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Health Care for Pregnant and Postpartum Incarcerated Women and Adolescent Females

ABSTRACT: Clinicians who provide care for incarcerated women should be aware of the special health care needs of pregnant incarcerated women and the specific issues related to the use of restraints during pregnancy and the postpartum period. The use of restraints on pregnant incarcerated women and adolescents may not only compromise health care but is demeaning and rarely necessary.

Between 1990 and 2009, the number of incarcerated women increased 153% (1). Most women are incarcerated for nonviolent crimes, including drug and property offenses (2). On average, 6–10% of incarcerated women are pregnant, with the highest rates in local jails (3). Data on rates of pregnancy in juvenile facilities are limited, but indicate higher rates than in adult facilities (4, 5).

The women in the criminal justice system are among the most vulnerable in our society. Pregnancies among incarcerated women are often unplanned and high-risk and are compromised by a lack of prenatal care, poor nutrition, domestic violence, mental illness, and drug and alcohol abuse (6). Upon entry into a prison or jail, every woman of childbearing age should be assessed for pregnancy risk by inquiring about menstrual history, heterosexual activity, and contraceptive use and tested for pregnancy, as appropriate, to enable the provision of adequate perinatal care and abortion services. Incarcerated women who wish to continue their pregnancies should have access to readily available and regularly scheduled obstetric care, beginning in early pregnancy and continuing through the postpartum period. Incarcerated pregnant women also should have access to unscheduled or emergency obstetric visits on a 24-hour basis. The medical care provided should follow the guidelines of the American College of Obstetricians and Gynecologists (see Box 1) (7).

Special Clinical Considerations

Because of high rates of substance abuse (8) and human immunodeficiency virus (HIV) infection (9) among incarcerated women, prompt screening for these conditions in pregnant women is important. All pregnant

Box 1. Recommended Care

Intake

- Assess for pregnancy risk by inquiring about menstrual history, heterosexual activity, and contraceptive use and test for pregnancy as appropriate

During Pregnancy

- Provide pregnancy counseling and abortion services
- Provide perinatal care following guidelines of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists*
- Assess for substance abuse and initiate treatment; prompt initiation of opioid-assisted therapy with methadone or buprenorphine is critical for pregnant women who are opioid-dependent
- Test for and treat human immunodeficiency virus (HIV) to prevent perinatal HIV transmission
- Screen for depression or mental stress during pregnancy and for postpartum depression after delivery and treat as needed
- Provide dietary supplements to incarcerated pregnant and breastfeeding women
- Deliver services in a licensed hospital that has facilities for high-risk pregnancies when available
- Provide postpartum contraceptive methods during incarceration

*American Academy of Pediatrics, American College of Obstetricians and Gynecologists. Guidelines for perinatal care. 6th ed. Elk Grove Village (IL): AAP; Washington, DC: ACOG; 2007.

women should be questioned about their past and present use of alcohol, nicotine, and other drugs, including the recreational use of prescription and over-the-counter medication (7). Identification of pregnant women who are addicted to opioids facilitates provision of opioid-assisted therapy with methadone or buprenorphine. Maintenance of opioid-assisted therapy can reduce the risk of withdrawal, which can precipitate preterm labor or fetal distress (10). In addition, substance abuse can continue during incarceration despite efforts to prevent drugs from entering correctional facilities. Effective drug and alcohol treatment programs are essential. Pregnant women universally should be tested for HIV infection with patient notification unless they decline the test as permitted by local and state regulations (7). Screening for HIV infection allows for the initiation of essential treatment to optimize maternal health and to prevent perinatal HIV transmission for HIV-positive pregnant women. Incarcerated pregnant women should be screened for depression or mental stress and for postpartum depression after delivery and be appropriately treated.

Good maternal nutrition can contribute positively to the delivery of a healthy, full-term newborn of an appropriate weight. The recommended dietary allowances for most vitamins and minerals increase during pregnancy (7). Therefore, provision of dietary supplements to incarcerated pregnant and breastfeeding women is recommended, as is access to a nutritious diet and timely and regular meals.

Pregnant women who are required to stand or participate in repetitive, strenuous, physical lifting are at risk of preterm birth and small for gestational age infants. In addition, a recovery period of 4–6 weeks generally is required after delivery for resumption of normal activity (7). This should be taken into consideration when assigning work to incarcerated pregnant women and during the postpartum period.

Pregnant women are at high risk of falls. Activities with a high risk of falling should be avoided (7). Specifically, incarcerated women should be given a bottom bunk during pregnancy and the postpartum period.

Although maintaining adequate safety is critical, correctional officers do not need to routinely be present in the room while a pregnant woman is being examined or in the hospital room during labor and delivery unless requested by medical staff or the situation poses a danger to the safety of the medical staff or others. Delivery services for incarcerated pregnant women should be provided in a licensed hospital with facilities for high-risk pregnancies when available. Incarcerated pregnant women often have short jail or prison stays and may not give birth while incarcerated. Postpartum contraceptive options should be discussed and provided during incarceration to decrease the likelihood of an unintended pregnancy during and after release from incarceration (11).

It is important to avoid separating the mother from the infant. Prison nurseries or alternative sentencing of women to community-based noninstitutional settings should be considered for women during the postpartum period. Correctional facilities should have provisions for visiting infants for women in facilities without prison nurseries. When adequate resources are available for prison nursery programs, women who participate show lower rates of recidivism, and their children show no adverse effects as a result of their participation. In fact, by keeping mothers and infants together, prison nursery programs have been shown to prevent foster care placement and allow for the formation of maternal–child bonds during a critical period of infant development (12).

The American College of Obstetricians and Gynecologists strongly supports breastfeeding as the preferred method of feeding for newborns and infants (13). Given the benefits of breastfeeding to both the mother and the infant, incarcerated mothers wishing to breastfeed should be allowed to either breastfeed their infants or express milk for delivery to the infant. If the mother is to express her milk, accommodations should be made for freezing, storing, and transporting the milk. This can be difficult to facilitate and is another argument for prison nurseries or alternative sentencing of women to community-based noninstitutional settings.

Barriers to Care

Barriers currently exist to the provision of recommended care for incarcerated pregnant women and adolescents. Thirty-eight states have failed to institute adequate policies, or any policies, requiring that incarcerated pregnant women receive adequate prenatal care. Forty-one states do not require prenatal nutrition counseling or the provision of appropriate nutrition to incarcerated pregnant women, and 48 states do not offer pregnant women HIV screening (14).

Limiting Use of Restraints

Use of restraints, often called *shackling*, is defined as using any physical restraint or mechanical device to control the movement of a prisoner's body or limbs, including handcuffs, leg shackles, and belly chains. In 2007, the U.S. Marshals Service established policies and procedures for the use of authorized restraining devices, indicating that restraints should not be used when a pregnant prisoner is in labor, delivery, or in immediate postdelivery recuperation (15). In 2008, the Federal Bureau of Prisons ended the practice of shackling pregnant inmates as a matter of routine in all federal correctional facilities (16). That same year, the American Correctional Association approved standards opposing the use of restraints on female inmates during active labor and the delivery of a child. The standards also state that before active labor and delivery, restraints used on a pregnant inmate should not put the woman or the fetus at risk (17). More recently, in October 2010, the National Commission on Correctional Health Care, which accredits correctional facilities, adopted a position statement that opposes the

use of restraints on pregnant inmates (18). These standards serve as guidelines and are voluntary, not mandatory. State and local prisons and jails are not required to abide by either the Federal Bureau of Prisons policy or the National Commission on Correctional Health Care standards, but several state legislatures and departments of corrections have enacted antishackling policies recently. Despite progress, 36 states and the Immigration and Customs Enforcement agency of the Department of Homeland Security, which detains individuals who are in violation of civil immigration laws pending deportation, fail to limit the use of restraints on pregnant women during transportation, labor and delivery, and postpartum recuperation (14).

The use of restraints on pregnant incarcerated women and adolescents may not only compromise health care but is demeaning and rarely necessary. The apparent purpose of shackling is to keep incarcerated women from escaping or harming themselves or others. There are no data to support this rationale because most incarcerated women are nonviolent offenders. In addition, no escape attempts have been reported among pregnant incarcerated women who were not shackled during childbirth (19). This demonstrates the feasibility of preserving the dignity of incarcerated pregnant women and adolescents and providing them with compassionate care. The safety of health care personnel is paramount and for this reason, adequate correctional staff must be available to monitor incarcerated women, both during transport to and from the correctional facility and during receipt of medical care.

Physical restraints interfere with the ability of health care providers to safely practice medicine by reducing their ability to assess and evaluate the mother and the fetus and making labor and delivery more difficult. Shackling may put the health of the woman and fetus at risk (see Box 2). Shackling during transportation to medical care facilities and during the receipt of health services should occur only 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. Exceptions include when there is imminent risk of escape or harm. 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. The woman should be allowed to lie on her side, not flat on her back or stomach. Pressure should not be applied either directly or indirectly to the abdomen. Correctional officers should be available and required to remove the shackles immediately upon request of medical personnel. Women should never be shackled during evaluation for labor or labor and delivery. If restraint is used, a report should be filed by the Department of Corrections and reviewed by an independent body. There should be consequences for individuals and institutions when use of restraints was unjustified.

Box 2. Examples of the Health Effects of Restraints

- Nausea and vomiting are common symptoms of early pregnancy. Adding the discomfort of shackles to a woman already suffering is cruel and inhumane.
- It is important for women to have the ability to break their falls. Shackling increases the risk of falls and decreases the woman's ability to protect herself and the fetus if she does fall.
- If a woman has abdominal pain during pregnancy, a number of tests to evaluate for conditions such as appendicitis, preterm labor, or kidney infection may not be performed while a woman is shackled.
- Prompt and uninhibited assessment for vaginal bleeding during pregnancy is important. Shackling can delay diagnosis, which may pose a threat to the health of the woman or the fetus.
- Hypertensive disease occurs in approximately 12–22% of pregnancies, and is directly responsible for 17.6% of maternal deaths in the United States*. Preeclampsia can result in seizures, which may not be safely treated in a shackled patient.
- Women are at increased risk of venous thrombosis during pregnancy and the postpartum period†. Limited mobility caused by shackling may increase this risk and may compromise the health of the woman and fetus.
- 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.
- 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.
- As the infant grows, mothers should be part of the child's care (ie, take the baby to child wellness visits and immunizations) to enhance their bond. Shackling while attending to the child's health care needs may interfere with her ability to be involved in these activities.

*Diagnosis and management of preeclampsia and eclampsia. ACOG Practice Bulletin No. 33. American College of Obstetricians and Gynecologists. Obstet Gynecol 2002;99:159–67.

†Thromboembolism in pregnancy. Practice Bulletin No. 123. American College of Obstetricians and Gynecologists. Obstet Gynecol 2011;118:718–29.

Recommendations

- Federal and state governments should adopt policies to support provision of perinatal care for pregnant and postpartum incarcerated women and adolescents that follow the guidelines of the American College of Obstetricians and Gynecologists. Mechanisms to ensure implementation of these policies and adequate funding to provide this care need to be put in place.
- Educational efforts are needed to increase the knowledge of health care providers and correctional officers about issues specific to incarcerated pregnant and postpartum women and adolescents.
- Obstetrician–gynecologists should support efforts to improve the health care of incarcerated pregnant and postpartum women and adolescents at the local, state, and national levels. Activities may include the following:
  - Advocating at the state and federal levels to restrict shackling of incarcerated women and adolescents during pregnancy and the postpartum period.
  - Partnering with other organizations in the medical community opposed to shackling incarcerated pregnant women such as the American Medical Association and the Association of Women's Health, Obstetric and Neonatal Nurses (20, 21).
  - Gaining representation on the boards of correctional health organizations.
  - Working in correctional facilities to provide services to incarcerated pregnant and postpartum women and adolescents and continuing care after the woman's release, when feasible.
  - Undertaking efforts to ensure that medical needs of pregnant and postpartum incarcerated women and adolescents are being addressed appropriately, such as by providing training or consultation to health care providers and correctional officers in prison settings.

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