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**Testimony by Gail T. Smith,
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Before Assembly Committees on Health and Corrections
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Thank you for the opportunity to provide information about women's health care in the New York State correctional system. My name is Gail Smith, and I am the director of the Women in Prison Project of the Correctional Association of New York. The information provided here comes from years of monitoring visits to women's prisons, from letters and phone calls from women incarcerated in New York prisons, from a survey on conditions at Bedford Hills Correctional Facility in August 2017 which included 39 questions about health care of 145 total questions, from our 2015 report *Reproductive Injustice*, and from information provided by the Department of Corrections and Community Supervision (DOCCS). Women come into prison with serious health issues due to their histories of gender victimization and poverty. A Bedford Hills study in 1999 found that 94% of women had experienced physical or sexual abuse during their lives.ⁱ These experiences affect overall health and can lead to substance abuse.ⁱⁱ The impact of trauma, the lack of adequate primary care for low-income communities, and their family histories contribute to serious health problems that require prompt, thorough, and quality care. The incidence of HIV and Hepatitis C is higher for incarcerated women than for men. The rate of women's HIV infection in New York facilities is 2.8%; 1.9% of men in New York prisons are infected, according to the New York Department of Health Zero Prevalence Study.ⁱⁱⁱ Tests of persons newly admitted to DOCCS in 2015 showed that 10.3% of men and 24.2% of women were infected with Hepatitis C. As of 2014, DOCCS reported that the per capita health care cost for men in custody was just under \$6,000, and the per capita cost for women was just over \$12,000.^{iv}

Our major concerns for women's health care in New York prisons include the delay of necessary medical care, the disrespect and dismissiveness with which women often are treated by medical personnel, the poor quality of care and lack of oversight of prison medical care, the failure to consistently provide care that is trauma-informed, and an ineffective grievance process that does not address problems.^v Both Bedford Hills and Albion are classified as medical level one prisons; they are expected to provide the most intensive medical services available in prisons. They each have an infirmary and are staffed 24 hours a day. Bedford Hills also has a Regional Medical Unit capable of providing long-term nursing care. Taconic is classified as a medical level two prison. Medical care should be equivalent to the community standard of care^{vi}, and must be trauma-informed in order to be effective for women who have survived multiple incidents of abuse in their lives.^{vii}

On each Correctional Association visit to women's prisons, women tell us about serious problems they face in accessing appropriate health care and the challenges of securing women-specific care during their incarceration. Inadequate medical care is consistently one of the most highly grieved areas for men and women in DOCCS custody.^{viii} For example, according to the Annual Grievance Reports for Bedford Hills Correctional Facility, 107 of the 563 grievances filed (19%) in 2016 and 123 of the 720 grievances filed (17%) in 2015 concerned medical care, the highest category of grievances by far.^{ix} At the time of

our visit to Bedford there had been two unanticipated deaths with unexplained medical causes; one woman died in her bed and one in the hospital.

The first finding of the Correctional Association's 2015 report *Reproductive Injustice* was that there is virtually no oversight of health care; written policies are substandard, and there is inadequate data collection and analysis. DOCCS has not established a systematic review of its health services and the State Department of Health plays no role in evaluating health care in prison, except concerning HIV and Hepatitis C. Many prisons could not supply basic information about reproductive health care and outcomes in response to our requests, and a recent request for information to Bedford Hills resulted in gaps in information. DOCCS' written reproductive health policies are not comprehensive, fail to reference community standards and deviate from those standards in key areas.

We analyzed 94 completed surveys from our August mailing to women in Bedford Hills. Of 90 women who answered the question whether they have a serious medical condition more than half, 53%, reported a serious medical condition (Figure 1). Of the 41 women who chose to report their specific illnesses, 58.5% reported having asthma. Other conditions they reported include diabetes Type 1 and 2, seizure disorders, hypertension and strokes, HIV, Hepatitis C, lupus, and cardiac problems.

Access to Medical Care

Because of the nature of incarceration, it is difficult to get prompt access to medical care when you need it in prison. In the community, the worst case scenario is that people without a primary care doctor go to an emergency room or urgent care center, options that are not available to the women no matter how great the emergency. We asked whether the women have adequate access to sick call and half answered "no" (Figure 2). At sick call, nurses are the gatekeepers to the doctor, physician's assistant, and nurse practitioners, and if they do not take the time to listen to a woman's symptoms and evaluate her condition accurately, the clinicians may not have accurate information or the woman may be denied further care entirely. Well over half of the women, 64%, say that the nurses do not accurately evaluate their medical needs (Figure 3), and 51% say that the nurses do not refer them to the doctor when necessary (Figure 4). 68% say that they do not have access to a doctor, physician's assistant or nurse practitioner when they need one (Figure 5). 65% of women reported having had a serious medical issue or injury requiring immediate medical attention. They reported dangerous delays in having access to medical care: the median amount of time they waited was seven days for an urgent need. Four women reported waiting several months and four women waited more than a year to be seen. 59% of the women said that they do not have adequate access to medical staff for an emergency (Figure 6). 76% of women report that they do not have adequate access to a dentist.

Quality of Care

The Correctional Association's 2015 report *Reproductive Injustice* found serious problems with data collection and with clear health policies. Consistent, thorough data collection and analysis are necessary for DOCCS to assess and respond to women's health needs and to determine how to best allocate resources and staff. Despite having a system of codes to document medical conditions, prisons were often unable to provide information about medical conditions when the Correctional Association asked for data over the past seven years.

More than half of the women, 53%, rated the sick call nurses' quality "poor"; 10% rated it "good" and 37% "fair" (Figure 7). 70% report that doctors do not give them a thorough exam (Figure 8) and 72% say

that doctors do not give them enough time to talk about the medical problem (Figure 9). The fact that so many women report that the clinicians don't give them sufficient time to explain their medical problem is of particular concern due to the need for women to have trauma-informed care and medical staff whom they can trust. 74% say that the doctors do not adequately treat their medical problems (Figure 10). Women reported a pattern of having their prescriptions for serious, chronic conditions stopped with no explanation, or having prescriptions that were effective changed without warning or explanation. 87% of women had been prescribed medication, and just over 40% of women report delays in getting their medication. 83% report that no one explained the side effects of their prescriptions. About half of the women surveyed rate the doctors' quality of care as "poor", with 35% rating them as "fair" and only 15% rating them as "good" (Figure 11).

Respect and Confidentiality

The lack of respect, dismissiveness, and lack of consistent confidentiality that women experience from prison health care staff is a barrier to effective medical care. 63% of women answering the question whether the doctor treats them with respect and concern answered "no" (Figure 12). In a setting where officers use private information to taunt and humiliate women, confidentiality is particularly crucial to allow trust between the clinician and patient. 42% of women reported that nurses do not maintain confidentiality (Figure 13) and some women reported that nurses not only were careless but actually gossiped with officers about the women's medical conditions. Doctors were somewhat better, with 47% of women reporting that doctors respected confidentiality and 28% answering "no" (Figure 14), but this is still a troubling proportion of doctors.

Reproductive Health Care

Reproductive health care in prison is fundamental to the well-being of families and communities, as almost everyone in prison eventually goes home. Yet there is virtually no oversight of reproductive health care, substandard written policies, poor quality medical charts, a lack of health education, and inadequate data analysis. Women report delays in gynecological care and inadequate access to the gynecologist. Some clinicians do not treat women with respect and dignity. 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, which 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.^x 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.^{xi} Many of the reproductive health survey respondents who reported feeling "bad" after gynecological appointments said they felt this way because of past experiences of abuse.

DOCCS should improve its written policies and practices for aging women. Appropriate treatment must be provided for menopause and bone density tests must be available to screen for osteoporosis.

The top positive findings in the 2015 *Reproductive Injustice* report include:

- Timely and quality prenatal care
- Annual gynecological exams for most women
- Valuable programming for trauma survivors
- Beneficial HIV education programming

Improvements in the past two years

There have been crucial improvements since the Correctional Association's *Reproductive Injustice* report and our rigorous advocacy based on its findings. The most dramatic change is regarding the use of restraints on pregnant women. Since the December 2015 passage of the more comprehensive law protecting women from the use of restraints throughout pregnancy, we have heard few concerns about shackling during pregnancy, and none during labor and delivery. Almost all of the incidents reported to us have occurred while the women were in county custody, not state custody. We commend both the legislature and DOCCS for this improvement, along with the many women who worked to ensure that no one would have to go through what they experienced while giving birth. We are glad to see that DOCCS is providing training to their officers and notice to the women regarding this important change in policy. We will continue to document the experiences of women in custody and we will try to ensure full implementation of the new law.

Another important policy change is that DOCCS reports that it no longer places pregnant women in solitary confinement. We have not yet seen DOCCS directive on the policy. We urge the legislature to codify an end to this dangerous practice, and we commend the Assembly for passing Assembly Bill 1610, which restricts the segregated confinement of pregnant women to situations in which exceptional circumstances create an unacceptable risk to other women or staff.

Our recent survey showed an increase in the number of women over age 40 who receive annual mammograms. 75.6% of women surveyed received a mammogram in the past year, compared with 67% at the time of our 2015 report. Moreover, of the ten women over 40 who had not had a mammogram, three were in custody less than a year and two had turned 40 less than 2 months before the survey, so compliance may be even better. We will work to ensure that other facilities are improving their practice as well.

Gynecological Care

When asked about the quality of gynecological care, 63% of women said that the gynecologist performed a thorough exam and 23% answered "no"; 63% said that the gynecologist communicates clearly while 29% said that she did not; 65% of women felt the gynecologist respected confidentiality while 10% said she did not and 24% were unsure. 50% of women who had an abnormal test result which could indicate cancer or another serious problem said that there were serious delays in follow-up for test results, and 6% said they never got their results (Figure 15). 56% of women answered that the gynecologist adequately treats their needs and 33% said that she does not, with about 12% uncertain (Figure 16).

The number of women who reported having a Pap test in the prior year declined from 94% in our 2015 report to 84% this year. 56% of women said that they did not receive timely notice of abnormal test results from the gynecologist, and 50% reported that there were significant delays with follow-up after an abnormal test result.

HIV and Hepatitis C Care

The social conditions and experiences that often lead women to be criminalized and prosecuted—poverty, addiction, domestic violence, trauma, sex work, being prostituted—are experiences that also

put women at risk for HIV. Because the criminal legal system targets low income communities of color, a disproportionate number of women in New York's prisons are women of color and women from communities with high HIV seroprevalence rates. Ensuring that people in prison have access to HIV services is simply good public health.

Most women say 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, the 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. These remain serious barriers for incarcerated women in accessing these services. Women reported that pervasive myths and negative attitudes about HIV among both staff and incarcerated women fuel a climate of fear, harassment and discriminatory treatment. Women also reported that violations of privacy and medical confidentiality are common, as noted above, and these contribute to women's reluctance to access services that might suggest they are HIV-positive. More work is needed to confirm the number of HIV-positive women in DOCCS and to create conditions in which incarcerated women can feel safe revealing their HIV status.

While DOCCS offers routine HIV testing opportunities, there is room for improvement. The only time DOCCS requires staff to offer an HIV test proactively is during the medical exam conducted at reception, and only to people who fall into certain indicated categories, such as people who have a sexually transmitted disease (STD) and have not been tested for HIV in the last year; women who are pregnant; and people who have a positive PPD test, active tuberculosis, or symptoms consistent with AIDS. DOCCS does not require its staff to offer testing at other opportune moments, such as when women are transferred to other DOCCS facilities or during annual GYN exams. Only 22% of reproductive health survey respondents reported that the gynecologist spoke to them about getting tested for HIV, HCV and other STDs during their last check-up. In addition, women report difficulty obtaining an HIV test if they had a previous test and they request a test for sexual health reasons.

As stated above, the NY Department of Health Zero Prevalence Study of newly admitted persons found a 24.2% rate of Hepatitis C infection for women in NY State prisons.^{xii} Bedford Hills reports 92 HCV + patients and 68 who are chronically infected. While the stated Department policy is to treat Levels 1 through 4, Bedford Hills reported that as of this month four women are receiving treatment, and that the total number of women treated for HCV was seven in 2015, three in 2016, and nine in 2017. Since only a small number of the infected population are likely to be Level Zero^{xiii}, this raises a potential concern that the facility may not be fully evaluating and treating HCV+ patients that DOCCS policy would treat for the virus.

The nationally-recognized peer-led ACE program (AIDS Counseling and Education Program) still operates weekly according to DOCS, with peer education training and certification scheduled twice a year. However, the number of peer educators has been reduced from three to two.

Pregnant Women and Mother-Infant Separation

(a) A pregnant prisoner should receive necessary prenatal and postpartum care and treatment, including an adequate diet, clothing, appropriate accommodations relating to bed assignment and housing area temperature, and childbirth and infant care instruction.

(e) Governmental and correctional authorities should strive to meet the legitimate needs

of prisoner mothers and their infants, including a prisoner's desire to breastfeed her child. Governmental authorities should ordinarily allow a prisoner who gives birth while in a correctional facility or who already has an infant at the time she is admitted to a correctional facility to keep the infant with her for a reasonable time, preferably on extended furlough or in an appropriate community facility or, if that is not practicable or reasonable, in a nursery at a correctional facility that is staffed by qualified persons. Governmental authorities should provide appropriate health care to children in such facilities.^{xiv}

ABA Criminal Justice Standards – Treatment of Prisoners, Standard 23-6.9 Pregnant prisoners and new mothers

Up to nine percent of women in correctional custody are pregnant while incarcerated. Over the past seven years, women consistently 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 NY prisons, many pregnant women reported inadequate heat and ventilation, too little privacy, and infestations of pests in their housing areas, which pose a risk of infection that could harm the fetus. During transport for outside appointments, women did not have seasonally appropriate clothing and were often transported without warm coats, hats, or scarves in the winter and in sweat pants on hot summer days. Women said that correctional officers' conduct ranged from fair and professional to deeply disrespectful and abusive, creating a level of stress that is contraindicated for anyone who has survived trauma but particularly for pregnant women. In terms of support and planning for their babies, 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. Women have reported being turned down arbitrarily for the nursery, and Bedford Hills reported this month that 22 beds of the 27 available are in use, although there have been 71 pregnant women at the prison this year. Some women may not have given birth while in custody, but it is unlikely that this amounts to 49 women, and only one miscarriage is reported. The nature of child development and maternal health make the separation of mothers and their newborn infants harmful to both. When prisons separate mothers from their babies soon after birth, they deny both of them the crucial period of mother-infant bonding that is so vital to human development. Since the vast majority of pregnant women in custody pose no risk to the community and are sentenced for nonviolent offenses, we urge the legislature to establish more community-based programs that permit mothers to care for their babies outside a prison setting. Breast milk contains antibodies that help babies fight off viruses and bacteria, and it lowers their risk of having asthma or allergies. Babies who are breastfed exclusively for the first 6 months, without formula, have fewer ear infections, respiratory illnesses, and bouts of diarrhea. For mothers, a history of lactation was associated with a reduced risk of type 2 diabetes, breast cancer, and ovarian cancer. Stopping breastfeeding early or not breastfeeding was associated with an increased risk of maternal postpartum depression. Despite these strong, well-established health benefits, new mothers in our *Reproductive Injustice* survey reported that correctional staff did not support their breastfeeding and at times actively thwarted it. DOCCS should keep mothers and infants together whenever possible to allow bonding and breastfeeding, should provide education about the importance of breastfeeding to all staff and pregnant women in women's facilities, institute policies and practices that encourage breastfeeding, require that staff comply with these policies and practices that encourage breastfeeding, and require that staff comply with these policies and practices.

The Gender-Informed Practice Assessment and Trauma-Informed Care

The Gender-Informed Practice Assessment (GIPA) is a national initiative developed by the National Institute of Corrections and the National Resource Center on Justice-Involved Women^{xv} in response to the dramatic increase in women's incarceration nationwide. The number of women in the American justice system grew more than 700%, from 1980 to 2014, and women of color in particular are disproportionately arrested and incarcerated^{xvi}.

The process of implementing the GIPA is extensive and is meant to be transformative. Departments of Corrections that elect to participate in the process commit to engaging in a challenging but deeply rewarding process of self-reflection and building gender-responsive, evidence-based, and trauma-informed policies and practices for and with justice-involved women and staff. This approach is meant to reach every aspect of life in the facility and every interaction between staff and women in custody. Gender-responsive approaches are those that intentionally allow research and knowledge on women to affect and guide policy and practice at all levels of service delivery.^{xvii} This research encompasses: women's socialization and psychological development; the social, political and economic realities of women's lives; women's unique risk, strength and need factors (pathways research); and cutting-edge evidence on what works with women. Gender Responsive approaches are further defined by the following Five CORE Practice Areas, which advise that every program, service and intervention should be: 1) Relationship-based; 2) Strengths-based; 3) Trauma-informed; 4) Culturally Responsive; and 5) Holistic.^{xviii}

These Five CORE Practice Areas should be applied at every level of assessment, service delivery and engagement with justice-involved women. They directly correspond to the defining developmental and ecological realities of women's lives: their unique risks, strengths and needs factors, their dramatically different pathways into and experiences within the justice system, their disproportionate experiences with sexual and/or domestic abuse, their higher rates of substance abuse and mental health needs that relate to their past and present abuse, their different offense patterns, their different parenting responsibilities and experiences, and their differential responses to treatment and correctional settings.^{xix}

New York applied and was accepted to become a GIPA site. It takes time to fully implement such a major change in correctional culture, but the apparent lack of change in the treatment of women in custody is cause for concern regarding the success of the process. The continued incidence of verbal and physical abuse of women and the chronic disrespect by staff has been obvious in the two visits we have made to facilities this year and in the concerns women express about ongoing physical and chronic verbal abuse. This has a pervasive and profound influence on medical care in that it affects women's access to care, destroys trust, and promotes a sense of hopelessness. Women express reluctance to file grievances cannot demand quality care, fair treatment, or respect. 64% of the women answered "No" to our recent survey question whether they were satisfied with the results of grievances they filed, and most women who did not file grievances said the reason was that they feared retaliation or didn't think that filing a grievance would do any good. Only three women were satisfied with the resolution of a grievance they filed. This was also evident in the women's interviews and letters about the grievance process, especially regarding medical care. We learned from DOCCS that even in cases when a grievance is denied and then appealed, and the woman who filed the grievance is vindicated, DOCCS does not inform her of this result, so she is not able to follow up on appropriate medical care.

Staffing

We hope that the NY Legislature can assist DOCCS in finding a solution to the difficulty they have in recruiting and maintaining qualified staff. Given the greater need that women have for access to health care, this is an even greater problem for them, and this is illustrated in the delays they report and the sometimes rushed, indifferent quality of care. Since 2012 Bedford Hills has reduced the number of authorized positions for physicians by one and a half and has reduced the physician assistant position from one full-time to one half-time position, while increasing the number of nurses. More assessment is needed to determine how this affects the delivery of and quality of care, but the women’s concerns about confidentiality and professionalism of the nurses raises concerns about this development.

Bedford Hills Medical Staff		
Positions	2012	2017
MD authorized	6	4.5
MD vacancy	2.5	1.5 reported, or 1 (1 PT contracted)
N/P or P/A authorized	1	.5
N/P or P/A vacancy	0	1
Nurses	13	25 (includes RMU)
Nurse vacancy	5	0
LPN	2	5
LPN vacancy	0	0
Clinician Ratio	169.8	151.8
Nurse Ratio	77.36	30.36 (but includes RMU nurses)

Figure 17

Continuity of Care

A larger proportion of women are convicted of relatively minor and nonviolent offenses, and as a result, their population turns over faster than men’s and many are released from prison sooner. This presents a challenge for discharge planning and continuity of medical care in the community, and this planning needs to be accomplished on an accelerated schedule. On our July visit to Bedford Hills, the staff responsible for planning and the O.R.C.’s were clearly overworked and overwhelmed.

Women are more likely to be caregivers of young children on their release and also are more likely to be caregivers for their aging relatives. This means they have less time to focus on their own health care, and it becomes all the more important to remove barriers to access on their return home. This increases the urgency of continuity of care, especially for chronic illnesses and for mental health treatment and prescriptions. The 2007 law that allows suspension rather than termination of Medicaid for those who are eligible helps a great deal, but DOCCS and the Department of Health need to work together closely to ensure a smooth transition for the sake of women’s health, community health, and parole success, as lack of medical care can be a factor in repeat arrests. DOCCS must track which women were receiving Medicaid and work with them to ensure they get benefits as soon as they are released.

Key recommendations

For the Department of Corrections and Community Supervision:

1. Develop comprehensive written health policies for women that reflect and reference community standards, collect and analyze data, and conduct regular assessments of health care at prisons. Track medical conditions and outcomes including pregnancy outcomes,
2. Ensure that the 2015 Anti-shackling law is complied with and report on all exceptions made.
3. Take affirmative action to eliminate delays in provision of medical care.
4. Apply the Gender-Informed Practice Assessment standards and principles in training of medical staff as well as all correctional staff. Provide rigorous training on evidence-based, trauma-informed practices, on women's health needs across the life span, and on best practices for professional, compassionate, trauma-informed clinical interactions.
5. Improve basic conditions for pregnant women. Provide providing adequate, nutritious food and supplements. Provide seasonally-appropriate clothing especially during transports, and safe and sanitary living conditions. Provide supportive services. For all women, maintain clean, weather-appropriate housing conditions, and strengthen mechanisms to prevent and respond to abusive treatment by correctional staff.
6. Whenever possible, keep mothers and their children together in community-based programs or, if that is impossible, in the nursery, until the mother completes her sentence. If it is not possible for the babies to stay with their mothers, provide supportive services to assist the mothers in finding a safe, appropriate placement and in maintaining frequent visits with her baby.

For the 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; rigorously collect and analyze data regarding service delivery, medical outcomes, and pregnancy outcomes.
2. Establish basic written standards for reproductive health care for incarcerated women, and require robust internal and external oversight of that care.
3. Address the shortage of medical staff; allocate funds for DOCCS to hire sufficient medical and gynecological staff, and raise salaries for DOCCS clinical providers.
4. Enact a law that allows most women to serve their sentences in the community alternatives to incarceration, and that allows women in the nursery program to complete their sentences with their children in community-based programs.
5. Establish oversight regarding the GIPA principles and their implementation in women's prisons.
6. Continue New York's trend away from prison and toward alternatives to incarceration.
7. Allocate funding for health education programs, in prison and in the communities, and provide for state hiring of certified peer health educators.

Thank you for this opportunity to address women's health care in New York prisons and for your consideration of these recommendations.

ⁱ Avon Global Center for Women and Justice at Cornell Law School and Women in Prison Project of the Correctional Association of New York, *From Protection to Punishment: Post-Conviction Barriers to Justice for Domestic Violence Survivor-Defendants in New York State*; Browne, Miller and Maguin, "Prevalence and Severity of Lifetime Physical and Sexual Victimization Among Incarcerated Women," *International Journal of Law & Psychiatry* 22(3-4)(1999). The authors state that lifetime prevalence rates of the types of violence studies may be underreported for a number of reasons. Moreover, "childhood traumas seem to be at the root of most of the women's troubles. Eighty-two percent experienced some sort of severe assault during childhood. More than half of the girls had been sexually molested as children, and more than 70 percent had been severely attacked physically by an adult caretaker... 'You see an onset of substance abuse, early depression, and post-traumatic stress responses,' says Browne. The latter category can include nightmares and dissociation from one's environment as a way of dealing with pain and danger. Drug and alcohol abuse are another escape strategy. The changes go as deep as blood chemistry, which may respond to molestation and violence with a characteristic elevation in the "stress hormone" cortisol.' This history of traumas has a profound negative affect on women's health. <https://harvardmagazine.com/1999/09/right.chains.html>.

ⁱⁱ Young, V. D. & Reviere, R. (2006). *Women behind bars: Gender and race in U.S. prisons*, Boulder, CO: Lynne Rienner Publishers; Reichert, J. and Bostwick, L., *Post-traumatic stress disorders and victimization among female prisoners in Illinois*, November 2010, Illinois Criminal Justice Information Authority, Chicago, IL, http://www.icjia.state.il.us/assets/pdf/ResearchReports/PTSD_Female_Prisoners_Report_1110.pdf

ⁱⁱⁱ 2015 New York Department of Health Zero Prevalence Study. Nationwide in 2010, the rate of HIV infection was 1% for men in prison and 2% of women in prison. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, *HIV in Prison, 2010-2015 Statistical Tables*, August 2017, NCJ 250641.

^{iv} 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.

^v 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.

^{vi} American Bar Association Criminal Justice Standards – Treatment of Prisoners, 3d Edition, 2011, Washington, DC.

^{vii} Kraft-Stolar, *Reproductive Injustice: The State of Reproductive Health Care for Women in New York State Prisons*, 2015, Correctional Association of New York.

^{viii} *Reproductive Injustice*, NY DOCCS.

^{ix} Bedford Hills Annual Grievance Report, October 2, 2017; Annual Reports 2015 and 2016, provided by DOCCS October 13, 2017 on file at the CA.

^x 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.

^{xi} Hilden, M., Schei, B., Swahnberg, K., Halmesmaki, E., Langhoff-Roos, J., Offerdal, K., Pikarinen, U., et al. (2004). 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

^{xii} 2015 New York Department of Health Zero Prevalence Study.

^{xiii} *Hepatology*. 2013 June; 57 (6); 2164-2170, Baltimore, MD.

^{xiv} American Bar Association Criminal Justice Standards – Treatment of Prisoners, 3d Edition, 2011, Washington, DC.

^{xv} <https://community.nicic.gov/blogs/nic/archive/2012/04/04/assistance-available-to-conduct-a-gender-informed-practice-assessment-gipa.aspx>

^{xvi} The Sentencing Project, <http://www.sentencingproject.org/wp-content/uploads/2016/02/Incarcerated-Women-and-Girls.pdf>

^{xvii} National Resource Center on Justice Involved Women, <https://community.nicic.gov/blogs/nic/archive/2012/04/04/assistance-available-to-conduct-a-gender-informed-practice-assessment-gipa.aspx>

^{xviii} *Ibid.*

^{xix} *Ibid.*