A Call to Action: The National Symposium on the Use of Restraints on Pregnant Women Behind Bars

Sponsored by the U.S. Department of Justice *with* the Rebecca Project for Human Rights[1]

Convened: November 22, 2010

Context and Purpose of the Symposium

The National Symposium on the Use of Restraints on Pregnant Women Behind Bars was convened on November 22, 2010 in Washington, D.C. by the U.S. Department of Justice, Office of Justice Programs, in partnership with the Rebecca Project for Human Rights. The Symposium was planned – along with staff from the Rebecca Project – and facilitated by the Center for Effective Public Policy and was designed to promote awareness and advance a national dialogue that will inform future reform initiatives. The Symposium was attended by a broad range of stakeholders and interested parties including criminal justice policymakers, practitioners, and representatives; medical experts; human rights advocates; and other key stakeholders. This paper is designed to frame the issues that emerged, highlight key discussion points and recommendations offered by Symposium participants, and identify specific steps interested parties have agreed to take to advance dialogue and action in this area.[2]

Identified Concerns

The use of restraints[3] can pose health risks for mother and child and can interfere with healthcare during pregnancy, labor, and delivery.

1. Pregnancy impacts a woman's balance[i], particularly in the second and third trimesters[ii]; the limited physical movement due to restraints threatens to further affect balance, increase the potential to trip and/or fall, prevent the mother from breaking her fall, and can consequently increase the risk of injury to the mother and fetus[iii];
2. The presence of restraints can interfere with the performance of routine examinations and procedures during the course of pregnancy[iv];
3. Restraints limit the mobility that is important to the progression of labor, the management of pain and discomfort during labor, and the process of delivery[v]; and
4. The presence of restraints can hamper the ability to respond effectively to emergency circumstances and acute complications with the mother (e.g., pre-eclampsia) or fetal distress during pregnancy, labor, delivery, and post-delivery[vi].

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[2] The symposium notes and a list of participants are also available at www.cjinvolvedwomen.org.

[3] Handcuffs, leg shackles, and/or belly chains.

Adjustment and emotional difficulties for new or expecting mothers in custody may be induced or exacerbated by the use of restraints.

- The risk for depression among women is already heightened during pregnancy and post-partum[vii], and the experience of being restrained may be counter-therapeutic in and of itself;
- As a group, and relative to males in custody, a substantial proportion of females in custody have experienced maltreatment during childhood/adolescence or have been exposed to or experienced sexual abuse and/or domestic violence[viii]; the experience of being restrained has the potential to be re-traumatizing and increase/resurface depressive or anxiety-related symptoms[ix];
- As pregnancy progresses, more frequent obstetrical/gynecological appointments are required[x] and, if these services are provided outside of the correctional facility, the use of restraints – and the potential for associated emotional/psychological impact – may become more frequent; and
- Being unable to have physical contact with one's newborn after delivery because of restraints can be traumatic for women in custody[xi].

Restricted physical contact between newborns and their mothers – in part a function of the use of restraints following delivery – can be detrimental to the wellness of the child.

- Limited physical contact between mother and child following an infant's birth can critically impair the development of healthy attachment and bonding[xii], which is a strong protective factor in a child's short- and long-term development;
- Restraints and separation, and the accompanying emotional stressors, can prevent and interrupt the breastfeeding process[xiii]; and
- Growing evidence suggests that infants in neonatal intensive care improve more quickly when the mother is nearby and readily accessible[xiv].

Policies, operating procedures, and practices pertaining to the use of restraints on women in custody vary considerably within and across federal, state, and local jurisdictions and agencies[xv].

- Restraint policies and operating procedures in some agencies and jurisdictions are explicitly addressed, whereas in others, they are silent with respect to pregnant women in custody[xvi];
- When in place, specialized policies and operating procedures may be limited to restrictions or prohibitions during the latter part of pregnancy (e.g., third trimester) or during labor and delivery[xvii];
- Some agencies/jurisdictions allow for the use of restraints during labor and delivery[xviii];
- Policy expectations that prohibit or restrict the use of restraints with pregnant women in custody are not always reflected in practice[xix]; and
- Quality control mechanisms and other safeguards may not be established, routinely monitored, or consistently enforced in some agencies/jurisdictions[xx].

The widespread use of restraints as a risk management tool for justice-involved women is not supported by evidence.

5. Many historical and current correctional policies and practices for managing males in custody – such as the use of restraints – have been applied to females, but are not grounded by research-supported differences between these populations. Such differences include the following:
    - Women are less likely to be in custody for charges, convictions, or histories involving violent offenses or other crimes against persons; rather, non-violent and drug-related offenses are more prevalent among women offenders[xxi];
    - Institutional violence/aggression toward others is less common among women in custody than for men;[xxii] self-injurious behaviors are more likely among women involved in the criminal justice system;[xxiii]
    - Women in custody often have greater treatment/intervention needs than risk management issues[xxiv]; and
    - The incidence of absconding is exceptionally uncommon[xxv].

The use of restraints is only one facet of the need for system reform regarding pregnant women in custody.

- Policy-driven mechanisms and necessary resources must also be in place to address inconsistencies and gaps with respect to:
    - Detecting pregnancies at intake, and dating pregnancies immediately via early ultrasound[xxvi];
    - Screening to identify and rule out ectopic pregnancy and other complications[xxvii];
    - Assessing for potential pregnancy-impacting risk factors such as diabetes, smoking, substance abuse, medication side effects, sexually transmitted diseases, and HIV[xxviii];
    - Offering genetic testing and counseling, reviewing pregnancy options, and discussing family planning[xxix];
    - Initiating and/or maintaining appropriate prenatal care[xxx];
    - Ensuring special accommodations (e.g., specialized housing units, mattresses/bunks, work detail, nutrition)[xxxi];
    - Conducting ongoing screenings for depression, other emotional/mental health difficulties, and substance abuse during pregnancy and post-delivery[xxxii];
    - Providing programs and services that facilitate routine contact and attachment between mothers and infants[xxxiii];
    - Ensuring adequate training for custody officers and staff to understand common issues, needs, and considerations for pregnant women in custody[xxxiv]; and
    - Promoting continuity of care and successful transition from institutional settings to the community (e.g., specifically with respect to prenatal and pediatric care, social services, sobriety, and mental health)[xxxv].

Factors Contributing to Current Problems and Barriers to Reform

Symposium participants indicated that a myriad of factors contribute to the current policy, procedural, and practice concerns, not only regarding the use of restraints with this population, but also in terms of system responses to justice-involved pregnant women overall. Key examples noted by participants include the following:

- Historical correctional-system practices of applying policies developed for justice-involved men to justice-involved women;
- Limited awareness among some representatives of stakeholder groups (e.g., lawmakers, agency officials, custody staff, community leaders, the public) regarding the unintended collateral consequences of the use of restraints on pregnant women in custody;
- Limited data and research from the legal, medical, and correctional fields about this special population and the effectiveness and impact of the use of restraints (and alternatives);
- Limited opportunities for the voices of justice-involved women, their partners/families, and children to be heard;
- A lack of communication and inter-disciplinary dialogue regarding these issues and the roles, responsibilities, and interests of the various stakeholders in advancing policy and practice;
- Limited options and alternatives available to the courts/judges to allow for individualized and maximally responsive dispositions for justice-involved women;
- The absence of national standards pertaining to the use of restraints on pregnant women in custody, and concerns about the potential loss of autonomy at the state level that may result from the establishment of federal mandates;
- Concerns about legal challenges that may stem from differential standards for the use of restraints for males and females in custody; and
- The absence of a comprehensive, unifying strategy that balances security, risk management, and responsiveness to the unique intervention needs of pregnant women in the criminal justice system.

Positive Influences Supporting Reform

Although a number of significant barriers were noted by those in attendance at the Symposium, multiple factors were also reported as having the potential to support and advance reform efforts in this arena. These include the following:

- The continued movement toward identifying and adopting evidence-based approaches in the criminal justice system, including gender-responsive policies and practices;
- A growing acknowledgement of the differences between men and women involved in the justice system and, in particular, differences in terms of the level of risk they pose and appropriate interventions;
- An increased appreciation for the potential for justice-involved individuals to change, and the desire for cost-effective, successful outcomes that extend beyond risk management and containment;

- The clear investment of correctional administrators and officers, medical professionals, and other stakeholders to ensuring the health and overall well-being of pregnant women in custody (and their children);
- A growing body of research and awareness about the needs and interests of children of incarcerated parents, which can draw attention to issues specific to mothers who are incarcerated;
- A focus in the medical community regarding collateral consequences associated with the use of restraints with pregnant women in custody (e.g., American Congress of Obstetricians and Gynecologists, Committee on Health Care for Underserved Women);
- The increased visibility of human rights advocacy coalitions regarding this issue;
- The precedent established by at least 14 states who have enacted legislation specific to the use of restraints on pregnant women in custody, as well as formal position statements from stakeholder organizations and entities[xxxvi];
- A demonstrated commitment by officials within the U.S. Department of Justice to advance the dialogue on this topic; and
- Multiple federal initiatives that have provided models for addressing other challenging issues in the correctional system (e.g., prison rape elimination, mentally ill individuals in the justice system).

Priority Recommendations

Based on the concerns, barriers, and influences explored throughout the Symposium, a wide range of recommendations were identified by participants[4], largely reflected in the following priorities:

1. Commission a multidisciplinary national task force to critically and systematically assess current policies and practice trends; review key research reports and policy analyses in this area; and develop a comprehensive, multidisciplinary framework to guide policy and practice at the federal, national, state and local levels, including proposed standards, guidelines, and quality control mechanisms;

2. Encourage national organizations (e.g., American Correctional Association; American Correctional Health Services Association; American Jail Association; Association of State Correctional Administrators; Congress of National Conference of State Legislatures; National Governor's Association; National Sheriff's Association) to develop position statements, model policies, and performance indicators pertaining to the key issues involving pregnant justice-involved women where not currently present;

3. Establish a national clearinghouse/resource center specifically designed to increase awareness and knowledge among key stakeholder groups (e.g., federal, state, and local lawmakers and agency officials; prison and jail administrators; intake, case management, and custody staff; court officials; probation and parole supervision officials; medical, mental health, and social services representatives; the public) about the management of pregnant women involved in the criminal justice system through information dissemination, training, and targeted technical assistance; and

[4] See the symposium notes for the full range of recommendations.

4. Develop funding programs to conduct research about this special population, identify effective/promising intervention strategies (including alternatives to detention/incarceration), and support jurisdictions' planning and implementation efforts to enhance responses in this area.

Action Item Commitments that Resulted from this Symposium

- The SAMHSA National Center Promoting Alternatives to Seclusion and Restraint through Trauma Informed Practices will assume a leadership role in convening and facilitating continued national dialogue among stakeholders interested in reshaping policy and practice with regard to the use of restraints on pregnant incarcerated women.

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- The newly established National Resource Center on Justice-Involved Women (NRCJIW)[5] will build awareness and encourage advancement of policy and practice in this area by devoting a page on its website (see the Critical Issues page at www.cjinvolvedwomen.org/critical-issues) to this topic, developing and posting a series of fact sheets on the use of restraints on pregnant women who are in custody, and providing support to the National Technical Assistance Center to Promote Trauma-Informed Practices and Alternatives to Seclusion and Restraint in the convening of further discussions on this topic.

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- In addition, the NRCJIW will advance evidence-based, gender-responsive practices for *all* women involved in the justice system through awareness building, information dissemination, policy and practice analysis, and training and technical assistance.

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[5] The National Resource Center on Justice-Involved Women is funded by the U.S. Department of Justice, Bureau of Justice Assistance, in collaboration with the National Institute of Corrections, and is administered by the Center for Effective Public Policy and its partners.

[i] Weight gain during pregnancy shifts a woman's center of gravity, which can affect a woman's balance, particularly later in pregnancy. For more information, see http://www.acog.org/publications/patient_education/bp119.cfm, last accessed August 11, 2011.

[ii] Ibid.

[iii] The American College of Obstetrics and Gynecology (ACOG) reports that because "pregnant women in their third trimesters may already have balance problems; shackling their legs heightens the risk that women will fall, potentially injuring them and their fetuses." See http://www.acog.org/acog_districts/dist9/ShacklingPregnantInmates.pdf, last accessed August 11, 2011.

[iv] ACOG confirms that health risks associated with shackling include increased likelihood of trauma and limited access for treatment during medical emergencies. ACOG members have reported concerning instances of attempting to treat pregnant women during transport who were not in labor but had life-threatening medical conditions, and have suggested that the "restraints made it virtually impossible to provide the urgent care they required." For more information, see http://www.acog.org/acog_districts/dist9/ShacklingPregnantInmates.pdf, last accessed August 11, 2011.

[v] Women undergoing childbirth need to be mobile so that they can assume various positions as needed, and women's mobility is greatly limited and sometimes altogether prevented due to shackling, see, e.g., Amnesty International, Abuse of Women in Custody at http://www.amnestyusa.org/pdf/custodyissues.pdf, last accessed August 18, 2011. Additionally, because of the relatively common need for emergency cesareans ("C-sections"), shackling women poses additional risks because "[i]f there were a need for a C-Section, the mother needs to be moved to an operating room immediately and a delay of even five minutes could result in permanent brain damage for the baby." See, e.g., www.amnesty.org/en/library/asset/AMR51/019/1999/en/7588269a-e33d-11dd-808b-bfd8d459a3de/amr510191999en.pdf, last accessed August 11, 2011. Further, "Women in labor need to be mobile so that they can assume various positions as needed and so they can quickly be moved to an operating room. Having the woman in shackles compromises the ability to manipulate her legs into the proper position for necessary treatment. The mother and baby's health could be compromised if there were complications during delivery, such as hemorrhage or decrease in fetal heart tones." See, e.g., Garcia, as quoted in http://www.wcl.american.edu/journal/genderlaw/16/2sichel.pdf?rd=1, last accessed August 11, 2011.

[vi] See, e.g., http://www.acog.org/acog_districts/dist9/ShacklingPregnantInmates.pdf for a discussion from ACOG about the considerable health risks associated with shackling, including limited access for treatment for shackled women during medical emergencies. ACOG also notes that minor forces may be sufficient to shear the placental attachments and increase the risk of a placental abruption after blunt abdominal trauma. For more information about the potential health risks to a baby caused by shackling, see, e.g., Amnesty International, Abuse of Women in Custody at http://www.amnestyusa.org/pdf/custodyissues.pdf, last accessed August 18, 2011, which suggests that "[t]he mother and baby's health could be compromised if there were complications during delivery such as hemorrhage or decrease in fetal heart beat," in which case immediate removal of the shackles would be required and delays could cause further complications.

[vii] According to ACOG, between 14% and 23% of pregnant women will experience depression symptoms during pregnancy and an estimated 5%-25% of women will have postpartum depression. Untreated maternal depression negatively affects an infant's cognitive, neurologic, and motor skill development. A mother's untreated depression can also negatively impact older children's mental health and behavior. During pregnancy, depression can lead to preeclampsia, preterm delivery, and low birth weight. For further discussion of these issues, see, e.g., http://www.acog.org/from_home/publications/press_releases/nr01-21-10.cfm.

[viii] Women in the correctional population report higher rates of childhood abuse than women in the general population (37% v. 17%) (Harlow, 1999). According to a 1999 Bureau of Justice Statistics publication, 1 in 4 women in State prison reported experiencing physical abuse compared to 1 in 10 men in State prison. In *A Profile of Jail Inmates*, it was reported that almost 50% of jailed women had experienced physical and/or sexual abuse at some point in their lives. See: Harlow CW. April 1998. *Profile of Jail Inmates 1996*. U.S. Department of Justice. Office of Justice Programs. Bureau of Justice Statistics Special Report. NCJ 164620. Online at http://www.ojp.usdoj.gov/bjs/abstract/pji96.htm, last accessed August 11, 2011; and Harlow CW. 1999. *Prior abuse reported by inmates and probationers*. April 1999. NCJ 172879 Bureau of Justice Statistics Selected Findings. Office of Justice Programs. U.S. Department of Justice. Online at http://bjs.ojp.usdoj.gov/content/pub/pdf/parip.pdf, last accessed August 18, 2011.

[ix] As many as 80% of incarcerated women meet the criteria for at least one lifetime psychiatric disorder; substance abuse or dependence, post traumatic stress disorder and depression appear to be some of the most common mental health problems for this population. See, e.g., Teplin LA, Abram KM, McClelland GM. 1996. *Prevalence of psychiatric disorders among incarcerated women, I: Pretrial jail detainees*. Archives of General Psychiatry. 53(6): 505-512; and Jordan BK, Schlenger WE, Fairbank JA, Caddell JM. 1996. *Prevalence of psychiatric disorders among incarcerated women, II: Convicted women felons entering prison.* Archives of General Psychiatry. 53:513-519. See Covington, 2000 and Johnsen, 2006 for a discussion of how posttraumatic stress is elevated by strip-and-cavity searches, handcuffs and shackles, confinement to small cells, isolation, and control by predominantly male staff: Covington S. S. 2000, May. *Incarcerated women: Exacerbation of issues, needs and barriers*. Paper presented at a conference titled "Perinatal Addiction: More Than Substance Abuse" in Richmond, VA; and Johnsen C. 2006. Course 30db: *Women in prison* [Electronic version].

[x] High risk pregnancies typically require more medical visits over the course of a gestational period, and pregnancies of women in custody are often considered high-risk events, complicated by drug and alcohol abuse, smoking, and sexually transmitted infection (see, e.g., Baldwin K. M, Jones J. 2000. *Health issues specific to incarcerated women: Information for state maternal and child health programs*. Women's and Children's Health Policy Center, Johns Hopkins University School of Public Health. http://www.jhsph.edu/bin/o/e/prison.pdf, last accessed August 18, 2011; Covington S. S. 2000, May. *Incarcerated women: Exacerbation of issues, needs and barriers.* Paper presented at a conference titled "Perinatal Addiction: More Than Substance Abuse" in Richmond, VA; Fearn N. E, Parker K. Washington State's residential parenting program: An integrated public health, education and social service resource for pregnant inmates and pregnant mothers. *Californian Journal of Health Promotion.* 2004;2(4):34–48; LaLonde R. J, George S. M. 2002. Incarcerated mothers: The Chicago project on female prisoners and their children. Chicago: The University of Chicago Irving B. Harris Graduate School of Public Policy Studies), in http://www.jhsph.edu/bin/o/e/prison.pdf, last accessed August 11, 2011. For a discussion of the emotional impact of restraints on women, see Amnesty International. United States of America – Rights for all – "Not part of my sentence" – Violations of the human rights of women in custody. 1999a. New York: Author: last accessed August 18, 2011, from http://www.amnesty.org/en/library/info/AMR51/019/1999.

[xi] For a discussion of the compromising of the critical bonding period that occurs as a result of the separation of mothers and newborns in correctional settings, see, e.g., Baldwin K. M, Jones J. 2000. *Health issues specific to incarcerated women: Information for state maternal and child health programs.* Women's and Children's Health Policy Center, Johns Hopkins University School of Public Health. Last accessed August 18, 2011, from http://www.jhsph.edu/bin/o/e/prison.pdf. .

[xii] A number of studies have demonstrated the benefits to mothers and newborns derived from proximity after birth and during the early days following birth (See, e.g., Bergman, N. J., Linley, L. L., & Fawcus, S. R. (2004). Randomized controlled trial of skin-to-skin contact from birth versus conventional incubator for physiological stabilization in 1200- to 2199- gram newborns. *Acta Paediatrica, 93,* 779–785; Bystrova, K., Matthiesen, A.-S., Widstrom, A.-M., Ransjo-Arvidson, A.-B., Welles-Nyström, B., Vorontsov, I., et al. (2007). The effect of Russian maternity home routines on breastfeeding and neonatal weight loss with special reference to swaddling. *Early Human Development, 83*(1), 29–39; Bystrova, K., Widstrom, A.-M., Matthiesen, A.-S., Ransjo-Arvidson, A.-B, Welles-Nyström, B., Vorontsov, I., et al. (2007). Early lactation performance in primiparous and multiparous women in relation to different maternity home practices: A randomized trial in St. Petersburg. *International Breastfeeding Journal, 2*, 9; Christensson, K., Siles, C., Moreno, L., Belaustequi, A., De La Fuente, P., Lagercrantz, H., et al. (1992). Temperature, metabolic adaptation and crying in healthy full-term newborns cared for skin-to-skin or in a cot. *Acta Paediatrica, 81*(6–7), 488–493; International Lactation Consultant Association. (1999). *Evidence-based guidelines for breastfeeding management during the first 14 days* [Booklet]. Raleigh, NC: Author; Moore, E. R., & Anderson, G. C. (2007). Randomized controlled trial of very early mother-infant skin-to-skin contact and breastfeeding status. *Journal of Midwifery & Women's Health, 52*(2), 116–125; Moore, E. R., Anderson, G. C., & Bergman, N. (2007). Early skin-to-skin contact for mothers and their healthy newborn infants. *Cochrane Database of Systematic Reviews ,* Issue 3, Art. No.: CD003519; World Health Organization [WHO]. (1998). *Evidence for the ten steps to successful breastfeeding* (rev. ed., WHO/CHD/98.9). Geneva, Switzerland: Author.

[xii] Epidemiologic research shows that human milk and breastfeeding of infants provide advantages with regard to general health, growth, and development, while significantly decreasing risk for a large number of acute and chronic diseases. There are also a number of studies that indicate possible health benefits for mothers (see, e.g., http://aappolicy.aappublications.org/cgi/reprint/pediatrics;100/6/1035.pdf, last accessed August 11, 2011). Breastfeeding requires a substantial degree of physical mobility as mothers often must position themselves in a number of different positions in order to nurse successfully (see, e.g., http://www.llli.org/faq/positioning.html, last accessed August 12, 2011).

It is recommended that breastfeeding should begin as soon as possible after an infant's birth, usually within the first hour and that to facilitate breastfeeding, newborn infants should remain with and have full access to their mothers throughout the recovery period; procedures that may interfere with breastfeeding or traumatize the infant should be avoided or minimized (see, e.g., Righard, L., and Alade, M. *Effect of delivery room routines on success of first breast-feed*. Lancet. 1990; 336:1105–1107 and Van Den Bosch CA, Bullough CHW. *Effect of early suckling on term neonates' core body temperature*. Annals of Tropical Paediatrics. 1990;10:347–353). Skin-to-skin contact between the mother and her baby immediately after birth reduces crying, improves mother-infant interaction, keeps the baby warm, and helps the mother to breastfeed successfully (see, e.g., Puig G, Sguassero Y. Early skin-to-skin contact for mothers and their healthy newborn infants: RHL commentary (last revised: 9 November 2007). *The WHO Reproductive Health Library*; Geneva: World Health Organization.) Interrupting, delaying, or limiting the time that a mother and her baby spend together may have a harmful effect on their relationship and on breastfeeding success (see, e.g., Enkin, M., Keirse, M. J. N. C., Neilson, J. Crowther, C., Duley, L., Hodnett, E., et al. (2000). *A guide to effective care in pregnancy and childbirth.* New York: Oxford University Press.

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[xiv] For preterm infants, supportive interactions with mothers post delivery increases infant neurobehavioral organization and improves long-term outcomes (see, e.g., Als, H., Gilkerson, L., Duffy, F. H., McAnulty, G. B., Buehler, D. M., Vandenberg, K. et al. (2003). A three-center, randomized, controlled trial of individualized developmental care for very low birth weight preterm infants: Medical, neurodevelopmental, parenting, and caregiving effects. *Journal of Developmental and Behavioral Pediatrics*, *24*(6), 399–408; and Symington, A., & Pinelli, J. (2000). Developmental care for promoting development and preventing morbidity inpreterm infants. *Cochrane Database of SystematicReviews (Online: Update Software)*, *4*, CD001814; discussion in http://jpepsy.oxfordjournals.org/content/30/8/667.full.pdf, last accessed August 11, 2011. A central tenet of these interventions is that the mother's behavior with the infant is the most significant environmental modification that can be provided for high-risk infants (see, e.g., Browne, J. V., MacLeod, A. M., & Smith-Sharp, S. (1996). *Family infant relationship support training*. Denver, CO: Center for Family and Infant Interaction).

[xv] A number of states remain silent on the practice of shackling pregnant inmates during childbirth. See, e.g., http://www.wcl.american.edu/journal/genderlaw/16/2sichel.pdf?rd=1. For self reported practices regarding shackling pregnant inmates during pregnancy, labor, and childbirth, see http://www.asca.net/system/assets/attachments/2460/2010_ASCA_Survey_Restraints_on_Females_During_Labor.pdf?1300115896, last accessed August 18, 2011.

xvi See, e.g., see http://www.asca.net/system/assets/attachments/2460/2010_ASCA_Survey_Restraints_on_Females_During_Labor.pdf?1300115896, last accessed August 18, 2011.

xvii Ibid.

xviii Ibid.

[xix] This recommendation emerged as the result of participant workgroups convened during the November 22, 2010 Department of Justice and Rebecca Project Symposium: Use of Restraints on Pregnant Women Behind Bars.

[xx] Ibid.

[xxi] See, e.g., Greenfeld, L., and Snell, T., *Women Offenders* (2000), U.S. Department of Justice, Washington, D.C. (noting that in 1999 women comprised eight percent of convicted violent felons, twenty-three percent of property felons and seventeen percent of drug felons); and The Sentencing Project, Women in the Criminal Justice System (2007) at http://www.sentencingproject.org/doc/publications/womenincj_total.pdf , last accessed August 12, 2011.

[xxii] Within prison settings, incidents of violence and aggression committed by incarcerated women are extremely low, with studies indicating that only 3-5% of incarcerated women commit such acts (see, e.g., Hardyman, 2000; Harer & Langan, 2001; cited in Wright, Van Voorhis, Salisbury, and Bauman, OCT/NOV 2009). Wright, E., Van Voorhis, P., Salisbury, E. & Bauman, A., (2009). Lessons from the NIC/UC Gender-Responsive Classification Project. *Women, Girls, & Criminal Justice, 10(6):* 85-87, 95-96. Available at: http://www.uc.edu/womenoffenders/WGC.pdf, last accessed August 12, 2011.

[xxiii] Research indicated that justice-involved women are more likely than men to have past psychiatric hospitalizations and suicide thoughts, feelings or attempts (see, e.g., Clements-Nolle, Wolden and Bargmann-Losche, 2009). Clements-Nolle,K., Wolden, M.& Bargmann-Losche,J.(2009). Childhood trauma and risk for past and future suicide attempts among women in prison. *Women's Health Issues, Volume 19, Issue 3*, Pages 185-192 (May 2009).

[xxiv] See Van Voorhis, P., Bauman, A., Wright, E., & Salisbury, E. (2009). Implementing the Women's Risk/Need Assessment (WRNAs): Early lessons from the field. *Women, Girls, & Criminal Justice*, 10(6): 81-96. Available at: http://www.uc.edu/womenoffenders/WGC.pdf. Van Voorhis, P., Wright, E., Salisbury, E., & Bauman, A. (2010). Women's risk factors and their contributions to existing risk/needs assessment: The current status of a gender-responsive supplement. *Criminal Justice and Behavior,* 37(3): 261-288.

[xxv] See, e.g., *Correctional Population in the United States, 1998,* U.S. Department of Justice, Washington, D.C. This report suggests that less than 1% of women abscond from custody. Report available at http://bjs.ojp.usdoj.gov/index.cfm?ty=pbdetail&iid=690, last accessed August 18, 2011.

[xxvi] Comments from presentation given by Dr. Maureen Phipps, Associate Professor of Obstetrics and Gynecology and Community Health, Alpert Medical School of Brown University, Women and Infants Hospital of Rhode Island and Chair of the Committee on Health Care for Underserved Women, American Congress of Obstetricians and Gynecologists, during the November 22, 2010 Department of Justice and Rebecca Project Symposium: Use of Restraints on Pregnant Women Behind Bars.

[xxvii] Ibid.

[xxviii] Ibid.

[xxix] Ibid.

[xxx] Ibid.

[xxxi] Ibid.

[xxxii] Ibid.

[xxxiii] Ibid.

[xxxiv] This recommendation emerged as the result of participant workgroups convened during the November 22, 2010 Department of Justice and Rebecca Project Symposium: Use of Restraints on Pregnant Women Behind Bars.

[xxxv] This recommendation emerged as the result of a panel convened during the November 22, 2010 Department of Justice and Rebecca Project Symposium: Use of Restraints on Pregnant Women Behind Bars.

[xxxvi] As of September 2011, the following states have passed laws banning or limiting the use of restraints on pregnant women: California, Colorado, Hawaii, Idaho, Illinois, New Mexico, New York, Nevada, Pennsylvania, Rhode Island, Texas, Vermont, Washington, and West Virginia.