women on long trips to stop so that women can walk around and use the bathroom, and give pregnant women adequate food and water before, during and after the ride.

For agencies that contract with DOCCS to provide services to incarcerated pregnant women

- 1) Train all staff on the provisions of the Anti-Shackling Law.

For New York State Legislature and Governor

- 1) Amend the Anti-Shackling Law to include mechanisms to ensure compliance, including requirements to: 1) inform incarcerated pregnant women about their rights under the law; 2) post information about the law in multiple common areas throughout each correctional facility housing women; 3) publicly report shackling practices and violations of the law; 4) train security and medical staff in each correctional facility housing women about the law; and 5) train staff at agencies that contract with state and local corrections to provide services to incarcerated pregnant women about the law.
- 2) Enact a law banning the use of shackles on women during all stages of pregnancy, the full postpartum recovery period, and during trips for babies to receive medical care outside the prison.

Special Issues: Women in Solitary Confinement, Women Growing Older & Women Living With HIV

REPRODUCTIVE HEALTH CARE AND WOMEN IN SOLITARY CONFINEMENT

Overview

Solitary confinement causes intense suffering and harm to all who experience it.³²⁰ The CA regularly witnesses the destructive effects of solitary during prison visits and has interviewed dozens of people for whom solitary has caused severe psychological deterioration.³²¹

There is widespread opposition to the use of solitary, particularly for long periods of time and for vulnerable populations such as people with mental illness, young people and pregnant women.³²² Confining people in solitary beyond 15 days has been condemned as a form of torture by the United Nations Special Rapporteur on Torture.³²³

Solitary is a torturous
punishment that causes
intense suffering and harm

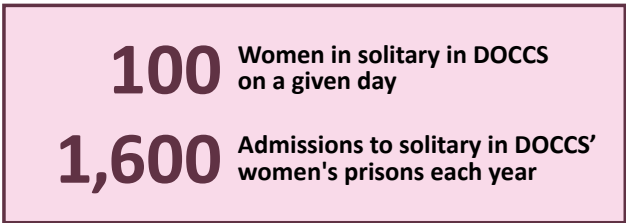
In New York, solitary confinement consists of being locked down for 23 hours per day in a cell the size of a large elevator, with extremely limited contact with other people in prison and the outside world. People in solitary do not participate in programs, cannot receive packages, cannot use the phone except to make legal and emergency calls, and are permitted only one non-legal visit per week. Even basic amenities are restricted. Showers, for example, are allowed only three times each week for five to ten minutes.

There are two main types of solitary in DOCCS: the Special Housing Unit (SHU), which DOCCS uses as punishment for more serious rule violations, and keeplock, which DOCCS uses as punishment for less serious infractions.³²⁴ Both SHU and keeplock require people to stay in a cell for 23 hours per day. People generally spend less time in keeplock (usually no more than 60

days) while people in SHU can spend months, years or even decades in confinement. SHU cells are always in a separate area, usually a designated cellblock or a free-standing building.³²⁵ For keeplock, people are confined to their own cells unless they live in a dorm setting, in which case they are usually sent to a special keeplock unit elsewhere in the prison.³²⁶

Keeplock is less restrictive than SHU. People in keeplock are allowed to keep their personal property while people in SHU are denied almost all personal property and receive only minimal, state-issued items and limited purchases from the prison commissary.³²⁷ People in keeplock are also generally not shackled when they leave their cells while people in SHU always are, even when they walk to the shower or go to the medical building.³²⁸

DOCCS' use of solitary is extensive, and the women's prisons are no exception.³²⁹ In 2012, there were at least 1,600 admissions to solitary in the women's prisons in DOCCS. Roughly 100 women (about 4% of the total women's population) are in solitary in DOCCS at any given time. About half of reproductive health survey respondents (52%, 145 of 281) said they had been in SHU or keeplock at some point during their incarceration. Like men, women can be, and often are, sent to solitary for minor, non-violent rule violations like talking too loudly.³³⁰



There are 72 SHU beds in women's prisons, representing about 1% of the roughly 5,000 total SHU beds in DOCCS.³³¹ Albion's SHU has 48 cells and Bedford's has 24. Albion's SHU cells are 77 square feet and Bedford's are 82 square feet. For keeplock, Albion and Taconic have designated separate units in addition to regular keeplock for women who are locked down in their own cells.³³² Cells in these units measure 74 square feet at Albion and 85 square feet at Taconic. Women at Bedford who live in dorms serve keeplock sentences in vacant general population cells. These cells measure 66 square feet.

The cells in the SHU units at Albion and Bedford look similar: they contain a bed, a metal sink, a metal toilet bowl with no cover, and a small, barred window. The doors are thick metal with a "feed-up slot" (where officers deliver and collect meal trays) and a small window covered with plastic that prison staff can slide open. The recreation areas, where people in SHU can spend their daily hour of out-of-cell time, are different: Albion's area has individual fenced-in cells that resemble large dog cages, and Bedford has two larger caged-in pens with no individual units.³³³

The women's prisons vary widely in rates of admission to solitary, and there seems to be a particularly excessive use of SHU at Albion. For example, in 2012, Albion had five times as many admissions to SHU as Bedford (441 versus 88), even though Albion's population is only about one-fifth bigger than Bedford's. Albion's average SHU census each month is 42, compared to eight at Bedford.

Mirroring its higher rates of SHU placement, Albion imposes a punishment known as restricted diet, or “the loaf,” much more frequently than Bedford. Over the past 10 years, Albion reported using the loaf 65 times while Bedford reported using it only once. The loaf, described by the CA in a 2003 report on solitary as a “dense, binding, tasteless one-pound loaf of bread” served with a side of cabbage, is one of the most severe punishments, or “deprivation orders,” DOCCS uses to discipline people in SHU who violate prison rules.³³⁴ Most people in SHU who are put on the loaf refuse to eat all three servings “because it is unpalatable and difficult to digest.”³³⁵ DOCCS continues to use the loaf even though the American Correctional Association prohibits using food as punishment, and the practice has been condemned internationally and abolished in the Federal Bureau of Prisons and many states.³³⁶ Other deprivation orders consist of punishments like limiting access to water and denying recreation, showers, haircuts, cleaning supplies, bedding and clothing.³³⁷

The average SHU sentence for women in DOCCS is about three months, though some women spend considerably longer in solitary.³³⁸ The longest time served in SHU at Bedford in 2010, 2011 and 2012 was one year. The longest time served in SHU at Albion was one year in 2010, 16 months in 2011 and 18 months in 2012.

“After [9 months in solitary], my kids won’t even have a gerbil because I don’t want to have anything in a cage.”

Both Bedford and Albion report that the average number of women in keeplock each month is about 25. Taconic’s average keeplock census is five. The average keeplock sentence is 27 days at Bedford, 18 days at Albion and 14 days at Taconic.

Alternative to SHU for women with mental illness

DOCCS runs five units, including one for women at Bedford, which function as alternatives to solitary for people with serious mental illness.³³⁹ DOCCS created these units after a class-action lawsuit filed in 2002 and legislation passed in 2008 which prohibits corrections officials, absent extraordinary circumstances, from holding people with serious mental illness in SHU for extended periods of time.³⁴⁰ The units are jointly run by DOCCS and the New York State Office of Mental Health, which provides mental health services in the state’s prison system.³⁴¹

The women’s alternative unit at Bedford is called the Therapeutic Behavioral Unit (TBU). Created in June 2005, the TBU is located on the third floor of Bedford’s Regional Medical Unit and has 16 cells. Each cell measures 67 square feet and looks similar to the cells in SHU although the doors have bars and not solid metal. The average sentence in the TBU is six months. The longest time a woman served in TBU at Bedford in 2010, 2011 and 2012 was one year.

Overall, the CA believes that women with serious mental illness should be in community-based facilities designed to treat their condition, and not prison. When this is not possible, the TBU is

a significantly better option than SHU for women with mental illness facing time in solitary. The unit has enhanced mental health services, better trained correction staff, less severe penalties for prison rule violations and increased opportunities for women to earn reductions in their disciplinary sentences. In addition, women in the TBU are allowed out of their cells for five hours per day (four hours for programming and another hour for recreation) as opposed to the single hour granted to women in SHU.

The main problem with the TBU is its underuse. While the TBU can hold 16 women, the unit's average census seems to range from 10 to 13.³⁴² These low numbers persist even though hundreds of women are sent to SHU each year and many have been diagnosed with a serious mental illness. On a number of visits, the CA interviewed women in SHU who seemed to be appropriate candidates for the TBU yet had not been approved for transfer to the unit.

DOCCS' alternative to solitary for women with mental illness can hold 16 women yet the average census is only 10 to 13

Women and solitary confinement

Incarcerated women face specific issues related to solitary, especially because of their high rates of mental illness, widespread histories of trauma and abuse, roles as mothers and primary caregivers, vulnerability to staff sexual misconduct and unique reproductive health care needs.³⁴³

Solitary is devastating for people living with mental illness, often causing them to completely decompensate, harm themselves and violate more prison rules, which can result in even more time in confinement.³⁴⁴ An estimated 39% of women in DOCCS have been diagnosed with serious mental illness.³⁴⁵ Solitary can also have a terrible impact on people with histories of trauma and abuse, which is the case for almost every woman in prison. Being locked down and under constant surveillance by male correction officers can retraumatize survivors and trigger flashbacks, anxiety and depression.³⁴⁶

Women experience gender-specific issues and devastation related to solitary

Women who report sexual abuse while in custody are sometimes put in solitary, either as "protection" or as retaliation and punishment if prison authorities think the woman is lying.³⁴⁷ This response is entirely inappropriate and leaves women even more vulnerable to continued assaults and harassment from officers.

Solitary also damages family relationships as people in solitary have restricted access to the telephone and limited family visits. This lack of contact can devastate parents and children, and aggravate the worry they feel about each other's well-being. The consequences of limited contact can be particularly drastic for parents with children in foster care. Under state law,

parents have approximately 15 months to find a home for their children and prove to the foster care agency that they are maintaining consistent contact with their children, which can be difficult to do without visits. A change in New York’s child welfare laws in 2010 helps incarcerated parents protect their rights by expanding foster care agencies’ discretion to delay or forgo filing termination papers when a parent is in prison.³⁴⁸ To use this discretion, however, foster care agencies must be persuaded that an incarcerated parent has a meaningful relationship with her children, a tall order in the absence of seeing a parent interact with her child. These issues are of special concern to women as 70% of women in DOCCS are mothers, and an estimated 11% of mothers in prison nationwide have a child in foster care, compared to 2% of incarcerated fathers.³⁴⁹

Finally, solitary compromises women’s ability to fulfill their needs related to health care, including reproductive health care. Women in solitary have trouble accessing doctors, receive superficial evaluations from medical staff, and experience repeated violations of their privacy and medical confidentiality in the course of trying to address any single health concern. These experiences can dissuade women from seeking needed care, particularly for sensitive GYN issues. Shackling during medical encounters and insufficient toilet paper and sanitary napkin supplies are also problems.

Solitary is especially dangerous for pregnant women because it impedes access to critical OB care and prevents women from getting the regular exercise and movement that are vital for a healthy pregnancy.³⁵⁰ In addition, many pregnant women experience stress and depression regardless of whether they have a mental illness, and solitary can greatly exacerbate those feelings.³⁵¹ High levels of stress are hazardous for pregnant women, lowering their ability to fight infection and increasing the risk of preterm labor, miscarriage and low birth weight in babies. One pregnant woman the CA interviewed suffers from anxiety and bipolar disorder yet was held in keeplock for two months, including five weeks after prison staff confirmed that she was pregnant.

Solitary is also harmful for women in postpartum recovery as it can increase the risk of women experiencing full-blown postpartum depression.³⁵² For women participating in the nursery, solitary has dire consequences. If a mother on the nursery is sent to solitary, she loses her spot in the program and is separated from her baby for the rest of her incarceration. She must immediately find a guardian in the community who can care for her baby, and, if she cannot, her baby will enter foster care.

Hospital medical staff told one high-risk pregnant woman she needed more physical activity for her cramping and constipation.

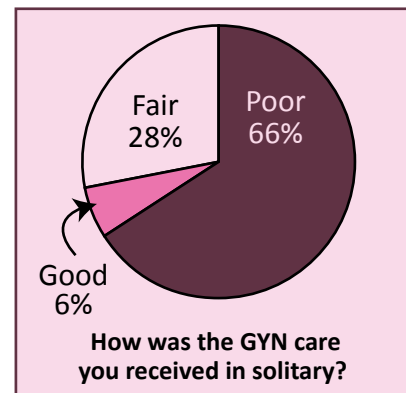
Because she was confined 23 hours per day in solitary, prison nurses could suggest only that she “walk around in [her] room.”

Accessing GYN care

Many women have the experience of requesting GYN care while in solitary confinement. Almost half (43%, 60 of 140) of reproductive health survey respondents who had been in solitary said they signed up for sick call for a GYN issue at some point during their time there.

The CA found widespread dissatisfaction with medical services in solitary. Two-thirds (66%, 45 of 68) of reproductive health survey respondents who had been in SHU or keeplock rated the GYN care they received there as “poor.” Only 6% (4 of 68) said the care was “good.”

Some women reported waiting weeks between being placed on the call-out list and seeing the doctor. When asked what happened with their symptoms while they waited, responses included: “Herpes outbreak continued and spread;” “experienced chronic abdominal pain, loss of sleep, appetite, discharge and difficulty urinating;” “the pain was excruciating;” “rash spread;” “the bump got bigger;” “very heavy bleeding, cramps.” One woman said, “I had a urinary tract infection that was very bad. Had they took me before, it would not have been so bad.”



Some women also reported that nurses doing sick call rounds in solitary dismissed their concerns and refused to schedule them to see the doctor. One woman in keeplock commented that when she asked the nurse to schedule her for a GYN appointment because “I knew my body and I knew something was wrong,” the nurse told her, “You need a better reason to see the GYN.” It took this woman a month and a half to get an appointment. Another woman wrote, “Each time [the nurses] came to see me, they refused to schedule me to see a doctor because my issue was not considered an emergency.”

Violations of privacy

Women in solitary experience multiple violations of their medical confidentiality in the course of trying to address any single health concern. The first violation occurs when women must ask a correction officer to sign them up to see a nurse during sick call rounds.³⁵³ While some officers put women’s names on the sick call list automatically, other officers make women give further explanation. More than one-third (39%, 23 of 59) of reproductive health survey respondents who signed up for sick call while in solitary said they had to provide an officer with specific details about their medical issue to get on to the list.

Women commented that speaking with an officer about personal medical issues made them feel “embarrassed,” “horrid,” “uncomfortable,” “invalid,” “inferior” and “violated.” One woman

wrote than an officer said he was “disgusted” when she explained her need to speak with a nurse about a vaginal discharge issue. Another wrote that she had “a bump that was painful” and that the officer “laughed and said it was nasty” when she signed up for sick call. These types of interactions led one woman to write that she had lost her “dignity and integrity.” Many women said they felt this way even when officers were “kind” and responded “fairly.” One woman, for example, wrote that she still felt uncomfortable even though the officer “told me it wasn’t a big deal and that women go through that in life.”

This practice keeps some women from seeking care altogether, particularly for GYN care, which most women regard as more personal and private than other medical issues, and for illnesses that carry heavy stigma such as HIV and hepatitis C. One woman, for example, dealing with issues related to “pelvic pains and a certain discharge my body was producing,” wrote that she was “embarrassed” and waited until she was released from keeplock to seek medical attention “so no one was in my business.” One woman summed up the general feeling when she wrote that DOCCS should “allow people to just say they [want] sick call. Take them to medical so every other inmate is not in the personal life of others.”

Another violation of privacy occurs during sick call rounds and doctor visits. Sick call nurses do their medical assessments in solitary by standing outside the cell and speaking with women through the closed cell door. The only exception is for women in keeplock at Bedford who are allowed to talk to nurses with the door open. Many doctor visits in solitary are also done through a closed door. Even though each prison said they transfer women in solitary to the medical building for GYN appointments, a number of women reported that the doctor met with them about their GYN issue right outside their cell.³⁵⁴ Six of 26 (23%) reproductive health survey respondents said the doctor spoke with them about their GYN issue either outside their cell or in the exam room on the SHU unit.

“You don’t get any privacy at all because [the medical staff] speak to you right in front of your cell door and it’s not right at all because your medical business is all heard on the gallery.”

By their very nature, cell-side medical visits violate patient confidentiality, especially in SHU where women must speak loudly to be heard and where officers are always present during the interaction. This system is also ineffective and dangerous as clinicians cannot conduct thorough medical evaluations through a solid metal door, and it can be virtually impossible for providers to see their patients clearly through the small window. Cell-side medical visits also compel women to stand upright at the door, no matter how much pain they may be in.

For women in SHU, even being taken to the separate exam room on the SHU unit did not protect their privacy. Women reported that the door to the SHU exam room was often kept slightly ajar for security reasons, potentially exposing them to officers. One woman at Albion

wrote that the prison’s SHU exam room has “speakers” and “nothing to keep the guards from listening,” as well as a window in the door that is not covered during appointments.

Overall, 13 of 25 (52%) reproductive health survey respondents said they did not have enough privacy during their interaction with medical providers in SHU and keeplock. Increased privacy during medical interactions and seeing doctors in a proper exam room were two of the most commonly cited improvements respondents said they wanted. Comments include:

- “People all around can hear your issues and the nurse screams, ‘Speak up, I can’t hear you,’ when you try to be discreet.”
- “[Nurses] open the glass on your door when they come for nurses screening [in SHU], officer present.”
- “I had a male officer who was extremely insensitive and stood there just to listen to what I had to say.”
- “The rooms in keeplock are close together so the other inmate is listening or can hear everything being said.”
- “[Y]ou have to tell them what is wrong from your cell door while everyone else can hear you.”

Restraints during medical interactions

DOCCS written policy is to shackle people in SHU on the way to and from medical appointments, and to remove shackles for the appointment at the doctor’s request.³⁵⁵

Twenty-five reproductive health survey respondents said they had GYN exams in solitary, and seven of them said they remained in shackles during the exam. One woman wrote that she had to “lay on the table with cuffs” during her appointment. Another woman wrote that her wrists were cuffed behind her back during her appointment. Other women commented: “I was handcuffed the entire time until they did [the] examination and uncuffed one arm.” “[I had] wrist and ankle shackles, I felt embarrassed.” “Unless you are being seen by the GYN for a pelvic exam, they leave you shackled.”

“When getting blood drawn, we are handcuffed and shackled. It’s a horrible experience.”

A few women wrote that their number one improvement for GYN care in solitary would be to eliminate shackles during medical exams, or at least to be handcuffed “in the front rather than in the back” during appointments.

As a general matter, women should not be shackled during medical exams. Restraints can interfere with a doctor's ability to conduct a thorough examination, cause discomfort for patients who may already be feeling unwell and are rarely necessary for security reasons.

Sanitary supplies

Although DOCCS' written policy states that women in SHU should receive "feminine hygiene items as required," women consistently report not getting enough sanitary napkins and toilet paper in SHU.³⁵⁶ A number of reproductive health survey respondents rated obtaining pads and toilet paper as their top improvement for conditions in SHU.

Women in SHU are given very few sanitary napkins at a time: Albion gives women two pads and Bedford gives five. To receive more, women must wait until one of the officers on the unit conducts rounds. Many women said that making multiple requests for sanitary napkins each day during their period was tiresome and frustrating, for them and for the officers. For toilet paper, women have to turn in the empty cardboard roll to get more. This leaves women without any toilet tissue at all if they need to use the bathroom before they can secure additional supplies.³⁵⁷

According to prison officials, sanitary supplies are rationed as part of the general restriction on property in SHU. As items necessary for preserving health and personal dignity, sanitary napkins and toilet paper are not properly classified as personal property and should be exempt from the restrictions associated with SHU time.

An additional rationale the CA heard was that some women might use the supplies to flood their cells by intentionally plugging up the toilet. It is misguided to punish all women for the actions of a few, and women who do engage in this behavior are likely struggling with mental health issues and should receive more intensive support instead of being subject to even stricter punishment.

Pregnant women in solitary

Until recently, DOCCS had no written policy on pregnant women and solitary confinement. The only reference the CA found was in Bedford's policy on transporting pregnant women: "In the case of a pregnant inmate in SHU, the Area Security Supervisor will see that the inmate is cuffed in the front."³⁵⁸

As a result of a class-action lawsuit, DOCCS agreed in early 2014 to reevaluate its use of solitary and limit confinement for certain groups of people, including pregnant women. The lawsuit was filed in 2012 by two incarcerated men and one incarcerated woman with their counsel, the New York Civil Liberties Union (NYCLU), Morrison & Foerster LLP and Benjamin N. Cardozo School

of Law Professor Alexander Reinert. As a result of the agreement, DOCCS issued an internal memo establishing a “presumption” against housing pregnant women in SHU unless there is an “exceptional circumstance,” a term left to the discretion of Department officials.³⁵⁹

While the memo represents a positive step forward, it still allows pregnant women to be held in SHU if DOCCS finds an “exceptional circumstance.” It also allows pregnant women to be held in 23-hour lockdown in keeplock, a setting that can be just as unsafe for pregnant women as SHU. In fact, the memo suggests keeplock as one of two alternate placements for pregnant women who receive a SHU sentence (the other is the prison infirmary).³⁶⁰ Because the new regulations allow for the possibility that pregnant women will still be confined in solitary, it remains important to review conditions for this group of women.

DOCCS does not require its prisons to keep data on how many pregnant women are held in solitary each year. Based on recollections by prison staff, pregnant women are almost never sent to solitary. Data compiled by the CA, however, shows a more frequent incidence.

The CA identified seven women between 2009 and 2012 who were held in solitary at some point during their pregnancy. The CA heard directly from four of the women, and prison officials identified the other three.

Of the four women the CA heard from: one was held in SHU, first at Albion and then at Bedford, for a total of more than two weeks in 2010; two were held in Bayview’s keeplock unit, one in 2010 for five weeks after her pregnancy was confirmed and the other in 2009 for almost two weeks after her pregnancy was confirmed; and one, who was only 17 at the time, was keeplocked in her cell in 2010 for three and a half days at Bedford. Of the three women identified by prison officials: two spent time in keeplock at Bedford in 2012, one for two weeks and the other for one month; and one in her second trimester was housed in keeplock at Taconic in 2012 for one month.

At least 7 women between 2009 and 2012 were held in solitary at some point during their pregnancy

The CA interviewed three of the seven women, and all described serious problems accessing prenatal care from solitary. One of the women, Tonya, had trouble getting a pregnancy test and medical attention despite persistent complaints of bleeding even after her pregnancy was confirmed. She spent more than four weeks in keeplock, and was likely removed at that point only because of the CA’s intervention. Ultimately, Tonya was diagnosed with an ectopic pregnancy, a life-threatening condition. Another woman, Doreen, spent more than two months in keeplock without adequate care even though she had a high-risk pregnancy and complained repeatedly of cramping.

The third woman the CA interviewed, Amy, spent more than two weeks in SHU – more than one week at Albion and another week at Bedford – even though she had a high-risk pregnancy. Amy

had the disturbing experience of a prison nurse serving as the hearing officer who determined her disciplinary sentence for violating work release rules. At one point during the hearing, the nurse stopped the tape recorder and told Amy that he had reviewed her hospital sonogram results and thought everything looked “fine.” He then started the tape again and sentenced Amy to three months in SHU. After speaking with the CA about this incident, DOCCS issued a policy barring nurse administrators from serving as disciplinary hearing officers.³⁶¹

Amy also reported that after a week in Bedford’s SHU, she was moved to the infirmary to serve the rest of her disciplinary sentence. Amy said that while she preferred being in the infirmary, it was far from ideal as she was not allowed to go outside for the entire two weeks she was there.

The situation of the woman, Iris, who wrote that she was keeplocked in her cell for three and a half days at Bedford during her pregnancy is troubling because she was barely 17 years old at the time. Solitary is profoundly damaging for young people, negatively impacting their ability to develop and mature in a healthy way.³⁶² Iris was two months pregnant when she was keeplocked for “disobeying a direct order,” a non-violent charge that can be for an incident as minor as talking back to a correction officer. She reported that medical staff did not visit during her first 24 hours in confinement, as DOCCS’ policy mandates, but that she did see the OB-GYN after that and continued to receive prenatal vitamins.³⁶³

Overall, Iris rated the care she received in solitary as “poor.” When asked what should be changed to make conditions better, Iris wrote: “I would create a law that pregnant women would not go to SHU/keeplock.”

TONYA

It all started when Tonya, age 23, was on work release at Bayview Correctional Facility and her aunt passed away. When DOCCS denied Tonya’s request to attend the funeral, she did not report for work release and went to the funeral anyway. When she turned herself in, Bayview officials gave Tonya a 90-day sentence in solitary confinement, 30 days to be served in keeplock and 60 days to be served in SHU.

The day Tonya went to Bayview’s keeplock unit, she told her prison counselor and the nurses on the unit that she thought she was pregnant. It took medical staff two weeks to give Tonya a pregnancy test after she asked for one, and another four days after that for Tonya to get the positive test result and see a doctor.

During her appointment with the doctor, Tonya said she had been spotting blood.³⁶⁴ Despite this complaint and Tonya’s high-risk conditions (she is anemic and had a previous stillbirth), the doctor did not conduct a pelvic exam, schedule an ultrasound,

order standard prenatal tests, prescribe prenatal vitamins or refer Tonya to an OB, which is required by DOCCS' policy.³⁶⁵

When the CA visiting team met Tonya in Bayview's keeplock unit, about one week after her appointment with the doctor, she was very concerned because she was still bleeding. She had repeatedly signed up to see a nurse but was told that they "couldn't do anything" because Bayview "does not provide prenatal care" and that she would soon be transferred to Bedford Hills Correctional Facility.

During this time, nurses wrote nothing in Tonya's medical chart to document her concerns and, in fact, wrote nothing to document even the basic fact that Tonya was pregnant. The CA visiting team informed prison officials about Tonya's situation, and the next day Tonya had her first appointment with an OB.

On the OB's recommendation, Tonya was put on bed rest in Bayview's infirmary. She was scheduled to be transferred to Bedford and to go to a hospital for an ultrasound on the way. At the hospital, the ultrasound did not show Tonya's pregnancy, an indication that the pregnancy might be in one of her fallopian tubes instead of her uterus. Tonya went from the hospital to Bedford and stayed in the infirmary.

Four days later, Bedford's GYN sent Tonya to the hospital for another ultrasound. This time, hospital doctors diagnosed Tonya with an ectopic pregnancy, one of the few pregnancy conditions that a woman can die from because her fallopian tube can rupture and cause internal bleeding.³⁶⁶

The hospital did a procedure immediately to remove Tonya's pregnancy. Less than one month after this traumatic episode, Tonya was sent back to Bedford's SHU to complete her sentence. Tonya wrote the CA to express her devastation about the way her pregnancy ended and about having her life and health placed in jeopardy because of Bayview's negligence. "I am mentally and emotionally exposed because in a place [where] health is supposed to be a priority, no one cares. They took me and my baby as a joke. A baby cannot grow in a tube for long. What if I would have died?"

An OB-GYN on the CA visiting team commented about Tonya's case: "This patient's reports of consistent spotting should have been a red flag and prompted a quick response from medical staff. Instead, nurses and doctors remained largely unresponsive. The lack of attention in this case is disturbing and could have produced a devastating outcome."

DOREEN

Doreen, 30 years old, found out she was pregnant while she was on work release at Bayview Correctional Facility. When Doreen told her work release counselor, the counselor said that Doreen would be removed from work release and transferred to Bedford Hills Correctional Facility. After hearing this, Doreen stopped reporting for work release. A few weeks later, Doreen was caught and given a sentence of five months in solitary confinement, 60 days to be served at Bayview and the rest at Bedford.

Shortly after Doreen went to Bayview's keeplock unit, she told nurses she was pregnant and asked for a pregnancy test to confirm it. It took almost one week for Doreen to get the test and another week after that to get the results. While she waited, Doreen told the nurses she had cramping and lower abdominal pain, and asked to see the doctor. The nurses told Doreen to rest and said they would make an appointment only if her pain continued or changed. Doreen had to complain of cramping two more times before the nurses scheduled a doctor appointment for her.

During the appointment, the doctor told Doreen she was pregnant but did not conduct a pelvic exam, arrange for an ultrasound, order standard prenatal tests or make a referral to an OB per DOCCS' policy.³⁶⁷

Even though Doreen continued to complain about cramping after this appointment and even though she had a high-risk pregnancy (she has bipolar disorder and a history of blood clots, asthma and seizures), it took another two weeks before she saw the doctor again.³⁶⁸ The doctor's notes from this second meeting reflect neither discussion of Doreen's cramping nor a solid follow-up plan. The only item written under the "plan" section of the doctor's notes is "IUP [intrauterine pregnancy]" – problematic itself considering that an ultrasound is the only way to confirm that a pregnancy is in the uterus.³⁶⁹

Two weeks after her second appointment, Doreen complained again of cramping and was admitted to Bayview's infirmary. She saw the doctor, and this time the doctor scheduled her for an ultrasound. The hospital that gave Doreen the ultrasound recommended she increase her physical activity to help with the cramping. Because Doreen was still in keeplock, however, the nurses responded to this instruction by suggesting that Doreen "walk around in [her] room."

Over the next few days, Doreen's cramping persisted but lessened in severity. Four days after she got the ultrasound, Doreen was transferred to Bedford. She was put in full shackles (handcuffs, black box, waist chains and ankle shackles) during the nearly two-hour trip. Once at Bedford, Doreen received appropriate access to prenatal care, and eventually her cramping subsided. She was still forced to remain in keeplock at Bedford, however, for another full month.

RECOMMENDATIONS

For DOCCS

- 1) Eliminate the use of solitary confinement for pregnant women, women in the full postpartum recovery period, women in the nursery program and other vulnerable groups. Strictly limit the use of solitary for all people.
- 2) Allow women to sign up for sick call without explaining to correction staff why they need to see a nurse.
- 3) Require sick call interactions in solitary to take place either with the door open and out of earshot of correction officers or, if that is not possible, in the exam room on the SHU unit, and require doctor visits in solitary to take place either in the exam room on the SHU unit or in the medical building. For GYN-related visits, use only the medical building to reflect the heightened level of privacy appropriate for those appointments.
- 4) Investigate complaints about lack of access to doctors for women in solitary and ensure that women in solitary who need medical care have prompt access to clinical providers.
- 5) Strictly limit the use of shackles during medical encounters.
- 6) Give women in solitary as many sanitary napkins and toilet paper rolls as they need at one time.
- 7) Require prison staff to provide a pregnancy test and the results of that test within 24 hours to women in solitary who request one.
- 8) Transfer pregnant women to Bedford within 24 hours after their pregnancies are confirmed.
- 9) Expand the policy prohibiting nurse administrators from conducting disciplinary hearings to prohibit all medical providers from participating in disciplinary hearings or assuming other security roles.

For New York State Legislature and Governor

- 1) Enact a law that eliminates the use of solitary confinement for pregnant women, women in the postpartum recovery period, women in the nursery program and other vulnerable groups, and that strictly limits the use of solitary for all people.

REPRODUCTIVE HEALTH CARE AND WOMEN LIVING WITH HIV

Overview³⁷⁰

Incarcerated women suffer from extremely high rates of HIV. A 2012 U.S. Bureau of Justice Statistics report, which contains the most recent published data on HIV-positive women in New York's prisons, indicates that 12% of women in DOCCS were living with HIV in 2010.³⁷¹ This figure is more than double the rate for men in prison (5%) and nearly 42 times the rate in the general public (.29%).³⁷² The report states that 3,080 people in DOCCS custody were living with HIV in 2010, 260 of whom were women.³⁷³ New York has the largest number of HIV-positive incarcerated people and the second-largest number of HIV-positive incarcerated women of all prison systems in the country.³⁷⁴

Women in prison are disproportionately affected by HIV because the experiences that lead women to be criminalized and incarcerated, including addiction, being prostituted, engaging in sex work, and experiencing domestic violence and trauma, put women at greater risk for contracting the virus.³⁷⁵ In addition, rates of HIV are disproportionately high among African-American and Latina women who, as a result of the criminal justice system's targeting of communities of color, are overrepresented in prison.³⁷⁶

An estimated 12% of women in DOCCS are HIV-positive, more than double the rate for men in prison and nearly 42 times the rate in the general public

Timely reproductive health care is especially urgent for women living with HIV.³⁷⁷ HIV-positive women are more prone to vaginal infections and sexually transmitted diseases (STDs), which can accelerate the progression of HIV and lead to infertility if not treated, and are at greater risk of developing serious illnesses, including cancer.³⁷⁸ Inadequate care also increases the chance that HIV-positive women will transmit the virus to others.³⁷⁹

Pregnant women who are HIV-positive also have specific health care needs.³⁸⁰ Appropriate care protects the health of HIV-positive pregnant women and can virtually eliminate the chance that a baby will contract HIV in utero and during childbirth. The American College of Obstetricians and Gynecologists (ACOG) states that "99% of HIV-infected women will not pass HIV to their babies" if their doctors follow basic guidelines for HIV-specific pregnancy care.³⁸¹

Despite the urgency and growing recognition that the impact of HIV on women must be addressed to curtail the epidemic, the New York State Department of Health (DOH) largely ignored women-specific issues during its two assessments of HIV care in DOCCS in 2010 and 2013. DOH carried out these assessments as part of its efforts to implement a 2009 law

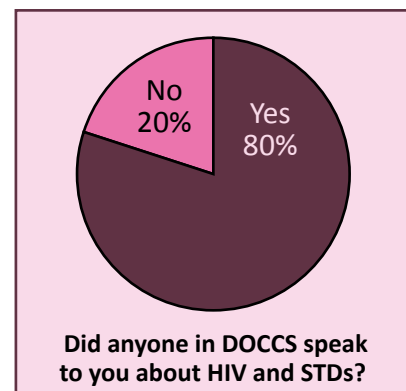
requiring DOH to conduct annual reviews of HIV and hepatitis C care in New York’s prisons and jails. The law also requires DOH to publicly report on their findings and to mandate improvements so that care in prison mirrors community standards.³⁸²

While DOH has made progress in launching a process for prison reviews, its overall efforts to monitor care have fallen far short of what the 2009 statute requires.³⁸³ DOH’s 2010 review assessed only written policies and did not include medical chart reviews or interviews with incarcerated people to evaluate the quality of care, which is essential as prison policy often differs from practice. DOH’s 2013 review included a limited examination of medical charts but once again failed to include individual interviews.³⁸⁴ The 2013 review also narrowly focused on only four prisons, none of which housed women.³⁸⁵ Prior to its reviews, DOH did not provide the public with adequate notice of its visiting plans or sufficient time to submit comments, both of which the statute requires.³⁸⁶

The CA’s research suggests that DOCCS generally provides HIV-positive women at Bedford, Albion and Taconic with adequate monitoring and HIV treatment but falls short in ensuring that they have access to the GYN services they need.³⁸⁷ In addition, DOCCS’ written policies on GYN-related care for HIV-positive women are not fully consistent with community standards. For HIV-positive pregnant women, the CA’s research indicates that DOCCS generally provides quality OB care. DOCCS’ written policies on care for HIV-positive pregnant women improved significantly in 2011 after DOH issued a report calling for DOCCS to enhance its policies in this area. Before these improvements, DOCCS’ written policies on HIV-positive pregnant women were sorely deficient.

HIV and STD education

Eighty percent (578 of 719) of general survey respondents said that someone in DOCCS had spoken with them about STDs and HIV prevention during their incarceration. This figure is likely a reflection of the good work of the Criminal Justice Initiative (CJI), a joint initiative between DOCCS and DOH that allows non-profits to provide HIV testing, prevention education and support services to incarcerated people.³⁸⁸ CJI programs operate in many of the state’s prisons, including Bedford, Albion and Taconic.



Many CJI programs include a peer component where CJI staff train incarcerated people to provide HIV education and support groups. The CJI, and particularly the peer education component, was inspired by a groundbreaking program called AIDS Counseling and Education (ACE) started in the late 1980s by incarcerated women at Bedford in collaboration with prison administrators.³⁸⁹ ACE still operates as Bedford’s CJI program.

Pathstone Inc.³⁹⁰ runs the CJJ program at Albion, and the Women’s Prison Association³⁹¹ provides CJJ services at Bedford and Taconic. Of these prisons, Albion seems to have the most robust CJJ program, and Taconic, the least. When they were open, Bayview and Beacon had more limited CJJ programs and no peer educator component.

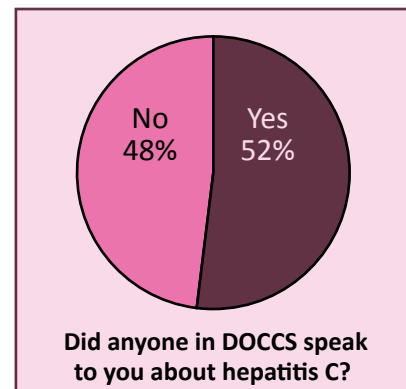
All three CJJ programs received praise from women the CA interviewed and surveyed. Three-quarters (75%, 79 of 105) of HIV survey respondents, for example, rated the CJJ program they participated in as “good,” and only 4% (4 of 105) as “poor.” Many women praised the CJJ peers in particular:

- “I believe the best encouragement [for HIV testing] comes from our fellow peers.”
- “[T]hey don’t feel they are better, and they actually understand us.”
- “Peer education is a real gift. They give the message that we are in a safe space [and] that we can go to get tested without fearing stigma or breach of confidentiality.”

Peer education also provides an opportunity for women hired as peers to engage in meaningful training and bolster their chances for employment in the health field after release. One peer expressed the general sentiment of the peer educators when she said, “I love my job.”

Women said that the top improvements they wanted for the CJJ programs were more speakers living with HIV and more updated health information.

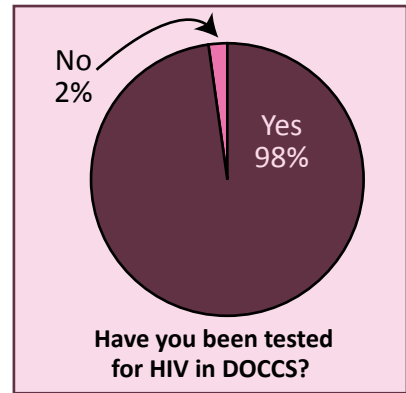
The CA’s research suggests that DOCCS has been less effective in informing women about hepatitis C. This information is vital given that an estimated 17% of women in DOCCS have hepatitis C, a rate significantly higher than the rate for incarcerated men and the rate in the general public.³⁹² Only half (52%, 55 of 105) of HIV survey respondents said they had received information about hepatitis C since their incarceration began. Such information, which can bolster prevention and encourage affected women to seek help, has become even more important with the recent arrival of new, highly successful hepatitis C treatments.³⁹³



HIV and STD testing

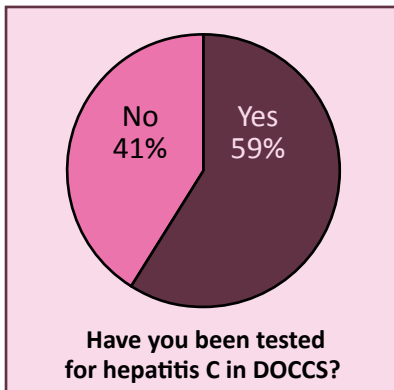
DOCCS seems to be doing a solid job providing opportunities for HIV testing. Nearly all HIV survey respondents (98%, 83 of 85) said they had been tested for HIV at least once since entering DOCCS custody.

There is still room for improvement, however, including better access to tests for women who were recently tested and women who request a test for sexual health reasons. Said one woman, “I requested an HIV test while in Bedford Hills and was denied because I was ‘recently tested.’ I even explained my risk behavior!” Another woman who was denied an HIV test explained her reason for seeking a test this way: “[E]ven though sex is forbidden in prison, it does happen and we need protection.” Overall, 19% (20 of 108) of HIV survey respondents said that, at some point during their incarceration, they requested an HIV test but did not receive it.



Testing for hepatitis C can also likely be improved. For example, only 59% (62 of 105) of HIV survey respondents said they had been tested for hepatitis C since their incarceration.

In terms of other STDs, women are screened for chlamydia, gonorrhea and syphilis when they first enter DOCCS custody. General STD testing is not offered routinely on any other occasion, including prior to overnight trailer visits or in preparation for work release or going home. Clinicians do not seem to discuss the importance of STD testing consistently: only about one-quarter (22%, 44 of 198) of reproductive health survey respondents said that their GYN provider spoke to them about getting tested for STDs during their last check-up.



Estimates of the incidence of STDs varied widely from prison to prison. Based on the experience of clinicians, Bedford and Taconic reported that the most common STDs seem to be chlamydia and trichomoniasis; Albion reported that chlamydia is the most common. Beacon reported that trichomoniasis and HPV were the most common, and Bayview was unable to provide any information in this area.

DOCCS’ written policies on STD treatment are seriously outdated. The most recent policy, dated October 1998, states that DOCCS’ practices should “adhere to the guidelines developed in the 1994 Sexually Transmitted Diseases Treatment Guidelines” from DOH.³⁹⁴

Identifying women with HIV

The exact number of HIV-positive women in DOCCS is difficult to confirm. The most recent published data on HIV-positive women in New York’s prisons is contained in a U.S. Bureau of Justice Statistics report published in 2012. This report states that 12% of women in DOCCS are living with HIV.³⁹⁵ This figure is based on data submitted by DOCCS, and it is unclear exactly how the Department calculated the data.

Other data compiled by DOH suggests that HIV rates for women in DOCCS may be lower. This data is based on studies of blood samples drawn every two years from women when they first enter DOCCS custody. The blood samples in these studies, which are kept anonymous, are drawn for other purposes but DOH tests them for HIV.³⁹⁶ DOH found that the HIV rate among the women studied was 11% in 2007 and 5% in 2009. These studies have shortcomings, however, including that DOH sampled only a small portion of women entering DOCCS custody and that the samples included a higher percentage of white women than were represented in DOCCS' women's population overall at the time.³⁹⁷

Based on reports from each women's prison, as of spring 2013, DOCCS had identified 86 women living with HIV in its custody.³⁹⁸ Given DOCCS' estimate that 12% of women – about 280 women – in its custody are HIV-positive, the data DOCCS reported to the CA suggests that there are many HIV-positive women whose identity is unknown to the Department.³⁹⁹

This situation does not seem to be due to a lack of testing but rather that women who already know they are HIV-positive choose not to reveal their status. Women the CA surveyed and interviewed reported that the reluctance to self-identify is driven by ongoing stigma and discrimination in prison against people with HIV, fear that prison staff will not keep information confidential and general distrust of the medical care that DOCCS provides.

Many women do not reveal their HIV status in DOCCS because of stigma, discrimination and a lack of confidentiality

DOCCS recently took a positive step to address these problems by participating in a pilot initiative funded by the Centers for Disease Control and Prevention (CDC) called Positive Pathways. Positive Pathways is a public health demonstration program carried out by DOCCS, five community-based organizations and the HIV Center at Columbia University. The program aims to reduce HIV stigma in prison, identify new and existing cases of HIV, and ensure access to care for HIV-positive people during and after incarceration. The pilot exists at 18 state prisons, including Albion, Bedford and Taconic.⁴⁰⁰

Myths, stigma, discrimination and confidentiality

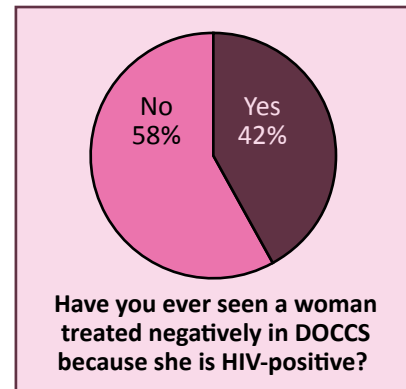
Women the CA surveyed and interviewed reported that many myths about HIV persist in prison. Two of the most pervasive myths women identified are that a person can contract HIV by touching or sharing facilities with HIV-positive people, and that a person will only begin to show signs of HIV if she knows she has the disease. This myth is particularly dangerous as people who delay testing may be sicker when they finally do seek medical help.⁴⁰¹

Women also reported problems with lack of confidentiality, stigma and discriminatory treatment of HIV-positive women among both staff and other women in DOCCS. Women

explained that this atmosphere makes women reluctant to reveal their status and seek HIV information. Thirty-eight percent (39 of 104) of HIV survey respondents said they would not feel comfortable asking for HIV information or services in DOCCS. Forty-two percent (43 of 103) said they had observed an HIV-positive woman being treated negatively because of her status during their incarceration. Comments include:

“I keep my condition to myself.
... People are very unkind and
say very malicious things.”

- “Staff tends to know who is sick and who is not. If they don’t like you because you are a troublemaker, the word would get around about your illness.”
- “[A] 19-year-old woman here at Bedford found out she was HIV-positive. Somehow, the information came out. Officers and [women] were saying she had the monster and is the living dead.”
- “When you start asking for information. . . women tend to look down on you and shun you as if you are contagious, and the rumors start, and it becomes very uncomfortable.”
- “A woman that was HIV-positive got into a fight and an inmate screamed, ‘Don’t touch her, she has AIDS.’ The officer started to wipe down the COs’ station with Windex and then put on rubber gloves. . . .”
- “[W]e were going on a court trip and the CO made [a woman with HIV] pull her socks up all the way to put her shackles on.”
- “[In] 2010 at Albion, people didn’t want to share a bathroom or shower. . . didn’t want to sit with. . . and were in general rude to [a woman] because she had HIV. They treated it like the plague.”

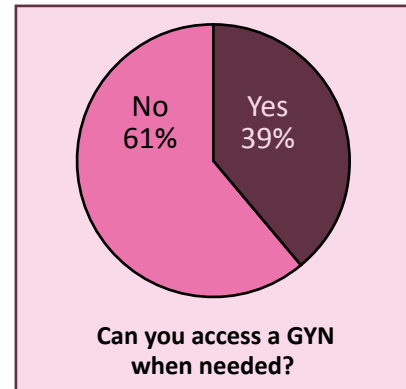


Many women commented that more education could help counter these problems, especially if that education came from HIV-positive women themselves. DOCCS reported that the annual 40 hours of training for correction officers includes information on HIV, but it is unclear whether this information goes beyond strategies to avoid contracting the illness to address stigma and confidentiality. Women also suggested that HIV information should be presented in settings that do not require women to risk being labeled HIV-positive such as during each of the three phases of DOCCS’ transitional services program.⁴⁰²

GYN care for women with HIV

At Bedford and Taconic, GYN care for women with HIV is co-managed by the facility GYN provider and a contracted infectious diseases doctor who runs an HIV clinic at Bedford. At Albion, care is co-managed by the facility's GYN and the physician on staff who is an HIV specialist.

Women have trouble accessing timely GYN care in DOCCS, and women with HIV are no exception. More than half (61%, 23 of 38) of HIV-positive general survey respondents said they could not access a GYN when needed. One HIV-positive woman wrote that, as a result of waiting for her GYN appointment, "my yeast infection itched badly and I scratched skin off my vagina. . . ." Yeast infections are harder to treat in women with HIV and should receive medical attention as soon as symptoms appear.⁴⁰³



DOCCS' written policy on Pap smears for women with HIV is not fully consistent with community standards. HIV-positive women should have two Pap tests six months apart for the first year after their diagnosis, followed by annual tests if the results are normal, and tests at least every six months if they are not.⁴⁰⁴ DOCCS' written policy does not reflect this distinction and requires Pap tests every six months regardless of prior test results.⁴⁰⁵ The policy also does not specify that HIV-positive women with abnormal Pap smear results should be referred for a colposcopy (a cervical exam) to rule out more serious cervical disease.⁴⁰⁶

The CA's research suggests that most HIV-positive women receive at least one Pap test each year: 89% (31 of 35) of HIV-positive general survey respondents reported that they had at least one Pap smear in the last year. The CA does not know how many of the respondents had two Pap smears or how many had one only after establishing a track record of normal results. The data does suggest room for improvement, as a few of the survey respondents said they had gotten no Pap smear at all in the past year and nearly one-quarter (23%, 9 of 39) said they had not seen the GYN at all in the last year.

Overall, about one-third (38%, 12 of 32) of HIV-positive general survey respondents who had seen a GYN in the last year rated the quality of GYN care at their prison as "good." Just under half (44%, 14 of 32) rated it as "fair," and one-quarter (19%, 6 of 32) rated it as "poor." In addition, about one-third of HIV-positive general survey respondents (35%, 14 of 38) said they did not have enough time with the GYN to talk about their needs. This is unfortunate as good communication and trust play critical roles in motivating women to speak openly and honestly with their doctors, and to stick to the treatment plans their doctors prescribe.

HIV testing for pregnant women

DOCCS has a clear written policy on prenatal HIV testing which states that the Department will offer all pregnant women an HIV test but will not require them to take one. This mirrors the informed consent HIV testing standard in New York State.⁴⁰⁷ The policy also states that pregnant women will be “strongly encouraged to consent to testing,” and that women whose test results are negative will be offered testing again in their second trimester.⁴⁰⁸

In its 2010 review, DOH recommended that DOCCS alter its protocols to ensure that HIV testing and counseling for pregnant women incorporate information about preventing HIV transmission to babies.⁴⁰⁹ In response, DOCCS updated its policy in 2011 to require pre-test counseling that includes education about ways to minimize the possibility of transmission during pregnancy, delivery and breastfeeding. The policy also requires women to be informed that their newborns will be tested for HIV even if they choose not to be.⁴¹⁰ The policy does not require post-test counseling.

DOCCS seems to be doing a good job of offering pregnant women HIV testing but only a mediocre job of ensuring that they receive pre- and post-test counseling. All but one of the women the CA surveyed and interviewed (95%, 18 of 19) about HIV testing during pregnancy said they were offered an HIV test while they were pregnant in DOCCS. The woman who was not offered a test wrote, “Bedford did not test me. The hospital did right before birth.” Almost half (42%, 8 of 19) of the women said they did not receive any counseling before the test, and more than half (63%, 12 of 19) said they had not gotten any counseling after.



Counseling is especially important for incarcerated women as the prospect of adding more stress to the already stressful experience of being pregnant in prison may discourage women from wanting to know their HIV status. For example, in response to a question about what would have made her more comfortable taking an HIV test, one pregnancy survey respondent wrote: “Some more support.”

Care for pregnant women with HIV

OB care for women with HIV at Bedford and Taconic is co-managed by facility OB-GYN providers and the infectious diseases doctor DOCCS contracts with to run an HIV clinic at Bedford. In 2010, DOH called for DOCCS to amend its written policies to reflect this practice, which is consistent with community standards, and to require “co-management by an OB and HIV-experienced provider.”⁴¹¹ DOCCS issued new written policies with this adjustment in 2011.⁴¹²

DOCCS prisons do not adequately collect systemic data on how many pregnant women are HIV-positive. Bedford estimated housing at least one pregnant woman with HIV each year from 2006 to 2012. Taconic reported that only one pregnant woman in its custody had HIV during this time period.

Because only one pregnant woman the CA interviewed or surveyed, Kim, reported being HIV-positive, the CA cannot fully evaluate the experience of HIV-positive pregnant women in DOCCS. Kim's experiences, however, indicate strengths and weaknesses.

On the positive side, Kim said her HIV medication was never delayed. She also reported that Bedford's OB-GYN spoke with her about special health considerations for HIV-positive pregnant women, including that she should not breastfeed in order to decrease the chance of passing HIV to her baby, which is standard advice in the community.⁴¹³ Like other women who did not breastfeed, however, Kim was not given anything to help with the discomfort she experienced. She wrote that, in the beginning, her breasts "hurt like hell."

Of concern is that Kim said she saw the high-risk OB only once during the five months she was pregnant in DOCCS custody. Whether Kim saw Bedford's staff OB-GYN at more regular intervals is unclear. Overall, Kim rated the quality of the care she received during pregnancy and labor in DOCCS as "fair," and the quality of postpartum care as "poor."

Before 2011, DOCCS' policy on HIV medication for pregnant women consisted only of one sentence: that women "should receive optimal ART [antiretroviral treatment] regardless of pregnancy status" and that the medication should be in "optimum schedules and dosages."⁴¹⁴ While this policy generally mirrored community standards, it lacked important detail about key guidelines. During its 2010 review, DOH picked up on these deficiencies and called for DOCCS to enhance its protocols in this area, including incorporating information about HIV medication and testing for women and their newborns during and after delivery.⁴¹⁵ DOCCS included this information in its updated written policy in 2011.⁴¹⁶

DOCCS' current policy states that recommendations made by infectious diseases doctors about antiretroviral medication will be "reviewed by a DOCCS OB/GYN Provider within 24 hours" so that DOCCS can offer the pregnant woman "appropriate services." The policy also states that DOCCS will provide information to the hospital where the woman is giving birth to "assure that appropriate antiretroviral medications" are available for both the woman and her newborn.⁴¹⁷

Even with these important adjustments, DOCCS' policy is still missing some key guidelines followed in the community, including that: 1) providers should avoid or be cautious in prescribing certain HIV-related medications for pregnant patients; 2) pregnant women taking HIV medication should continue unless the medication is contraindicated; and 3) pregnant women not taking HIV medication should have a doctor assess the severity of their HIV and document a plan for whether medication should be started immediately or after the first trimester.⁴¹⁸

Education about HIV medication, transmission and other issues can help HIV-positive pregnant women protect their own health and the health of their babies.⁴¹⁹ Before 2011, DOCCS did not require its doctors to provide any specific information to HIV-positive pregnant women. DOH noted this oversight and called for DOCCS to incorporate “early infant feeding guidance” in its policies.⁴²⁰ In 2011, DOCCS updated its policy to require its doctors to offer this information to their HIV-positive pregnant patients. The policy also states that DOCCS will use DOH educational materials to “promote prevention of mother to child transmission.”⁴²¹

RECOMMENDATIONS

For DOCCS

- 1) Partner with DOH in developing a methodology to more accurately estimate HIV seroprevalence rates of women in custody.
- 2) Provide HIV tests for women who request them, regardless of whether they had an HIV test recently or request a test for sexual health reasons.
- 3) Take steps to encourage more women to disclose their HIV status by enhancing the quality of health services, building trust between women and medical providers, improving the enforcement of confidentiality protocols and taking appropriate disciplinary action against staff who break confidentiality protocols.
- 4) Provide security and civilian staff with comprehensive training on HIV and working with HIV-positive women.
- 5) Continue Positive Pathways beyond its pilot phase to allow more time to determine the efficacy of the program.
- 6) Ensure that HIV information available to women is up-to-date, user-friendly and easily accessible, and invite HIV-positive women from the community to speak with incarcerated women and staff.
- 7) Offer women HIV information in less stigmatizing settings, including in each of the three phases of DOCCS transitional services program and in a general women’s health education program (*see Section 2, p. 80*).
- 8) Provide HIV-positive women with prompt access to the GYN when they request it.
- 9) Update written policies to reflect community standards on Pap smear test frequency and follow up for HIV-positive women.

- 10) Offer all pregnant women an HIV test per DOCCS' policy along with pre- and post-test counseling, and add a requirement for post-test counseling in DOCCS' written policies.

For New York State Department of Health

- 1) Partner with DOCCS to develop a methodology to more accurately estimate the HIV seroprevalence rates of women in DOCCS custody, including reevaluating the scope and methodology of the biannual seroprevalence study in DOCCS and how data from those studies are analyzed.
- 2) In keeping with the mandates of the 2009 DOH Oversight Law, conduct a thorough review of HIV care policies and practices for incarcerated women, including an evaluation of GYN care and OB care. Include in this review interviews with, and chart reviews for, HIV-positive women. Give the public adequate notice and sufficient time to submit comments prior to prison reviews.
- 3) Request from the Governor and Legislature sufficient funds to carry out thorough annual prison and jail reviews as mandated by the 2009 DOH Oversight Law.⁴²²

For New York State Legislature and Governor

- 1) Allocate funds for enhanced HIV training and programming in DOCCS.
- 2) Allocate sufficient funds to DOH to carry out its legal mandate to monitor HIV and hepatitis C care in New York's prisons and jails.

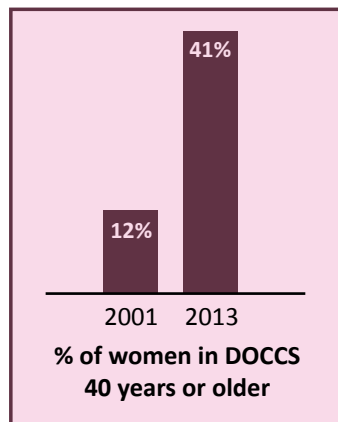
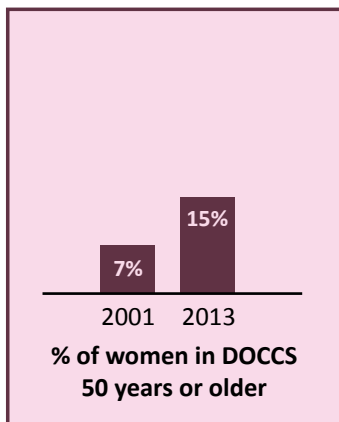
REPRODUCTIVE HEALTH CARE AND WOMEN GROWING OLDER

Overview

There has been a dramatic rise in the number of older people in prison over the past few decades, both in New York and nationwide. Since the early 1980s, the number of incarcerated people 55 years or older in the U.S. has risen by more than 1,300%. By 2030, that number is projected to grow even more, leading to a staggering increase of 4,400% over a 50-year time span.⁴²³

Since the 1980s, the number of incarcerated people 55 years or older in the U.S. has risen by more than 1,300%

Incarcerated women are no exception. For example, the number of women in U.S. prisons in the 45- to 54-age range increased by 300% between 2000 and 2010.⁴²⁴ In DOCCS, the percentage of women in DOCCS 50 years or older more than doubled (from 7% to 15%) between 2001 and 2013, and the percentage of women 40 years or older more than tripled (from 12% to 41%).⁴²⁵ In 2013, there were about 940 women over 40, and 340 women over 50 in DOCCS.⁴²⁶



The increase in the number of older people in prison is largely the result of harsh, unjust sentencing laws enacted in the 1970s and 1980s that imposed long prison terms and lengthened the time a person must serve before being eligible for release. An equally significant factor are parole boards that repeatedly deny release, particularly to people convicted of violent crimes, even when a person has served her

minimum sentence and poses no threat to public safety.⁴²⁷ This perpetual punishment persists even in the face of evidence that older incarcerated people have extremely low recidivism rates, much lower than their younger counterparts.⁴²⁸

Such policies served as a rudder for the explosion in the overall U.S. prison population, which has increased by 500% over the past 40 years.⁴²⁹ They have also swelled already bloated prison budgets as it costs two to three times more to incarcerate an older person than a younger person.⁴³⁰

There is a growing movement to address these problems. Proposals for reform include increasing opportunities for older people to earn release, making better use of early release

programs already in place, establishing fairer parole policies and practices, and changing sentencing laws that require fixed prison terms.⁴³¹

Incarceration creates unique stresses for older people because of anxiety about aging and dying in prison, and because daily prison life can be especially challenging as people grow older and become more frail.⁴³² Older people are also more likely to confront a range of serious medical conditions.⁴³³

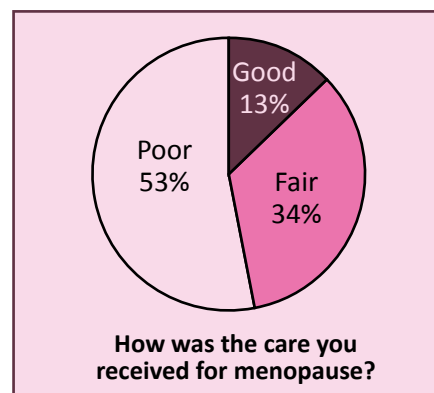
Among the special medical issues women 50 and older face are menopause, a series of physical changes that women experience when they stop menstruating,⁴³⁴ and osteoporosis, a condition disproportionately affecting women that puts women at great risk of breaking their bones.⁴³⁵

Sixteen percent (54 of 350) of reproductive health survey respondents were 50 or older at the time they sent in the survey, roughly the same percentage as women in DOCCS overall. The top three answers from survey respondents who were 50 or older about what could improve medical care for women in their age group were: 1) more respect and communication from doctors; 2) better information and education on specific aging-related medical conditions, including menopause; and 3) more opportunities for women growing older to support each other through difficult health challenges.

In explaining her responses, one 64-year-old woman wrote that doctors should “[a]cknowledge the issues women my age have and our concerns. Listen and act to our issues before the issues get beyond help.” Another woman, 63, wrote: “Communication is number one for two persons to have an understanding. Just because [the doctors] prescribe a medication doesn’t mean you feel secure. A woman who reaches 50 and over needs a lot of support when it comes to medical issues.” Another woman, 60, suggested: “[H]ave a day once a month just for menopause (groups or one-on-one) and just plain talk about colonoscopy exams, mammos, cancers, etc.”

Menopause

Menopause is a stressful experience for women, even more so in prison, where women have little control over their schedule, clothing and diet, and where even something as basic as taking a break to deal with hot flashes is rarely permitted.⁴³⁶ As one woman wrote, “I’m still experiencing it, the hot flashes being in programs and hav[ing] to come out [of] your clothes. Everybody knows you are having a hot flash. I don’t like it.”



Women typically go through menopause anywhere from age 45 to 55 and continue to adjust to physical symptoms and changes for some time after that.⁴³⁷ None of the prisons could tell the

CA how many women were going through menopause at a given time. DOCCS' policies contain a thorough explanation of menopause and its related symptoms. They do not, however, include recommendations for, or even discussion about, possible treatments for menopause-related symptoms, either medical treatments or adjustments to diet, vitamin supplements or exercise activities.⁴³⁸

About half (53%, 60 of 114) of reproductive health survey respondents who reported experiencing menopause while in DOCCS rated the care they received as "poor." Many women said they gave this rating because nurses and doctors were insensitive to their concerns, did not spend time discussing suggestions for how to cope and refused to consider alternative treatments, even when women raised specific ideas. Comments include:

- "I have a million questions no one will answer!"
- "Very uncomfortable. Hot flashes and major mood swings. I get more info from friends than medical."
- "I asked for vitamin E because it helps me with my hot flashes due to menopause and they denied my request."
- "[The doctor] acted like she didn't wanna give me anything on my second appointment. I asked about vitamin B12 after reading a book on menopause."

One woman who was in solitary confinement wrote that it was particularly hard to go through menopause while being locked down in a small cell 23 hours per day: "The new windows [in the Special Housing Unit] don't give a breeze," she wrote. She also said that she wanted to cool off by removing some of her clothing during hot flashes but was not allowed to do so.

"It's hell going through menopause here. . . . I would like for the doctors and nurses to take the issue more seriously."

Women going through menopause also report negative experiences with sick call nurses. Of the survey respondents who went to sick call for menopause-related symptoms, more than one-third (41%, 13 of 32) rated their experience as "poor." Women said that sick call nurses frequently dismissed them and refused to schedule doctor appointments. One woman going through menopause wrote that a nurse told her to "get over it." Another woman said a nurse told her, "Everybody gets menopause. Join the club." Another woman going through menopause said a nurse asked her, "Why are you here? There is nothing wrong with you."

Women said that more information and more emotional support would have helped them cope with the menopause experience:

- “[S]upport would have been great. I had a full hysterectomy and am fully menopausal. My nerves, night sweats, horrible. Very difficult.”
- “It is terrible, especially the hot flashes and mood swings. There should be some kind of support group so women can know what is going on with their bodies.”
- “Have classes to explain what to expect when you are in menopause.”
- “More information so that I know what to ask the doctor and what I need.”

Osteoporosis

During and after menopause, women are at increased risk of developing osteoporosis because their bodies produce less estrogen, which is an important component of strong bones. Osteoporosis causes bones to become weak and brittle, and women may suffer fractures as a result.⁴³⁹

Based on estimates provided by each prison, less than 1% of women in DOCCS have osteoporosis. This figure seems low considering that an estimated 8% of women over 20 and 13% to 18% of women over 50 have osteoporosis in the community.⁴⁴⁰ Responses from reproductive health survey respondents more closely aligned with community rates: 9% (24 of 272) of respondents reported having osteoporosis. This data suggests that DOCCS is either not adequately identifying women with osteoporosis or not adequately keeping track of the information.⁴⁴¹

The section on osteoporosis in DOCCS’ Women’s Health Primary Care Practice Guideline seems to be the most comprehensive section in the document, with a thorough discussion of how to identify and address osteoporosis through medicine, diet, calcium and exercise. Still, the guidelines have two problems. First, the policies recommend that bone density tests only be “considered” for women over age 65 and women with osteoporotic risk factors.⁴⁴² This deviates from community standards which recommend routine, not case-by-case, testing for women 65 and older as well as for those with risk factors.⁴⁴³ Second, the guidelines contain a troubling statement that doctors should conduct bone density tests only on women who are willing to be treated “based on the results.”⁴⁴⁴ No such requirement exists in the community, and women who express hesitation about treatment before testing may well be inspired to reconsider depending on their results. Women’s access to testing should not depend on agreeing to a certain course of action before they even get their results.

The CA does not have sufficient data to analyze whether DOCCS is complying with its policy on osteoporosis. A few reproductive health survey respondents with osteoporosis, however, commented that they had trouble accessing treatment and support. One woman with osteoporosis who was almost 59 wrote: “[I was given] calcium pills – but I need nutritious food

– our food is beyond bad and I’m on a special diet.” Another woman, 50, wrote: “Why would I lie about having an illness like osteoporosis and be asking for meds if I didn’t have it? I waited four months to get my meds.”

Colonoscopies

While not a reproductive health service per se, colonoscopy is a basic health service for people over age 50, and the CA included questions about colonoscopies to help assess how DOCCS is meeting the needs of older women in custody. DOCCS’ policy on colonoscopies comports with community standards: people over 50 years of age are supposed to receive a colonoscopy every 10 years, and more frequently if they are at risk of contracting colorectal cancer (cancer of the colon, rectum or surrounding areas),⁴⁴⁵ which is the third-leading cause of cancer deaths among women.⁴⁴⁶ Better access to colonoscopies was a top answer to the question of what could improve medical services for women over 50. This suggests that either DOCCS is not complying with its policy or that women are not being informed of the recommended time frame for colonoscopies and think they should have the procedure more frequently than necessary, or some combination of both.

RECOMMENDATIONS

For DOCCS

- 1) Train clinicians on health issues affecting women growing older, especially menopause, and ensure that medical staff treat older women with compassion and professionalism, and provide them with adequate information about their health concerns.
- 2) Train sick call nurses to schedule doctor appointments for women with menopause-related symptoms when they request appointments.
- 3) Revise policies on menopause to include recommendations on treatments including diet, nutritional supplements and exercise which comport with community standards.
- 4) Collect data on the number of women experiencing menopause and improve data collection related to osteoporosis.
- 5) Update written policies to reflect community standards on bone density tests, and eliminate the requirement that women must be willing to accept a predetermined course of treatment in order to receive a test.
- 6) Provide women with colonoscopies when appropriate and inform women of the recommended frequency of the procedure for their age group.

- 7) Initiate a support group at each prison for women growing older where women can share experiences and provide support for one another.

For New York State Legislature and Governor

- 1) Take actions to reduce the number of older people in prison, including increasing opportunities for older people to earn early release, establishing fairer parole policies, and enacting laws that shorten sentences and allow more people to serve their time in alternative-to-incarceration programs.
- 2) Expand funding for programs that help older people released from prison navigate their reentry home.

APPENDIX: BIOGRAPHIES OF EXPERT READERS

Jack Beck, Esq. is the Director of the CA's Prison Visiting Project and a nationally recognized expert on prison health care.

Barbara J. Berg, Ph.D. is a teacher, writer and activist whose work on women's rights focuses on women's health, parenting and childbirth. She is a member of the CA's Board of Directors.

Barbara Blanchard, J.D. is a Senior Staff Associate at Columbia University School of Nursing's Center for Children and Families. From 2005 to 2010, she directed Bedford Hills' Children's Center.

Kathy Boudin, Ed.D. is co-founder of the Center for Justice at Columbia University, where she is also an adjunct associate professor. During her 22 years in prison, she led work on a range of social issues, including education, parenting and HIV.

Judith Clark has been incarcerated since 1981. Throughout her 34 years of incarceration, Judy has served as a role model, and as a peer advocate and leader on numerous critical issues including education, parenting, HIV and pregnant women.

Nereida Ferran-Hansard, M.D. is a physician board certified in internal medicine and nephrology who works at Jacobi Medical Center. Nereida is an expert on HIV and prison health care, and a member of the CA's Board of Directors.

Philip Genty, Esq. is the Everett B. Birch Clinical Professor in Professional Responsibility at Columbia Law School, where he directs the Prisoners and Families Clinic. He has written and done advocacy and consulting on issues affecting incarcerated parents.

Donna Hylton, M.A. is a Community Health Advocate for Mt. Sinai/St. Luke's Coming Home Program. During her 27 years in prison, Donna led many efforts to improve conditions for incarcerated women and their families.

Sharon Katz, Esq. is Special Counsel for Pro Bono at Davis Polk & Wardwell LLP, where she has worked since 1982 in various capacities. She is also a member of the CA's Board of Directors.

Rachel Roth, Ph.D. is a writer, advocate and consultant on reproductive justice and prison policy. She helped lead the successful campaign for a state law mandating minimum standards for incarcerated pregnant women in Massachusetts.

Maria Teresa Timoney, C.N.M. is the Director of Women's HIV Services at the Bronx Lebanon Hospital Center. She is a Certified Nurse Midwife in the Department of Obstetrics and Gynecology and the AIDS Program.

ENDNOTES

1. “Why is Reproductive Justice Important for Women of Color?” SisterSong Women of Color Reproductive Justice Collective. Retrieved on September 1, 2014 from sistersong.net/index.php?option=com_content&view=article&id=141&Itemid=8
2. “What is Reproductive Justice?” Asian Communities for Reproductive Justice. Retrieved on September 1, 2014 from strongfamiliesmovement.org/what-is-reproductive-justice. See also: www.forwardtogether.org.
3. Inadequate medical care is consistently one of the most highly grieved areas for men and women in DOCCS custody. DOCCS defines a grievance as a “complaint, filed with an IGP [Inmate Grievance Program] clerk, about the substance or application of any written or unwritten policy, regulation, procedure or rule of the Department of Correctional Services or any of its program units, or the lack of a policy, regulation, procedure or rule.” NYS DOCCS. (7/12/2006). *Directive 4040: Inmate Grievance Program*. (On file at the Correctional Association of New York, hereinafter the CA).
At Taconic, medical was the most highly grieved area in 2011 and 2012. At Albion, medical was the second most highly grieved area in 2011 and 2012. At Bedford Hills, medical was the fourth most highly grieved area in 2011 and 2012. At Bayview, medical was the most highly grieved area in 2009 (the latest year for which the CA has data). (Grievance reports on file at the CA).
4. See Roth, R. (2012). “She Doesn’t Deserve to be Treated Like This”: Prisons as Sites of Reproductive Injustice. *Reproductive Laws for the 21st Century Papers*. Center for Women Policy Studies. Retrieved on June 17, 2014 from www.centerwomenpolicy.org/news/newsletter/documents/RothCWPSUpdated13July2012FINAL.pdf
Parents are at risk of losing their rights to their children under the Adoption and Safe Families Act (ASFA), a law that almost always requires foster care agencies to file termination of parental rights papers when a child has been in foster care for 15 of the last 22 months. See Adoption and Safe Families Act of 1997, Pub. L. No. 105-89, § 103(a)(3)(E), 111 Stat 2115 (1997).
Incarcerated parents in New York were granted some reprieve as a result of a 2010 law which allows foster care agencies to delay or forgo filing for termination if a parent is in prison. See Chapter 113 of the Laws of 2010, signed into law by Governor David Paterson on June 15, 2010. Codified in N.Y. Soc. Serv. Law §§ 384-b(3)(l)(i), 384-b(3)(l)(v), 384-b(7)(a), 384-b(7)(e)(i), 384-b(7)(f)(6), 409-e(2), 409-e(3) (2010).
See also Correctional Association of New York. (2006). *When “Free” Means Losing Your Mother: The Collision of Child Welfare and the Incarceration of Women in New York State*. New York, NY. Retrieved on June 17, 2014 from www.correctionalassociation.org/wp-content/uploads/2012/05/When_Free_Rpt_Feb_2006.pdf
Lee, A.F., Genty, P.M. & Laver, M. (2005). *The Impact of the Adoption and Safe Families Act on Children of Incarcerated Parents*. Washington, D.C.: Child Welfare League of America Press.
5. See Clear, T.R. (2007). *Imprisoning Communities: How Mass Incarceration Makes Disadvantaged Neighborhoods Worse*. New York, NY: Oxford University Press.
National Research Council. (2014). *The Growth of Incarceration in the United States: Exploring Causes and Consequences*. Washington, DC: The National Academies Press.
6. Hughes, T. & Wilson, D.J. (2014). *Reentry Trends in the United States: Inmates returning to the community after serving time in prison*. Bureau of Justice Statistics, U.S. Department of Justice. Retrieved on June 17, 2014 from www.bjs.gov/content/reentry/reentry.cfm
7. The CA’s estimate that nearly 4,000 women are in DOCCS’ custody over a given year is based on the following data: As of January 1, 2013, there were 2,301 women in DOCCS custody. NYS DOCCS. (2013). *Under Custody Report: Profile of Inmate Population Under Custody on January 1, 2013*. Albany, NY. Retrieved on July 15, 2014 from www.doccs.ny.gov/Research/Reports/2013/Under_Custody_Report_2013.pdf (hereinafter *DOCCS Under Custody Report 2013*).
There were 491 women returned to DOCCS on parole violations in 2011. See NYS DOCCS. (2012). *Table 2B. Crime by Predicate Felony Status by Gender; Parole and PRS Violators Admitted to NYSDOCCS During 2011*. (On file at the CA).
There were 1,052 women sent to DOCCS for new crimes in 2011. See NYS DOCCS. (2012). *Table 1B. Crime by Predicate Felony Status by Gender; 2011 New Court Commitments*. (On file at the CA).
NYS DOCCS (2012). *Table 7: Offenders Admitted to NYDOCCS by Latest Admission Facility*. (On file at the CA).
8. “In 1977, the U.S. imprisoned 11,212 women....” Frost, N., Greene, J. & Pranis, K. (2006). *HARD HIT: The Growth in the Imprisonment of Women, 1977-2004*. p.7. Women’s Prison Association. Retrieved on October 20, 2014 from csdp.org/research/HardHitReport4.pdf

- The U.S. Bureau of Justice Statistics reports that there were 111,287 women in state or federal prison in 2013. See Table 1 in: Carson, E.A. (2014). *Prisoners in 2013*. Bureau of Justice Statistics, U.S. Department of Justice. Retrieved on October 20, 2014 from www.bjs.gov/content/pub/pdf/p13.pdf
9. According to the U.S. Census, the total world female population in 2010 was 3,408,416,669. U.S. Census Bureau. (2010). *World Midyear Population by Age and Sex for 2010*. Retrieved on July 29, 2014 from www.census.gov/population/international/data/idb/worldpop.php
According to the U.S. Census, the total U.S. female population in 2010 was 156,964,212. Howden, L.M. & Meyer, J.A. (2011). Age and Sex Composition: 2010. *2010 Census Briefs*. U.S. Census Bureau. Retrieved on July 29, 2014 from www.census.gov/prod/cen2010/briefs/c2010br-03.pdf
"More than 625,000 women and girls are held in penal institutions throughout the world, either as pre-trial detainees (remand prisoners) or having been convicted and sentenced....Nearly a third of these are in the United States of America (201,200)." Walmsley, R. (8/3/12). *World Female Imprisonment List*, Second Ed. London, U.K.: International Study Centre for Prison Studies. Retrieved on July 29, 2014 from www.prisonstudies.org/sites/prisonstudies.org/files/resources/downloads/wfil_2nd_edition.pdf
 10. See notes 48-57.
 11. For examples of incarcerated women's activism, see Boudin, K. (2007). The Resilience of the Written-Off: Women in Prison as Women of Change. *Women's Rights Law Reporter*, 29(19), 15-22.
Fine, M., Torre, M., Boudin, K., Bowen, I., Clark, J., Hylton, D., Martinez, M., "Missy," Roberts, R., Smart, P., & Upegui, D. (2001). *Changing Minds: The Impact of College in a Maximum-Security Prison*. Ronald Ridgeway, Inc. Law, V. (2009). *Resistance Behind Bars: Struggles of Incarcerated Women*. Oakland, CA: PM Press.
The Members of the ACE Program of the Bedford Hills Correctional Facility (1998). *Breaking the Walls of Silence: AIDS and Women in a New York State Maximum-Security Prison*. New York, NY: The Overlook Press.
 12. See Boudin, K. (1998). Lessons from a Mother's Program in Prison. *Women & Therapy*, 21(1), 103-125.
Correctional Association of New York. (2006). *Report on Conditions of Confinement at Albion Correctional Facility*. New York, NY. Retrieved on July 15, 2014 from www.correctionalassociation.org/wp-content/uploads/2012/05/Albion_2005.pdf
See note 4, *When "Free" Means Losing Your Mother*.
 13. For many years, DOCCS' policy required an incarcerated person to sign a contract stating that if she wanted to cancel an outside medical appointment, she had to do so within five days of the appointment or face disciplinary action. In winter 2013, DOCCS eliminated the contract signing process and issued a new policy that an incarcerated person will face disciplinary action for refusing to "obey a direct order" only if she declines to go to a medical appointment on the day of the appointment itself. This new policy seems even more punitive than the old one, as the contract process at least offered incarcerated people prior warning about the potential consequences of their actions.
"I understand that if I withdraw my agreement after (5) business days or decline to participate on the day(s) of the appointment(s), I will be charged with a violation of inmate rule 106.10, "Refusal to Obey a Direct Order" and be subject to disciplinary action." NYS DOCCS Form 3126E3: *Contract for Specialty Care Appointment* (3/2004), NYS DOCCS Directive 4308: *Contracts for Specialty Care Appointments* (6/15/2004). This policy was rescinded on 1/7/2013.
DOCCS' current policy states: "If an inmate refuses to attend a medical appointment (regardless if the appointment is scheduled in the facility or at an outside location), he/she should be given a direct order to go to the appointment. If the inmate refuses despite the order, he/she will be subject to disciplinary action for refusal to obey a direct order....It is also important to emphasize that the order to the inmate to attend a scheduled medical trip or in-house medical appointment is not mandating that he/she receive care. An inmate has the right to refuse the care, but not the trip/appointment." Memorandum from NYS DOCCS Deputy Commissioner Joseph F. Bellnier and NYS DOCCS Deputy Commissioner and Chief Medical Officer Dr. Carl Koenigsmann, *Rescission of Directive #4308, Contracts for Specialty Care Appointments* (2/19/13).
 14. Allen, S.A., Cohen, L.C. & Rold, W.J. (2006). Dual Loyalties: Our Role in Preventing Inmate Abuse. *Correct Care*, 20(3), 1,16-17. Retrieved on June 17, 2014 from www.ncchc.org/filebin/images/Website_PDFs/20-3.pdf
Allen, S.A., Wakeman, S.E., Cohen, R.L. & Rich, J.D. (2010). Physicians in US Prisons in the Era of Mass Incarceration. *International Journal of Prisoner Health*, 6(3), 99-106. Retrieved on June 17, 2014 from mountsinaiphr.files.wordpress.com/2011/01/allen_etal_ijph63.pdf
Pont, J., Stöver, H. & Wolff, H. (2012). Dual Loyalty in Prison Health Care. *American Journal of Public Health*, 102(3), 475-480. Retrieved on June 17, 2014 from www.ncbi.nlm.nih.gov/pmc/articles/PMC3487660/

15. After speaking with the CA about this incident, DOCCS issued a policy in August 2014 barring Nurse Administrators from serving as disciplinary hearing officers. "Effective immediately, Nurse Administrators will not be designated to conduct Tier Hearings." Memorandum from NYS DOCCS Deputy Commissioner Joseph F. Bellnier, *Hearing Officer Designation* (8/4/14). (On file at the CA).
16. After increasing steeply by 880% between 1973 and 1997, the number of women in New York's prisons began to decline. Since 1997, the state's female prison population has decreased by 38%, from about 3,700 in 1997 to 2,300 in 2013. This note also applies to the chart, *Trends in New York's Female Prison Population*, on p. 30. See note 7, *DOCCS Under Custody Report 2013*.
 Letter from DOCS Director of Public Information (5/15/01). (On file at the CA).
 NYS DOCCS. (1997). *The Hub System: Profile of Inmates Undercustody on January 1, 1997*. Albany, NY. (On file at the CA.)
 The total state prison population has fallen by 23% over the past 13 years, from 71,400 in 2000 to about 54,800 in 2013. See NYS DOCCS. (2000). *The Hub System: Profile of Inmates Undercustody on January 1, 2000*. Albany: NY. (On file at the CA). See note 7, *DOCCS Under Custody Report 2013*.
 New York made reforms to the state's Rockefeller drug laws in 2003, 2004 and 2009. These reforms allowed people convicted of certain drug crimes to be resentenced and made more defendants eligible for non-incarcerative sentences.
 The existence of an effective network of community-based alternative to incarceration programs in New York City made it more likely that judges would use this discretion to divert individuals to those programs. For further information, see The ATI/Reentry Coalition's website: www.ati-ny.org.
 The number of women in prison for drug offenses dropped by almost 70% between 2004 and 2013 (from 1,200 to 360 women). See NYS DOCCS. (2004). *Hub System: Profile of Inmate Population Undercustody on January 1, 2004*. Albany: NY. (On file at the CA); NYS DOCCS. (2013). See note 7, *DOCCS Under Custody Report 2013*.
 In addition, in 1997, New York established a Merit Time program that allows incarcerated people convicted of certain non-violent offenses to earn time off their prison terms. See N.Y. Correct. Law § 803. In 2009, New York established a Limited Credit Time Allowance that allows incarcerated people convicted of certain violent offenses to earn six months off their sentences. See N.Y. Correct. Law § 803-B.
 Over the past decade, researchers report that New York City police have started arresting more people for misdemeanor crimes (for which people are sent to local jails) and fewer for felonies (for which people are sent to prison). See Austin, J. & Jacobson, M. (2013). *How New York City Reduced Mass Incarceration: A Model for Change?* New York, NY: Vera Institute of Justice, Brennan Center for Justice & The JFA Institute. Retrieved on June 17, 2014 from www.brennancenter.org/sites/default/files/publications/How_NYC_Reduced_Mass_Incarceration.pdf
 Further reforms to sentencing laws along with reforms in parole and release policies could accomplish even more substantial reductions. See Correctional Association of New York (2012). Testimony of the Correctional Association of New York, New York State Sentencing Commission, December 12, 2012. (On file at the CA).
 Correctional Association of New York (2013). Testimony of the Correctional Association of New York Before the Hearing of the NYS Assembly's Corrections Committee, December 4, 2013. Retrieved on September 24, 2014 from www.correctionalassociation.org/wp-content/uploads/2013/12/CA-Parole-Testimony-12-4-13-Hearing-FINAL.pdf
17. The other organization with a legislative mandate to monitor prison conditions is the Pennsylvania Prison Society: "The Prison Society's Official Visitors are provided access to all state and county correctional facilities through act of legislature." (p. 4). Johnston, N. (n.d). *Prison Reform in Pennsylvania*. The Pennsylvania Prison Society. Retrieved July 15, 2014 from media.wix.com/ugd//4c2da0_41bed342ea390827839e1ffa4b3dca97.pdf
18. Unusual incidents are defined by DOCCS as "events that disrupt or affect facility operations" within DOCCS (p. 4). New York State Department of Corrections and Community Supervision (hereinafter referred to as NYS DOCCS). (2013). *Unusual Incident Report, January-December 2011*. Albany, NY. Retrieved on July 15, 2014 from www.doccs.ny.gov/Research/Reports/2013/UI_Report_Jan-Dec_2011.pdf
19. See note 3.
20. In these instances, a woman can be handcuffed by one wrist if "extraordinary circumstances" exist where restraints are "necessary to prevent [the] woman from injuring herself or medical or correctional personnel." N.Y. Correct. Law § 611.
21. Letter from NYS DOCCS FOIL Unit (8/9/2012, Log No. 12-0790) in response to Correctional Association of New York FOIL request, p. 1. (On file at the CA).

22. "Privileged Correspondence is defined as correspondence addressed by an inmate to any of the following persons or entities...Governmental/Public Officials: Any American Federal, State, or local government official, department or agency; any official of a Nation, State, or tribe of which an inmate is a citizen; or the Correctional Association of New York State...." NYS DOCCS. (1/13/14). *Directive 4421: Privileged Correspondence*. (On file at the CA).
23. NYS DOCCS. (2010). *Under Custody Report: Profile of Inmate Population Under Custody on January 1, 2010*. Albany, NY. Retrieved on July 15, 2014 from www.prisonpolicy.org/scans/nydocs/UnderCustody_Report2010.pdf
24. Letter from NYS DOCCS Commissioner Brian Fischer to Correctional Association of New York (6/1/2010) provides median age data for women housed in DOCCS facilities as of April 1, 2010. (On file at the CA).
25. DOCCS uses the following categories to classify the race/ethnicity of people in its custody: White, African-American, Hispanic, Native American, Asian, Other and Unknown.
26. NYS DOCCS. (2010). *Table 14. Inmates Under DOCCS Custody on April 1, 2010: Median Time Served at Facility (in Months) by Gender*. (On file at the CA).
27. NYS DOCCS. (2010). *Table 3B. Crime by Predicate Felony Status by Gender, Under Custody at NYSDOCS as of April 1, 2010*. (On file at the CA).
28. See note 7, *DOCCS Under Custody Report 2013*.
29. In a July 26, 2013 press release DOCCS announced plans to close an additional four men's prisons. See NYS DOCCS. (2013). NYS DOCCS announces prison reforms that will save taxpayers over \$30 million annually following decline in crime rate and inmate population [press release]. Retrieved on July 15, 2014 from www.doccs.ny.gov/PressRel/2013/Prison_Closure_Announcement.html
30. NYS DOCCS. (2011). *DOCCS Fact Sheet: Merger of Department of Correctional Services and Division of Parole*. Retrieved on October 2, 2014 from www.doccs.ny.gov/FactSheets/DOCS-Parole-Merger.html
31. See www.doccs.ny.gov
32. For DOCCS' total budget for fiscal year 2015, See New York State Budget 2014-15 Enacted Appropriation Bills. Retrieved on October 5, 2014 from the New York State Division of the Budget website: publications.budget.ny.gov/budgetFP/enacted1415.html
 NYS DOCCS. (2013). *Handbook for the Families and Friends of New York State DOCCS Offenders*. Retrieved on July 15, 2014 from www.doccs.ny.gov/FamilyGuide/FamilyHandbook.html
 New York state public employment by agency (n.d.). *Democrat & Chronicle*. Retrieved on July 15, 2014 from roccdocs.democratandchronicle.com/database/new-york-state-public-employment-agency
 Seward, Z. (2012). New York's 10 largest employers. *Innovation Trail*. Retrieved on July 15, 2014 from innovationtrail.org/post/new-yorks-10-largest-employers
 U.S. Census Bureau. (2012). 2012 Public Employment and Payroll Data, State Governments, New York. *2012 Census of Governments: Employment*. Retrieved on July 15, 2014 from www2.census.gov/govs/apes/12stny.txt
33. While the CA supports prison closures, the organization urged Governor Andrew Cuomo to halt the closures of Bayview and Beacon until a plan was put in place to replicate the important opportunities those prisons provided for incarcerated women to stay connected with their families and prepare for a successful return home. See Correctional Association of New York. (2013). Testimony of the Correctional Association of New York, Public Protection Committee Budget Hearing – February 6, 2013. Retrieved on July 15, 2014 from www.correctionalassociation.org/wp-content/uploads/2013/02/cany-testimony-nys-budget-bayview-beacon-closures-feb-6-2013.pdf
 Kraft-Stolar, T. (2014). Women inmates deserve better. *Times Union*, Commentary, February 14. Retrieved on July 15, 2014 from www.timesunion.com/opinion/article/Women-inmates-deserve-better-4280527.php
 See also Correctional Association of New York, April 1, 2013 press release, available at www.correctionalassociation.org/press/critical-opportunities-for-women-will-be-lost-as-governor-continues-trend-of-closing-minimum-security-and-downstate-prisons
34. See NYS DOCCS. (6/1/1994). Medical Classification System. *Health Services Policy Manual*, 1.26. (On file at the CA).
35. "[RMUs] are secure facilities that provide a range of medical services for inmates who are too ill to be treated in regular prison infirmaries but who do not require acute care.... RMUs provide step-down care for inmates returning from a hospital stay, rehabilitation care, chronic disease care, long-term care and hospice care.

- Outpatient clinics in such specialty areas as ophthalmology, infectious disease, endocrinology, orthopedics, dermatology, gastroenterology, podiatry and urology are offered.” (p. 27). Correctional Association of New York. (2000). *Health Care in New York State Prisons*. New York, NY. Retrieved on July 15, 2014 from www.correctionalassociation.org/wp-content/uploads/2012/05/healthcare_report.pdf
36. This figure includes personnel, non-personnel and medication costs. Letter from NYS DOCCS received on September 4, 2014 in response to Correctional Association of New York’s information request sent on July 29, 2014. (On file at the CA).
 37. “Although the [New York State] prison population decreased by less than 1% during 2013 and by 7.3% since January 2010, medical staffing [in DOCCS] for FY 2014-2015 will be reduced by 14.8% over the past four years, which is double the prison population decline.” Correctional Association of New York (2014). Testimony of the Correctional Association of New York Before Joint Legislative Hearing on the 2014-15 Proposed Budget for Public Protection. (On file at the CA).
 38. “Essentially, the Department is downsizing medical staff by not filling authorized positions, and then making these cuts permanent by incorporating these staffing reductions in the upcoming fiscal year. The reductions each year have been imposed without adequate legislative oversight, and the new DOCCS budget again obscures the reductions in health staff being made. We are particularly concerned because healthcare staffing is taking a greater reduction than other DOCCS operations. Overall, security staff reductions for the past four budget years, including all the prison closures, will result in a total reduction of only 6.8%, which is less than half the rate of medical staff losses.” *Id.*
 39. See note 36, Letter from NYS DOCCS received on September 4, 2014.
 40. See note 7, *DOCCS Under Custody Report 2013*. Data regarding race/ethnicity obtained from this report.
 41. Albion’s Intake Center has a capacity of 14 beds. See NYS DOCCS (2012). *Table 23: Daily Population Capacity Report*. (On file at the CA).
The Intake Center was opened to help save transportation costs for upstate counties. See NYS DOCCS. (2008). DOCCS to Open New Inmate Intake Centers at Albion and Auburn at Sheriffs’ Request; Move Will Save Money for Property Taxpayers [press release]. Retrieved on July 15, 2014 from www.doccs.ny.gov/NewsRoom/sheriff.html
NYS DOCCS. (2008). New Intake Centers at Albion, Auburn to Save Counties Money. *DOCCS Today*, 1(4). Retrieved on July 15, 2014 from www.doccs.ny.gov/PressRel/DOCCSToday/Summer2008edition.pdf
 42. “SHU units are segregated cellblocks in most maximum - and some medium - security prisons, where individuals must spend 23 hours per day in their cell, are offered one hour per day of recreation, and have meals delivered to their cells. Keeplock refers to individuals confined for 23 hours a day either in their cells or in a separate cellblock.” (p. 1). Correctional Association of New York. (2012). Testimony by The Correctional Association of New York Before the Senate Judiciary Committee’s Subcommittee on the Constitution, Civil Rights and Human Rights Reassessing Solitary Confinement - June 19, 2012. Retrieved on July 15, 2014 from www.correctionalassociation.org/wp-content/uploads/2012/10/testimony-solitary-confinement-june-2012.pdf
 43. “In order to be considered for Temporary Release, the Correction Law requires that an inmate must be within two years of his or her earliest possible release date on Parole. The inmate must also obtain the requisite score on a point rating system, cannot be convicted of a homicide or sex-related crime or a violent felony, and must also survive a stringent casework review at several levels.” (p. 6). NYS DOCCS. (n.d). *Temporary Release Program: 2010 Annual Report*. Retrieved on July 15, 2014 from www.doccs.ny.gov/Research/Reports/2011/TempReleaseProgram2010.pdf
In 1996, then Governor George Pataki closed temporary release programs, including work release, to people convicted of violent offenses. A law was enacted in 2002 that restored temporary release for certain domestic violence survivors convicted of violent crimes against their abusers. See N.Y. Correct. Law §851
Correctional Association of New York & Avon Global Center for Women and Justice at Cornell Law School. (2011). *From Protection to Punishment: Post-Conviction Barriers to Justice for Domestic Violence Survivor-Defendants in New York State*. New York, NY. Retrieved on July 15, 2014 from www.correctionalassociation.org/wp-content/uploads/2011/06/from_protection_to_punishment.pdf
 44. Depending on the incarcerated person’s particular history, DOCCS may require the person to be enrolled in or complete mandatory programs to be eligible for the Family Reunion Program. Eligible visitors are legal spouses, including spouses of the same gender, to whom the incarcerated person has been married for at least six months, children of the incarcerated person, parents or individuals who have acted as parents to the

incarcerated person, and grandparents. DOCCS can approve nieces, nephews, aunts, uncles, siblings and their legal spouses, step-children and grandchildren after a special review. DOCCS requires approved visitors to have established a “recent visiting pattern,” defined as three visits within the past year but DOCCS can make exceptions for elderly, ill, or out of state visitors. If a person is known to be HIV-positive, s/he must agree to have her/his status shared with her/his spouse in order to participate in the program. The facility provides cooking and eating utensils, pillows, blankets, bed linens, towels, soap and condoms. Visitors are responsible for providing food for themselves and the incarcerated person.

See NYS DOCCS. (4/21/2011, Rev. 2/28/2012). *Directive 4500: Family Reunion Program*. (On file at the CA).

45. For more information about the *Puppies Behind Bars* program, visit www.puppiesbehindbars.com.
46. Correctional Association of New York. (2007). *Report on Mental Health Programs and Services at Bedford Hills Correctional Facility*. New York, NY. Retrieved on July 15, 2014 from www.correctionalassociation.org/wp-content/uploads/2012/05/Bedford_MentalHealth_2007.pdf
47. NYS DOCCS & State of New York Office of Alcoholism and Substance Abuse Services. (2010). State’s First Re-entry Program for Women Offering Chemical Dependence Services [press release]. Retrieved on July 15, 2014 from www.doccs.ny.gov/NewsRoom/BayviewProcurement2010.html
NYS DOCCS. (2009). Bayview Correctional Facility Opens Reentry Unit for Female Offenders Returning to New York City, Suburbs [press release]. Retrieved on July 15, 2014 from www.doccs.ny.gov/PressRel/2009/BayviewCorrectionalFacility.html
48. The median annual income figure is based on data from the CA’s general survey. This figure is in the lowest income bracket in the state: “Less than \$10,000” for households and families. See U.S. Census Bureau. (2002). *New York: 2000, Census 2000 Profile*. Retrieved on June 17, 2014 from www.census.gov/prod/2002pubs/c2kprof00-ny.pdf
49. These figures are based on data from the CA’s general survey. Of women who responded to these three questions in the survey, 391 of 949 women reported being unemployed prior to arrest, 340 of 961 women reported receiving public assistance prior to arrest, and 555 of 960 women reported being insured by Medicaid prior to arrest.
50. See note 7, *DOCCS Under Custody Report 2013*.
Based on the U.S. Census Bureau’s 2012 American Community Survey, 64.7% of women in New York State identified as white alone. See U.S. Census Bureau. (2012). Sex by Age (White Alone), New York. 2012 American Community Survey 1-Year Estimates. Retrieved on August 11, 2014 from factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_12_1YR_B01001A&prodType=table,
U.S. Census Bureau. (2012). Sex by Age, New York. 2012 American Community Survey 1-Year Estimates. Retrieved on August 11, 2014 from factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_12_1YR_B01001&prodType=table
51. See note 7, *DOCCS Under Custody Report 2013*.
52. NYS DOCCS. (2012). *Table 18. Number of Incarcerated Offenders in Need of Substance Abuse Treatment; Incarcerated Offenders Under NYSDOCCS Custody as of April 1, 2012*. (On file at the CA).
See also Correctional Association of New York. (2011). *Treatment Behind Bars: Substance Abuse Treatment in New York Prisons 2007-2010*. New York, NY. Retrieved on June 17, 2014 from www.correctionalassociation.org/wp-content/uploads/2012/05/satp_report_and_appendix_february_2011.pdf
53. See note 7, *DOCCS Under Custody Report 2013*.
54. A 1999 study of women in Bedford Hills found that 94% of the women interviewed had experienced physical or sexual violence in their lifetime, 82% had been severely physically or sexually abused as children, and 75% had suffered serious physical violence by an intimate partner during adulthood. See Browne, A., Miller, B. & Maquin, E. (1999). Prevalence and Severity of Lifetime Physical and Sexual Victimization Among Incarcerated Women. *International Journal of Law & Psychiatry*, 22(3-4), 301–22.
A 1994 study of 557 incarcerated women in Oklahoma found that 80% of the women studied reported having been abused in the past. See Marcus-Mendoza S., Sargent, E. & Yu, C.H. (1994). Changing Perceptions of the Etiology of Crime: The Relationship Between Abuse and Female Criminality. *Oklahoma Criminal Justice Research Consortium Journal*, 1, 13-25.
A 1999 report by the federal Bureau of Justice Statistics, the most recent study assessing abuse history among women in state prisons across the country, found that 57% of women in state facilities had experienced physical

or sexual abuse before incarceration. The study also found that more than 37% of women in state prisons had been raped prior their incarceration. See Wolf Harlow, C. (1999). *Selected Findings: Prior Abuse Reported by Inmates and Probationers*. Bureau of Justice Statistics, U.S. Department of Justice. Retrieved on May 15, 2014 from bjs.ojp.usdoj.gov/content/pub/pdf/parip.pdf

In 2002, the Bureau of Justice Statistics reported that 55% of female jail inmates indicated past abuse. See James, D.J. (2004). *Special Report: Profile of Jail Inmates, 2002*. Bureau of Justice Statistics, U.S. Department of Justice. Retrieved on May 15, 2014 from bjs.ojp.usdoj.gov/content/pub/pdf/pji02.pdf.

It is likely that the Bureau's figures are underestimates given the findings of the Bedford Hills study cited above and the experience of numerous organizations that work with currently and formerly incarcerated women. See Correctional Association of New York & Avon Global Center for Women and Justice at Cornell Law School. (2011). *From Protection to Punishment: Post-Conviction Barriers to Justice for Domestic Violence Survivor-Defendants in New York State*. New York, NY. Retrieved on June 17, 2014 from www.correctionalassociation.org/wp-content/uploads/2011/06/from_protection_to_punishment.pdf

55. 54% (538 of 993) of respondents to the CA's general survey reported having a serious or chronic medical condition and, of those women, 44% (228 of 518) reported having at least two such conditions. According data submitted by DOCCS to the Bureau of Justice Statistics in 2010, 5.2% of men in custody and 11.7% of women in custody were living with HIV. See Table 2 in: Maruschak, L. (2012). HIV in Prisons, 2001-2010. *Bureau of Justice Statistics Bulletin, NCJ 238877*. Bureau of Justice Statistics, U.S. Department of Justice. Retrieved on June 17, 2014 from www.bjs.gov/content/pub/pdf/hivp10.pdf
"Although no reliable data is available concerning the number of women in DOCCS with HCV, we estimate that 17% are infected, a rate significantly higher than in the male population." Correctional Association of New York. (2013). *2013 Comments re: DOH Oversight of HIV/HCV Care in NYS Prisons*. Retrieved on June 17, 2014 from www.correctionalassociation.org/wp-content/uploads/2013/10/CA-Memo-2013-Comments-DOH-Oversight-Law-Final-Draft.pdf
The HCV rate among the general public is 1.3-1.9%. See Beck, J., Paltrowitz, S. & Elijah, S. (2013). Infectious Diseases in State Prisons. In E. Waltermaurer & T.A. Akers (Eds), *Epidemiological Criminology: Theory to Practice* (pp. 162-175). New York, NY: Routledge.
56. See note 7, *DOCCS Under Custody Report 2013*.
439 of 692 (63%) respondents to the CA's general survey reported living with their children prior to arrest. 244 of 573 (43%) respondents to the CA's general survey reported caring for their children on their own prior to arrest.
57. NYS DOCCS. (2001). Under Custody Population January 1, 2001. (On file at the CA.)
See note 7, *DOCCS Under Custody Report 2013*.
58. See note 3.
59. See *Todaro v. Ward*, 431 F.Supp. 1129 (S.D.N.Y. 1977), aff'd, 565 F.2d 48 (2d Cir. 1977); see also *id.*, Stipulation and Order, 74 Civ. 4581 (RJW) (Oct. 2002).
60. In 2014-2015, the budget for DOCCS was approximately \$3 billion. See New York State Budget 2014-15 Enacted Appropriation Bills. Retrieved on October 5, 2014 from the New York State Division of the Budget website: publications.budget.ny.gov/budgetFP/enacted1415.html
Vera Institute of Justice. (2012). *The Price of Prisons: What Incarceration Costs Taxpayers, New York*. Fact Sheet. New York, NY. Retrieved on June 17, 2014 from www.vera.org/files/price-of-prisons-new-york-fact-sheet.pdf
Nationwide, corrections expenditures were approximately \$80 billion in 2010. See U.S. Department of Justice. (2013). *Smart on Crime: Reforming the Criminal Justice System for the 21st Century*. Retrieved on June 17, 2014 from www.justice.gov/ag/smart-on-crime.pdf
61. The Bureau of Justice Statistics found that approximately two-thirds of people were re-arrested within three years of release from state prison, and about three-quarters within five years. See Cooper, A.D., Durose, M.R. & Snyder, H.N. (2014). Recidivism of Prisoners Released in 30 States in 2005: Patterns from 2005 to 2010. *Special Report, NCJ 244205*. U.S. Department of Justice, Bureau of Justice Statistics. Retrieved on June 17, 2014 from www.bjs.gov/content/pub/pdf/rprts05p0510.pdf
See also Clear, T.R. (2007). *Imprisoning Communities: How Mass Incarceration Makes Disadvantaged Neighborhoods Worse*. New York, NY: Oxford University Press.
National Research Council. (2014). *The Growth of Incarceration in the United States: Exploring Causes and Consequences*. Washington, DC: The National Academies Press.
The New York Times Editorial Board. (2014). End Mass Incarceration Now. *The New York Times Sunday*

Review, May 24. Retrieved on June 17, 2014 from www.nytimes.com/2014/05/25/opinion/sunday/end-mass-incarceration-now.html

The Pew Center on the States. (2009). *One in 31: The Long Reach of American Corrections*. Washington, DC: The Pew Charitable Trusts. Retrieved on June 17, 2014 from www.pewtrusts.org/en/research-and-analysis/reports/0001/01/01/one-in-31

The Sentencing Project. (2014). *Fewer Prisoners, Less Crime: A Tale of Three States*. Washington, D.C. Retrieved on July 28, 2014 from sentencingproject.org/detail/news.cfm?news_id=1862&id=167

62. The annual cost of incarcerating a person in New York State is approximately \$60,000, whereas most alternative to incarceration programs in New York City cost about \$11,000 per year per person. See Vera Institute of Justice. (2012). New York Fact Sheet. *The Price of Prisons: What Incarceration Costs Taxpayers*. New York, NY. Retrieved on August 11, 2014 from www.vera.org/pubs/special/price-prisons-what-incarceration-costs-taxpayers
- The ATI/Reentry Coalition. (2010). *The New York City ATI/Reentry Coalition Services Report 2010*. New York, NY. Retrieved on June 11, 2014 from www.ati-ny.org/files/ATI-final.pdf
- “Drug-addicted, nonviolent felony offenders with 5 prior drug arrests and an average of 4 years behind bars achieved significantly lower recidivism rates and higher employment rates through the DTAP program than comparable offenders who were sent to prison.” The National Center on Addiction and Substance Abuse at Columbia University. (2003). *Crossing the Bridge: An Evaluation of the Drug Treatment Alternative-to-Prison (DTAP) Program*. New York, NY. Retrieved on June 17, 2014 from www.casacolumbia.org/addiction-research/reports/crossing-bridge-evaluation-drug-treatment-alternative-prison-dtap-program
63. In 2000, DOCCS’ Division of Health Services established a Central Office-based Continuous Quality Improvement (CQI) program to help prisons collect and analyze data to identify problems with their delivery of medical services. See NYS DOCCS. (6/9/2008). Continuous Quality Improvement Committee. *Health Services Policy Manual*, 7.19. (On file at the CA).
- In 2003, DOCCS required each prison to establish its own Quality Improvement (QI) Committee to meet quarterly to assess facility medical policies and practices. See NYS DOCCS. (9/3/2003). Facility-based Quality Improvement Program. *Health Services Policy Manual*, 7.19a. (On file at the CA).
- As part of its CQI program, the Division of Health Services created assessment tools for the prison-based QI Committees to use in evaluating their services. While the launch of the CQI program and QI Committees was a very positive step, these initiatives have not lived up to their potential overall. “DOCS’s Division of Health Services has implemented a meaningful Continuing Quality Improvement (CQI) Program that attempts to standardize clinical protocols and monitor their implementation. Despite these efforts, the quality improvement programs at some prisons are inadequate. The CQI program should enhance its efforts to compel prisons to develop remedial plans to address areas in which facilities are not fully complying with clinical standards” (p. 10); and: “A component of reviewing the quality of prison healthcare involves assessment of the medical staff...inmate-patients frequently complain to the CA about the attitude, thoroughness, responsiveness and demeanor of the prison staff during medical encounters. There appears to be limited DOCS oversight concerning this aspect of care. The quality assessment tools of clinicians consist primarily of chart reviews of medical encounters. It is unlikely that these records will contain data about these aspects of patient-staff relations.” (p. 75). Correctional Association of New York. (2009). *Healthcare in New York Prisons, 2004-2007*. New York, NY. Retrieved on July 15, 2014 from www.correctionalassociation.org/wp-content/uploads/2012/05/Healthcare_Report_2004-07.pdf
64. See *Quality Improvement*, U.S. Department of Health and Human Services Health Resources and Services Administration. Retrieved on July 15, 2014 from: www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/
65. The 2009 law mandates the State Department of Health to conduct an annual review of DOCCS’ HIV and HCV policies and practices, and to assess whether they are consistent with “current, generally accepted medical standards and procedures.” N.Y. Pub. Health § 206(26)
66. The CA’s research found that 54% of women reported a serious or chronic illness, and 44% of these women have at least two such conditions. In 2009, the CA estimated that about 6% of people in DOCCS had HIV, 14% had hepatitis C, 11% had hypertension, 4% had diabetes and 15% had asthma. See note 64, *Healthcare in New York Prisons, 2004-2007*.
- According to the Bureau of Justice Statistics, “An estimated 44% of state inmates and 39% of federal inmates reported a current medical problem other than a cold or virus....Female inmates in both state and federal prisons were more likely to report having a current medical problem than male inmates, but were equally likely

to report a dental problem. Among both state and federal inmates, females were more than 1½ times more likely to report 2 or more current medical problems than male inmates....More than half of female inmates in state (57%) and federal (52%) prisons reported having a current medical problem. About a quarter of female inmates reported one medical problem and another quarter reported multiple problems. Females reported higher percentages of most of the specific types of medical problems than male inmates. Arthritis, asthma, and hypertension were the most commonly reported medical problems among female inmates.” (pp. 1-2). Bureau of Justice Statistics, U.S. Department of Justice. (2008). *Medical Problems of Prisoners*. Retrieved on July 15, 2014 from www.bjs.gov/content/pub/pdf/mpp.pdf

67. NYS DOCCS. (4/14/2000). Patient Bill of Rights. *Health Services Policy Manual*, 1.04. (On file at the CA).
68. NYS DOCCS. (11/5/1993). Correctional Health Care Professionals Code of Ethics. *Health Services Policy Manual*, 6.02. (On file at the CA).
69. Women from Albion are sent to Strong Memorial Hospital and women from Bedford and Taconic (as well as Bayview and Beacon when they were open) are usually sent to Mt. Vernon Hospital.
70. For a description of DOCCS’ Regional Medical Units, see note 35. Women at Taconic (and at Bayview and Beacon before these prisons closed) also accessed services at Bedford’s RMU. Before it closed, women from Beacon could access certain services at the RMU at Fishkill Correctional Facility as well, a men’s medium security prison that was located very close to the prison. Women at Albion go to the RMU at Wende Correctional Facility, a men’s maximum security prison nearby.
71. See *Todaro v. Ward*, 431 F.Supp. 1129 (S.D.N.Y. 1977), *aff’d*, 565 F.2d 48 (2d Cir. 1977)
72. See *Todaro v. Ward*, Second Modified. Judgment, 74 Civ. 4581 (RJW) (October, 1993); *see also id*, Stipulation and Order (Oct. 2002).
73. “Sick Call is defined as the system through which an inmate requests and receives individualized appropriate health care services for a self-reported illness or injury. All inmates will have unrestricted access to health care services through sick call and be able to initiate requests for sick call services on a daily basis.” NYS DOCCS. (9/3/2003). Sick Call. *Health Services Policy Manual*, 1.34. (On file at the CA).
“The Department of Correctional Services nursing staff screens inmates at sick call according to mandated standards...Timely arrangements are then made to address the inmate’s complaint using the health unit’s suggested nursing parameters. Examples of nursing interventions are as follows: Monitoring/documenting of physical signs and symptoms, e.g. headaches, dizziness, paraesthesias, weakness; referral to M.D. call out; referral to in-house clinics such as asthma clinic, blood pressure clinic; patient education.” NYS DOCCS. (12/28/1995). Nursing Practices. *Health Services Policy Manual*, 1.48.
74. During 2013, Bedford reported 369 sick call appointments each month, Taconic reported 250 sick call appointments each month, and Albion reported 850 sick call appointments each month. During 2013, Bedford reported 147 emergency sick call appointments each month, Taconic reported 260 emergency sick call appointments each month, and Albion reported 80 emergency sick call appointments each month.
75. Of the 369 sick call appointments at Bedford each month in 2013, the prison estimated that 49 were for GYN related issues. Taconic estimated that 14 of its 250 sick call appointments were for GYN issues, and Albion did not track the number of GYN related sick call appointments.
76. Bedford estimated that of 147 emergency sick call appointments per month, about three are GYN-related. Taconic estimated that of 260 emergency sick call appointments, four are for GYN-related issues each month.
77. Nurses at Albion, Bedford and Taconic also have the option of using telemedicine (telemed) videoconferencing equipment to consult with a doctor for emergency care if needed. If telemed is used, the nurse is supposed to record the telemed doctor’s assessment and recommendations in the patient’s chart and give the chart to whichever doctor is on-site at the facility next.
78. Taconic estimated that two to three medical emergencies occur per month when no medical staff are on site. The prison was not able to specify how many instances involved GYN issues on average. If no nurse is on-site at Taconic during a medical emergency and an officer believes the situation is serious enough, the officer can call an ambulance for the woman directly. If a nurse is on site at Taconic during a medical emergency, the nurse decides whether the woman should remain at Taconic, be transferred to Bedford, or be taken to a hospital via ambulance.
79. According to the DOCCS *Health Services Policy Manual*, there are “two levels of appraisal conducted at DOCS

facilities; the initial health appraisal and the periodic health appraisal. The initial health appraisal includes a complete history and physical, laboratory testing and preventive screening for immunization conducted at reception. The periodic health appraisal updates the appraisal assessment and provides scheduled appraisals in accordance with age and gender.” (p.1). NYS DOCCS (2/20/2004). Health Appraisal. *Health Services Policy Manual*, 1.19. (On file at the CA).

“Upon arrival at a DOCS facility, every newly received or transferred inmate will receive a health screening by an RN that includes an inquiry into the inmate’s current and past health/mental health history and immediate referral of any inmate to a health provider if indicated...Inmates will be screened by an RN within 24 hours of arrival.” (p. 1). NYS DOCCS (2/20/2004). Health Screening of Inmates. *Health Services Policy Manual*, 1.44. (On file at the CA).

80. See note 43.
81. See N.Y. Correct. Law § 851(2)(a). See also note 54, *From Protection to Punishment*, pp. 18-21.
82. Office on Women’s Health, U.S. Department of Health and Human Services. (2008). *Frequently Asked Questions: Vaginal Yeast Infections*. Retrieved on July 15, 2014 from womenshealth.gov/publications/our-publications/fact-sheet/vaginal-yeast-infections.pdf
83. See note 3.
84. Limited staffing can pose particular challenges for GYN care as women may have to reschedule appointments if they are menstruating when the GYN is on-site. One contracted DOCCS provider recounted an instance where a woman had to wait three months for a colposcopy in part because she had her period each time the specialist was on-site.
85. DOCCS’ budget for health services has been reduced by 17% over the past three years. In 2012, the CA found that medical vacancy rates across DOCCS were 28% for physicians and 18% for nurses. The CA also found that: “Limitations on staffing resources are correlated with delays in care and can result in degradation in the quality of care provided by overtaxed staff....Expenditures for specialty care contract services have declined by more than 10% in the last three fiscal years.” See note 55, *2013 Comments re: DOH Oversight of HIV/HCV Care in NYS Prisons*, pp. 4-5.
86. Hilden, M., Schei, B., Swahnberg, K., Halmesmaki, E., Langhoff-Roos, J., Offerdal, K., Pikarinen, U., et al. (2004). A History of Sexual Abuse and Health: A Nordic Multicentre Study. *BJOG: An International Journal of Obstetrics and Gynaecology*, 111, 1121-1127.
Leeners, B., Stiller, R., Block, E., Görres, G., Imthurn, B. & Rath, W. (2007). Effect of Childhood Sexual Abuse on Gynecologic Care as an Adult. *Psychosomatics*, 48(5), 385-393.
Plichta, S.B. (2007). Interactions Between Victims of Intimate Partner Violence Against Women and the Health Care System: Policy and Practice Implications. *Trauma, Violence & Abuse*, 8(2), 226-239.
Wood, M. (2003). Victims of sex abuse refusing Pap tests. *The Sun-Herald*, Nov. 16. Retrieved on July 15, 2014 from www.smh.com.au/articles/2003/11/15/1068674436780.html?from=storyrhs&oneclick=true
87. See note 54.
88. Leeners, B., Stiller, R., Block, E., Görres, G., Imthurn, B. & Rath, W. (2007). Effect of Childhood Sexual Abuse on Gynecologic Care as an Adult. *Psychosomatics*, 48(5), 385-393.
89. Bedford reported that they make efforts to have female GYNs see women with known domestic violence histories. Albion reported that, when possible, they try to have female sick call nurses evaluate GYN issues. Although these are steps in the right direction, they do not go far enough to address the problem.
90. “‘Trauma-informed’ services are not specifically designed to treat symptoms or syndromes related to sexual or physical abuse or other trauma, but they are informed about, and sensitive to, trauma-related issues present in survivors. A “trauma-informed” system is one in which all components of a given service system have been reconsidered and evaluated in the light of a basic understanding of the role that violence plays in the lives of people seeking mental health and addictions services (Harris & Falot, 2001). A “trauma informed” system uses that understanding to design service systems that accommodate the vulnerabilities of trauma survivors and allows services to be delivered in a way that will avoid inadvertent retraumatization and will facilitate consumer participation in treatment. It also requires, to the extent possible, closely knit collaborative relationships with other public sector service systems serving these clients and the local network of private practitioners with particular clinical expertise in “traumatology” (Harris & Falot, 2001).” (p. 15). Jennings, A. (2004). *Models for*

Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services. National Technical Assistance Center for State Mental Health Planning, the National Association of State Mental Health Program Directors. Retrieved on July 15, 2014 from www.theannainstitute.org/MDT.pdf

See also Havig, K. (2008). The health care experiences of adult survivors of child sexual abuse: a systematic review of evidence on sensitive practice. *Trauma, Violence and Abuse*, 9(1), 19-33. Leeners, B., Stiller, R., Block, E., Görres, G., Imthurn, B. & Rath, W. (2007). Effect of Childhood Sexual Abuse on Gynecologic Care as an Adult. *Psychosomatics*, 48(5), 385-393.

Plichta, S.B. (2007). Interactions Between Victims of Intimate Partner Violence Against Women and the Health Care System: Policy and Practice Implications. *Trauma, Violence & Abuse*, 8(2), 226-239.

Wood, M. (2003). Victims of sex abuse refusing Pap tests. *The Sun-Herald*, Nov. 16. Retrieved on July 15, 2014 from www.smh.com.au/articles/2003/11/15/1068674436780.html?from=storyrhs&oneclick=true

91. Participants have groups twice per week and individual counseling sessions once per week with the Female Trauma Recovery Program (FTRP) instructor. DOCCS requires women who have substance abuse histories to complete a substance abuse program before joining the FTRP. DOCCS also requires women to have at least six months until their release date to be eligible for the program. For additional information on FTRP See NYS DOCCS. (n.d.). *Female Trauma Recovery (FTR) Program*. Retrieved on July 15, 2014 from www.doccs.ny.gov/ProgramServices/substanceabuse.html#ftr
92. There were 13 women enrolled in the Female Trauma Recovery Program at Taconic as of April 2013 and 15 women enrolled in the program at Albion as of May 2013.
93. Women's comfort levels varied considerably by prison: 72% of women at Beacon, 60% of women at Bedford and 59% of women at Taconic said they felt comfortable speaking with their GYN, while 45% of women at Bayview and 44% of women at Albion said the same.
94. "The ability of health professional to demonstrate warmth and concern for the patient (Falvo et al. 1980), to demonstrate empathy (Luborsky et al. 1985), and to generate a trusting, cooperative environment that provides patients with freedom of choice appear to be important components in the relationships between patient and health professional to facilitate compliance." (p. 15). Falvo, D. (2004). *Effective Patient Education: A Guide to Increased Compliance*. Sudbury, MA: Jones and Bartlett Publishers, Inc.
95. "Your doctor will do a pelvic exam to look for swelling and discharge. Your doctor may also use a swab to take a fluid sample from your vagina. A quick look with a microscope or a lab test will show if yeast is causing the problem." Office on Women's Health, U.S. Department of Health and Human Services. (2008). *Frequently Asked Questions: Vaginal Yeast Infections*. Retrieved on July 15, 2014 from womenshealth.gov/publications/our-publications/fact-sheet/vaginal-yeast-infections.pdf
"Each STI causes different health problems. But overall, untreated STIs can cause cancer, pelvic inflammatory disease, infertility, pregnancy problems, widespread infection to other parts of the body, organ damage, and even death.....Many STIs have only mild or no symptoms at all. When symptoms do develop, they often are mistaken for something else, such as urinary tract infection or yeast infection." Office on Women's Health, U.S. Department of Health and Human Services. (2008). *Sexually transmitted infections (STI) factsheet*. Retrieved on July 15, 2014 from www.womenshealth.gov/publications/our-publications/fact-sheet/sexually-transmitted-infections.html
96. DOCCS does have a limited computerized system that tracks "problem lists," which are lists of the types of illnesses incarcerated patients have. In some prisons, this system is used to coordinate patient appointments, including specialty care appointments. Better use of this computerized system could help improve monitoring of patients and monitoring of trends and systemic problems.
97. Bickely, L.S. & Szilagyi, P.G. (2009). *Bates' Guide to Physical Examination and History Taking*, 10th Ed, Table 2-1. Baltimore, MD: Lippincott, Williams & Wilkins.
98. For example, more than 72% of incarcerated women on the mental health caseload at Bedford Hills (304 women) were taking psychotropic medication as of January 2007. See note 46, *Report on Mental Health Programs and Services at Bedford Hills Correctional Facility*.
99. The Joint Commission on Accreditation of Healthcare Organizations. (2006). Using medication reconciliation to prevent errors. *Sentinel Event Alert*, 35. Retrieved on July 15, 2014 from www.jointcommission.org/assets/1/18/SEA_35.PDF
100. NYS DOCCS. (12/9/1998). Documentation Guide. *Health Services Policy Manual*, 4.04.
NYS DOCCS. (9/17/1991). Progress Notes. *Health Services Policy Manual*, 4.5(14).

NYS DOCCS. (11/1/1993). Correcting Health Record Entries. *Health Services Policy Manual*, 4.06. (All on file at the CA).

101. *Id.*, *Health Services Policy Manual*, 4.04.
102. "Each female inmate 30 years of age or older will be offered a GYN exam and Pap test with HPV screening annually." (p. 4). NYS DOCCS. (2011). *Women's Health Primary Care Practice Guideline*. Albany: NY. (On file at the CA).
103. Committee on Gynecologic Practice, The American College of Obstetricians and Gynecologists. (2012). Well-Woman Visit. *Committee Opinion*, 35. Retrieved on July 15, 2014 from www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Gynecologic_Practice/Well-Woman_Visit
104. "The pelvic exam is a very important part of a woman's periodic gynecological visit — also called a gyn exam. Gynecology is health care for women. A gyn exam checks out a woman's health — especially her sexual and reproductive health." Planned Parenthood. (2014). *Pelvic Exam*. Retrieved on July 15, 2014 from www.plannedparenthood.org/health-topics/womens-health/pelvic-exam-4306.htm
105. See note 102.
106. Current standards for women without histories of HPV, abnormal Paps or cervical cancer state that: (1) women under 21 and over 65 should not have regular Pap tests at all; (2) women in their 20s should have a Pap test every one to three years; and (3) women from 30 to 65 should have both a Pap test and HPV screening but only every five years. The standards also state that women of any age with an abnormal Pap history may need to have additional tests, to be determined by the provider based on the patient's history and situation. See The American College of Obstetricians and Gynecologists. (2012). *Ob-Gyns Recommend Women Wait 3 to 5 Years Between Pap Tests*. Retrieved on July 15, 2014 from www.acog.org/About_ACOG/News_Room/News_Releases/2012/Ob-Gyns_Recommend_Women_Wait_3_to_5_Years_Between_Pap_Tests
107. DOCCS states that at the initial health exam during reception, screening for HPV should be conducted for "all women age 30 and older and on all atypical squamous cells and glandular cell findings (ACS-US, ASC-H, SIL, AGCUS)" (p. 2), and that "Each female inmate 30 years of age and older will be offered a GYN exam and Pap test with HPV screening annually....All with HPV positive for 16/18 strain should be referred for Colposcopy even when the PAP test is normal. Follow up specialty care should otherwise be initiated based on the results of the PAP and HPV test. See attachment 1." See note 102, *Women's Health Primary Care Practice Guideline*, p. 4. The American Society for Colposcopy and Cervical Pathology adopts a different standard because HPV is highly prevalent in women under the age of 30 and, in most cases, resolves without treatment. See Massad, L.S., Einstein, M.H., Warner, K.H., et al., American Society for Colposcopy and Cervical Pathology. (2013). 2012 Updated Consensus Guidelines for the Management of Abnormal Cervical Cancer Screening Tests and Cancer Precursors. *Journal of Lower Genital Tract Disease*, 17(5), S1-S27. Retrieved on July 15, 2014 from www.asccp.org/Portals/9/docs/ASCCP%20Updated%20Guidelines%20%20-%203.21.13.pdf
108. Massad, L.S., Einstein, M.H., Warner, K.H., et al., American Society for Colposcopy and Cervical Pathology. (2013). 2012 Updated Consensus Guidelines for the Management of Abnormal Cervical Cancer Screening Tests and Cancer Precursors. *Journal of Lower Genital Tract Disease*, 17(5), S1-S27. Retrieved on July 15, 2014 from www.asccp.org/Portals/9/docs/ASCCP%20Updated%20Guidelines%20%20-%203.21.13.pdf DOCCS' policy also states that benign cellular changes should get a repeat Pap in either six months or three months, but community standards treat benign cellular changes as negative and reactive cellular changes as negative. See note 102, *Women's Health Primary Care Practice Guideline*, Attachment 1.
109. Incarcerated women have a higher rate of abnormal Pap histories than women in the general U.S. population. Nationwide, 6% of Pap smears completed are abnormal. See Ramaswamy, M., Kelly, P.J., Koblitz, A., Kimminau, K.S. & Engelman, K.K. (2011). Understanding the Role of Violence in Incarcerated Women's Cervical Cancer Screening and History. *Women & Health*, 51(5), 423-441. Springer, S. (2010). Improving Healthcare for Incarcerated Women. *Journal of Women's Health*, 19(1), 13-15. Retrieved on July 15, 2014 from www.ncbi.nlm.nih.gov/pmc/articles/PMC2828190/ In 2007, researchers reviewing the medical charts of 785 women incarcerated in Rhode Island between 1999 and 2004 found that 25 percent of women who received Pap smears had at least one abnormal screening result during their incarceration. See Clarke, J., Phipps, M., Rose, J., Hebert, M., Rosengard, C., Ray, M. & Stein, M. (2007). Follow-Up of Abnormal Pap Smears Among Incarcerated Women. *Journal of Correctional Health Care*, 13(1), 22-26. In 2010, researchers surveyed a random sample of 100 women incarcerated in Rhode Island and found that

40% of participants reported an abnormal Pap history. See Nijhawan, A., Salloway, R., Nunn, A., Poshkus, M. & Clarke, J. (2010). Preventive Healthcare for Underserved Women: Results of a Prison Survey. *Journal of Women's Health, 19*(1), 17-22.

110. Incarcerated women are at higher risk for STDs and cervical abnormalities than women in the general population. See Centers for Disease Control and Prevention (2014). *HIV in Correctional Settings*. Retrieved on July 15, 2014 from www.cdc.gov/hiv/risk/other/correctional.html
Crow, J., Deery, A.R.S., Downey, G.P. & Walker, G.P. (1994). Management of Female Prisoners with Abnormal Cervical Cytology. *British Medical Journal, 308*(6941), 1412-1413. Retrieved on July 15, 2014 from www.ncbi.nlm.nih.gov/pmc/articles/PMC2540339/pdf/bmj00442-0036.pdf
Onorato, M. (2001). HIV Infection Among Incarcerated Women. *HIV & Hepatitis Education Prison Project, 4*(5), 1-4. Retrieved on July 15, 2014 from img.thebody.com/legacyAssets/29/54/may01.pdf
"We reviewed 1024 conventional cervical smears, 73 cervical biopsies and 2 loop electrosurgical excision procedure (LEEP) specimens referred to us from the Correctional Center in Columbus, Ohio during a 12-month period. The results were compared to 40,993 Pap smears from the general population for the same 12-month period.... A significantly higher prevalence of HGSIL cervical cytology and unsatisfactory smears was encountered in female inmates..." (Abstract para. 2 & 4). Proca, D.M., Rofagha, S. & Keyhani-Rofagha, S. (2006). High grade squamous intraepithelial lesion in inmates from Ohio: cervical screening and biopsy follow-up. *Cytojournal, 3*, 15. Retrieved on July 15, 2014 from www.ncbi.nlm.nih.gov/pmc/articles/PMC1475623/pdf/1742-6413-3-15.pdf
111. "The American Cancer Society supports the use of mammograms, complemented by CBE [clinical breast exam] along with finding and reporting changes early, offers women the best opportunity to reduce the breast cancer death rate through early detection. This approach is clearly better than any one exam. Without question, breast physical examination without mammogram would miss the opportunity to detect many breast cancers that are too small for a woman or her clinician to feel, but can be seen on mammograms. While mammograms are the most sensitive screening method, a small percentage of breast cancers do not show up on mammograms, but can be felt by a woman or her clinician." See note 102, *Women's Health Primary Care Practice Guideline*, p. 3.
112. The American College of Obstetricians and Gynecologists (ACOG) recommends annual clinical breast exams (CBE) for women ages 40 and older, and every one to three years for women ages 20-39. See The American College of Obstetricians and Gynecologists. (2011). *Annual Mammograms Now Recommended for Women Beginning at Age 40*. Washington, DC. Retrieved on July 15, 2014 from www.acog.org/About_ACOG/News_Room/News_Releases/2011/Annual_Mammograms_Now_Recommended_for_Women_Beginning_at_Age_40
The Susan G. Komen Breast Cancer Foundation recommends CBE at least every three years among women aged 20 to 39 and annually beginning at age 40. See Susan G. Komen. (2013). *Clinical Breast Exam*. Retrieved on July 15, 2014 from www5.komen.org/BreastCancer/ClinicalBreastExam.html
The American Cancer Society also recommends CBE about every three years for women in their 20s and 30s and every year for women 40 and over. See The American Cancer Society. (2013). *American Cancer Society Guidelines for the Early Detection of Cancer*. Retrieved on July 15, 2014 from www.cancer.org/Healthy/FindCancerEarly/CancerScreeningGuidelines/american-cancer-society-guidelines-for-the-early-detection-of-cancer
"The American Medical Association recommends CBE every 1 to 2 years for women aged 40 to 49 years and annually beginning at 50 years of age." (p. 328). Saslow, D., Hannan, J., Osuch, J., et al. (2004). Clinical Breast Examination: Practical Recommendations for Optimizing Performance and Reporting. *CA: A Cancer Journal for Clinicians, 54*(6), 327-344. Retrieved on July 15, 2014 from www.cdph.ca.gov/programs/cancerdetection/Documents/CBE-PrRe.pdf
113. "...women should be aware of how their breasts normally look and feel and report any new breast changes to a health professional as soon as they are found...It is acceptable for women to choose not to do a BSE [breast self exam] or to do BSE occasionally... Women who choose not to do BSE should still know how their breasts normally look and feel and report any changes to their doctor right away." American Cancer Society. (2013). *Breast Awareness and Self-Exam*. Retrieved on July 15, 2014 from www.cancer.org/cancer/breastcancer/moreinformation/breastcancerearlydetection/breast-cancer-early-detection-acs-recs-bse?docSelected=breast-cancer-early-detection-acs-recs-clinical-breast-exam
See also Mayo Clinic. (2011). *Tests and Procedures: Breast exam*. Retrieved on July 15, 2014 from www.mayoclinic.com/health/breast-exam/MY00743

- MedlinePlus. (2012). *Breast self exam*. U.S. National Library of Medicine, National Institutes of Health. Retrieved on July 15, 2014 from www.nlm.nih.gov/medlineplus/ency/article/001993.htm
- National Cancer Institute. (2014). *Mammograms*. Retrieved on July 15, 2014 from www.cancer.gov/cancertopics/factsheet/Detection/mammograms
114. "Mammography should be performed annually for women of 40 years of age and above. It may be performed at other intervals according to risk factors and at the discretion of the physician." See note 102, *Women's Health Primary Care Practice Guideline*, p. 4
See also note 79, *Health Services Policy Manual*.
 115. The American College of Obstetricians and Gynecologists and the American Cancer Society recommend that women should have yearly mammograms starting at age 40. See American Cancer Society. (2013). *American Cancer Society Guidelines for the Early Detection of Cancer: Breast Cancer*. Retrieved on July 15, 2014 from www.cancer.org/Healthy/FindCancerEarly/CancerScreeningGuidelines/american-cancer-society-guidelines-for-the-early-detection-of-cancer
The American College of Obstetricians and Gynecologists. (2014). *Ob-Gyns Continue to Recommend Annual Mammograms for Women Beginning at Age 40*. Washington, DC. Retrieved on July 15, 2014 from www.acog.org/About_ACOG/News_Room/News_Releases/2014/Ob-Gyns_Continue_to_Recommend_Annual_Mammograms_for_Women_Beginning_at_Age_40
 116. The U.S. Preventive Services Task Force recommends that women have a mammogram every two years after 50. See U.S. Preventive Services Taskforce. (2010). *Screening for Breast Cancer*. Retrieved on July 15, 2014 from www.uspreventiveservicestaskforce.org/uspstf/uspsbrca.htm
 117. "Women with a family history of diagnosed breast cancer in a first-degree relative should have mammography annually at age 35." See note 102, *Women's Health Primary Care Practice Guideline*, p. 4.
 118. Bedford estimated 10% (5 of 52) of mammograms per month return abnormal, Albion estimated 9% (3 of 33) per month return abnormal, Beacon estimated 20% (2 to 3 of 10) per month return abnormal, and Taconic estimated 39% (11 of 28) per month return abnormal.
 119. "Usually it takes one to three weeks to get Pap test results." Office on Women's Health, U.S. Department of Health and Human Services. (2013). *Pap test*. Retrieved on July 15, 2014 from www.womenshealth.gov/publications/our-publications/fact-sheet/pap-test.html
 120. "Some women report having a strong emotional reaction, or feeling down, after a hysterectomy. Most feel better after a few weeks, but some women do feel depressed for a long time. Other women experience a feeling of relief after a hysterectomy. No longer being able to bear children can cause emotional problems for some women. Some women feel changed or feel they have suffered a loss." New York State Department of Health. (2010). *Hysterectomy*. Retrieved on July 15, 2014 from www.health.ny.gov/community/adults/women/hysterectomy/#alterna
 121. "Hysterectomy is done when other treatments have not worked or are not possible or the fibroids are very large." The American College of Obstetricians and Gynecologists. (2011). *Frequently Asked Questions: Uterine Fibroids*. Retrieved on July 15, 2014 from www.acog.org/~media/For%20Patients/faq074.pdf?dmc=1&ts=20130702T1101169283
The American College of Obstetricians and Gynecologists. (2011). *Frequently Asked Questions: Hysterectomy*. Retrieved on July 15, 2014 from www.acog.org/~media/For%20Patients/faq008.pdf?dmc=1&ts=20130702T1051014234
The American College of Obstetricians and Gynecologists. (2012). *Frequently Asked Questions: Abnormal Uterine Bleeding*. Retrieved on July 15, 2014 from www.acog.org/~media/For%20Patients/faq095.pdf?dmc=1&ts=20130702T1116160914
 122. Only some prisons were able to estimate the percentage of women in custody each year with medical symptoms resulting from fibroids: Bedford estimated 2%, Taconic 2% and Beacon 10%. Albion reported the information was "not tracked by facility" and Bayview reported the number was "unknown." The CA does not have sufficient quantitative and qualitative data to analyze thoroughly the quality of care for women in DOCCS dealing with fibroid-related medical problems. Such problems are likely prevalent in DOCCS considering that upwards of 20% of women under age 50 develop fibroids and that 44% of women in New York's prisons are African American – a group three times more likely than other women to have fibroids. See Office on Women's Health, U.S. Department of Health and Human Services. (2008). *Frequently Asked Questions: Uterine Fibroids*.

Retrieved on July 15, 2014 from www.womenshealth.gov/publications/our-publications/fact-sheet/uterine-fibroids.pdf

Office on Women's Health, U.S. Department of Health and Human Services. (2010). Minority Women's Health: Uterine Fibroids. Retrieved on July 15, 2014 from www.womenshealth.gov/minority-health/african-americans/uterine-fibroids.html

123. See note 67, *Health Services Policy Manual*. NYS DOCCS. (6/11/1991). Informed Consent. *Health Services Policy Manual*, 7.07. (On file at the CA).
124. "Most women are asked to make a follow up appointment with the surgeon's office two to six weeks after surgery." Feldman, S. (2014) *Patient information: Care after gynecologic surgery (Beyond the Basics)*. UpToDate. Retrieved on September 23, 2014 from www.uptodate.com/contents/care-after-gynecologic-surgery-beyond-the-basics?view=print
See also Jolicoeur, L., Payette, S. & Sumure, G. (n.d.). Understanding your Abdominal Hysterectomy. *The Society of Gynecologic Oncology of Canada*. Retrieved on July 15, 2014 from www.g-o-c.org/en/patientadvocacy/cancers/abd_hyster.aspx
Midwest Women Obstetrician/Gynecology, Ltd. (n.d.). *Post Operative Instructions for Vaginal Hysterectomy*. Retrieved on July 15, 2014 from www.midwestwomenobgyn.com/08_mw_postopfaq/07_VAGHYST.pdf
125. The number of sanitary napkins DOCCS distributes to women in its custody is not dictated by written policy. DOCCS Directive 4009 includes only a reference to the provision of sanitary supplies, not the amount: "The following shall be provided at time of reception: A. Bar of soap; B. Toothbrush; C. Toothpaste; D. Disposable razor (this item may be made available as needed; to be returned when the shave is completed); E. Drinking cup; F. Roll of toilet paper. [...] G. Comb of non-hazardous design and material; H. Sanitary napkins for female inmates." (p. 2). NYS DOCCS. (7/15/2011). *Directive 4009: Minimum Provisions for Health and Morale*. (On file at the CA).
126. During communication with the CA in summer 2014, DOCCS reported that Taconic's practice on distributing sanitary napkins is as follows: "Medical staff have been giving an incontinence pad (Serenity Pad) to inmates who have come to medical and indicated that they have a need for a heavy menstrual pad. The facility plans to replace the Serenity Pad with a Super Kotex napkin for heavy menstrual flow. Ultimately, the inmate will be given a pack of 20 Super Kotex napkins, in addition to the regular issue of 2 packs of 12 regular napkins (24). On occasion, inmates have complained that they need more sanitary napkins or heavier sanitary napkins, but many do not also want to then be assessed by medical staff for the heavier sanitary napkins, which is a precautionary health care protocol (blood counts, pelvic exams, cancer screenings, etc.), to see if they have a more serious problem that may need medical attention. Lastly, the facility reported that an agreement was reached with the Inmate Liaison Committee whereby extra personal items, including sanitary napkins, were placed in the housing units. The facility also noted that sanitary napkins are placed within inmate program areas and visiting bathrooms. Lastly, the facility explained that they had not received any complaints or grievances on this matter." See note 36, Letter from NYS DOCCS received on September 4, 2014.
127. Centers for Disease Control and Prevention. (2011). Heavy Menstrual Bleeding. Retrieved on July 15, 2014 from www.cdc.gov/ncbddd/blooddisorders/women/menorrhagia.html
128. "...period pain is caused by a temporary reduction in blood flow to or over-distension of hollow organs such as the bowel or uterus, causing local tissue damage and activating pain receptors....The heat doesn't just provide comfort and have a placebo effect....It actually deactivates the pain at a molecular level in much the same way as pharmaceutical painkillers work." BBC World News. (2006). *Heat 'blocks body's pain signals.'* Retrieved on July 15, 2014 from news.bbc.co.uk/2/hi/health/5144864.stm
129. For example, getting enough calcium can help reduce the risk of osteoporosis and reduce *Premenstrual Syndrome* (PMS) symptoms, and getting appropriate nutrition can help reduce abdominal pain in women with endometriosis. See The American College of Obstetricians and Gynecologists. (2011). *Premenstrual Syndrome*. Retrieved on July 15, 2014 from www.acog.org/~media/For%20Patients/faq057.pdf?dmc=1&ts=20121106T2041419387
endometriosis.org (2006). *Endometriosis Plays a Role in Reproductive Health*. Retrieved on July 15, 2014 from endometriosis.org/news/research/nutrition-plays-a-role-in-reproductive-health/
130. Bates, G.W. (n.d.). *Abnormal Body Weight: A Preventable Cause of Infertility*. American Society for Reproductive Medicine. Retrieved on July 15, 2014 from www.asrm.org/uploadedFiles/ASRM_Content/Resources/Patient_Resources/Protect_Your_Fertility/bodyweight_infertility.pdf

- van der Steeg, J.W., Steures, P., Eijkemans, M., et al. (2008). Obesity affects spontaneous pregnancy changes in subfertile, ovulatory women. *Human Reproduction*, 23(2), 324-328. Retrieved on July 15, 2014 from humrep.oxfordjournals.org/content/23/2/324.full
131. “Most of us, at one time or another have used food to numb or deny our feelings, to comfort ourselves, or to put some order in our lives. Who among us hasn’t at one time either binged or felt nauseated when scared, depressed, angry, lonely, or sad? However, when we let food become the major outlet for expressing our feelings, we risk damaging our physical and emotional health. Eating this way is a common strategy for many women to cope with a variety of issues: family problems, stress, anger, verbal, and physical abuse, racism, sexism, homophobia, and general feelings of inadequacy. Though disordered eating is often seen as the main problem, it may be a symptom of these other, deeper emotional issues and deflect attention from them” (p. 38). The Boston Women’s Health Book Collective. (2005). *Our Bodies, Ourselves*. New York, NY: Touchstone.
- “Research suggests that prolonged stress contributes to high blood pressure, promotes the formation of artery-clogging deposits, and causes brain changes that may contribute to anxiety, depression, and addiction. More preliminary research suggests that chronic stress may also contribute to obesity, both through direct mechanisms (causing people to eat more) or indirectly (decreasing sleep and exercise).” Harvard Medical School. (2011). Understanding the stress response. *Harvard Mental Health Letter*, 27(9), 4-5. Retrieved on July 15, 2014 from www.health.harvard.edu/newsletters/Harvard_Mental_Health_Letter/2011/March/understanding-the-stress-response
- See also Fallon, P., Katzman, M.A., & Wooley, C.M. (1994). *Feminist Perspectives on Eating Disorders*. New York, NY: The Guilford Press
- Schulherr, S. (2008). *Eating Disorders for Dummies*. Hoboken, NJ: Wiley Publishing, Inc.
132. NYS DOCCS. (2007). *Nutritional Services Operations Manual*. (On file at the CA).
133. NYS DOCCS. (2003). Cook/chill providing meals to every prison, weighing outside contracts. *DOCS Today*, 12(9), 4. Retrieved on July 15, 2014 from www.doocs.ny.gov/PressRel/DOCSToday/September2003edition.pdf
134. See note 132.
- NYS DOCCS. (1/18/2008, Rev. 10/07/2009). Directive 4202: Religious Programs and Practices. (On file at the CA).
135. NYS DOCCS. (2002). *Medical Nutrition Therapy (MNT) Manual*. (On file at the CA).
136. “A 28-day cycle menu with seasonal changes provides 2900-3500 calories and 96-118 grams of protein daily depending on portion sizes.” *Id.*, p. 8.
137. Chow, E.A., Foster, H., Gonzalez, V., McIver, L. (2012). The Disparate Impact of Diabetes on Racial/Ethnic Minority Populations. *Clinical Diabetes*, 30(3), 130-133. Retrieved on July 15, 2014 from m.clinical.diabetesjournals.org/content/30/3/130/full.pdf
138. NYS DOCCS. (3/9/2009). Vitamins. *Health Services Policy Manual*, 1.02. (On file at the CA).
139. “...multivitamin supplementation of people infected with HIV, particularly pregnant women, is strongly suggested.” (Abstract). Mehta, S. & Fawzi, W. (2007). Effects of vitamins, including vitamin A, on HIV/AIDS patients. *Vitamins & Hormones*, 75, 355-83.
- “Most of the studies we examined do not provide strong evidence for beneficial health-related effects of [multivitamin] supplements taken singly, in pairs, or in combinations of three or more. Within some studies or subgroups of the study populations, there is encouraging evidence of health benefits, such as increased bone mineral density and decreased fractures in postmenopausal women who use calcium and vitamin D supplements. However, several other studies also provide disturbing evidence of risk, such as increased lung cancer risk with β -carotene use among smokers.” NIH State-of-the-Science Conference Statement on Multivitamin/Mineral Supplements and Chronic Disease Prevention (2006). *NIH Consensus State Sci Statements*, May 15-17, 23(2), 1-30. Retrieved on July 15, 2014 from www.ncbi.nlm.nih.gov/pubmed/17332802
140. This may be connected to reductions in DOCCS medication budget over the past few years. “Funding for medical supplies and medications has declined by 6.3% during the past three fiscal years.” See note 55, 2013 *Comments re: DOH Oversight of HIV/HCV Care in NYS Prisons*, p. 5.
141. “...multivitamin supplementation of people infected with HIV, particularly pregnant women, is strongly suggested.” (Abstract). Mehta, S., & Fawzi, W. (2007). Effects of vitamins, including vitamin A, on HIV/AIDS patients. *Vitamins & Hormones*, 75, 355-83.
142. NYS DOCCS. (3/9/2009). Vitamins. *Health Services Policy Manual*, 1.02. (On file at the CA).

143. U.S. Department of Health and Human Services. (2014). *Get Enough Calcium: The Basics*. Healthcare.gov. Retrieved on July 15, 2014 from healthfinder.gov/HealthTopics/Category/nutrition-and-physical-activity/nutrition/get-enough-calcium
144. Some national health organizations recommend that all women take Calcium supplements beginning at age 19. See Institute of Medicine (US) Standing Committee on the Scientific Evaluation of Dietary Reference Intakes. (1997). *Dietary Reference Intakes for Calcium, Phosphorus, Magnesium, Vitamin D, and Fluoride*. Washington, DC: National Academies Press.
Others recommend that women take supplements only if they have particular risk factors, such as decreased bone density, or are unlikely to get enough calcium from their daily diet. The New York State Department of Health recommends that healthy individuals, including pregnant and breastfeeding women, consume the following total daily calcium (from diet and supplements if necessary) to help maintain healthy bones: ages 9-18, 1300mg; ages 19-50, 1000mg; ages 51 and older, 1200mg. The National Institutes of Health and the National Osteoporosis Foundation recommend the same.
See New York State Department of Health. (2003). *Worksheet to Estimate Total Daily Calcium Intake*. Retrieved on July 15, 2014 from www.health.state.ny.us/diseases/conditions/osteoporosis/estimate.htm
National Institutes of Health Office of Dietary Supplements. (2013). *Dietary Supplement Fact Sheet: Calcium*. Retrieved on July 15, 2014 from ods.od.nih.gov/factsheets/calcium/
National Osteoporosis Foundation. (n.d.). *Calcium and Vitamin D: What You Need to Know*. Retrieved on July 15, 2014 from nof.org/articles/10#CALCIUM
145. The recommended calcium intake for women age 19 to 50 is 1,000 milligrams daily, and women age 50 and over need 1,200 milligrams. An 8oz glass of milk and a cup of yogurt each contain only 300 milligrams of calcium. See MedlinePlus. (2013). *Calcium in diet*. U.S. National Library of Medicine, National Institutes of Health. Retrieved on July 15, 2014 from nlm.nih.gov/medlineplus/ency/article/002412.htm
146. Forrest, K.Y. & Stuhldreher, W.L. (2011). Prevalence and correlates of vitamin D deficiency in US adults. *Nutrition Research, 31*(1), 48-54.
Harvard School of Public Health. (n.d.). *Vitamin D and Health*. Retrieved on July 15, 2014 from www.hsph.harvard.edu/nutritionsource/vitamin-d/
147. The DOCCS' Medical Nutrition Therapy Manual includes handouts to educate patients about nine special diets: diabetes mellitus, gastroesophageal reflux disease, gluten-free, high fiber, lactose intolerance, low fat/low cholesterol, low potassium, low sodium, and pregnancy/breastfeeding. See note 135.
148. "Women who can successfully delay a first birth and plan the subsequent timing and spacing of their children are more likely than others to enter or stay in school and to have more opportunities for employment and for full social or political participation in their community; Improved maternal health means...more time for and greater ability of mothers to care for and nurture their children; Fewer STIs means reduced infertility and the stigma associated with it and with HIV/AIDS..." (p. 6). Cohen, S. (2004). The Broad Benefits of Investing in Sexual and Reproductive Health. *The Guttmacher Report on Public Policy 7*(1). Retrieved on July 15, 2014 from www.guttmacher.org/pubs/tgr/07/1/gr070105.html
See also The Guttmacher Institute. (2010). *Facts on Publicly Funded Contraceptive Services in the United States*. Retrieved on July 15, 2014 from www.guttmacher.org/pubs/fb_contraceptive_serv.html
149. DOCCS' written policy mentions the now-closed Planned Parenthood initiative but not the other limited exceptions: "Contraceptive services are available through Planned Parenthood 3 months before an inmate's earliest release date. No treatments for infertility are provided by DOCS". See note 102, *Women's Health Primary Care Practice Guideline*, p. 5.
See note 44, *Directive 4500: Family Reunion Program*.
See Ghany, M.G., Strader, D.B., & Seeff, L.B. (2009). Diagnosis, management, and treatment of hepatitis C: an update. *Hepatology, 49*(4), 1335-74.
Retrieved on July 15, 2014 from onlinelibrary.wiley.com/doi/10.1002/hep.22759/abstract
150. Planned Parenthood. (2014). *Birth Control Pills at a Glance*. Retrieved on July 15, 2014 from www.plannedparenthood.org/health-info/birth-control/birth-control-pill
151. Planned Parenthood. (2014). *Birth Control Shot (Depo-Provera)*. Retrieved on July 15, 2014 from www.plannedparenthood.org/health-topics/birth-control/birth-control-shot-depo-provera-4242.htm
152. Planned Parenthood. (2014). *Birth Control Implant (Implanon and Nexplanon)*. Retrieved on July 15, 2014 from www.plannedparenthood.org/health-topics/birth-control/birth-control-implant-implanon-4243.htm

153. Planned Parenthood. (2014). *Birth Control Vaginal Ring (NuvaRing)*. Retrieved on July 15, 2014 from www.plannedparenthood.org/health-topics/birth-control/birth-control-vaginal-ring-nuvaring-4241.htm
154. Planned Parenthood. (2014). *IUD*. Retrieved on July 15, 2014 from www.plannedparenthood.org/health-topics/birth-control/iud-4245.htm
155. Before 2012, Bedford and Taconic offered a wider range of birth control options and it is unclear why the other methods were discontinued.
156. It is also unfortunate that DOCCS never contracted with Planned Parenthood at Lakeview Shock Incarceration Facility, Willard Drug Treatment Campus and Edgecombe Correctional Facility, all of which also house women. See also Kasdan, D. (2009). Abortion Access for Incarcerated Women: Are Correctional Health Practices in Conflict with Constitutional Standards? *Perspectives on Sexual and Reproductive Health*, 41(1), 59-62. Retrieved on July 15, 2014 from www.guttmacher.org/pubs/psrh/full/4105909.pdf See also Clarke, J.G., Rosengard, C., Rose, J.S., et al. (2006). Improving Birth Control Service Utilization By Offering Services Prerelease Vs Postincarceration. *American Journal of Public Health*, 96(5), 840-845. Retrieved on July 15, 2014 from www.ncbi.nlm.nih.gov/pmc/articles/PMC1470571/pdf/0960840.pdf
157. See note 44.
158. The National Institutes of Health notes that an individual's birth control choice depends on many factors, including the "willingness of a partner to accept and support a given method..." *MedlinePlus*. (2012). Birth control and family planning. U.S. National Library of Medicine, National Institutes of Health. Retrieved on July 15, 2014 from www.nlm.nih.gov/medlineplus/ency/article/001946.htm See also Planned Parenthood. (2014). *Condom*. Retrieved on July 15, 2014 from www.plannedparenthood.org/health-topics/birth-control/condom-10187.htm
159. The American College of Obstetricians and Gynecologists. (2012). *Frequently Asked Questions: Abnormal Uterine Bleeding*. Retrieved on July 15, 2014 from www.acog.org/~media/For%20Patients/faq095.pdf?dmc=1&ts=20130520T0852212720 The American College of Obstetricians and Gynecologists. (2012). *Frequently Asked Questions: Ovarian Cysts*. Retrieved on July 15, 2014 from www.acog.org/~media/For%20Patients/faq075.pdf?dmc=1&ts=20130520T0854081187 The American College of Obstetricians and Gynecologists. (2012). *Frequently Asked Questions: Endometriosis*. Retrieved on July 15, 2014 from www.acog.org/~media/For%20Patients/faq013.pdf?dmc=1&ts=20130520T0850022886
160. Beyaz, commonly referred to as "Yaz," is a type of oral contraceptive. See Bayer Healthcare Pharmaceuticals, Inc. (n.d). *Beyaz: Highlights of Prescribing Information*. Retrieved on July 15, 2014 from labeling.bayerhealthcare.com/html/products/pi/fhc/Beyaz_PI.pdf
161. Reproductive Rights Project, New York Civil Liberties Union. (n.d.). *Access to Reproductive Healthcare in New York State Jails*. New York, NY. Retrieved on July 15, 2014 from www.nyclu.org/files/publications/nyclu_pub_healthcare_jails.pdf
162. New York State Commission of Correction. (3/3/2008). *Reproductive Services for Women in Jail. Chairman's Memorandum, No. 4-2008*. Retrieved on July 15, 2014 from www.scoc.ny.gov/pdfdocs/chair2008_4.pdf
163. *Medication Guide: Coumadin*. (n.d.). Approved by the U.S. Food and Drug Administration. Retrieved on July 15, 2014 from www.fda.gov/downloads/drugs/drugsafety/ucm088578.pdf
164. Planned Parenthood. (2014). *The Morning-After Pill (Emergency Contraception)*. Retrieved on July 15, 2014 from www.plannedparenthood.org/health-topics/emergency-contraception-morning-after-pill-4363.asp
165. *Id.* See also Jacobson, J. (4/5/2013). Court Orders FDA to Make Emergency Contraception Available Over-the-Counter for All Ages. *RH Reality Check*. Retrieved on July 15, 2014 from rhrealitycheck.org/article/2013/04/05/court-orders-fda-to-make-emergency-contraception-available-over-the-counter-for-all-ages/
166. Aids.gov. (2013). *Post-Exposure Prophylaxis*. U.S. Department of Health and Human Services. Retrieved on July 15, 2014 from aids.gov/hiv-aids-basics/prevention/reduce-your-risk/post-exposure-prophylaxis/
167. PEP begins to lose its efficacy if taken more than 72 hours after a person has been exposed. *Id.* Emergency contraception works best if taken immediately and is 89% effective if taken within three days after unprotected sex. See note 164.
168. All people who are raped need access to emotional support, to mechanisms that can hold the person who

committed the rape accountable and prevent it from happening again, and to appropriate medical care. For women who have been raped, appropriate medical care includes specific services to help women prevent unwanted pregnancies including access to abortion and emergency contraception.

See New York State Department of Health. (2004, Rev. 2008). *Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault*. Retrieved on July 15, 2014 from www.health.ny.gov/professionals/protocols_and_guidelines/sexual_assault/docs/adult_protocol.pdf

Safe Horizon. (n.d.). *After Sexual Assault: A Recovery Guide for Survivors*. New York, NY. Retrieved on July 15, 2014 from www.safehorizon.org/images/uploads/misc/1272296041_After_Sexual_Assault_Bklt.pdf

Smith, B.V. (1998). *An End to Silence: Women Prisoners Handbook for Identifying and Addressing Sexual Misconduct*. Washington, D.C.: National Women's Law Center.

169. Data collected by the U.S. Bureau of Justice Statistics as a result of PREA confirms the pervasiveness of the problem. The Bureau found that an estimated 4% of people in prison in 2011-2012 were sexually victimized by either another incarcerated person or prison staff in the past year and that about 10% of formerly incarcerated people in the U.S. say they were sexually victimized at some point during their incarceration. The Bureau also found that the women's jail on Rikers Island (New York City's main jail) was among the facilities with the highest rates of sexual victimization in the country. See Beck, A.J., Berzofsky, M., Caspar, R. & Krebs, C. (2013). See Beck, A.J., Berzofsky, M., Caspar, R. & Krebs, C. (2013). *Sexual Victimization in Prisons and Jails Reported by Inmates, 2011-12*. U.S. Bureau of Justice Statistics. Retrieved on July 15, 2014 from www.bjs.gov/content/pub/pdf/svpjri1112.pdf
- In its 2010 PREA study, the Bureau of Justice Statistics found that Bayview Correctional Facility had the highest rate of reported staff sexual misconduct of all facilities surveyed nationwide. Two New York men's prisons, Elmira and Attica, were also among the 2010 study's worst facilities in this category. See Beck, A.J., Harrison, P.M., Berzofsky, M., Caspar, R. & Krebs, C. (2010). *Sexual Victimization in Prisons and Jails Reported by Inmates, 2008-09*. U.S. Bureau of Justice Statistics. Retrieved on July 15, 2014 from bjs.ojp.usdoj.gov/content/pub/pdf/svpjri0809.pdf
- In 1996, New York's Penal Law was amended to explicitly recognize that incarcerated people do not have the capacity to consent to sexual acts with correctional staff. See N.Y. Penal Law § 130.05(3)(e).
- In 2003, The Legal Aid Society filed a class-action lawsuit against DOCCS on behalf of incarcerated women who had been sexually assaulted by prison staff detailing numerous instances of abuse, ranging from verbal degradation to rape. See The Legal Aid Society. (n.d.). *Amador v. Andrews, 03 Civ. 0650 (KTD) (S.D.N.Y.)*. Retrieved on July 15, 2014 from www.legal-aid.org/en/lawreform/lawreform/prisonersrightsproject/activecases/violenceandpersonalsafety/amadorvandrews.aspx
- See also Albany Times Union. (2013). Raped behind bars, New York prisons have a problem: "A fox guarding the henhouse." *Albany Times Union*, September 9. Retrieved on September 23, 2014 from www.timesunion.com/local/article/Raped-behind-bars-4795883.php#page-1
170. Department of Justice. (n.d.). *National Standards to Prevent, Detect, and Respond to Prison Rape*. Final Rule. 28 CFR Part 115. Billing Code 4410-05; 4410-18. Retrieved on July 15, 2014 from www.ojp.usdoj.gov/programs/pdfs/prea_final_rule.pdf
- See National PREA Resource Center, www.prearesourcecenter.org/about/prison-rape-elimination-act-prea
171. "Educating patients about their condition, treatment, risks, and benefits is an essential part of patient care. It stands to reason that patient education is also a major factor in patient compliance because patients are unable to follow recommendations for which they have no knowledge or understanding." (p. 16). Falvo, D. (2004). *Effective Patient Education: A Guide to Increased Compliance*. Sudbury, MA: Jones and Bartlett Publishers, Inc.
172. Incarcerated men are also disproportionately affected by illness and chronic diseases. See note 55, *Epidemiological Criminology: Theory to Practice*.
173. *Id.*
174. See note 102, *Women's Health Primary Care Practice Guideline*, p. 11.
175. The handouts cover 12 topics: heart disease, osteoporosis, Pap smear tests, premenstrual syndrome, smoking, vaginal infection, fibroids, breast self-exams, breast cancer, menopause, dysmenorrhea (painful periods), and amenorrhea (when women stop menstruating for reasons other than menopause). The guideline states that the supplements on amenorrhea, dysmenorrhea, breast cancer, heart disease, menopause, osteoporosis, Pap tests, and smoking are also available in Spanish. See note 102, *Women's Health Primary Care Practice Guideline*, p. 14.

176. According to DOCCS, 43% of women in custody do not have a high school diploma and 14% read below a 5th grade level. See note 7, *DOCCS Under Custody Report 2013*.
177. In 2008, the most recent year DOCCS made this information public, the Department estimated that 55 of 2,750 women in its custody spoke Spanish only, Spanish and limited English, or Spanish and moderate English. See NYS DOCCS. (2008). *Hub System: Profile of Inmate Population Under Custody on January 1, 2008*. Albany, NY. Retrieved on July 15, 2014 from www.doccs.ny.gov/Research/Reports/2008/Hub_Report_2008.pdf
178. For more information, including where to order *Our Bodies, Ourselves*, See www.ourbodiesourselves.org/publications/our-bodies-ourselves-2011/. See note 131, *Our Bodies, Ourselves*.
179. For example, Bedford Hills did not have “readily available” data on the number of pregnant women in its custody from 2004 to 2008. Taconic did not have data on the number of pregnant women in its custody from 2004 to 2006. Bayview reported faulty data for 2009. Albion reported that it does not track the number of pregnant women housed at the prison before they are transferred to Bedford Hills.
180. An estimated 3% of women in federal prisons and an estimated 5% of women in local jails are pregnant at the time of incarceration. See note 66, *Medical Problems of Prisoners*. Maruschak, L.M. (2006). *Special Report: Medical Problems of Jail Inmates*. Bureau of Justice Statistics, U.S. Department of Justice. Retrieved on July 15, 2014 from www.bjs.gov/content/pub/pdf/mpji.pdf
181. “Routine pregnancy screening (urine or serum) shall be performed on all females during the initial reception physical and upon reentry to confinement (absconder or rescinded work release status). If pregnancy is confirmed, the patient shall be referred to an OB-GYN specialist for initial exam and management of the pregnancy.” See note 102, *Women’s Health Primary Care Practice Guideline*, p. 5. NYS DOCCS. (4/27/11). HIV and the Perinatal Period. *Health Services Policy Manual*, 1.12d, p. 1. (On file at the CA).
182. In response to the CA’s request for the directive regarding transporting pregnant women, DOCCS responded: “Your request is denied pursuant to Public Officers’ Law § 87(3)(f).” Publ. Off. Law § 87(3)(f) allows agencies to deny the public access to records if they believe that disclosing them would “endanger the life or safety of any person.” Letter from NYS DOCCS FOIL Unit (September 23, 2010, Log No. 10-1409) in response to Correctional Association of New York’s FOIL request regarding Directive 4916. (On file at the CA).
183. In part, the dramatic decrease in the number of people on work release is the result of former Governor George Pataki’s Executive Orders prohibiting people convicted of violent offenses from participating in the program. The CA supports an increase in the use of work release, including through bolstering the participation of people currently eligible and re-opening eligibility to people convicted of violent offenses. See Correctional Association of New York. (2012). Testimony of the Correctional Association of New York, New York State Sentencing Commission December 12, 2012. (On file at the CA).
184. See Warth, P. & Rosenthal, A. (n.d.). *How New York Could Save Millions: The Potential Cost Savings and Public Safety Benefits of the Temporary Release Program*. Syracuse, NY: Center for Community Alternatives. Retrieved on July 15, 2014 from www.communityalternatives.org/pdf/TemporaryReleasePolicyPaper.pdf See also Center for Community Alternatives. (2011). Testimony of the Center for Community Alternatives before the Assembly Committee on Correction Regarding Merger of the Department of Correctional Services and the Division of Parole. Syracuse, NY. Retrieved on July 15, 2014 from www.communityalternatives.org/pdf/TestimonyDOCS-DOP-Merger.pdf Transitional work release programs are especially important given the tremendous stigma individuals with felony convictions face as they enter an already difficult job market. In March 2013, the unemployment rate in upstate New York was 8.1%, and in downstate New York it was 7.9%. See New York State Department of Labor. (2014). *State Labor Department Releases Preliminary March 2014 Area Unemployment Rates*. Albany, NY. Retrieved on July 15, 2014 from www.labor.ny.gov/stats/pressreleases/prlaus.shtml
185. “Routine pregnancy screening (urine or serum) shall be performed on all females during the initial reception physical.... Routine pregnancy screening (urine or serum) shall be performed on all females...upon re-entry to confinement (absconder or rescinded work release status).” See note 102, *Women’s Health Primary Care Practice Guideline*, p. 5.
186. While wait times for home pregnancy tests vary, most test directions state that the results will be ready in two to three minutes. According to the U.S. Department of Health and Human Services, “Research suggests that waiting 10 minutes will give the most accurate result [for home pregnancy tests].” Office on Women’s Health,

- U.S. Department of Health and Human Services. (2009). *Frequently Asked Questions: Pregnancy Tests*. Retrieved on July 15, 2014 from www.womenshealth.gov/publications/our-publications/fact-sheet/pregnancy-tests.pdf
187. Bedford Hills and Albion reported that the GYN provides options counseling for pregnant women. Taconic reported that the Facility Health Services Director handles this responsibility. When it was open, Bayview reported that any doctor could speak with pregnant women in general population about their options and was unclear about who maintained responsibility for counseling pregnant women on work release.
 188. American Civil Liberties Union. (n.d.). *State Standards for Pregnancy-Related Healthcare and Abortion for Women in Prison – Map*. Retrieved on July 15, 2014 from www.aclu.org/state-standards-pregnancy-related-health-care-and-abortion-women-prison-map
 Kasdan, D. (2009). Abortion Access for Incarcerated Women: Are Correctional Health Practices in Conflict with Constitutional Standards? *Perspectives on Sexual and Reproductive Health*, 41(1), 59-62. Retrieved on July 15, 2014 from www.guttmacher.org/pubs/psrh/full/4105909.pdf
 Roth, R. (2004). Do Prisoners Have Abortion Rights? *Feminist Studies*, 30(2), 353-381.
 Roth, R. (2010). Obstructing Justice: Prisons as Barriers to Medical Care for Pregnant Women. *UCLA Women's Law Journal*, 18(1), 79-105. Retrieved on July 15, 2014 from escholarship.org/uc/item/31n7q2sx
 See also note 161.
 189. The Guttmacher Institute. (2014). State Policies on Later Abortions. *State Policies in Brief*, May 14. New York, Washington DC. Retrieved on July 15, 2014 from www.guttmacher.org/statecenter/spibs/spib_PLTA.pdf
 190. "An abortifacient act is justifiable when committed upon a female with her consent by a duly licensed physician acting (a) under a reasonable belief that such is necessary to preserve her life, or, (b) within twenty-four weeks from the commencement of her pregnancy. A pregnant female's commission of an abortifacient act upon herself is justifiable when she acts upon the advice of a duly licensed physician (1) that such act is necessary to preserve her life, or, (2) within twenty-four weeks from the commencement of her pregnancy. The submission by a female to an abortifacient act is justifiable when she believes that it is being committed by a duly licensed physician, acting under a reasonable belief that such act is necessary to preserve her life, or, within twenty-four weeks from the commencement of her pregnancy." N.Y. Penal Law § 125.05(3)
 See also The Guttmacher Institute. (2014). An Overview of Abortion Laws. *State Policies in Brief*, May 10. New York, Washington DC. Retrieved on July 15, 2014 from www.guttmacher.org/statecenter/spibs/spib_OAL.pdf
 191. Led by the New York Women's Equality Coalition, advocates in New York are working to bring New York's abortion laws in line with federal law. For more information, see www.nywomensequality.org.
 192. Bedford reported that 30 women had abortions from 2004 to 2013: five in 2004, three in 2005, 2006 and 2007, seven in 2008, three in 2009, one in 2010, three in 2011, two in 2012 and none in 2013 through April. Taconic reported that no women had abortions from 2010 to 2013. Staff could remember only one woman who requested an abortion in the past decade. Bayview reported that three women had abortions from 2004 to 2007, two in 2004 and one in 2006, but did not have data for 2008 and 2009. Beacon reported no pregnancies and therefore no abortions. Albion initially reported that no women had abortions in the past decade but later amended that statement and reported that a "very small number" of women had an abortion during this timeframe. The hospital which provides abortions for Albion estimated serving eight to 10 incarcerated women each year, though they were unsure how many were for women from Albion and how many were for women from the local county jail. They thought most women were from county jail.
 193. Bedford and Taconic reported that they do not have any specific written policies on abortion and Albion reported that their policies were contained in DOCCS *Health Services Policy Manual*, 1.40. This document, however, makes no mention of abortion or any pregnancy-related care. See NYS DOCCS. (1/15/1994). Elective Procedures. *Health Services Policy Manual*, 1.40. (On file at the CA).
 194. See note 188, *State Standards for Pregnancy-Related Healthcare and Abortion for Women in Prison – Map*. Committee on Health Care for Underserved Women, The American College of Obstetricians and Gynecologists. (2012). Reproductive Health Care for Incarcerated Women and Adolescent Females. *Committee Opinion*, 535. Retrieved on July 15, 2014 from www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Health_Care_for_Underserved_Women/Reproductive_Health_Care_for_Incarcerated_Women_and_Adolescent_Females
 195. "Abortion is safe, and serious complications are rare – but the risk to your health increases the longer a pregnancy continues." Planned Parenthood. (2014). *Thinking About Abortion*. Retrieved on July 15, 2014 from

www.plannedparenthood.org/health-topics/pregnancy/abortion-21519.htm

See also Planned Parenthood. (2014). *In-Clinic Abortion Procedures*. Retrieved on July 15, 2014 from www.plannedparenthood.org/health-topics/abortion/in-clinic-abortion-procedures-4359.asp

196. "Every pregnant or suspected case of pregnancy will be seen in the OB/GYN Clinic with four (4) days of arrival at the facility." (p. 2). Bedford Hills Correctional Facility. (7/27/2006). H-HS-73 Pregnancy Management. *Policy and Procedure*. (On file at the CA).
Taconic's policy contains the exact same language quoted above from Bedford's policy about the timeframe within which pregnant women at the facility should be seen "in the OB/GYN clinic." Taconic does not, however, have such a clinic on-site. (p. 1). Taconic Correctional Facility. (9/5/2008). Policy #604 Pregnancy Management. *Policy and Procedure*. (On file at the CA).
197. "I understand that if I withdraw my agreement after (5) business days or decline to participate on the day(s) of the appointment(s), I will be charged with a violation of inmate rule 106.10, "Refusal to Obey a Direct Order" and be subject to disciplinary action." NYS DOCCS Form 3126E3: *Contract for Specialty Care Appointment* (3/2004), NYS DOCCS Directive 4308: *Contracts for Specialty Care Appointments* (6/15/2004). This policy was rescinded on 1/7/2013.
198. See note 13.
199. DOCCS generally requires two officers to go on hospital trips off prison grounds (one or both of whom may be armed) and requires the officers to "post themselves in a position that permits an unobstructed view of the inmate" at all times during the trip. Outside hospital trip security coverage is determined by "the Deputy Superintendent of Security or security equivalent" and can include as little as one unarmed officer and as much as two armed officers. See NYS DOCCS. (6/12/1997, Rev. 9/24/1999). *Directive 4904: Rules and Regulation for the Operation of Outside Hospital Detail*. (On file at the CA).
200. DOCCS policy states, "Whenever two or more officers are assigned to a security detail, no more than one may be of the opposite sex of the inmate. If only one officer is assigned to a security detail, that officer shall be of the same sex of the inmate. If, however, a "roving officer" is assigned to the hospital and is the same sex as the inmate, the sex of the officer assigned individual coverage is immaterial." *Id.*, p. 4.
201. See yourbackline.org
202. See exhaleprovoice.org/after-abortion-support
203. See note 199, *Directive 4904: Rules and Regulations for the Operation of Outside Hospital Detail*, p. 3.
204. Kaelber, L. (2012). *Eugenics: Compulsory Sterilization in 50 American States*. Presentation at the 2012 Social Science Historical Association. Retrieved on July 15, 2014 from www.uvm.edu/~lkaelber/eugenics/
Roberts, D. (1997). *Killing the Black Body: Race, Reproduction and the Meaning of Liberty*. New York, NY: Pantheon Books.
205. The Center for Investigative Reporting broke this story in July 2013 based largely on research gathered by Justice Now, a non-profit advocacy and legal services group in California. See Johnson, C.G. (2013). *Female inmates sterilized in California prisons without approval*. The Center for Investigative Reporting. Retrieved on July 15, 2014 from cironline.org/reports/female-inmates-sterilized-california-prisons-without-approval-4917
Efforts are underway to prevent sterilization abuses from happening again. "California Gov. Jerry Brown signed a new bill Thursday, Sept. 25 banning forced sterilization as a form of birth control in state prisons....The new law will protect women in county jails, state prisons and other detention centers by requiring that inmates first receive extensive counseling from independent physicians in life-threatening situations before they comply to having tubal ligations and hysterectomies, which have been against the law since 1979." Orozco, L. (2014). California Bans Forced Sterilizations in Prisons Following Investigations by CIR. *Golden Gate Express*, Oct. 6. Retrieved on November 18, 2014 from www.goldengatexpress.org/2014/10/06/forced-sterilization-prisons-ban/
See also Justice Now's testimony on sterilization abuses presented to the California legislature in March 2012: Justice Now. (2012). March 15 Hearing on CDCR – Female Offenders, Testimony Submitted by Justice Now, Budget Issues Related to Conditions of Confinement and Illegal Sterilizations. Budget And Fiscal Review Subcommittee No. 5 On Corrections, Public Safety, And The Judiciary. Retrieved on July 15, 2014 from jnow.org/downloads/JusticeNow.3.15.BudgetTestimony.FemaleOff.pdf
206. For example, the New York City Administrative Code requires informed consent 30 days before any sterilization procedure performed in New York City and prohibits obtaining consent from "a female patient during

admission or hospitalization for childbirth or abortion.” New York City Administrative Code §§ 17-403, 17-404, 17-405(1).

Similarly, federal Medicaid regulations state that Medicaid will only reimburse sterilizations if women give informed consent 30 days before the procedure is performed and also prohibits attempts to obtain informed consent from women who are “in labor or childbirth” and who are “seeking to obtain or obtaining an abortion.” Informed consent, 42 CFR § 441.257 (2012)

207. See Roth, R. & Ainsworth, S. L. “If They Hand You a Paper, You Sign It’: A Call to End the Sterilization of Women in Prison,” forthcoming, *Hastings Women’s Law Journal*, vol. 26, issue 1 (Winter 2014).
208. See *Mentally Incompetent or Institutionalized Individuals*, 42 CFR § 441.254 (2012), which states that federal monies are “not available for the sterilization of a mentally incompetent or institutionalized individual.”
209. MedlinePlus. (2013). *Ectopic Pregnancy*. U.S. National Library of Medicine, National Institutes of Health. Retrieved on July 15, 2014 from www.nlm.nih.gov/medlineplus/ency/article/000895.htm
The American College of Obstetricians and Gynecologists. (2013). *Frequently Asked Questions: Early Pregnancy Loss*. Retrieved on July 15, 2014 from www.acog.org/~media/For%20Patients/faq090.pdf?dmc=1&ts=20130805T1543261576
American College of Obstetricians and Gynecologists. (2009). *Management of Stillbirth*. *ACOG Practice Bulletin*, 102. Retrieved on July 15, 2014 from www.starlegacyfoundation.org/files/ACOG%20Management%20of%20Stillbirth%5B1%5D.pdf
210. American College of Obstetricians and Gynecologists. (2011). *Frequently Asked Questions: Ectopic Pregnancy*. Retrieved on July 15, 2014 from www.acog.org/~media/For%20Patients/faq155.pdf?dmc=1&ts=20130426T1151018450
211. Planned Parenthood. (2014). *Miscarriage*. Retrieved on July 15, 2014 from www.plannedparenthood.org/health-topics/pregnancy/miscarriage-19894.htm
Planned Parenthood. (2014). *Ectopic Pregnancy*. Retrieved on July 15, 2014 from www.plannedparenthood.org/health-topics/pregnancy/ectopic-pregnancy-4259.htm
212. *Id.*, *Ectopic Pregnancy*.
March of Dimes. (2009/2010). *Pregnancy Loss: Stillbirth*. Retrieved on July 15, 2014 from www.marchofdimes.com/loss/stillbirth.aspx
213. Mayo Clinic. (2013). *Diseases and Conditions: Miscarriage*. Retrieved on July 15, 2014 from www.mayoclinic.org/diseases-conditions/pregnancy-loss-miscarriage/basics/definition/con-20033827
214. For example, Doreen, whose case study is on p. 157 of this report, did not see Bedford’s OB-GYN until nine days after she arrived at the prison, even though Bedford knew she was pregnant. “Every pregnant or suspected case of pregnancy will be seen in the OB/GYN Clinic with four (4) days of arrival at the facility.” See note 196, Bedford Hills Correctional Facility H-HS-73 Pregnancy Management, p.2.
215. Office on Women’s Health, U.S. Department of Health and Human Services. (2009). *Frequently Asked Questions: Prenatal Care*. Retrieved on July 15, 2014 from www.womenshealth.gov/publications/our-publications/fact-sheet/prenatal-care.pdf
216. “Every pregnant inmate or suspected case of pregnancy will be seen on a regular basis unless advised by a physician to attend clinics more frequently.” See note 196, Bedford Hills Correctional Facility H-HS-73 Pregnancy Management, p.1.
“Every pregnant or suspected case of pregnancy will be seen on a monthly basis unless advised by a physician to attend clinics more frequently.” See note 196, Taconic Correctional Facility. Policy #604 Pregnancy Management, p. 1.
217. Mayo Clinic. (2014). *Pregnancy week by week: Staying Comfortable*. Retrieved on July 15, 2014 from www.mayoclinic.com/health/pregnancy/WL00035/NSECTIONGROUP=2
Office on Women’s Health, U.S. Department of Health and Human Services. (2010). *Pregnancy: Staying healthy and safe*. Retrieved on July 15, 2014 from www.womenshealth.gov/pregnancy/you-are-pregnant/staying-healthy-safe.cfm#f
218. The American College of Obstetricians and Gynecologists. (2013). *Frequently Asked Questions: Ultrasound Exams*. Retrieved on July 15, 2014 from www.acog.org/~media/For%20Patients/faq025.pdf?dmc=1&ts=20140407T1444482103
219. Legal Services for Prisoners with Children & San Francisco State University Department of Health Education.

- (2005). *A Closer Look at the Oral Healthcare Experiences of Pregnant Prisoners at Valley State Prison for Women in California*. San Francisco, CA. Retrieved on July 15, 2014 from www.prisonerswithchildren.org/pubs/oralhealth.pdf
- New York State Department of Health. (2006). *Oral Health Care during Pregnancy and Early Childhood: Practice Guidelines*. Retrieved on July 15, 2014 from www.health.ny.gov/publications/0824.pdf
- Office on Women's Health, U.S. Department of Health and Human Services. (2012). *Oral health fact sheet*. Retrieved on July 15, 2014 from www.womenshealth.gov/publications/our-publications/fact-sheet/oral-health.html#g
220. Legal Services for Prisoners with Children & San Francisco State University Department of Health Education. (2005). *A Closer Look at the Oral Healthcare Experiences of Pregnant Prisoners at Valley State Prison for Women in California*. San Francisco, CA. Retrieved on July 15, 2014 from www.prisonerswithchildren.org/pubs/oralhealth.pdf
221. "Little information is known about the oral health of prisoners. Prisoners are likely to have extensive dental caries and periodontal disease, similar to members of lower socioeconomic groups in the general population. A study of a state prison system found that at every age group prisoners have more missing teeth and a higher percentage of unmet dental needs than U.S. employed adults (Treadwell and Formicola, 2005)." *Id.*, p. 12. The greater dental needs among incarcerated women may be related to the lack of access to quality dental care women had prior to their incarceration and the fact that many women suffered from addiction which can affect oral health. For example, 88% of women in prison have been identified by DOCCS as being in need of substance abuse treatment. See note 52, *Treatment Behind Bars: Substance Abuse Treatment in New York Prisons 2007-2010*. NYS DOCCS. (2007). *Identified Substance Abuse*. Albany, NY. Retrieved on July 15, 2014 from www.doccs.ny.gov/Research/Reports/2008/Identified_Substance_Abusers_2007.pdf
222. Under current law, an incarcerated person can accrue merit time only by obtaining or accomplishing one of the four following objectives: (1) a GED; (2) an alcohol and substance abuse treatment certificate; (3) a vocational trade certificate following at least six months of vocational programming; or (4) at least 400 hours of service as part of a community work crew. N.Y. Correct. Law § 803(1)(d)(iv). These regulations are overly restrictive.
223. "Feeling stressed is common during pregnancy. But too much stress can make you uncomfortable...High levels of stress that continue for a long time may cause health problems like high blood pressure and heart disease. When you're pregnant, this type of stress can increase the chances of having a premature baby or a low birthweight baby." March of Dimes. (2012). *Emotional and life changes: Stress and pregnancy*. Retrieved on July 15, 2014 from www.marchofdimes.com/pregnancy/lifechanges_stress.html
 "... between 14 percent and 23 percent of pregnant women will experience depressive symptoms while pregnant." American College of Obstetricians and Gynecologists & American Psychiatric Association. (2009). *Depression During Pregnancy: Treatment Recommendations*. Washington, DC. Retrieved on July 15, 2014 from www.acog.org/About_ACOG/News_Room/News_Releases/2009/Depression_During_Pregnancy
224. The estimated rate of mental illness among adults in the United States is 20%, according to a nationwide survey conducted by the Substance Abuse and Mental Health Services Administration. See Health Day. (2011). *Mental Illness Hit 1 in 5 U.S. Adults in Past Year*. *U.S. News & World Report*, Nov. 18. Retrieved on July 15, 2014 from health.usnews.com/health-news/family-health/brain-and-behavior/articles/2010/11/18/mental-illness-hit-1-in-5--us-adults-in-past-year
 In 2013, DOCCS classified 39% of incarcerated women as having a mental health diagnosis, compared with 14% of incarcerated men. See note 7, *DOCCS Under Custody Report 2013*.
 The Bureau of Justice Statistics found that "An estimated 73% of females in State prisons, compared to 55% of male inmates, had a mental health problem." (p. 4). James, D.J. & Glaze, L.E. (2006). *Mental Health Problems of Prison and Jail Inmates*. *Bureau of Justice Statistics Special Report*. U.S. Department of Justice. Retrieved on July 15, 2014 from www.bjs.gov/content/pub/pdf/mhppji.pdf
 "...pregnancy can affect a woman's mental health...Depression is a common problem during and after pregnancy." Office on Women's Health, U.S. Department of Health and Human Services (2010). *Trying to conceive, pregnancy, and mental health*. Retrieved on July 15, 2014 from www.womenshealth.gov/mental-health/pregnancy-conceive/
225. Regulation 4-4139, "Showers," states: "Inmates have access to operable showers with temperature-controlled hot and cold running water, at a minimum ratio of one shower for every eight inmates..." (p. 39); Regulation 4-4153, "Heating and Cooling," states: "Temperatures in indoor living and work areas are appropriate

to the summer and winter comfort zones.” (p. 42); Regulation 4-4332 under “Section D: Sanitation and Hygiene” states: “The institution provides for the control of vermin and pests.” (p. 93). American Correctional Association. (2003). *Standards for Adult Correctional Institutions*, 4th Edition. Alexandria, VA.

226. “If a woman has an LCMV infection [which can be carried by mice] while pregnant the unborn baby can also become infected. LCMV infection can cause severe birth defects or loss of the pregnancy (miscarriage).” Centers for Disease Control and Prevention. (2010). *Lymphocytic Choriomeningitis Virus (LCMV) and Pregnancy*. Retrieved on July 15, 2014 from www.cdc.gov/pregnancy/infections-lcmv.html
227. American College of Obstetricians and Gynecologists. (2011). Frequently Asked Questions: Easing Back Pain During Pregnancy. Retrieved on July 15, 2014 from www.acog.org/~media/For%20Patients/faq115.pdf?dmc=1&ts=20140520T1819526939
American Pregnancy Association. (2007). *Sleeping Positions During Pregnancy*. Retrieved on July 15, 2014 from www.americanpregnancy.org/pregnancyhealth/sleepingpositions.html
228. Correctional Association of New York. (2007). *Report on Conditions of Confinement at Bedford Hills Correctional Facility*. New York, NY. Retrieved on July 15, 2014 from www.correctionalassociation.org/wp-content/uploads/2012/05/bedford_2007.pdf
The incarcerated woman who was punched and another woman involved in the incident sued the officer and were awarded minimal monetary damages in 2011 (\$8,000 and \$5,000 respectively) as part of a settlement agreement where the officer did not have to admit any wrong doing.
229. See *Time Warner Cable News Rochester*. (2014). Albion Corrections Officer Charged with Rape. *Time Warner Cable News Rochester*, June 21. Retrieved on September 23, 2014 from rochester.twcnews.com/content/news/746878/albion-corrections-officer-charged-with-rape/
Lohud The Journal News. (2014). Bedford Hills Guard Accused of Inmate Rape. *Lohud The Journal News*, July 8. Retrieved on September 23, 2014 from www.lohud.com/story/news/crime/2014/07/08/rape/12364339/
Bedford-Katonah Patch. (2014). Another Corrections Officer Arrested for Sexual Assault of Bedford Hills Correctional Facility Inmate. *Bedford-Katonah Patch*, July 19. Retrieved on September 23, 2014 from patch.com/new-york/bedford/another-corrections-officer-arrested-for-sexual-assault-of-bedford-hills-correctional-facility-inmate#.VCGD9CfjaEN
Albany Times Union. (2013). Raped behind bars, New York prisons have a problem: “A fox guarding the henhouse.” *Albany Times Union*, September 9. Retrieved on September 23, 2014 from www.timesunion.com/local/article/Raped-behind-bars-4795883.php#page-1
230. NYS DOCCS. (12/13/2011). *Directive 4910: Control and Search for Contraband*, p. 2 and p. 4. (On file at the CA).
231. *Id.*, p. 2.
232. DOCCS does have some restrictions on pat frisks as a result of *Hamilton v. Goord*, a class-action lawsuit brought in 1997 on behalf of incarcerated women in DOCCS’ custody alleging that cross-gender pat frisks violated their constitutional rights. The settlement agreement that resulted from *Hamilton* lasted for two years, and, after the court terminated the agreement, DOCCS agreed voluntarily to maintain the protocols the agreement established. These protocols require female correction officers perform pat frisks on women “whenever possible” and prohibit non-emergency pat frisks by a male officer if the woman objects and a female officer is available to perform the pat frisk, or when the woman has a special card – called a “Cross Gender Pat Frisk Exemption” – issued by DOCCS confirming that New York State Office of Mental Health staff working in DOCCS have diagnosed her with Axis 1 Post-Traumatic Stress Disorder (PTSD). The protocols do not prohibit male officers from performing pat frisks if there is an emergency, a female officer is not available, or the male officer is “directed or authorized” by his supervisors to do so. The protocols also state that male officers conducting pat frisks on women must use the back of their hands instead of their palms when patting down a woman’s breasts and must “use care” to not pat the woman’s “nipples” or her “genital area.” Male officers are also required to “make a reasonable effort to conduct the pat frisk in a location where there is regular access and traffic by inmates, staff, or both, rather than in a more remote or less traveled area of the facility.” *Hamilton v. Goord*, 97-CV-1363 (RO), Stipulation and Order Regarding Notice to the Class Pursuant to F.R.C.P. 23(e) (S.D.N.Y. June 2004).
233. See note 230, *Directive 4910: Control and Search for Contraband*.
234. “Various factors contribute to foot and ankle swelling during pregnancy. For starters, your body produces and retains more fluid during pregnancy. Also, your growing uterus puts pressure on your veins, which impairs

return of blood to your heart. In turn, this can lead to swelling in the legs, ankles and feet. Hormonal changes might play a role as well. Foot and ankle swelling during pregnancy is common and usually goes away after delivery.” (para. 1-2). Harms, R.W. (2011). *What causes ankle swelling during pregnancy – and what can I do about it?* Mayo Clinic. Retrieved on July 15, 2014 on www.mayoclinic.org/healthy-living/pregnancy-week-by-week/expert-answers/swelling-during-pregnancy/faq-20058467

235. American College of Obstetricians and Gynecologists. (2013). *Frequently Asked Questions: Nutrition During Pregnancy*. Retrieved on July 15, 2014 from www.acog.org/~media/For%20Patients/faq001.pdf?dmc=1&ts=20140520T1836120073
- Office on Women’s Health, U.S. Department of Health and Human Services. (2010). *Pregnancy: Staying healthy and safe*. Retrieved on July 15, 2014 from www.womenshealth.gov/pregnancy/you-are-pregnant/staying-healthy-safe.cfm#f
- U.S. Department of Agriculture. (n.d.). *Health and Nutrition Information for Pregnant and Breastfeeding Women: Nutritional Needs During Pregnancy*. Retrieved on July 15, 2014 from www.choosemyplate.gov/pregnancy-breastfeeding/pregnancy-nutritional-needs.html
236. “Listeriosis can be passed to an unborn baby through the placenta even if the mother is not showing signs of illness. This can lead to: Premature delivery, Miscarriage, Stillbirth, Serious health problems for the newborn... USDA’s Food Safety and Inspection Service (FSIS) and the U.S. Food and Drug Administration (FDA) provide the following advice for pregnant women: Do not eat hot dogs, luncheon meats, or deli meats unless they are reheated until steaming hot.” Centers for Disease Control and Prevention. (2011). *Listeriosis (Listeria) and Pregnancy*. Retrieved on July 15, 2014 from www.cdc.gov/pregnancy/infections-listeria.html
237. NYS DOCCS. (09/18/2000). Lower Bunk Placement. *Health Services Policy Manual*, 1.49. (On file at the CA).
238. “Women who received continuous labour support were more likely to give birth ‘spontaneously’, i.e. give birth with neither caesarean nor vacuum nor forceps. In addition, women were less likely to use pain medications, were more likely to be satisfied, and had slightly shorter labours. Their babies were less likely to have low 5-minute Apgar Scores. No adverse effects were identified. We conclude that all women should have continuous support during labour.” Hodnet, E.D., Gates, S., Hofmeyr, G.J., Sakala, C. & Weston, J. (2013). Continuous Support for Women during Childbirth. *Cochrane Database of Systematic Reviews*, 2. See also Campbell, D.A., Lake, M.F., Falk, M. & Backstrand, J.R. (2006). A Randomized Control Trial of Continuous Support in Labor by a Lay Doula. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 35(4), 456-464; Rice Simpson, K. & Creehan, P. (2007). *Perinatal Nursing*, 3rd Ed. Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN).
- For particular importance of support during birth from trauma survivors, See Heimstad, R., Dahloe, R., Laache, I., Skogvoll, E. & Schei, B. (2006). Fear of childbirth and history of abuse: implications for pregnancy and delivery. *Acta Obstetrica et Gynecologica Scandinavica*, 85(4), 435-40.
- Rhodes, N. & Hutchinson, S. (1994). Labor Experiences of Childhood Sexual Abuse Survivors. *Birth*, 21(4), 213-220.
- Weinstein, A. (2004). The Impact of Childhood Sexual Abuse on Pregnancy, Labor and Birth. *Birth Psychology*, 18(4), 313-26.
239. DOCCS permits family members listed “on the inmate’s contact sheet” to visit after birth during hospital visiting hours. Other individuals are permitted to visit at the discretion of DOCCS officials. NYS DOCCS. (10/10/1991, Rev. 11/11/1993). *Directive 4403: Inmate Visitor Program*. (On file at the CA).
- “The inmate may receive visitors only with the permission of and in accordance with the instructions of the doctor and the rules of the hospital. They will be permitted only during regular hospital visiting hours and will not exceed two hours unless the inmate is on the critical list. For purposes of this Directive, an inmate may be visited only by his or her spouse, mother, father, grandparents, aunts, uncles, brothers, sisters, sons, daughters and legal guardians. Visits by other than those listed must be approved by the Superintendent, Deputy Superintendent for Security Services, or equivalent, or by the Facility Officer of the Day.” See note 199, *Directive 4904: Rules and Regulations for the Operation of Outside Hospital Detail*, p.5.
240. Centers for Disease Control and Prevention. (2014). *Births – Method of Delivery*. Retrieved on July 15, 2014 from www.cdc.gov/nchs/fastats/delivery.htm
- CesareanRates.com. (n.d.). *New York Cesarean Rates 2011*. Retrieved on July 15, 2014 from www.cesareanrates.com/new-york-cesarean-rates/
- C-section rates in the US have increased dramatically over the past 20 years. “The cesarean rate rose by 53% from 1996 to 2007, reaching 32%, the highest rate ever reported in the United States. From 1996 to 2007, the

cesarean rate increased for mothers in all age and racial and Hispanic origin groups. The pace of the increase accelerated from 2000 to 2007. [...] In 2007, cesarean delivery rates were slightly higher for non-Hispanic black women compared with non-Hispanic white women (34% and 32%, respectively). American Indian or Alaska Native women had the lowest cesarean delivery rate (28%).” Menacker, F. & Hamilton, B.E. (2010). Recent Trends in Cesarean Delivery in the United States. *NCHS Data Brief*, 35. U.S. Department of Health and Human Services. Retrieved on July 15, 2014 from www.cdc.gov/nchs/data/databriefs/db35.htm#citation

241. Mayo Clinic. (2012). *C-section: Why it's done*. Retrieved on July 15, 2014 from www.mayoclinic.com/health/c-section/MY00214/DSECTION=why-its-done
242. A doula is a person trained to help support women during childbirth and sometimes after childbirth as well. See, for example, nycdoulacollective.com/.
243. If there are no complications, women accepted to Bedford's nursery go from the hospital directly to the nursery unit. Women not accepted to the nursery return to general population. All but one pregnancy survey respondent reported being placed either in the nursery or the infirmary after returning from the hospital.
244. La Leche League International. (2009). Good for Moms, Too. *New Beginnings*, 26(2), 46. Retrieved on July 15, 2014 from www.llli.org/nb/nbmarapr09p46.html
La Leche League International. (2004). *The Womanly Art of Breastfeeding*, 7th Revised Edition. New York, NY: Penguin Group.
Myer, S. (2006). What Makes Human Milk Special? *New Beginnings*, 23(2), 82-83. Retrieved on July 15, 2014 from www.llli.org/nb/nbmarapr06p82.html
Wall, G. (2013). *Outcomes of Breastfeeding*. Evergreen Perinatal Education. Retrieved on July 15, 2014 from www.llli.org/docs/cbi/outcomes_of_breastfeeding_jan_2013.pdf
245. American College of Obstetricians and Gynecologists. (2013). *Frequently Asked Questions: Breastfeeding Your Baby*. Retrieved on July 15, 2014 from www.acog.org/publications/faq/faq029.cfm#1
Office on Women's Health, U.S. Department of Health and Human Services. (2011). *Breastfeeding: Why breastfeeding is important*. Retrieved on July 15, 2014 from www.womenshealth.gov/breastfeeding/why-breastfeeding-is-important/
246. N.Y. Pub. Health § 2505-a
New York State Department of Health. (n.d.). *Breastfeeding Mothers' Bill of Rights*. Retrieved on July 15, 2014 from www.health.ny.gov/publications/2028.pdf
247. Mayo Clinic. (2012). *Postpartum care: What to expect after a vaginal delivery*. Retrieved on July 15, 2014 from www.mayoclinic.org/healthy-living/labor-and-delivery/in-depth/postpartum-care/art-20047233
248. *Id.* See also Blenning, C.E. & Paladine, H. (2005). An Approach to the Postpartum Office Visit. *American Family Physician*, 72(12), 2491-2496. Retrieved on July 15, 2014 from www.aafp.org/afp/2005/1215/p2491.html
Centers for Disease Control and Prevention. (2007). Postpartum Care Visits. *Weekly*, 56(50), 1312-1316. Retrieved on July 15, 2014 from www.cdc.gov/mmwr/preview/mmwrhtml/mm5650a2.htm
249. Neither Bedford's nor Taconic's written policies specify that postpartum appointments for women who have C-sections should be two weeks. Taconic's policy states that women should see a "primary care physician" one to two days after their return to Taconic and should have an appointment after six weeks with a "GYN Physician" on-site "at Taconic." There is no on-site GYN at the prison. See note 196, Taconic Correctional Facility. Policy #604 Pregnancy Management, p. 2 and p. 4.
Bedford's policy states that women should see the OB-GYN "at the next available appointment" after they return from giving birth and then again within four to six weeks from delivery for "discharge from care." See note 196, Bedford Hills Correctional Facility H-HS-73 Pregnancy Management, p.3.
250. See note 247. These appointments are particularly important given that not all women in DOCCS custody are informed about warning signs to watch for after giving birth, such as fever, pain, heavy bleeding or blood clots: about one-third of all pregnancy survey respondents (35%, 8 of 21) said that hospital staff did not speak with them about these issues during their hospital stay.
251. The American College of Obstetricians and Gynecologists. (2011). *Frequently Asked Questions: Cesarean Birth*. Retrieved on July 15, 2014 from www.acog.org/~media/For%20Patients/faq006.pdf?dmc=1&ts=20130222T1954333525

252. See note 62. See also Women's Prison Association. (2009). *Mothers, Infants and Imprisonment: A National Look at Prison Nurseries and Community-Based Alternatives*. New York, NY. Retrieved on July 15, 2014 from www.wpaonline.org/wpaassets/Mothers_Infants_and_Imprisonment_2009.pdf
253. "In all situations continuous contact with the mother, who has been established as the primary caregiver and secure base during infancy, is supportive of continued attachment security. Separations threaten the evolving neurobiological attachment system....The overwhelming conclusion of existing research in psychology, psychiatry, and child development is that abrupt separation from a primary caregiver before 18 months of age has lifelong effects on a person's ability to establish healthy relationships and interact in a positive way with the world...Children who are separated from their primary caregivers during this period learn that they cannot depend on others to care for them and that the world is an unpredictable and frightening place... Neurochemical studies show that disruptions to the attachment process affect the growth and development of the brain, as well as social functioning, aggressiveness, reaction to stress, and risk for substance abuse during adulthood....Separation traumatizes mothers, too." (p. 2, p. 4 and p. 11). Byrne, M.W., Goshin, L. & Blanchard-Lewis, B. (2012). Maternal Separations During the Reentry Years for 100 Infants Raised in a Prison Nursery. *Family Court Review*, 50(1), 77-90. Retrieved on July 15, 2014 from www.ncbi.nlm.nih.gov/pmc/articles/PMC3275801/pdf/nihms341102.pdf
See also Yager, S. (2011). Prison Bonds: Nursery programs foster mother-child relationships behind bars. *Broad Recognition*, January 3. Retrieved on July 15, 2014 from broadrecognition.com/politics/prison-bonds-nursery-programs-foster-mother-child-relationships-behind-bars/
254. See note 252, *Mothers, Infants and Imprisonment*.
255. Staley, E.M. (2002). *Profile and Three Year Follow-up of Bedford Hills and Taconic Nursery Program Participants: 1997 and 1998*. Albany, NY: NYS DOCCS.
256. "We found eight states that have a women's prison that runs a nursery program for incarcerated mothers.... Illinois (Decatur Correctional Facility)... Indiana (Indiana Women's Prison)...Nebraska (Nebraska Correctional Center for Women)... New York (Bedford Hills Correctional Facility)... Ohio (Ohio Reformatory for Women)... South Dakota (South Dakota Women's Prison)... Washington (Washington Corrections Center for Women)... West Virginia (Lakin Correctional Center)... Sources: National Directory of Programs for Women with Criminal Justice Involvement, survey issued by Department of Correction, prison officials and websites." DeBoer, H. (2012). *Prison Nursery Programs in Other States*. Connecticut General Assembly, Office of Legislative Research. Retrieved on September 24, 2014 from www.cga.ct.gov/2012/rpt/2012-R-0157.htm
See also note 253, Maternal Separations During the Reentry Years for 100 Infants Raised in a Prison Nursery. "WPA interviewed officials at existing or soon-to-open prison nursery programs in nine states: California, Illinois, Indiana, Ohio, Nebraska, New York, South Dakota, Washington, and West Virginia." See note 252, *Mothers, Infants and Imprisonment*, p. 5.
257. When Taconic's nursery closed, women in the program were transferred to the nursery at Bedford Hills.
258. N.Y. Correct. Law § 611(2) ("A child so born may be returned with its mother to the correctional institution in which the mother is confined unless the chief medical officer of the correctional institution shall certify that the mother is physically unfit to care for the child, in which case the statement of the said medical officer shall be final. A child may remain in the correctional institution with its mother for such period as seems desirable for the welfare of such child, but not after it is one year of age, provided, however, if the mother is in a state reformatory and is to be paroled shortly after the child becomes one year of age, such child may remain at the state reformatory until its mother is paroled, but in no case after the child is eighteen months old.")
N.Y. Correct. Law § 611(3) ("If any woman, committed to any such correctional institution at the time of such commitment is the mother of a nursing child in her care under one year of age, such child may accompany her to such institution if she is physically fit to have the care of such child, subject to the provisions of subdivision two of this section.")
259. See Neppl, K.T., Conger, R.D., Scaramella, L.V. & Ontai, L.L. (2009). Intergenerational Continuity in Parenting Behavior: Mediating Pathways and Child Effects. *Developmental Psychology*, 45(5), 1241-1256. Retrieved on July 15, 2014 from www.ncbi.nlm.nih.gov/pmc/articles/PMC2748920/
260. "Results of the first longitudinal study of children who resided in a U.S. prison nursery provide evidence of positive infant, toddler, and post-release preschool outcomes. Children in this group had higher-than-expected rates of secure attachment during infancy and toddlerhood (Byrne, Goshin, & Joestl, 2010). For children in the prison nursery who reached their first birthday (the earliest age at which attachment can be reliably

determined), attachment was measured under laboratory conditions inside the prison using the validated and well-established Strange Situation Procedure (SSP; Ainsworth, Blehar, Waters & Wall, 1978). Seventy-five percent of these children were classified secure by blinded certified SSP coders.” See note 253, *Maternal Separations During the Reentry Years for 100 Infants Raised in a Prison Nursery*, p. 3.

261. “Healthy attachment to the mother built by repetitive bonding experiences during infancy provides the solid foundation for future healthy relationships. In contrast, problems with bonding and attachment can lead to a fragile biological and emotional foundation for future relationships.” (p. 3). Perry, B.D. (2001). *Bonding and Attachment in Maltreated Children: Consequences of Emotional Neglect in Childhood*. Retrieved on July 15, 2014 from www.cpri.ca/uploads/section000181/files/bonding%20and%20attachment%20in%20maltreated%20children.pdf
- “It is known that attachment security is associated with both short and long-term optimal child development...A rigorous follow-up study of behavioral development for infants enrolled in the nursery study was done during their preschool years. During the preschool period, children in this cohort had lower anxious/depressed behavior problem scores than children from a large national dataset who had been separated from their mother during infancy or toddlerhood because of incarceration...This result remained even after controlling for risks in the child’s environment, such as parenting stress and caregiver substance use.” See note 253, *Maternal Separations During the Reentry Years for 100 Infants Raised in a Prison Nursery*, p. 4.
262. *Id.*
263. DOCCS found that the recidivism rate was 13% for women who had lived on the nursery compared to 26% for women in the general population within the first three years after release. See note 255.
- An evaluation of an in-prison nursery program in Nebraska, which is modeled after the nursery at Bedford Hills, found that among women who had given birth while incarcerated, women in the nursery program had a much lower recidivism rate (measured as being convicted of another crime within three years of release) than women who were separated from their children. The Nebraska evaluation also suggested that prison nursery programs were less expensive than the national average cost of foster care services. In addition, women in the Nebraska program had fewer misconduct reports. See Carlson, J.R. (2001). *Prison Nursery 2000: A Five-Year Review of the Prison Nursery at the Nebraska Correctional Center for Women. Journal of Offender Rehabilitation, 33*(3), 75-97.
264. For example, Dr. Mary Byrne found in her study of 97 women at the Bedford and Taconic nurseries that “Almost 60% of children returned to the free community with their mother and the majority of these remained with her at the end of the third reentry year.” See note 253, *Maternal Separations During the Reentry Years for 100 Infants Raised in a Prison Nursery*, p. 7.
- See also note 253 and note 261.
265. See note 16.
266. The nursery at Rikers Island opened in 1985. While it has the capacity to hold 14 mothers and 15 babies, it has housed only about one to three mothers over the past few years. Similar to Bedford Hills, Rikers Island has a track record of denying women admission to the nursery if they have a child welfare history and if they have been convicted of, or even have pending charges involving, violent crimes. In a recent case, a woman sued the New York City Department of Correction for being denied entry to the nursery. The court found that the Department of Correction’s denial, based solely on the woman’s criminal charge and infractions, was “arbitrary, capricious and an abuse of discretion,” and not in line with the statute’s criteria (the best interests of the child) for determining whether a child should stay with her mother in the nursery. *Duarte v. New York City Dep’t of Corr.*, No. 7627/11, 2011 WL 1827896, slip op. 31223(U) (N.Y. Sup. Ct. Apr. 20, 2011). The trial court’s determination was upheld by the Appellate Division, Second Department, 936 N.Y.S.2d 671 (N.Y. App. Div. 2012), and the city’s appeal of the Appellate Division’s decision was dismissed as moot, 20 N.Y.3d 1067 (2013).
- As a result of the litigation, the New York City Department of Correction altered its administrative guidelines, removing singular automatic disqualifiers from participation in the nursery program. (Morales, V., Email Communication, 6/27/2014).
- That fewer women from New York City are being sent to prison is reflected in the nursery data. In 1997 and 1998, more than three-quarters (77%) of women in the nursery were from the New York City area. See note 255. By 2013, Bedford Hills reported that the figure had dropped to an estimated 25%.
267. The nursery manual includes an outline of how Bedford assesses women for the program, including a review of the applicant’s medical and mental health status, criminal record, sentence length, prison behavior record, prior child welfare involvement, and her relationships with her other children.

268. See note 258. See *Apgar v. Beuter*, 75 Misc. 2d 439, 441 (N.Y. Sup. Ct. 1973)
269. See *Bailey v. Lombard*, 101 Misc. 2d 56, 61 (N.Y. Sup. Ct. 1979)
270. See *Duarte*, Index No. 7627/11, 2011 WL 1827896, slip op. 31223(U) (N.Y. Sup. Ct. Apr. 20, 2011) *aff'd* 936 N.Y.S.2d 671 (N.Y. App. Div. 2012) (exclusion based solely on detainee's attempted murder charge and history of infractions is arbitrary and capricious); *Green v. New York State Dep't of Corr. and Cmty. Supervision*, Index No. 5228/2012 (N.Y. Sup. Ct. Dec. 21, 2012) (granting temporary restraining order where sole basis for nursery exclusion was conviction of violent offense); *Losurdo v. New York State Dep't of Corr. and Cmty. Supervision*, Index No. 14/2845 (N.Y. Sup. Ct. Aug. 1, 2014) (granting temporary restraining order where basis for nursery exclusion was child welfare history).
271. For example, in *Green*, the Honorable Susan Cacace granted a temporary restraining order prohibiting DOCCS from excluding Ms. Green from the Bedford Hills nursery or otherwise depriving her access to her baby. Index No. 5228/2012 (N.Y. Sup. Ct. Dec. 21, 2012). The case settled with Ms. Green being allowed into the nursery program. In *Woodside v. New York State Dep't of Corr. and Cmty. Supervision*, Index No. 2013-02408 (N.Y. App. Div. March 21, 2013), the Appellate Division, Second Department, reversed the denial of a temporary restraining order and granted Ms. Woodside access to the Bedford Hills nursery pending determination of her Article 78 proceeding. The case settled with Ms. Woodside being allowed into the nursery program. In *Losurdo*, the Honorable Barabara Zambelli granted a temporary restraining order staying DOCCS' denial of Ms. Losurdo's nursery application. Index No. 14/2845 (N.Y. Sup. Ct. Aug. 1, 2014). A ruling on the merits is pending.
272. See note 255.
273. "[The officer in charge of such institution] shall make provision for a child removed from the institution without its mother or a child born to a woman inmate who is not returned to the institution with its mother as hereinafter provided. He may, upon proof being furnished by the father or other relatives of their ability to properly care for and maintain such child, give the child into the care and custody of such father or other relatives, who shall thereafter maintain the same at their own expense. If it shall appear that such father or other relatives are unable to properly care for and maintain such child, such officer shall place the child in the care of the commissioner of public welfare or other officer or board exercising in relation to children the power of a commissioner of public welfare of the county from which such inmate was committed as a charge upon such county. ...Such commissioner of public welfare or other officer or board shall care for or place out such child as provided by law in the case of a child becoming dependent upon the county." N.Y. Correct. Law § 611
274. "(E) in the case of a child who has been in foster care under the responsibility of the State for 15 of the most recent 22 months, or, if a court of competent jurisdiction has determined a child to be an abandoned infant (as defined under State law) or has made a determination that the parent has committed murder of another child of the parent, committed voluntary manslaughter of another child of the parent, aided or abetted, attempted, conspired, or solicited to commit such a murder or such a voluntary manslaughter, or committed a felony assault that has resulted in serious bodily injury to the child or to another child of the parent, the State shall file a petition to terminate the parental rights of the child's parents." Adoption and Safe Families Act of 1997, Pub. L. No. 105-89, § 103(a)(3)(E), 111 Stat 2115 (1997).
See also note 4, *When "Free" Means Losing Your Mother* and *The Impact of the Adoption and Safe Families Act on Children of Incarcerated Parents*.
275. The 2010 law added a fourth exception that can be cited by foster care agencies to delay or forgo filing a termination of parental rights petition even if a child has been in foster care for 15 of the last 22 months: "(D) the parent or parents are incarcerated, or participating in a residential substance abuse treatment program, or the prior incarceration or participation of a parent or parents in a residential substance abuse treatment program is a significant factor in why the child has been in foster care for fifteen of the last twenty-two months, provided that the parent maintains a meaningful role in the child's life based on the criteria set forth in subparagraph (v) of this paragraph and the agency has not documented a reason why it would otherwise be appropriate to file a petition pursuant to this section." Chapter 113 of the Laws of 2010, signed into law by Governor David Paterson on June 15, 2010. Codified in NY Soc. Serv. Law §§ 384-b(3)(l)(i), 384-b(3)(l)(v), 384-b(7)(a), 384-b(7)(e)(i), 384-b(7)(f)(6), 409-e(2), 409-e(3) (2010).
See Correctional Association of New York. (2010). *A Fair Chance for Families Separated by Prison*. Retrieved on June 17, 2014 from www.correctionalassociation.org/news/a-fair-chance-for-families-separated-by-prison
276. See note 253, *Maternal Separations During the Reentry Years for 100 Infants Raised in a Prison Nursery*.

277. See www.hourchildren.org.
278. See note 222.
279. There are 13 single rooms and seven double rooms on the Bedford Hills nursery.
280. Bedford's nursery manual states that this set-up aims to "accommodate the round the clock needs of babies..." (p. 4). Bedford Hills Correctional Facility. (3/2008, Rev. 3/2009). *Nursery Manual*. (On file at the CA).
281. Office on Women's Health, U.S. Department of Health and Human Services. (2014). *Breastfeeding and everyday life*. Retrieved on July 15, 2014 from www.womenshealth.gov/breastfeeding/breastfeeding-and-everyday-life.php
See also note 244, *The Womanly Art of Breastfeeding*.
282. Mayo Clinic. (2012). *Prenatal vitamins: Why they matter, how to choose*. Retrieved on July 15, 2014 from www.mayoclinic.com/health/prenatal-vitamins/PR00160/NSECTIONGROUP=2
283. According to Bedford's nursery manual, mothers can also be removed from the nursery for engaging in behavior that "threatens the safety and well being of the babies, mothers or staff," or the "overall inability to adjust to the program" after repeated counseling. See note 280, pp. 11-12.
284. See note 253, Maternal Separations During the Reentry Years for 100 Infants Raised in a Prison Nursery.
285. For babies eating solid foods, DOCCS reports that all meals comport with the nutritional guidelines of the American Academy of Pediatrics.
286. See American Civil Liberties Union. (n.d.). *ACLU Briefing Paper: The Shackling of Pregnant Women & Girls in U.S. Prisons, Jails & Youth Detention Centers*. Retrieved on July 15, 2014 from www.aclu.org/files/assets/anti-shackling_briefing_paper_stand_alone.pdf
International Human Rights Clinic University of Chicago Law School, CLAIM & American Civil Liberties Union. (2013). *The Shackling of Incarcerated Pregnant Women: A Human Rights Violation Committed Regularly in the United States*. Retrieved on July 15, 2014 from ihrcclinic.uchicago.edu/sites/ihrcclinic.uchicago.edu/files/uploads/Report%20-%20Shackling%20of%20Pregnant%20Prisoners%20in%20the%20US%20%28Final%201.8.14%29.pdf
287. For example, Dr. Carolyn Sufrin, an OB-GYN expert on correctional healthcare for pregnant women, explains the issue this way: "Placing chains around a pregnant woman's ankles, belly or wrists is unsafe at any time... Anything that throws her further off balance or makes walking more difficult can increase her risk of falling. A fall in pregnancy is no small matter, as it can potentially harm the baby as well as the mother, and in serious cases, can cause stillbirth." Sufrin, C. (2010). End practice of shackling pregnant inmates. *San Francisco Chronicle*, August 26. Retrieved on July 15, 2014 from www.sfgate.com/opinion/openforum/article/End-practice-of-shackling-pregnant-inmates-3176987.php
288. "Shackling interferes with normal labor and delivery: The ability to ambulate during labor increases the likelihood for adequate pain management, successful cervical dilation, and a successful vaginal delivery. Women need to be able to move or be moved in preparation for emergencies of labor and delivery, including shoulder dystocia, hemorrhage, or abnormalities of the fetal heart rate requiring intervention, including urgent cesarean delivery." The American College of Obstetricians and Gynecologists. (2011, Reaffirmed 2013). Health Care for Pregnant and Postpartum Incarcerated Women and Adolescent Females. *Committee Opinion*, 511. Retrieved on July 15, 2014 from www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Health_Care_for_Underserved_Women/Health_Care_for_Pregnant_and_Postpartum_Incarcerated_Women_and_Adolescent_Females
"Physical restraints have interfered with the ability of physicians to safely practice medicine by reducing their ability to assess and evaluate the condition of the mother and the fetus, and have similarly made the labor and delivery process more difficult than it needs to be; thus, overall putting the health and lives of the women and unborn children at risk. Typically, these inmates have armed guards on site, which should be more than adequate to protect personnel helping a pregnant, laboring woman, or to prevent her from fleeing." Letter from Ralph Hale, Executive Vice President, The American College of Obstetricians and Gynecologists, to Malika Saada Saar, Executive Director, The Rebecca Project for Human Rights, June 13, 2007. (On file at the CA).
289. "After delivery, a healthy baby should remain with the mother to facilitate mother-child bonding. Shackles may prevent or inhibit this bonding and interfere with the mother's safe handling of her infant." *Id.*, Health Care for Pregnant and Postpartum Incarcerated Women and Adolescent Females.

290. "The Eighth Amendment to the U.S. Constitution prohibits cruel or unusual punishments, which some Federal courts have interpreted to prohibit the shackling of pregnant prisoners during childbirth." See note 286, *The Shackling of Incarcerated Pregnant Women*, p. 1.
291. See note 288, *Health Care for Pregnant and Postpartum Incarcerated Women and Adolescent Females*.
292. Brief for Nat'l Perinatal Assoc., et. al. as Amici Curiae. Supporting Appellee, *Nelson v. Corr. Med. Serv.*, No. 07-2481, 2008 WL 4127217 (8th Cir. Aug. 25, 2008). Retrieved on July 15, 2014 from advocatesforpregnantwomen.org/NelsonAmicusFinal%5B1%5D.pdf
293. *Id.*
294. *Id.*
295. APHA Task Force on Correctional Health. (2003). *Standards for Health Services in Correctional Institutions*, 3rd Ed. American Public Health Association.
296. "...our AMA support language recently adopted by the New Mexico legislature that "an adult or juvenile correctional facility, detention center or local jail shall use the least restrictive restraints necessary when the facility has actual or constructive knowledge that an inmate is in the 2nd or 3rd trimester of pregnancy. No restraints of any kind shall be used on an inmate who is in labor, delivering her baby or recuperating from the delivery unless there are compelling grounds to believe that the inmate presents: An immediate and serious threat of harm to herself, staff or others; or A substantial flight risk and cannot be reasonably contained by other means. If an inmate who is in labor or who is delivering her baby is restrained, only the least restrictive restraints necessary to ensure safety and security shall be used." (p.1). American Medical Association House of Delegates. (2010). *Shackling of Pregnant Women in Labor. Resolution: 203 (A-10)*. Retrieved on July 15, 2014 from: [www.prisonlegalnews.org/media/publications/american_medical_association_house_of_delegates_resolution_203_\(a-10\)_shackling_of_pregnant_women_in_labor_2010.pdf](http://www.prisonlegalnews.org/media/publications/american_medical_association_house_of_delegates_resolution_203_(a-10)_shackling_of_pregnant_women_in_labor_2010.pdf)
297. Association of Women's Health, Obstetric and Neonatal Nurses. (2011). AWHONN Position Statement: Shackling Incarcerated Pregnant Women. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 40(6), 817-818. Retrieved on July 15, 2014 from onlinelibrary.wiley.com/doi/10.1111/j.1552-6909.2011.01300.x/pdf
298. "Restraint is potentially harmful to the expectant mother and fetus, especially in the third trimester as well as during labor and delivery. Restraint of pregnant inmates during labor and delivery should not be used. The application of restraints during all other pre-and postpartum periods should be restricted as much as possible and, when used, done so with consultation from medical staff. For the most successful outcome of a pregnancy, cooperation among custody staff, medical staff, and the patient is required....Postpartum... Restraints should be avoided if possible during this period, because labor and delivery can result in exhaustion, dehydration, difficulty in urination or defecation, and complications such as hemorrhage. Necessary bed rest and rapid response to medical emergencies should also be taken into account, particularly for cesarean section (also known as a c-section) births....If restraints are required, they should allow for the mother's safe handling of her infant and mother-infant bonding, which is beneficial and very strong during the postpartum period." National Commission on Correctional Health Care. (2010). *Restraint of Pregnant Inmates*. Retrieved on July 15, 2014 from <http://www.ncchc.org/restraint-of-pregnant-inmates>
299. "Written policy, procedure and practice, in general, prohibit the use of restraints on female offenders during active labor and the delivery of a child. Any deviation from the prohibition requires approval by, and guidance on, methodology from the Medical Authority and is based on documented serious security risks. The Medical Authority provides guidance on the use of restraints on pregnant offenders prior to active labor and delivery.... Restraints on pregnant offenders during active labor and the delivery of a child should only be used in extreme instances and should not be applied for more time than is absolutely necessary. Restraints used on pregnant offenders prior to active labor and delivery should not put the pregnant offender nor the fetus at risk." American Correctional Association. (2008). *Standards Committee Meeting Minutes. ACA 138th Congress of Corrections*. Retrieved on July 15, 2014 from www.aca.org/standards/pdfs/Standards_Committee_Meeting_August_2008.pdf
300. Arizona (Ariz. Rev. Stat. § 31-601), California (Cal. Penal Code § 3407), Colorado (Colo. Rev. Stat. § 17-1-113.7), Delaware (11 Del. Code §§ 6603-6605), Florida (Fla. Stat. § 944.241), Hawaii (Haw. Rev. Stat. §§ 353-122-123), Idaho (Idaho Code §§ 20-901-903), Illinois (Ill. Comp. Stat. Ann. §§ 5/3-6-7 and 5/3-15003.6), Louisiana (La. Rev. Stat. Ann. §15:744.2-744.3), Maryland (214 Md. Laws ch. 212 (H.B. 27)), Massachusetts (127 Mass. Gen. Laws ch. 127 § 118), Minnesota (likely to be codified as Minn. Stat. Ann. § 241.89), Nevada (Nev. Rev.

Stat. §§ 209.376, 211.155), New Mexico (N.M. Stat. Ann. § 33-1-4.2), New York (N.Y. Correct. Law § 611(1)), Pennsylvania (61 Pa. Cons. Stat. § 5905), Rhode Island (R.I. Gen. Laws §§ 42-56.3-1-42-56.3-7), Texas (Tex. Gov't Code Ann. § 501.066, Tex. Local Gov't Code Ann. § 361.082, Tex. Hum. Res. Code Ann. § 244.0075), Vermont (28 Vt. Stat. Ann. § 801a), Washington (Wash. Rev. Code Ann. §§ 72.09.651, 70.48-500-502), and West Virginia (W. Va. Code Ann. §§ 12-1-16, 31-20-30a).

301. N.Y. Correct. Law § 611 states: “No restraints of any kind shall be used during transport to or from the hospital, institution or clinic where such woman receives care; provided, however, in extraordinary circumstances, where restraints are necessary to prevent such woman from injuring herself or medical or correctional personnel, such woman may be cuffed by one wrist. In cases where restraints are used, the superintendent or sheriff shall make and maintain written findings as to the reasons for such use. No restraints of any kind shall be used when such woman is in labor, admitted to a hospital, institution or clinic for delivery, or recovering after giving birth. Any such personnel as may be necessary to supervise the woman during transport to and from and during her stay at the hospital, institution or clinic shall be provided to ensure adequate care, custody and control of the woman. The superintendent or sheriff or his or her designee shall cause such woman to be subject to return to such institution or local correctional facility as soon after the birth of her child as the state of her health will permit as determined by the medical professional responsible for the care of such woman.” Jails in New York City restricted the use of shackles on pregnant women before the 2009 Anti-Shackling Law was passed because of a settlement agreement in the case of *Reynolds v. Schriro*, Index No. 81 Civ. 107 (RJS) (S.D.N.Y. Nov. 19, 2010). The settlement states that the New York City Department of Correction “will not place mechanical restraints on an outposted inmate-patient where a doctor determines that: (1) the inmate-patient is pregnant and is admitted for delivery of the baby and/or post-partum recovery....Inmate-patients with these conditions will not be mechanically restrained at any time in or out of bed unless DOC can articulate a clear and convincing reason why the inmate-patient poses a present danger of escape or injury to others....DOC shall maintain a written record of all decisions to use mechanical restraints in accordance with the provisions of this stipulation.” *Id.* at ¶ 26.
302. “232. BUREAU OF PRISONS POLICY ON RESTRAINING OF FEMALE PRISONERS. Not later than 1 year after the date of enactment of this Act, the Attorney General shall submit to Congress a report on the practices and policies of agencies within the Department of Justice relating to the use of physical restraints on pregnant female prisoners during pregnancy, labor, delivery of a child, or post-delivery recuperation, including the number of instances occurring after the date of enactment of this Act in which physical restraints are used on such prisoners, the reasons for the use of the physical restraints, the length of time that the physical restraints were used, and the security concerns that justified the use of the physical restraints.” Second Chance Act of 2007, Pub. L. 110-199, § 232, 122 Stat. 657 (2008).
303. “The ACLU welcomes the Bureau of Prisons’ recent policy change barring the shackling of pregnant inmates in federal prisons in all but the most extreme circumstances.” Leveille, V. (2008). *Bureau of Prisons Revises Policy on Shackling of Pregnant Inmates*. American Civil Liberties Union. Retrieved on July 15, 2014 from www.aclu.org/blog/content/bureau-prisons-revises-policy-shackling-pregnant-inmates
See policy: Federal Bureau of Prisons, U.S. Department of Justice. (10/6/2008). Escorted Trips, § 570.40(9): Selection of Escorts. *Program Statement*, OPI CPD/CSB, No. 5538.05. Retrieved on July 15, 2014 from www.aclu.org/files/pdfs/prison/bop_policy_escorted_trips_p5538_05.pdf
304. “Restraints should not be used when compelling medical reasons dictate, including when a pregnant prisoner is in labor, is delivering her baby, or is in immediate postdelivery recuperation. (added 10-30-2007)....Pregnant Prisoners: If a pregnant prisoner is restrained, the restraints used must be the least restrictive necessary to ensure safety and security. Any restraints used must not physically constrict the direct area of the pregnancy. Any deviations from the utilization of full standard restraints on a pregnant prisoner (waist chain, leg irons, and handcuffs) must first be approved by a USMS Management Official (SDUSM, CDUSM, or USM). (added 10-30-2007)” United States Marshals. (6/1/2010). 9.1 Prisoner Custody, Restraining Devices, Section 3. *USMS Directives: Prisoner Operations*. Retrieved on July 15, 2014 from www.usmarshals.gov/foia/directives/prisoner_ops/restraining_devices.pdf
305. “1. Restraints on Pregnant Women. A pregnant woman or woman in post-delivery recuperation shall not be restrained absent truly extraordinary circumstances that render restraints absolutely necessary as documented by a supervisor and directed by the on-site medical authority. This general prohibition on restraints applies to all pregnant women in the custody of ICE, whether during transport, in a detention facility, or at an outside medical facility. Restraints are never permitted on women who are in active labor or delivery. Restraints

should not be considered as an option, except under the following extraordinary circumstances: a. a medical officer has directed the use of restraints for medical reasons; b. credible, reasonable grounds exist to believe the detainee presents an immediate and serious threat of hurting herself, staff or others; or c. reasonable grounds exist to believe the detainee presents an immediate and credible risk of escape that cannot be reasonably minimized through any other method. In the rare event that one of the above situations applies, medical staff shall determine the safest method and duration for the use of restraints and the least restrictive restraints necessary shall be used. Even in the extraordinary circumstance when restraints are deemed necessary, no detainee known to be pregnant shall be restrained in a face-down position with four-point restraints, on her back, or in a restraint belt that constricts the area of the pregnancy. All attempts will be made to ensure that the detainee is placed on her left side if she is immobilized. The use of restraints requires documented approval and guidance from the on-site medical authority. Record-keeping and reporting requirements regarding the medical approval to use restraints shall be consistent with other provisions within these standards, including documentation in the detainee's A-file, detention and medical file." (p. 213). U.S. Immigration and Customs Enforcement. (2011). *Performance-Based National Detention Standards 2011*. Retrieved on July 15, 2014 from www.ice.gov/doclib/detention-standards/2011/pbnds2011.pdf

306. "The use of restraints on pregnant incarcerated women and adolescents may not only compromise health care but is demeaning and rarely necessary....Shackling...should only occur in exceptional circumstances for pregnant women and women within 6 weeks postpartum after a strong consideration of the health effects of restraints by the clinician providing care.... If restraint is needed, it should be the least restrictive possible to ensure safety and should never include restraints that interfere with leg movement or the ability of the woman to break a fall. Pressure should not be applied either directly or indirectly to the abdomen." See note 288, Health Care for Pregnant and Postpartum Incarcerated Women and Adolescent Females.
307. Roth, R. (2012). California Activists Prove the Third Time is the Charm: Governor Signs New Law against Shackling Pregnant Women [web log]. Retrieved on July 15, 2014 from www.momsrising.org/blog/california-activists-prove-the-third-time-is-the-charm-governor-signs-new-law-against-shackling
308. N.Y. Correct. Law § 611
309. The form states that "Restraints were applied from recovery room to secured ward."
310. Letter from NYS DOCCS FOIL Unit (August 9, 2012, Log No. 12-0790) in response to Correctional Association of New York FOIL request. (On file at the CA).
311. Following a Cesarean birth, women are advised to support their abdomen and care for the incision appropriately. See note 251. |
See also Mayo Clinic. (2012). *C-section recovery: What to expect*. Retrieved on July 15, 2014 from www.mayoclinic.org/healthy-living/labor-and-delivery/in-depth/c-section-recovery/art-20047310
MedlinePlus. (2012). *Going home after a C-Section*. U.S. National Library of Medicine, National Institutes of Health. Retrieved on July 15, 2014 from www.nlm.nih.gov/medlineplus/ency/patientinstructions/000624.htm
312. Letter from NYS DOCCS FOIL Unit (August 9, 2012, Log No. 12-0790) in response to Correctional Association of New York FOIL request. (On file with the CA).
313. Letters from NYS DOCCS FOIL Unit (September 23, 2010, Log No. 10-1341 & September 23, 2010, Log No. 10-1409) in response to Correctional Association of New York FOIL requests. (On file at the CA).
The CA's FOIL requests asked for DOCCS *Directive 4901: Transporting Prisoners and DOCCS Directive 4916: Transporting Pregnant Inmates and Mothers with Babies*. Both are categorized as "D" Directives, which means they are not available to the public. "D. Security Material: Directives containing information affecting the safety and security of correctional facilities shall be distributed to Central Office holders of the manual and facility Superintendents....D directives shall be handled as confidential material and restricted from unauthorized access." (p. 4). NYS DOCCS. (1/15/2013). *Directive 0001: Introduction to the Policy and Procedure Manual*.
Bedford is the only prison with an additional written policy that explicitly references transferring pregnant women to other prisons. It explains that Bedford uses DOCCS vans to transport pregnant women on all trips except for trips to the hospital for labor; for those trips, Bedford's policy states that they use an ambulance.
314. Bedford Hills Correctional Facility. (5/28/2009). S-TRO-9 Transporting Pregnant Women and Mothers with Babies. (p. 1 and p. 2). *Policy and Procedure*. (On file at the CA).
315. See note 196, Taconic Correctional Facility Policy #604 Pregnancy Management, p. 3.

316. "Avoid sitting for long periods during car or air travel. Prolonged sitting can affect blood flow in your legs. Try to limit driving to no more than 5 or 6 hours each day. Take frequent breaks to stretch your legs." Office on Women's Health, U.S. Department of Health and Human Services. (2010). *Pregnancy: Staying healthy and safe*. Retrieved on July 15, 2014 from www.womenshealth.gov/pregnancy/you-are-pregnant/staying-healthy-safe.cfm# "Buses tend to have narrow aisles and small restrooms. This mode of transportation can be more challenging. The safest thing is to remain seated while the bus is moving. [...] Try to limit the amount of time you are cooped up in the car, bus, or train. Keep travel time around five to six hours. Use rest stops to take short walks and to do stretches to keep the blood circulating." American Pregnancy Association. (2013). *Pregnancy and Travel*. Retrieved on July 15, 2014 from www.americanpregnancy.org/pregnancyhealth/travel.html
317. See note 288, Health Care for Pregnant and Postpartum Incarcerated Women and Adolescent Females. See also The American College of Obstetricians and Gynecologists. (2011). Practice Bulletin No. 123. Thromboembolism in Pregnancy. *Obstetrics & Gynecology*, 118(3), 718–29.
318. "The extra weight in the front of your body shifts your center of gravity and places stress on joints and muscles, especially those in the pelvis and lower back. This can make you less stable, cause back pain, and make you more likely to lose your balance and fall, especially in later pregnancy." The American College of Obstetricians and Gynecologists. (2011). *Frequently Asked Questions: Exercise During Pregnancy*. Retrieved on July 15, 2014 from www.acog.org/~media/For%20Patients/faq119.pdf?dmc=1&ts=20140521T1522111262
319. On the way to and from the transportation vehicle, Bedford's policy indicates that a mother may carry her baby while being pushed in a wheelchair in leg irons. "Once the baby is secured in the car-seat, the inmate will be placed in mechanical restraints, i.e., handcuffs and leg-irons. The escort officers should then ensure the car-seat is appropriately fastened and the baby is properly secured. The DSS or Watch Commander must consider each case individually regarding which restraints may or may not be used. This decision may be based on consultation with the FHSD [Facility Health Service Director]." (p. 2). Bedford's policy also states that: "During transportation, inmates are not allowed to breastfeed their baby, nor at any time will handcuffs be removed. Feeding must wait until the destination is reached because the baby cannot be removed from the car seat during transport. If the trip is very long, arrangements will be made by the DSS for the trip to stop at an appropriate and prearranged location, such as another facility or other approved site, to allow for the inmate to breastfeed." See note 315, S-TRO-9 Transporting Pregnant Women and Mothers with Babies, p. 2.
320. See note 42.
 Correctional Association of New York. (2003). *Lockdown New York: Disciplinary Confinement in New York State Prisons*. New York, NY. Retrieved on July 15, 2014 from www.correctionalassociation.org/wp-content/uploads/2012/05/lockdown-new-york_report.pdf
 Human Rights Watch. (2003). *Ill-Equipped: U.S. Prison and Offenders with Mental Illness*. Retrieved on July 15, 2014 from www.hrw.org/en/reports/2003/10/21/ill-equipped
 Metzner Fellner, J. J. (2010). Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics. *Journal of the American Academy of Psychiatry and the Law*, 38(1), 104-8. Retrieved on July 15, 2014 from www.hrw.org/news/2010/03/22/solitary-confinement-and-mental-illness-us-prisons
321. *Id.*, note 42 and *Lockdown New York*.
 See also note 46, *Report on Mental Health Programs and Services at Bedford Hills Correctional Facility*.
322. Letter to U.S. Acting Assistant Secretary Zeya, U.S. Acting Assistant Secretary Pittman, and U.S. Deputy Legal Advisor Biniaz, signed by 53 leading human rights, advocacy, and community organizations (June 19, 2013). Retrieved on July 15, 2014 from www.aclu.org/files/assets/coalition_letter_to_department_of_state_re_juan_mendez_visit.pdf
 See also *Think Outside The Box: New York Campaign for Alternatives to Isolated Confinement* at nycaic.org/.
323. The Special Rapporteur's full title is the United Nations Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. "The UN's torture investigator, Juan Mendez, yesterday called on UN member nations to ban nearly all uses of solitary confinement in prisons, warning that it causes serious mental and physical harm and often amounts to torture. ...As Reuters reports, Mendez stated that solitary confinement "can amount to torture or cruel, inhuman and degrading treatment or punishment when used as a punishment, during pretrial detention, indefinitely or for a prolonged period, for persons with mental disabilities or juveniles." He continued, "Segregation, isolation, separation, cellular, lockdown, supermax, the hole, secure housing unit...whatever the name, solitary confinement should be banned by states as a punishment or extortion (of information) technique." Casella, J. & Ridgeway, J. (2011). UN Torture Investigator

Calls on Nations to End Solitary Confinement. *Solitary Watch: News from a Nation in Lockdown*, October 19. Retrieved on July 15, 2014 from solitarywatch.com/2011/10/19/un-torture-investigator-calls-on-nations-to-end-solitary-confinement/

324. NYS DOCCS. (9/26/2013). *Directive 4933: Special Housing Units*. (On file at the CA).
“Special Housing Units (SHUs) are designated cellblocks or freestanding buildings in most maximum-security and some medium-security prisons. The majority of SHUs are located in old-style maximum-security prisons (Attica, Auburn, Clinton, Elmira, Great Meadow, Green Haven and Sing Sing), where cells tend to be dank and dimly lit, as the only natural light comes from windows across a corridor. Most SHU cells have bars on the front or back of the cell; others are far more isolating, with three concrete walls and a thick metal door.” See note 320, *Lockdown New York*, p. 9.
325. New York also has two prisons for men, Upstate and Southport, that are almost entirely comprised of solitary cells, and eight “S-Blocks” which are designated SHU buildings on the grounds of other men’s prisons: Cayuga, Collins, Fishkill, Gouverneur, Greene, Lakeview, Marcy, Mid-State, and Orleans.
See note 320, *Lockdown New York*.
New York Civil Liberties Union. (n.d.). *Boxed In: The True Cost of Extreme Isolation in New York’s Prisons*. New York, NY. Retrieved on July 15, 2014 from www.nyclu.org/files/publications/nyclu_boxedin_FINAL.pdf
326. Dorms are standard housing in many medium and minimum-security prisons, and many women at Albion and Taconic and some women at Bedford Hills live in dorm settings. “Inmates on keeplock are either confined to their cells or housed in a separate cellblock in the prison. While keeplock is considered the least restrictive form of disciplinary housing because inmates are permitted more personal property and the stays tend to be shorter, keeplock is still governed by the same Department directive (4933) that applies to inmates in Special Housing Units.” See note 320, *Lockdown New York*, p. 9.
327. See note 324.
328. *Id.*
See also note 320, *Lockdown New York*.
329. “Despite a substantial decline in the prison population since 2000, DOCCS continues to discipline an extraordinarily high number of individuals in its prisons....In fact, the percentage of the population in the most severe isolation, the SHU, has increased during the past ten years....The most recent data represents a 46% increase in the percentage of the prison population in the SHU [from 2003 to August 2006 compared to the 2000 to 2003 period]....According to data presented by the Vera Institute, taken from a DOJ Bureau of Justice Statistics report about the prison population in the United States in 2005, 81,622 individuals were in some restrictive housing in federal and state prisons, representing 5.7% of the entire prison population in the country. New York’s 2012 figure is 37% higher than the national average and does not include individuals in keeplock, administrative segregation or some other form of restrictive housing....Each year, approximately 150,000 violations of the prisons rules are prosecuted by DOCCS. Since approximately 95% of individuals charged with a prison violation are generally found guilty, most of these violations result in some form of punishment.... [From 2003 through August 2006], each year 12,200 SHU sentences were imposed, affecting a total of 22,525 individuals. Of these, approximately 4,500 individuals each year were given six months or more of SHU time, and annually more than 1,600 individuals were given a year or more in the SHU for a single violation....a majority of individuals given lengthy SHU sentences were given multiple SHU sentences during this time period.... Due to these multiple SHU sentences, many people spend many months and even years in the SHU.” See note 42.
330. For example, the three most common charges reproductive health survey respondents reported led to their placement in SHU and keeplock were, in order, disobeying a direct order, creating a disturbance, and being out of place. Only a very small number of women reported being sent to SHU for weapons possession or assaulting another incarcerated person or staff member.
See also note 320, *Lockdown New York* and note 325, *Boxed In*.
331. *Id.*, note 325, *Boxed In*.
See also note 42.
332. Women at Taconic who receive disciplinary sentences of more than 30 days are usually transferred to Bedford. The same was true at Bayview and Beacon when they were open. Women at Lakeview and Willard who receive disciplinary sentences of any type are often sent to other prisons’ disciplinary units.

333. Some women in SHU at Albion report that they stay in their cells during the recreation hour in the winter because the weather is so cold and they are not given adequate clothing and footwear to stay warm.
334. People in SHU can be put on the loaf for a maximum of 21 days. See note 320, *Lockdown New York*, p. 28.
335. *Id.*
336. *Id.*
337. See note 324.
338. The average SHU sentence in DOCCS overall is about five months, though many men spend considerably longer, and sometimes decades, in SHU. See note 325, *Boxed In*.
339. There is a Residential Mental Health Treatment Unit (RMHTU) at Attica Correctional Facility with a capacity of 10, an RMHTU at Five Points Correctional Facility with a capacity of 60, an RMHTU at Marcy Correctional Facility with a capacity of 100, a Behavioral Health Unit (BHU) at Great Meadow Correctional Facility with a capacity of 38, and the Therapeutic Behavioral Unit (TBU) at Bedford Hills with a capacity of 16.
340. The lawsuit was brought by the Prisoners Rights Project of the Legal Aid Society, Prisoners' Legal Services of New York, and Davis Polk & Wardwell on behalf of Disability Advocates, Inc. Among other things, the settlement in 2007 required DOCCS to enhance mental health services; increase mental health screening at reception; increase capacity of the Intermediate Care Programs; improve reviews of sentences for incarcerated people with mental illness in SHU; increase OMH input into the DOCCS' disciplinary process; and, prepare a variety of reports about DOCCS' mental health care. It also required OMH to create a 20-bed ward at Central New York Psychiatric Center and required DOCCS and OMH to create Residential Mental Health Units (RMHUs) for incarcerated people with mental illness who would otherwise remain in SHU. *Disability Advocates, Inc. v. New York State Office of Mental Health*, 02 Civ. 4002 (S.D.N.Y. April 27, 2007).
 The SHU Exclusion Law (Chapter 1 of the Laws of 2008) was passed in 2008 and went into effect fully in 2011. It requires better assessments of people in disciplinary confinement and requires people with serious mental illness to be diverted from disciplinary confinement to Residential Mental Health Treatment Units (RMHTU), except in exceptional circumstances. The law also defines RMHTU as units that "shall not be operated as disciplinary housing units" where "decisions about treatment and conditions of confinement shall be made based upon a clinical assessment of the therapeutic needs of the inmate and maintenance of adequate safety and security on the unit." The law requires incarcerated people in RMHTUs to be offered "at least four hours a day" out of their cells five days per week in addition to the one hour of recreation. N.Y. Correct. Law § 2(21). The law makes an exception for the Behavioral Health Unit which can limit out of cell time to two hours instead of four. The law also requires additional training on mental health for correction staff who work in units that provide programs for incarcerated people with mental illnesses and grants an independent agency authority to oversee compliance with the law's provisions, to report on progress and to make recommendations for improvements. Initially, this agency was the Commission on Quality of Care and Advocacy for Persons with Disabilities. This responsibility was assumed by the New York State Justice Center for the Protection of People with Special Needs when it was established in 2013 by Chapter 501 of the Laws of 2012. N.Y. Correct. Law § 401-a.
 See also Mental Health Alternatives to Solitary Confinement. (2011). *SHU Exclusion Law Fact Sheet*. Retrieved on September 24, 2014 from boottheshu.files.wordpress.com/2013/04/uucsr-exhibit-a-shu-exclusion-law-fact-sheet-7-1-11.pdf
 Correctional Association of New York. (2008). *The "SHU" Has Finally Dropped*. Retrieved on September 24, 2014 from www.correctionalassociation.org/news/the-shu-has-finally-dropped
 Correctional Association of New York. (2012). *Isolated Confinement: The Facts*. Retrieved on September 24, 2014 from www.correctionalassociation.org/news/isolated-confinement-the-facts
341. The New York State Office of Mental Health (OMH) provides mental health services in the state prison system. According to the OMH website, the agency "operates psychiatric centers across the State, and also regulates, certifies and oversees more than 2,500 programs, which are operated by local governments and nonprofit agencies." Office of Mental Health. (2014). *About OMH*. Retrieved on July 15, 2014 from www.omh.ny.gov/omhweb/about/
 In DOCCS, OMH provides mental health assessments and treatment services to incarcerated individuals in both outpatient and inpatient settings.
342. Bedford Hills reported to the CA that: 11 women were in the TBU as of July 2009; the average census for the TBU in 2012 was 13; and 10 women were in the TBU as of February 2013.

343. See American Civil Liberties Union. (2014). *Worse than Second-Class: Solitary Confinement of Women in the United States*. New York, NY. Retrieved on July 15, 2014 from www.aclu.org/sites/default/files/assets/worse_than_second-class.pdf
344. Correctional Association of New York. (2004). *Mental Health in the House of Corrections: A Study of Mental Health Care in New York State Prisons*. New York, NY. Retrieved on July 15, 2014 from www.correctionalassociation.org/wp-content/uploads/2004/06/Mental-Health.pdf
See note 320, *Ill-Equipped*.
345. In 2013 DOCCS classified 39% of incarcerated women as having a mental health diagnosis, compared with 14% of incarcerated men. See note 7, *DOCCS Under Custody Report 2013*.
346. See note 343.
347. *Id.*
Solitary Watch. (2013). Women in Solitary Confinement: Sent to Solitary for Reporting Sexual Assault. *Solitary Watch*, December 12. Retrieved on September 23, 2014 from solitarywatch.com/2013/12/12/women-solitary-confinement-sent-solitary-reporting-sexual-assault/
348. See note 3 and accompanying text.
349. See note 7, *DOCCS Under Custody Report 2013*.
Glaze, L.E. & Maruschak, L.M. (2008, Rev. 2010). *Special Report: Parents in Prison and Their Minor Children*. Bureau of Justice Statistics, U.S. Department of Justice. Retrieved on July 15, 2014 from www.bjs.gov/content/pub/pdf/pptmc.pdf
350. See note 343.
351. See note 223, *Depression During Pregnancy*. See also note 343.
352. Women in prison are likely to have one or more postpartum depression risk factors such as a history of mental illness, stressful events during pregnancy, and a lack of support from family and friends. Overall, 10 to 15% of women in the community experience postpartum depression and approximately 70 to 80% have mild depression (the “baby blues”) after childbirth.
See Centers for Disease Control and Prevention. (2008). Prevalence of Self-Reported Postpartum Depressive Symptoms – 17 States, 2004-2005. *Morbidity and Mortality Weekly Report*, 57(14), 361-366. Retrieved on July 15, 2014 from www.cdc.gov/mmwr/preview/mmwrhtml/mm5714a1.htm
Mayo Clinic. (2012). *Postpartum depression: Risk factors*. Retrieved on July 15, 2014 from www.mayoclinic.org/diseases-conditions/postpartum-depression/basics/risk-factors/con-20029130
New York State Department of Health. (2012). *Understanding Maternal Depression, A Fact Sheet for Care Providers*. Retrieved on July 15, 2014 from www.health.ny.gov/community/pregnancy/health_care/perinatal/maternal_factsheet.htm
353. “...(c) Sick call will be conducted daily. (1) The officer in charge will prepare a list of all inmates who request to see a medical practitioner.” See note 324.
354. Albion, Bedford and Taconic report that women in keeplock are taken to the medical unit for doctor appointments. For women in SHU, Albion and Bedford reported that the official process differs depending on the type of appointment: for general medical appointments, the prisons report that doctors use a side room on the SHU unit; for GYN appointments, the prisons report that women are transferred to the medical building exam room.
355. “An inmate assigned to SHU will be placed in mechanical restraints as described herein prior to exiting his or her cell.Once outside the cell, restraints shall be removed to accommodate the following: (i) A request of a Physician or a Physician’s Assistant (PA) when removal is necessary to permit medical treatment...” See note 324, p. 13.
356. *Id.*
357. DOCCS states that “[a]s soon as possible, but no more than 24 hours after admission, each inmate will be issued...1 roll toilet tissue...” and, “Female inmates shall be provided with basic feminine hygiene items as required.” *Id.*, p. 5.
358. See note 314, S-TRO-9 Transporting Pregnant Women and Mothers with Babies, p. 2.

359. "If the inmate is pregnant and the watch commander believes that not admitting the inmate to SHU would pose an immediate and substantial risk to the safety and security of the inmate or other persons, or an immediate and substantial threat to the safety and good order of the facility, he or she shall fully set forth the reason(s) for believing that such an exceptional circumstance exists....To the extent that an initial finding of an exceptional circumstance has been made by the Superintendent and approved by the Assistant Commissioner, such SHU sanction must be reviewed and renewed every 7 days in accordance with the process outlined above....In addition, on each day that a pregnant inmate is confined in SHU, a qualified medical practitioner shall examine the state of health of such inmate." Memorandum from NYS DOCCS Deputy Commissioner Joseph F. Bellnier, *Pregnant Inmates/Special Housing Confinement* (3/13/14), p. 1 and p.2. (On file at the CA).
360. *Id.*
361. See note 15.
362. See Human Rights Watch & American Civil Liberties Union. (2012). *Growing Up Locked Down: Youth in Solitary Confinement in Jails and Prisons Across the United States*. U.S.: Human Rights Watch. Retrieved on July 15, 2014 from www.hrw.org/sites/default/files/reports/us1012ForUpload.pdf
363. "Whenever an inmate is admitted to a SHU, a security supervisor will be present and the inmate will... be examined by a qualified member of the facility health services staff as soon as possible, but not later than 24 hours after admission." See note 324, p. 4.
364. "Many women have vaginal spotting or bleeding in the first 12 weeks of pregnancy...Slight bleeding often stops on its own. However, bleeding during pregnancy may mean something more serious." The American College of Obstetricians and Gynecologists. (2011). *Frequently Asked Questions: Bleeding During Pregnancy*. Retrieved on July 15, 2014 from www.acog.org/~media/For%20Patients/faq038.pdf?dmc=1&ts=20140522T0922284971
365. "If pregnancy is confirmed, the patient shall be referred to an OB-GYN specialist for initial exam and management of the pregnancy." See note 102, *Women's Health Primary Care Practice Guideline*, p. 5.
366. "Ectopic pregnancy is life-threatening. The pregnancy cannot continue to birth (term). The developing cells must be removed to save the mother's life." See note 209, *Ectopic Pregnancy*.
367. See note 362.
368. "Pregnancy and delivery often increase the symptoms of bipolar disorder: pregnant women or new mothers with bipolar disorder have a sevenfold higher risk of hospital admission and a twofold higher risk for a recurrent episode, compared with those who have not recently delivered a child or are not pregnant." National Alliance on Mental Illness. (2008). *Managing Pregnancy and Bipolar Disorder*. Retrieved on July 15, 2014 from http://www.nami.org/Content/ContentGroups/Research/Managing_Pregnancy_and_Bipolar_Disorder.htm
A history of blood clots can cause complications during pregnancy. See March of Dimes. (2014). *Pregnancy complications: Thrombophillias*. Retrieved on July 15, 2014 from www.marchofdimes.com/pregnancy/thrombophillias.aspx
Serious complications for both mother and baby can result from uncontrolled asthma during pregnancy. See American College of Allergy, Asthma, & Immunology. (n.d.). *When Pregnancy Is Complicated by Allergies and Asthma*. Retrieved on July 15, 2014 from www.acaai.org/allergist/liv_man/pregnancy/pages/default.aspx
Women with epilepsy are at a higher risk for complications during pregnancy. See Mayo Clinic. (2011). *Epilepsy and pregnancy: What you need to know*. Retrieved on July 15, 2014 from www.mayoclinic.com/health/pregnancy/PR00123
369. "A physical exam alone usually isn't enough to diagnose an ectopic pregnancy, however. The diagnosis is typically confirmed with blood tests and imaging studies, such as an ultrasound." Mayo Clinic. (2012). *Ectopic pregnancy: Tests and diagnosis*. Retrieved on July 15, 2014 from www.mayoclinic.com/health/ectopic-pregnancy/DS00622/DSECTION=tests%2Dand%2Ddiagnosis
370. The CA's Women in Prison Project has a forthcoming paper focused on HIV testing, prevention education and support services. Visit the CA's website for details: www.correctionalassociation.org.
371. See note 55, HIV in Prisons, 2001-2010.
372. See note 55, *Epidemiological Criminology: Theory to Practice*. Centers for Disease Control and Prevention. (2012). HIV/AIDS data through December 2008 provided for the Ryan White HIV/AIDS Treatment Extension Act of 2009, for fiscal year 2010. *HIV Surveillance Supplemental*

Report, 17(1). Retrieved on July 15, 2014 from www.cdc.gov/hiv/surveillance/resources/reports/2009supp_vol17no1/index.htm

See also *HIV in the United States: At A Glance*. Retrieved on June 17, 2014 from www.cdc.gov/hiv/statistics/basics/ataglance.html and Mackun, P. & Wilson, S. (2011). Population Distribution and Change: 2000 to 2010. *2010 Census Briefs*. U.S. Census Bureau. Retrieved on June 17, 2014 from www.census.gov/prod/cen2010/briefs/c2010br-01.pdf

373. See note 55, HIV in Prisons, 2001-2010.

In 2008, DOCCS reported that 3,500 individuals living with HIV were in its custody. See Appendix Table 1 in: Maruschak, L. (2009, Rev 2010). HIV in Prisons, 2007-08. *Bureau of Justice Statistics Bulletin*, NCJ 228307. Bureau of Justice Statistics, U.S. Department of Justice. Retrieved on July 15, 2014 from bjs.ojp.usdoj.gov/content/pub/pdf/hivp08.pdf

374. The CA estimates that about 2,700 to 3,000 HIV-positive people were in custody of DOCCS in 2013. This represents 17% of all HIV-positive incarcerated people in the country. See note 55, *2013 Comments re: DOH Oversight of HIV/HCV Care in NYS Prisons*.

Florida's prison system houses more HIV-positive women than New York (284 versus 260 in 2010). Texas has the third largest population of women with HIV in its prison system (241 women in 2010). See note 55, HIV in Prisons, 2001-2010.

375. See note 55, *Epidemiological Criminology: Theory to Practice*.

DeGroot, A.S. (2001). HIV Among Incarcerated Women: An Epidemic Behind the Walls. *Corrections Today*, 63(1), 77-81. Retrieved on July 15, 2014 from www.thefreelibrary.com/HIV+AMONG+INCARCERATED+WOMEN%3A+An+Epidemic+Behind+the+Walls.-a079589797

Onorato, M. (2001). HIV Infection Among Incarcerated Women. *HIV & Hepatitis Education Prison Project (HEPP)*, 4(5), pp. 287-95.

376. "The concentration of the HIV epidemic among women of color is striking. African American and Hispanic women together represent 86 percent of the 53,500 women who have been diagnosed with HIV and AIDS in New York. The rate of HIV infection among African American women in New York is more than 27 times higher than that of white women; the rate for Hispanic women is 13 times higher than white women." (p. 7). New York State AIDS Advisory Council. (2005). *Women in Peril: HIV & AIDS: The Rising Toll on Women of Color*. Albany, NY: New York State Department of Health. Retrieved on July 15, 2014 from www.hivlawandpolicy.org/sites/www.hivlawandpolicy.org/files/womeninperil-NYS%20AIDS%20Advisory%20Council-Dec2005.pdf

377. AIDS Institute, New York State Department of Health. (2000). *Promoting GYN Care for HIV-Infected Women: Best Practices for New York State*. Retrieved on July 15, 2014 from nationalqualitycenter.org/index.cfm/6166/14434

378. "...immune damage related to HIV can influence the progression of STDs. Several studies have shown that various STD symptoms may be more severe, last longer, and be harder to treat in people coinfecting with HIV. In fact, some sexually transmitted organisms, such as CMV and *Candida*, may not cause illness at all in persons with intact immune systems, but can cause serious symptoms in persons with HIV/AIDS....Persons coinfecting with HIV and HPV are more likely than HIV negative persons to develop multiple genital warts and warts that endure longer, as well as giant condyloma that can grow rapidly to a large size, potentially obstructing the vagina, anus, or throat and necessitating surgical removal. These more severe warts are less likely to develop in HIV positive people on successful antiretroviral regimens. Even more worrisome, several studies have shown that women with HIV are more likely to develop cervical and anal dysplasia...." Highleyman, L. (2000). Sexually Transmitted Diseases and HIV-Related Risks: Overview of STDs and Other Conditions that Increase Risk of HIV Transmission. *Bulletin of Experimental Treatment for AIDS*, Autumn. San Francisco AIDS Foundation. Retrieved on July 15, 2014 from www.thebody.com/content/art2722.html#synergy
See also Healthcommunities.com. (2000, Rev 2014). *Pelvic Inflammatory Disease (PID) Risk Factors, Symptoms, Diagnosis*. Retrieved on July 15, 2014 from www.healthcommunities.com/pelvic-inflammatory-disease-pid/risks.shtml. Office on Women's Health, U.S. Department of Health and Human Services. (2011). *HIV/AIDS: Vaginal yeast infections*. Retrieved on July 15, 2014 from www.womenshealth.gov/hiv-aids/opportunistic-infections-and-other-conditions/vaginal-yeast-infections-and-hiv-aids.cfm

379. "...The presence of an STD also makes it more likely that a coinfecting person will transmit HIV." Highleyman, L. (2000). Sexually Transmitted Diseases and HIV-Related Risks: Overview of STDs and Other Conditions that Increase Risk of HIV Transmission. *Bulletin of Experimental Treatment for AIDS*, Autumn. San Francisco AIDS Foundation. Retrieved on July 15, 2014 from www.thebody.com/content/art2722.html#synergy

380. A healthy pregnancy is especially important for women living with HIV: factors that increase the risk of transmission to the child include Vitamin A deficiency, malnutrition, STDs, in-uterine infections, and advanced HIV infection. "Special counseling about a healthy diet with attention given to preventing iron or vitamin deficiencies and weight loss as well as special interventions for sexually transmitted diseases or other infections (such as malaria, urinary tract infections, tuberculosis or respiratory infections) should be part of the prenatal care of HIV infected women." American Pregnancy Association. (2007). *HIV/AIDS During Pregnancy*. Retrieved on July 15, 2014 from www.americanpregnancy.org/pregnancycomplications/hiv aids.html (as linked to by the Office on Women's Health, U.S. Department of Health and Human Services).
381. The American College of Obstetricians and Gynecologists. (2012). *Frequently Asked Questions: HIV and Pregnancy*. Retrieved on July 15, 2014 from www.acog.org/~media/For%20Patients/faq113.pdf?dmc=1&ts=20130116T1439088091
382. N.Y. Pub. Health Law § 206(26).
Correctional Association of New York. (2009). Governor signs bill requiring department of health oversight of HIV, Hepatitis C care in New York's prisons and jails [press release]. Retrieved on July 15, 2014 from www.correctionalassociation.org/press/governor-signs-bill-requiring-department-of-health-oversight-of-hiv-hepatitis-c-care-in-new-yorks-prisons-and-jails
383. See note 55, *2013 Comments re: DOH Oversight of HIV/HCV Care in NYS Prisons*.
384. AI's inclusion of medical record reviews by an independent agency is a positive development, but... the instruments used by IPRO [a national non-profit organization providing "healthcare assessment and improvement services," ipro.org] for HIV and HCV care are not sufficient to identify the potential problems in this care. The six DOCCS HIV indicators utilized are not comparable to the 15 AI performance measures in the HIV-specific eHIVQUAL instrument or the 40 measures in the two eHIVQUAL instruments that are non-HIV-specific but address general issues of screening, vaccination, management and treatment, all crucial to the health of HIV-infected patients." *Id.*
385. The four prisons were Hale Creek, Marcy, Mid-State and Mohawk. "The combined population for these facilities is 4,400 persons, representing only 7.9% of the entire prison population." *Id.*
In addition, the CA concluded that "Given [the] variability [in the quality of HIV and hepatitis C care in each prison], it is crucial that each facility be examined to identify the barriers to quality care, both from a resources perspective and assessment of the quality of care provided by each healthcare person servicing this patient population." *Id.*
386. "Prior to starting its 2013 review of HIV/HCV care, AI only placed notices of its intentions on bulletin boards in the prisons and has generally failed to adequately inform currently and formerly incarcerated persons, their families, community providers, and prison and health advocates about the review process. The agency has not given sufficient details about the scope and procedures being employed to investigate care, not provided sufficient time for those interested in submitting comments....After objections by the CA and other outside agencies, AI reopened the review process but did not adequately publicize this fact or provide sufficient time for comments." *Id.*
387. "...the quality of care seems to vary significantly throughout DOCCS, in part due to limited medical resources at some facilities and apparent limitations in the training, skill and/or commitment of some medical staff to provide timely and effective care to every patient. We must emphasize that at some prisons, it appears that patients infected with HIV and/or hepatitis C are closely monitored, are receiving timely and appropriate care, and seem to have few complaints about the care they are receiving. In contrast, at other facilities, there is less access to care due to understaffing, patients have much more limited access to specialty care and other services, and patients express significant dissatisfaction with the quality of care they are receiving....Many CA-surveyed HIV-infected patients seemed stable and did not express significant concerns about their HIV care. Issues that did arise were the failure to have their viral loads monitored frequently, limitations on access to ID specialists, and delays in getting medications." *Id.*
388. "The Criminal Justice Initiative (CJI) was developed in response to the emerging prevention and service needs of HIV infected and at risk detainees, inmates and ex-offenders in New York State." New York State Department of Health. (2013). *Prevention and Support Services*. Retrieved on July 15, 2014 from www.health.state.ny.us/diseases/aids/about/prevsup.htm#cji
The Criminal Justice Initiative's "goal is to provide a comprehensive, seamless continuum of quality HIV prevention and supportive services to individuals in a correctional setting and ex-offenders returning to their

- home communities.” New York State Department of Health. (2014). *Corrections and HIV/AIDS*. Retrieved on May 19, 2014 from www.health.ny.gov/diseases/aids/providers/corrections/
389. The Members of the ACE Program of the Bedford Hills Correctional Facility (1998). *Breaking the Walls of Silence: AIDS and Women in a New York State Maximum-Security Prison*. New York, NY: The Overlook Press.
390. Pathstone, Inc. is a not-for-profit community development and human service organization providing services to low-income families and communities in New York and a number of other states. Formerly known as Rural Opportunities, Inc., Pathstone has carried out the DOCCS-Department of Health Criminal Justice Initiative at Albion for almost two decades. For more information, See www.pathstone.org/services/health-and-safety-services/.
391. The Women’s Prison Association (WPA) is a community-based, non-profit organization that provides a continuum of services for women involved in the criminal justice system. For more information, See www.wpaonline.org/.
392. See note 55, *2013 Comments re: DOH Oversight of HIV/HCV Care in NYS Prisons*.
393. “In late 2013, The Food and Drug Administration approved two new direct acting antiviral drugs, Sofosbuvir (Sovaldi™) and Simeprevir (Olysio™) to treat chronic HCV infection. Both medications have proven efficacy when used as a component of a combination antiviral regimen to treat HCV-infected adults with compensated liver disease, cirrhosis, HIV co-infection, and hepatocellular carcinoma awaiting liver transplant. Clinical trials have shown that these new medications achieve SVR [sustained virologic response] in 80%-95% of patients after 12-24 weeks of treatment.” Centers for Disease Control and Prevention. (2014). *Hepatitis C FAQs for Health Professionals*. Retrieved on September 6, 2014 from www.cdc.gov/hepatitis/HCV/HCVfaq.htm#section4 See also The New York Times. (2014). \$1,000 Hepatitis Pill Shows Why Fixing Health Costs Is So Hard. *The New York Times*, August 2. Retrieved on September 6, 2014 from www.nytimes.com/2014/08/03/upshot/is-a-1000-pill-really-too-much.html
394. NYS DOCCS. (10/14/1998). Sexually Transmitted Diseases Treatment Guidelines. *Health Services Policy Manual*, 1.20. (On file at the CA).
395. See note 55, HIV in Prisons, 2001-2010.
396. See New York State Department of Health. (2009). *Surveys of HIV Seroprevalence Among Inmates Entering New York State Correctional System: 1998-2007*. (On file at the CA).
397. *Id.*
New York State Department of Health. (2012). *BHAE 2009 Survey of Incoming Inmates in NYS Department of Corrections and Community Supervision (DOCCS): The Prison Study*. (On file at the CA).
398. In April 2013, Albion reported that 39 women in its custody were living with HIV, 32 of those women were on treatment and 1 was identified as having AIDS. In February 2013, Bedford reported that 30 women in its custody were living with HIV, 30 of those women were on treatment and 1 was identified as having AIDS. In April 2013, Taconic reported that 17 women in its custody were living with HIV, 0 of those women were on treatment and 1 was identified as having AIDS. In May 2013, Beacon reported that no women in its custody were living with HIV.
399. As of spring 2012, the CA estimated that DOCCS had identified only 40% of the women living with HIV in its custody. See note 55, *2013 Comments re: DOH Oversight of HIV/HCV Care in NYS Prisons*.
400. New York State Department of Health. (2013). *Positive Pathways*. (On file at the CA).
401. Centers for Disease Control and Prevention. *Testing Makes Us Stronger: HIV/AIDS Facts*. Retrieved on October 4, 2014 from hivtest.cdc.gov/stronger/hiv/index.html
402. For DOCCS’ description of its transitional services program, See www.doccs.ny.gov/ProgramServices/transitional.html#tsp
403. Office on Women’s Health, U.S. Department of Health and Human Services. (2011). *HIV/AIDS: Vaginal yeast infections*. Retrieved on July 15, 2014 from www.womenshealth.gov/hiv-aids/opportunistic-infections-and-other-conditions/vaginal-yeast-infections-and-hiv-aids.cfm
404. The New York State Department of Health AIDS Institute says that HIV-positive women should have Pap smear tests at the following frequency: “Baseline, 6 months after baseline, then annually as long as results are

normal....." AIDS Institute, New York State Department of Health. (2011). *Primary Care Approach to the HIV-Infected Patient*. Retrieved on July 15, 2014 from www.chcanys.org/clientuploads/2012_PDFs/CQI/HIV-AIDS/Guidelines/Primary%20Care%20Approach%20to%20the%20HIV%20Patient.pdf

"HIV-positive women should be provided cervical cytology screening twice (every 6 months) within the first year after initial HIV diagnosis and, if both tests are normal, annual screening can be resumed thereafter." Centers for Disease Control and Prevention. (2010). *Cervical Cancer Screening for Women Who Attend STD Clinics or Have a History of STDs. Sexually Transmitted Diseases Treatment Guidelines, 2010*. Retrieved on July 15, 2014 from www.cdc.gov/std/treatment/2010/cc-screening.htm

See also The American College of Obstetricians and Gynecologists. (2010, Reaffirmed 2012). *Gynecologic Care for Women With Human Immunodeficiency Virus. Practice Bulletin, 117*. Retrieved on July 15, 2014 from www.acog.org/~/media/Practice%20Bulletins/Committee%20on%20Practice%20Bulletins%20--%20Gynecology/Public/pb117.pdf?dmc=1&ts=20121127T0544419938

405. "HIV+ female inmates will be offered [gynecological] exams and smears every six months." (p. 4). NYS DOCCS. (2011). *Women's Health Primary Care Guideline*. Albany: NY. (On file at the CA).
406. The American College of Obstetricians and Gynecologists. (2010, Reaffirmed 2012). *Gynecologic Care for Women With Human Immunodeficiency Virus. Practice Bulletin, 117*. Retrieved on July 15, 2014 from www.acog.org/~/media/Practice%20Bulletins/Committee%20on%20Practice%20Bulletins%20--%20Gynecology/Public/pb117.pdf?dmc=1&ts=20121127T0544419938
407. See note 181, *Health Services Policy Manual*, p. 1.
"1. Except as provided in section three thousand one hundred twenty-one of the civil practice law and rules, or unless otherwise specifically authorized or required by a state or federal law, no person shall order the performance of an HIV related test without first having received informed consent of the subject of the test who has capacity to consent or, when the subject lacks capacity to consent, of a person authorized pursuant to law to consent to health care for such individual." N.Y. Pub. Health Law § 2781.
408. *Id.*, *Health Services Policy Manual*.
409. New York State Department of Health. (2010). *New York State Department of Health Review of New York State Department of Correctional Services Policies and Practices Related to HIV/AIDS and Hepatitis C Prevention and Care*, p. 8. (On file at the CA).
410. See note 181, *Health Services Policy Manual*, p. 1.
411. AIDS Institute, New York State Department of Health. (2010). *New York State Department of Health Review of New York State Department of Correctional Services Policies and Practices Related to HIV/AIDS and Hepatitis C Prevention and Care*. (On file at the CA).
For community standards in this area, See American Academy of HIV Medicine. (2009). *Connecting HIV Infected Patients to Care: A Review of Best Practices*. Retrieved on July 15, 2014 from www.aahivm.org/Upload_Module/upload/Provider%20Resources/AAHIVMLinkagetoCareReportonBestPractices.pdf
Horberg, A. & Berman, S. (2013). How to Improve the Multidisciplinary HIV Care Model: An Interview with Michael A. Horberg, M.D. *Medscape.com*, July 26. Retrieved on July 15, 2014 from www.medscape.com/
412. "All HIV positive pregnant women will be referred for consultations with an Infectious Disease (ID) Specialist and a High Risk OB/GYN Specialist. Consultant recommendations will be carefully considered and treatment will be consistent with DOCCS HIV Primary Care Practice Guidelines." See note 181, *Health Services Policy Manual*, p. 1.
413. "Because HIV can be transmitted through breast milk, women infected with HIV should not breastfeed their babies." AIDSinfo. (2012). *Fact Sheets: HIV and Pregnancy*. U.S. Department of Health and Human Services. Retrieved on July 15, 2014 from www.aidsinfo.nih.gov/contentfiles/Perinatal_FS_en.pdf
See also Office on Women's Health, U.S. Department of Health and Human Services. (2013). *Pregnancy and HIV/AIDS*. Retrieved on July 15, 2014 from www.womenshealth.gov/hiv-aids/living-with-hiv-aids/pregnancy-and-hiv.html
414. NYS DOCCS. (9/2/2005). *HIV Primary Care Practice Guidelines*, p. 4. (On file at the CA).
415. See note 411, *New York State Department of Health Review of New York State Department of Correctional Services Policies and Practices Related to HIV/AIDS and Hepatitis C Prevention and Care*.
See also Panel on Treatment of HIV-Infected Pregnant Women and Prevention of Perinatal Transmission. (2014).

Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-1-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the United States. U.S. Department of Health and Human Services. Retrieved on July 15, 2014 from aidsinfo.nih.gov/contentfiles/lvguidelines/PerinatalGL.pdf

416. See note 411, *New York State Department of Health Review of New York State Department of Correctional Services Policies and Practices Related to HIV/AIDS and Hepatitis C Prevention and Care.*
417. See note 181, *Health Services Policy Manual*, p. 2.
418. See Panel on Treatment of HIV-Infected Pregnant Women and Prevention of Perinatal Transmission. (2014). *Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-1-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the United States.* U.S. Department of Health and Human Services. Retrieved on July 15, 2014 from aidsinfo.nih.gov/contentfiles/lvguidelines/PerinatalGL.pdf
419. The American College of Obstetricians and Gynecologists. (2011). HIV and Other Important Pregnancy Tests. Retrieved on July 15, 2014 from [www.acog.org/About_ACOG/ACOG_Departments/HIV/~media/Departments/HIV/HIV%20%20OtherPregnTsts%20tear%20pad1.pdf](http://www.acog.org/About_ACOG/ACOG_Departments/HIV/~/media/Departments/HIV/HIV%20%20OtherPregnTsts%20tear%20pad1.pdf)
420. See note 411, *New York State Department of Health Review of New York State Department of Correctional Services Policies and Practices Related to HIV/AIDS and Hepatitis C Prevention and Care*, p. 8.
421. See note 181, *Health Services Policy Manual*, p. 2.
422. DOH has not requested adequate funds in prior years. "DOH has not apparently requested funding for AI [DOH's AIDS Institute] to perform its duties under Section 206(26) of the Public Health Law, and, therefore, AI has insufficient resources to adequately perform its legislative mandate....AI has suggested in discussions with the AAC [AIDS Advisory Council] Corrections Subcommittee that \$2.5 million is needed." See note 55, *2013 Comments re: DOH Oversight of HIV/HCV Care in NYS Prisons*, p. 9, p. 54.
423. See Chettiar, I., Bunting, W. and Schotter, G. (2012). *At America's Expense: The Mass Incarceration of the Elderly.* New York, NY: American Civil Liberties Union. Retrieved on September 23, 2014 from www.aclu.org/files/assets/elderlyprisonreport_20120613_1.pdf
424. The percentage was 5% in 2000 and 20% in 2010. See Beck, A.J. & Harrison, P.M. (2001). Prisoners in 2000. Bulletin, NCJ 188207. Bureau of Justice Statistics, U.S. Department of Justice. Retrieved on July 15, 2014 from bjs.ojp.usdoj.gov/content/pub/pdf/p00.pdf
Guerino, P., Harrison, P.M. & Sabol, W.J. (2012). Prisoners in 2010. *Bulletin, NCJ 236093.* Bureau of Justice Statistics, U.S. Department of Justice. Retrieved on July 15, 2014 from bjs.ojp.usdoj.gov/content/pub/pdf/p10.pdf
425. See note 7, *DOCCS Under Custody Report 2013.*
NYS DOCCS. (2001). *Under Custody Population January 1, 2001.* Albany, NY. (On file at the CA).
426. See note 7, *DOCCS Under Custody Report 2013.*
427. See note 423.
Chiu, T. (2010). *It's About Time: Aging Prisoners, Increasing Costs, and Geriatric Release.* New York, NY: Vera Institute of Justice. Retrieved on July 15, 2014 from www.vera.org/sites/default/files/resources/downloads/Its-about-time-aging-prisoners-increasing-costs-and-geriatric-release.pdf
Maschi, T., Morrissey, M.B., Immarigeon, R. & Sutfin, S. (2012). *Aging Prisoners: A Crisis in Need of Intervention.* New York: Fordham University Be the Evidence Project. Retrieved on July 15, 2014 from sites.google.com/site/betheevidenceproject/white-paper-aging-prisoner-forum
428. *Id.*
429. The Sentencing Project. *Fact Sheet: Trends in U.S. Corrections.* The Sentencing Project. Retrieved on September 23, 2014 from sentencingproject.org/doc/publications/inc_Trends_in_Corrections_Fact_sheet.pdf
430. See note 427.
431. See, for example, the Release Aging People in Prison (RAPP) website: nationinside.org/campaign/release-of-aging-people-in-prison/ and www.osborneny.org/images/uploads/printMedia/Osborne_Aging_WhitePaper.pdf
432. "For older people who frequently contend with multiple functional impairments and complex medical issues, prison routines and activities of daily life represent a significant safety issue. While many aging prisoners share the same challenges faced by elders in the outside community (such as bathing, dressing, using the bathroom, and getting in and out of bed), older prisoners must also contend with prison rules which require them to

drop to the ground for alarms, climb onto top bunks and undress for strip searches. Additionally, the built environment (for example, the limited number of bottom bunks, cells without handrails and long walks to the dining hall) contributes to making life difficult for older people. Many prisoners report they don't get the help they need from either medical or prison staff. Those who do receive assistance report that this help most often comes from other prisoners." (p. 16). Strupp, H. & Willmott, D. (2005). *Dignity Denied: The Price of Imprisoning Older Women in California*. San Francisco, CA: Legal Services for Prisoners with Children. (On file at the CA). See also Human Rights Watch. (2012). *Old Behind Bars: The Aging Prison Population in the United States*. Retrieved on July 15, 2014 from www.hrw.org/reports/2012/01/27/old-behind-bars

433. A Bureau of Justice Statistics report found that incarcerated people age 45 or older are more than four times more likely than the younger incarcerated population to have cancer, almost three times more likely to have diabetes, more than two times more likely to have heart or liver problems, and almost two times as likely to have hypertension. See note 66, *Medical Problems of Prisoners*, Table 2.
434. "Menopause is the permanent end of menstruation and fertility, defined as occurring 12 months after your last menstrual period." Mayo Clinic. (2013). *Menopause*. Retrieved on July 15, 2014 from www.mayoclinic.com/health/menopause/DS00119
Menopause symptoms listed in DOCCS Women's Health Primary Care Practice Guidelines include: "hot flashes, breast tenderness, worsening of premenstrual syndrome, decreased libido, fatigue, irregular periods, vaginal dryness, discomfort during sex, bladder control problems (stress, incontinence, urgency), mood swings/depression/irritability, difficulty sleeping, irregular or skipped periods, racing heart, headaches, joint and muscle pains." See note 102, *Women's Health Primary Care Practice Guideline*, p. 7.
435. "Osteoporosis, which means "porous bones," causes bones to become weak and brittle — so brittle that a fall or even mild stresses like bending over or coughing can cause a fracture. In many cases, bones weaken when you have low levels of calcium and other minerals in your bones." Mayo Clinic. (2013). *Osteoporosis*. Retrieved on July 15, 2014 from www.mayoclinic.com/health/osteoporosis/DS00128
"Of the 10 million Americans with osteoporosis, 8 in 10 are women." Office on Women's Health, U.S. Department of Health and Human Services (2010). *Osteoporosis*. Retrieved on July 15, 2014 from www.womenshealth.gov/aging/diseases-conditions/osteoporosis.html
See also Office on Women's Health, U.S. Department of Health and Human Services. (2012). *Osteoporosis fact sheet*. Retrieved on July 15, 2014 www.womenshealth.gov/publications/our-publications/fact-sheet/osteoporosis.html
National Institutes of Health Osteoporosis and Related Bone Diseases National Resource Center. (2011). *Osteoporosis Handout on Health*. U.S. Department of Health and Human Services. Retrieved on July 15, 2014 from www.niams.nih.gov/Health_Info/Bone/osteoporosis/osteoporosis_ff.asp
436. "The change in hormone levels may make you feel nervous, irritable, or very tired. These feelings may be linked to other symptoms of menopause, such as lack of sleep." The American College of Obstetricians and Gynecologists. (2013). *Frequently Asked Questions: Menopause*. Retrieved on July 15, 2014 from www.acog.org/~media/For%20Patients/faq047.pdf?dmc=1&ts=20121106T1603035115
"Three large prospective cohort studies indicate that the likelihood of depressed mood is approximately 30% to three times greater in the menopausal transition compared with the premenopausal stage." (p. 3). Maki, P.M., Freeman, E.W., Greendale, G.A., et al. (2010). Summary of the NIA-sponsored Conference on Depressive Symptoms and Cognitive Complaints in the Menopausal Transition. *Menopause*, 17(4), 815-822. Retrieved on July 15, 2014 from www.ncbi.nlm.nih.gov/pmc/articles/PMC2901893
437. "The average age of menopause is 51 years, but the normal range is 45 years to 55 years." *Id.*, *Frequently Asked Questions: Menopause*.
438. Mayo Clinic. (2013). *Menopause: Lifestyle and home remedies*. Retrieved on July 15, 2014 from www.mayoclinic.com/health/menopause/DS00119/DSECTION=lifestyle-and-home-remedies
National Institute on Aging. (2010). *Menopause: Time for a Change*. National Institutes of Health, U.S. Department of Health and Human Services. Retrieved on July 15, 2014 from www.nia.nih.gov/sites/default/files/menopause_time_for_a_change.pdf
439. See note 436, *Frequently Asked Questions: Menopause*.
U.S. National Library of Medicine. (2011). *Menopause*. Retrieved on July 15, 2014 from www.ncbi.nlm.nih.gov/pubmedhealth/PMH0001896/
440. Burke, M.S. (2008). Osteoporosis: A Neglected but Treatable Disease. *Annals of Long-Term Care*, 12(9).

Retrieved on July 15, 2014 from www.annalsoflongtermcare.com/article/3400#sthash.KJqFJlIC.dpuf
U.S. Department of Health and Human Services, Health Resources and Services Administration. (2009). Osteoporosis. *Women's Health USA 2009*. Rockville, MD. Retrieved on July 15, 2014 from mchb.hrsa.gov/whusa09/hstat/hi/pages/229o.html
Vermont Department of Health, Agency of Human Services. (n.d.). *Osteoporosis Surveillance*. Retrieved on July 15, 2014 from healthvermont.gov/research/chronic/osteoporosis.aspx

441. For osteopenia (low bone density but not low enough to be classified as osteoporosis), only Bedford and Beacon could provide data. Bedford reported four women, or approximately 0.5% of its total population, and Beacon reported 10 women, about 5% of its total population. While positive that Beacon seemed to take a more proactive approach to identifying osteopenia, which can lead to osteoporosis, some of the facility's diagnoses were based only on risk factors and not bone density tests, the most accurate way to diagnose the condition. Given national studies indicating that 49% of older women in the community suffer from osteopenia, it seems that many women in DOCCS with the condition remain unidentified. See Looker, C.L., Melton, L.J., III, Harris, T.B., Borrud, L.G. & Shepherd, J.A. (2010). Prevalence and Trends in Low Femur Bone Density Among Older US Adults: NHANES 2005-2006 Compared With NHANES III. *Journal of Bone and Mineral Research*, 25(1), 64-71. Retrieved on July 15, 2014 from www.ncbi.nlm.nih.gov/pmc/articles/PMC3312738/
442. NYS DOCCS. (2011). *Women's Health Primary Care Guideline*. Albany: NY. (On file at the CA).
443. "The U.S. Preventive Services Task Force recommends that women age 65 and older be screened routinely for osteoporosis. The task force also recommends that routine screening begin at age 60 for women who are at increased risk for osteoporotic fractures." National Institutes of Health Osteoporosis and Related Bone Diseases National Resource Center. (2012). *Bone Mass Measurement: What the Numbers Mean*. U.S. Department of Health and Human Services. Retrieved on July 15, 2014 from www.niams.nih.gov/Health_Info/Bone/Bone_Health/bone_mass_measure.asp#f
"BMD testing is indicated for: All postmenopausal women with medical causes of bone loss; all women age 65 and older...." (p. 45). North American Menopause Society. (2010). Management of osteoporosis in postmenopausal women: 2010 position statement of The North American Menopause Society. *Menopause*, 17(1), 25-54.
444. "Bone density testing is not appropriate if the person undergoing the test is not willing to take any treatment based on the results. Therefore, if bone density testing is done, it should be performed on women willing to take some specific action based on the results." See note 102, *Women's Health Primary Care Practice Guideline*, p. 9.
445. "Per HS Policy 1.19 the annual health screening for healthy, average risk inmates fifty years old and above includes a Digital Rectal Exam (DRE), FOBT times three OR colonoscopy (every ten years)." See note 102, *Women's Health Primary Care Practice Guideline*, p. 6.
As the risk of contracting colorectal cancer increases after age 50, women who are 50 and older are advised to have colonoscopies once every 10 years, or more frequently if they are at greater risk of contracting the disease. See U.S. Department of Health and Human Services. (2005). *Facts About Menopausal Hormone Therapy*. National Institutes of Health. Retrieved on July 15, 2014 from www.nhlbi.nih.gov/health/women/pht_facts.pdf
American Cancer Society. (2013). *American Cancer Society Guidelines for the Early Detection of Cancer*. Retrieved on July 15, 2014 from www.cancer.org/Healthy/FindCancerEarly/CancerScreeningGuidelines/american-cancer-society-guidelines-for-the-early-detection-of-cancer
Quaseem, A., Denberg, T.D., Hopkins, R.H, Humphrey, L.L., Levine, J., Sweet, D.E., Shekelle, P., Clinical Guidelines Committee of the American College of Physicians. (2012). Screening for colorectal cancer: a guidance statement from the American College of Physicians. *Annals of Internal Medicine*, 156(5), 378-86. Retrieved on July 15, 2014 from www.guideline.gov/content.aspx?id=38258&search=colorectal+cancer+screening
446. Lung cancer is the number one, and breast cancer the number two cause of cancer deaths among women. See Centers for Disease Control and Prevention. (2013). *Cancer Prevention and Control: Cancer Among Women*. Retrieved on July 15, 2014 from www.cdc.gov/cancer/dcpc/data/women.htm
U.S. Department of Health and Human Services. (2005). *Facts About Menopausal Hormone Therapy*. National Institutes of Health. Retrieved on July 15, 2014 from www.nhlbi.nih.gov/health/women/pht_facts.pdf