

2015

## Policy, Programs, and Interventions Regarding Pregnant Incarcerated Women

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### Recommended Citation

Dallaire, D. H., Forestell, C. A., & Shlafer, R. (2015). Policy, Programs, and Interventions Regarding Pregnant Incarcerated Women. Joyce A. Arditti & Tessa le Roux (Ed.), *And Justice for All: Families and the Criminal Justice System*. Ann Arbor, MI: Michigan Publishing. <https://scholarworks.wm.edu/asbookchapters/3>

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## **Chapter 3: Policy, Programs, and Interventions Regarding Pregnant Incarcerated Women**

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Nationally, at any point in time, between 6 and 10 percent of incarcerated women are pregnant (Center for Disease Control and Prevention [CDC], 2001). Pregnant women involved in the criminal justice system (CJS) are similar in many ways to other incarcerated women and incarcerated mothers. According to the 2000 Bureau of Justice Statistics report, Greenfeld and Snell report that between 55-73 percent of women involved in the CJS have completed high school; Glaze and Maruschak (2008) report rates of non-completion of high school at 28–37 percent among incarcerated mothers in federal and state facilities. At the time of their arrest, Greenfeld and Snell (2000) report that 60 percent are unemployed and 30 percent are receiving welfare assistance. Glaze and Maruschak (2008) also report high rates of past physical/sexual abuse (54–64%), substance abuse (51–70%) mental health problems (51–70%), and homelessness (4–16%). These characteristics are troubling, and in the context of pregnancy can be dangerous to the health of the developing baby.

Pregnancy within the context of incarceration poses many challenges to correctional facilities, which aim to preserve public safety and carry out sentencing orders. Despite this important goal, pregnant women have specific needs for their health and the health of their developing fetus, including access to prenatal care services, management of pregnancy-related health conditions (e.g., gestational diabetes), and proper nutrition. Many correctional facilities may be ill-equipped to deal with these core issues, and as a result incarcerated women may receive inadequate care throughout their pregnancies (Ferszt & Clarke, 2012). Women who remain in custody for the birth of their baby face the possibility of being shackled during labor, a fairly wide-spread, but dangerous practice. Core issues for the newborn include the right to be cared for in a safe, supportive environment following birth. In the following paragraphs we expand upon these issues by first discussing the national guidelines for pregnant incarcerated women and the typical level of care provided to these women while in custody with a focus on the mutual and competing goals of correctional facilities, pregnant incarcerated women, the developing fetus, and newborn. Lastly we discuss opportunities for interventions.

### **National Guidelines for Care of Pregnant Incarcerated Women**

According to policies outlined by The National Commission on Correctional Health Care (NCCCHC, 2015), as well as several other bodies such including the American Congress of Obstetricians and Gynecologists (ACOG, 2012), pregnant incarcerated women should receive prenatal health care which includes periodic health monitoring and evaluation throughout pregnancy, modified housing assignments and activities (e.g., work assignments), and nutritional

counseling. Additionally, they should be informed of their pregnancy rights, which include the right to adoption or abortion. Unfortunately, the implementation of these standards varies widely across the nation, and in many cases does not reach even minimal levels (Ferszt & Clarke, 2012; Medel, Mullins, Kelsey, Dallaire, & Forestell, 2015). However, in some states, this is beginning to change. As of March 2014, legislation was passed (Bill H.3978) in Massachusetts that promotes safe pregnancies for incarcerated women, which reflects the national guidelines. Minnesota also passed legislation relating to the care of incarcerated pregnant women (SF 2423). Among other things, Minnesota's law includes provisions for pregnancy testing, limits on the use of restraints, and access to prenatal education and doula care. That Massachusetts and Minnesota have recently passed these laws, and other states (e.g., Tennessee) are considering similar legislation, provides a promising precedent for other states to follow.

Above all, correctional facilities have a goal of maintaining order and safety for those incarcerated, as well as the public. In the case of a pregnant incarcerated woman, this mandate conceivably extends to the developing fetus. Thus, policies should be enforced that provide pregnant women with a safe environment that protects the health of the mother and fetus through proper prenatal care. In order to achieve this goal, pregnant women in the criminal justice system must be identified early. To that end, we recommend that all correctional facilities (including those that house individuals pre-adjudication) consider NCCHC's position statement which recommends offering pregnancy tests to all women of childbearing age (15-44 years) within 48-hours of admission into a facility (2015).

Pregnancy testing upon admission to a facility would lead to increased detection at an earlier stage of pregnancy and may motivate a woman to make important health-related changes and help the facility provide her with timely prenatal care. From the perspective of the facility, this procedure could improve compliance with the Prison Rape Elimination Act, which requires correctional facilities to maintain a zero-tolerance attitude for sexual activity or assault. By testing women at admission, the facility could rule out the possibility that a woman became pregnant after entering the facility. This is an important issue, especially for incarcerated populations who may be particularly vulnerable (e.g., low IQ individuals or non-native English speakers) to sexual assault or for individuals who may have difficulty communicating their health-related needs to jail staff (see also Belkrop, 2007; Chesney-Lind & Pasko, 2013).

The issue of pregnancy tests at admission also raises some public-health ethics and privacy issues. In fact, the American Civil Liberties Union (ACLU) of Northern California (2014) publicly filed a lawsuit against the Alameda County Sheriff over a policy that requires every woman in their custody younger than 60 to submit to a pregnancy test. This is certainly an important and even pivotal issue which requires careful consideration and thoughtful implementation.

Although many facilities do not currently provide pregnancy testing at time of admission, there is precedent for testing inmates when processed at a facility. For example, the CDC has reported success at identifying HIV positive individuals in correctional settings (CDC, 2009; 2011; 2012). Additional testing might also screen for the presence of drugs which might be threatening to the fetus (e.g., opiates) if the mother went into withdrawal (see Minozzi, Amato, Bellisario, Ferri, & Davoli, 2013). Standard procedures at many correctional facilities simply rely on women's self-

report of drug addiction and pregnancy. This could result in a dangerous situation. With respect to drug addiction, women involved in the criminal justice system may have a vested interest in hiding the fact that they recently used drugs, particularly if they are awaiting sentencing or trial. In addition, many women may not be aware that they are pregnant. In September of 2013, an incident occurred in western Pennsylvania in which a female inmate indicated that she was neither pregnant nor a drug user. It was later discovered that she was both (Signorini, 2013). As result of that incident, the facility now administers pregnancy and drug tests to all women at admission. Pregnant, drug-addicted women are either hospitalized while they withdraw, or they begin Methadone Maintenance Therapy (MMT), both of which are at the jail's expense.

In Virginia, some participants in the William & Mary Healthy Beginnings Project (W&M HBP[1]) have reported benefitting from beginning addiction treatment while incarcerated. For example, "Amy[2]" a 27 year-old mother of 3 children and a chronic user of crystal meth, heroin, and cocaine used throughout all three of her pregnancies. Likely due to this addiction, all of her children were delivered around 6 months of age. When she was approximately 5 months pregnant for her fourth child, Amy was arrested. While in jail, she was provided with MMT which continued throughout the rest of her pregnancy. This pregnancy turned out very different from her previous pregnancies. For the first time, Amy carried her baby to full term and because her addiction was well controlled throughout her pregnancy her baby did not experience withdrawals. Although drug therapy can improve birth outcomes, correctional facilities will likely incur increased costs when more pregnant women are identified at the facility. As a result, jails that choose to administer pregnancy tests to women at intake must have the necessary resources to provide proper care for and ensure the safety of an increasing number of pregnant women.

In addition to providing drug rehabilitation to pregnant women who are drug-addicted, facilities also need to provide access to affordable, basic medical and obstetric (OB) care, prenatal vitamins that include folate, and a safe and nutritious diet that includes adequate fluids (at least 64 oz of water). Additional protocols pertaining directly to the safety and well-being of incarcerated pregnant women include ensuring that they receive proper housing conditions, such as a lower-bunk classification, so as to avoid falling from a top bunk which would be a risk in later pregnancy, and eliminating teratogens in the environment, including but not limited to lead-based paint, particularly in facilities built prior to 1978.

Currently, facilities may try to offset some of the costs associated with providing care in a variety of ways, which makes it difficult for some women ensure their own health and that of their fetus. For example, many facilities do not provide pregnant women with additional snacks or meals to help meet their nutritional requirements, and those that do often provide processed meat, such as cold bologna. Processed meat carries the risk of listeriosis (Janakiraman, 2008), which can lead to fetal death (Mylonakis et al., 2002). In some facilities, women must pay for prenatal care and the birth of their baby. This includes a copayment for each medical visit (e.g., \$5 per visit; Virginia Department of Corrections, 2014). Given that many women may not have received care before their incarceration (Dumont et al., 2014) and it is recommended that women see their obstetrician on a weekly basis during later stages of pregnancy, this charge may place serious barriers to necessary services. A more reasonable alternative would be to charge a one-time copayment for OB care, as is standard with some insurance coverage programs. Indeed,

some correctional facilities offer non-violent offenders medical furloughs, which is a temporary leave of absence from the facility for their deliveries. In these cases, the responsibility of covering the costs incurred for medical care fall on the mother, rather than the jail. Dumont and colleagues found that 77.2 percent of women involved with the CJS had prenatal care paid by Medicaid and 80 percent reported having delivery paid by Medicaid.

This is a population which can likely benefit from the expansion of Medicaid under the Affordable Care Act (ACA; Kozhimannil & Schlafer, 2014). Currently, the “inmate exception” section of the Social Security Act, 42 U.S.C. §1396d(a) forbids states from receiving matching funds for services provided to incarcerated persons who are otherwise eligible recipients of Medicaid. This restriction likely makes facilities reluctant to identifying pregnancies and providing care to pregnant incarcerated women. Under the ACA, however, expanded Medicaid coverage can now reimburse for inmates’ hospital stays beyond 24 hours. This has important implications for pregnant inmates, as typical hospital stays for labor and delivery are between 48-72 hours. Thus, this policy change may improve the continuity of care for pregnant inmates by decreasing incentives to furlough pregnant women just before delivery to avoid incurring costs of childbirth-related care.

Other ways in which correctional facilities could reduce the cost of caring for pregnant incarcerated women would involve centralizing resources; that is smaller facilities could transfer pregnant women to larger facilities within the region that have the necessary resources available to provide adequate care for these women. Of course, one disadvantage to moving women further away from their communities is that it may create barriers for family members or friends to visit. Additionally, local jails might consider enlisting the help of community volunteers to work with these women. People with health-related backgrounds, such as nurses and nutritionists, who are willing to volunteer their time, would have the necessary training to serve as health advocates for pregnant incarcerated women. Currently in Southern Virginia, the Peninsula Women, Infants and Children (WIC) office recently received an internal grant to support their staff to provide nutritional counselling to small groups of women at local regional jails.

Alternatives to incarceration should also be considered, especially for non-violent offenders (see also Arditti, 2012, 2015 for further discussion). The Federal Bureau of Prisons (2015) allows pregnant women serving less than five years for non-violent crimes to participate in the Mothers and Infants Nurturing Together (MINT) program which is a residential facility where women can learn parenting skills and spend 3 months post-partum bonding with their newborn. For local and community jails house arrest or drug court programs may be especially helpful to this population as they can continue to receive prenatal care from providers in their community and prepare for the birth of their child in the environment in which they will rear that child.

## **The Needs of Incarcerated Pregnant and Postpartum Women**

Just as it is incumbent on correctional facilities to provide safe and healthy environments for inmates, pregnant women are responsible for providing a safe uterine environment for their developing children. However, this may be difficult for many pregnant women who are involved in the criminal justice system (CJS) given the many challenges that they face, including

relatively low-levels of health literacy (Donelle & Hall, 2014), poor access to prenatal care (Roberts & Pies, 2011), and poor health resulting from inadequate nutrition (Maruschack, 2006), sexually transmitted diseases (Clarke et al., 2006), and substance abuse (Acoca, 1998; Greenfeld & Snell, 2000). As a result, many of their pregnancies are considered to be high risk potentially resulting in poor birth outcomes (Clarke et al., 2006, Mertens, 2001). Additional factors may make childbirth and the postpartum period more difficult for these women, particularly the relatively common practice of shackling pregnant incarcerated women during and after labor and delivery, lack of contact with the baby after birth, and inability to provide breast milk to the newborn child. Issues related to the unique needs and circumstances of pregnant incarcerated women during pregnancy, labor and delivery, and the postpartum period are explored in this section.

### **The Rights and Needs of Pregnant Incarcerated Women**

When a woman tests positive for pregnancy and/or presents herself as pregnant at a correctional facility, she has a right to be informed of the state's law and the facility's policies regarding her care and options. In Virginia, for example, any pregnancy can be terminated up until the 19th week of gestation. Consistent with this law, incarcerated women at many jail facilities in Virginia who are less than 19 weeks pregnant can elect to pay to terminate their pregnancy. A woman who plans to continue her pregnancy should be informed of her adoption rights, the prenatal care she will receive, and the applicable fees for these services.

Making women aware of how their health-related behaviors may impact the developing fetus is important, particularly because of the high rates of substance abuse among this population. In addition to providing counseling and treatment for substance use, information should also be provided to women about the importance of taking a prenatal vitamin daily and making healthy decisions about diet and exercise. Our experiences working in facilities in southern Virginia with pregnant women enrolled in the W&M HBP (a nutrition program for women incarcerated in local jails) have shown that many incarcerated women have poor nutritional and exercise habits that can lead to serious complications before and after their pregnancy (see also Dallaire, Holmquist, & Kelsey, 2015). As a case in point, we recently worked with a woman who suffered from birth complications that were induced by poor nutritional habits throughout her pregnancy. This woman weighed approximately 350 pounds prior to her pregnancy. While in jail she refused her food trays and received most of her nutrition from canteen items that she combined to make "Swoles," which are extremely high calorie combinations of foods that contain noodles as a base and other high calorie foods such as chips, peanut butter, and often pickles. When she was released from jail two months prior to having her baby she continued to gain weight because she lived in an USDA defined "food desert"(areas without ready access to fresh, healthy, and affordable food), which offered only a 7-11 to shop for food. Over the entire course of her pregnancy she gained 50 pounds. Soon after she delivered her baby she began to have complications such as shortness of breath and chest pain. A chest x-ray revealed blood clots in her lungs. A complete blood count and electrolyte panel exposed severe malnutrition and prolonged clotting times that would require medical intervention. Despite her size, this woman was severely malnourished which contributed to her complications in the postpartum period.

In our work we have endeavored to provide women with nutritional counseling that demonstrates the importance of healthy eating and its effect on the developing fetus, our hope is that women may start to feel empowered to make better choices about the foods they purchase and consume. The correctional center environment poses certain challenges to envisioning this goal, but there are also opportunities to discuss the nutritional value of foods they can elect to purchase from canteen. For example, when reviewing the list of items available from purchase from canteen, we can discuss the nutritional value of “peanut butter and jelly squeeze” versus “Moonpies.” Nutritional education can also be provided by staff at local Women, Infants and Children (WIC) offices. WIC educators can provide information about nutrition and answer questions about how to access their services upon release.

In addition, medical staff can help women become more actively engaged in their pregnancy by providing them with the opportunity hear the fetal heart tone and see a sonogram picture of their baby. From a psychological perspective, these opportunities may help the mother accept the pregnancy and may provide her with the motivation to make important health-related changes (see Lumley, 1990). However for any of these strategies to be successful, facilities must engage the mother as a partner. Covington (2001) discusses the importance of taking a relational, gender-responsive approach to working with CJS-involved women. The W&M HBP utilizes motivational interviewing techniques and once a mother has identified some nutrition-based changes she would like to make we review information with her in a way that is non-intimidating and personalized for her needs. Our results show participants evidence gains in nutrition and pregnancy-related knowledge from pre-to-post counseling (Forestell & Dallaire, 2014) and also show marked declines in depressive symptoms (Ernesto et al., 2014). CJS-involved women’s relatively low levels of education suggest that they may have poor health literacy, making it difficult for them to make appropriate health decisions. Providing women with the appropriate resources to help them to reduce their exposure to nicotine, alcohol, and drugs and improve their eating habits may contribute to healthy pregnancies.

It is intriguing that some data suggests that longer incarcerations are associated with higher birth weights, a key indicator of newborn health (Cordero, Hines, Shibley, & Landon, 1991; Martin, Kim, Kupper, Meyer, & Hays, 1997). Some might interpret such data to suggest that incarceration itself is a strong intervention for pregnant, CJS-involved women. Indeed, on July 1, 2014, Tennessee became the first state to authorize the arrest and incarceration of women who use drugs while pregnant. The first woman charged with breaking that law had a newborn that tested positive for meth shortly after birth; the mother was arrested as she was discharged from the hospital (Lupkin, 2014). Although incarceration may prevent some women from using or misusing illegal or harmful substances, without other supports and services for these women, such legislation falls short of promoting healthy pregnancy outcomes and family reunification. Intervention and community-based services including substance abuse counseling and drug rehabilitation are critical, as are resources and support for other issues these women face, including homelessness, domestic violence, and unemployment. In fact, Poland, Dombrowski, Agerb, and Sokol (1993) found that a punitive law would deter pregnant women from seeking prenatal care and those who used drugs would “go underground” to avoid being caught.

## **Labor and Delivery in the Context of Incarceration**

Women and their baby have the right to be able to receive unhindered medical care by their physician during delivery. Shackling a woman who is in labor to a medical bed severely interferes with the doctor's ability to manipulate her or the baby during childbirth. Despite the opposition to shackling by most medical and correctional associations (e.g., American Medical Association, ACOG, American Public Health Association, Federal Bureau of Prisons, and the American Correctional Association), it is still common for restraints to be used on incarcerated women during labor and delivery throughout the U.S. Indeed, the practice of shackling during labor and delivery has been deemed by the ACLU (2014) as "dangerous and inhumane," "a violation of domestic constitutional law and international human rights," and "unnecessary." The ACLU (2014) report lists many reasons why shackling poses problems to a woman giving birth, not the least of which is the risk it puts the baby in particular in the final stages of labor, which may be "life-threatening." Fewer than 20 states have laws prohibiting or restricting the shackling of pregnant incarcerated women, although several states have recently passed legislation (e.g., Massachusetts, Minnesota) or have legislation pending. Given that shackling puts the safety of the incarcerated woman and the newborn in jeopardy, banning this practice during labor and delivery (at a minimum) would be an important step towards promoting healthy deliveries and postpartum recovery in this population of women.

Educational efforts directed to correctional staff and medical personnel would also help to decrease the incidence of shackling. Correctional staff may not be aware of the laws or regulations in their state pertaining to shackling. Medical staff may also be unaware. Increasing awareness and education about this issue may help decrease the incidence of this practice.

An issue which may compound the experience of being shackled during labor is the fact that many incarcerated women have experienced sexual abuse; such experiences may pose problems during the labor and delivery process (Burian, 1995), particularly if the abuse occurred during childhood. Women with a history of childhood sexual abuse are more likely to deliver preterm babies (Leeners, Stiller, Block, Görres, & Rath, 2010). Moreover, women who have a history of sexual abuse may experience flashbacks to the abuse during the delivery process, particularly during medical examinations (Burian, 1995). As a result, these women may be more distressed during labor and delivery, especially if they are shackled.

### **The Needs of Postpartum CJS-Involved Women**

Following childbirth, women typically need four to six weeks to heal physically; additional time may be needed for those who delivered via cesarean section. Consistent with recommendations from ACOG, incarcerated postpartum women should continue to receive medical care, and receive a follow-up medical appointment with an OB to ensure that they are healing adequately. Because incarcerated women are at especially high risk for postpartum depression, correctional facilities should have policies in place to help them through this process (see Chambers, 2009). For women who expect to unify with their newborn, expressing breast milk may help them feel more connected to their newborn. Breast milk has well- documented important benefits to the newborn (see Kramer & Kakuma,

2012), but it may have positive impacts for the postpartum incarcerated woman as well. Even if a facility cannot store the milk, simply allowing women to express the milk to maintain milk

supply may have potential maternal mental health benefits, in addition to the health benefits for the child if she were able to resume breastfeeding when she were released. Indeed, the American Academy of Family Physicians (2015) recommends that in instances of separation women should be assisted in their efforts to maintain lactation.

### **Newborns Born to an Incarcerated Woman**

Although this chapter is focused on the issues incarcerated pregnant women may face, key issues about the newborn's rights seem appropriate to discuss here, particularly because a CJS-involved woman may deliver during her incarceration. Although a correctional facility is charged with maintaining the safety of those incarcerated at the facility, and a pregnant woman is responsible for maintaining a safe uterine environment, it is unclear who is responsible for protecting the newborns of incarcerated women. Following the birth of the child, if a woman is returning to jail or prison, the correctional facility is not obligated to keep the child safe and in most instances (excluding prison-nursery and co-residential facilities, e.g., California's Community Prisoner Mother Programs) the mother will be unable to care for the newborn during her incarceration. Most older children with incarcerated mothers do not come into contact with the child welfare system as a direct result of the mother's incarceration (see Johnson & Waldfogel, 2002). Typically, a mother identifies a caregiver for the child or newborn and the placement occurs with little formal involvement of social service agencies. While the mother's choice of caregiver may be adequate in most instances, there may be reason to further consider potential risks to a newborn baby if they are placed in an inadequate home. At a minimum, in situations where a woman is returning to jail or prison following the birth of her child, she should be provided legal counsel regarding her parental rights and how to assign guardianship to the child's taker. Making informed decisions about who will care for the newborn before the child is born may be an important step towards safeguarding their rights and ensuring that the caregiver will be eligible to sign the child up for health care and other services for which the child may be eligible (e.g., WIC).

### **Promising Interventions that Address the Needs of Pregnant Incarcerated Women**

Some research suggests that the incarceration itself is an intervention, as evidenced by higher birth weights of newborns born to women who are incarcerated for longer periods. It has been hypothesized that because many incarcerated women live in environments in which they are exposed to negative life events and/or engage in unhealthy behaviors, incarceration may protect the fetus from these negative events. However, as suggested above, more can be done to provide pregnant incarcerated women with higher standards of care while they are in custody to ensure that their developing fetus is healthy. Hotelling (2008) reviews a number of programs including successful doula programs in Washington State and Cook County, IL, and more comprehensive, residential treatment programs including the Women and Infants at Risk program in Detroit, MI and the MINT program in Fort Worth, TX. Below we describe two additional programs that the authors have been involved in implementing and evaluating.

The William & Mary Healthy Beginnings Project (W&M HBP) has been working to improve the birth outcomes of children born to pregnant incarcerated women in regional jails since 2012.

Through generous funding from the W.K. Kellogg Foundation, this multifaceted program provides pregnancy testing to all women of childbearing age who are processed at participating jails, high-quality prenatal vitamins to all who are pregnant, and multiple individual counseling sessions that are tailored to individuals needs and goals.

Because the national recommendations identify nutrition as one important aspect of pregnancy support, one program counseling session is devoted to nutrition counseling. In this 45-minute session, motivational interviewing techniques are used to provide information about healthy eating and nutrition throughout pregnancy that is consistent with goals that participants set for themselves. Using a plate and a series of pictures that represent both healthy and comparable, but relatively unhealthy, choices (e.g., grilled vs. fried chicken), participants are asked to choose foods for the plate that they might typically eat in a meal. Based on these choices, different options are discussed, each of the food groups and their recommended number of daily servings are reviewed, as well as how they might incorporate these choices into their diets both in jail and after they are released. The W&M HBP discusses everyday choices the women make while incarcerated by discussing jail and canteen menus and different options. For example, although most pregnant women are provided with a “snack bag” which includes a cold bologna sandwich, we have informed the women that they can request a snack bag which instead has a peanut butter sandwich to decrease the chance of contracting listeriosis. Evaluation of this program is still ongoing but preliminary results show that the W&M HBP increases women’s knowledge about healthy eating and nutrition during pregnancy, and of special note, increases in knowledge about healthy eating are associated with higher birth weights (Forestell & Dallaire, 2014; Gorman, Hull, Kelsey, Dallaire, & Forestell, 2015).

Additional sessions are devoted to providing women with individualized support through the provision of information on a variety of topics related to their pregnancy and children. The W&M HBP helps women complete any necessary paperwork required to receive requested resources, such as Medicaid, WIC, or a free car seat, or by providing referrals to programs, such as those that offer residential drug rehabilitation. Through these sessions, additional issues may be revealed in which the program may be able to intervene to reduce undue stress. This may involve advocating on behalf of participants who may not be receiving prenatal vitamins from the jail staff, appropriate housing (i.e., sleeping in an upper bunk), or appropriate care for pre-existing conditions that may adversely affect pregnancy outcomes. Perhaps at least partially as a function of addressing these stress-inducing situations, we observe that as women progress through the program they experienced significantly less depression (Ernesto et al., 2014).

Over the last two years, nearly a third (28%) of the 140 participants in this program found out they were pregnant upon entering the jail facility; that is, as a direct result of the pregnancy tests provided by the W&M HBP program. Early identification allowed these women to receive timely prenatal care, and to fully participate in the W&M HBP, which works best when participants can engage in multiple individual counseling sessions before their release from the jail facility.

Another innovative approach to caring for incarcerated pregnant women and their developing fetuses is through doula support (Schroeder & Bell, 2005). One example of such a program is Isis Rising - a prison-based pregnancy and parenting support program at the Minnesota

Correctional Facility-Shakopee. Isis Rising has two core components: 1) a 12-week support group and 2) doula support for pregnant women. The support group is facilitated weekly for two hours and aims to increase women's knowledge about reproductive health and the physiology of pregnancy and birth; increase their tangible parenting skills and life skills; and increase their support from peers and professional staff associated with Isis Rising. Pregnant women also have the opportunity to be matched with a doula - a trained professional who provides physical, emotional, and informational support before, during and after birth. In their systematic review of doula care among non-incarcerated women, Hodnett, Gates, Hofmey, and Sakala (2013) found that women who received continuous intrapartum support had shorter labors, were more likely to have spontaneous vaginal deliveries, and less likely to report dissatisfaction with their childbirth experiences. Thus, given their increased perinatal risks, doula care may be a particularly promising approach with incarcerated women. Particularly as the doula approach is relational and emphasizes building an interpersonal connection (see Covington, 2007). Pregnant prisoners who are matched with a doula have at least two, one-on-one appointments. These meetings include prenatal education, emotional support, and assistance with preparing a birth plan. When the woman goes into labor, her doula meets her at the hospital and provides continuous labor and delivery support throughout her labor and delivery. This involves providing the woman with emotional support, physical comfort, and assisting the mother in making informed decisions. Prison doulas also provide an important role during the postpartum period and are present to support the mother when she is separated from her baby at the hospital and returned to the prison (typically within 48 to 72 hours following the delivery). Finally, the doula provides two, one-on-one visits with the woman after she returns to the prison to provide postpartum education and support. Pilot results from the program are promising - between October 2011 and December 2013, none of the babies born with doula support (n = 32) were born preterm or low birth weight and only one (3%) was delivered via cesarean section.

In addition to helping prepare the mother's for the birth of their newborn, these programs may also have important mental health benefits for the mother. Perhaps at least partially as a function of addressing stress-inducing situations, we observe that as women progress through the W&M HBP they experienced significantly less depression (Ernesto et al., 2014). Participants in Isis Rising also show decreases in depressive symptomology from pre-participation to post-intervention. According to the March of Dimes (2015) depression during pregnancy is associated with greater health-risk behaviors (like smoking and substance abuse) and poorer birth outcomes (low birth weight, prematurity).

## **Conclusion**

The overlapping goals of a correctional facility to create a safe environment and for a pregnant woman to create a safe uterine environment are often complementary. To create a safe environment, a facility must begin by identifying pregnant women with pregnancy tests for all women processed at the facility and initiating care and services at that time. Additionally, facilities can adopt policies and procedures which protect the pregnant mother and developing fetus including the provision of meal and fluid supplements during pregnancy, and limiting or eliminating the use of shackles during delivery. Pregnant women can create and maintain a safe uterine environment while incarcerated by eating healthfully and avoiding harmful substances including nicotine, alcohol and drugs. Programs which support health and nutrition education

during a woman's incarceration will be important to supporting healthy pregnancies. Lastly, the safety of the newborn should be considered when a woman returns to jail or prison. Because an incarcerated mother often cannot assume responsibility for the child and the correctional facility usually will not be expected to assume responsibility of the safety of the incarcerated woman's newborn baby, the rights of this most vulnerable individual should be further considered.

Throughout this chapter, three over-arching issues emerge. First, despite recent increases in rates in incarceration, few alternatives to incarceration are available for pregnant women. This may be particularly important for community corrections as the MINT program is available to federal inmates (Federal Bureau of Prisons, 2015). Residential and diversion programs which assist with education and job training may provide several benefits to both mother and child. Women in residential and diversion programs can use the time of incarceration more productively to educate themselves and prepare for the birth of their baby in the mother's community. Secondly, there is a need for gender-responsive programming for women. National organizations such as the National Institute of Corrections have acknowledged the need for correctional facilities to recognize the different needs of men and women under correctional supervision (Bloom, Owen, & Covington, 2003). It is clear that there is a need for gender-responsive strategies in community corrections, strategies that adopt a trauma-informed approach to care for women involved in the CJS, particularly pregnant CJ-involved females. Lastly, Nelson Mandela wisely said "Education is the most powerful weapon which you can use to change the world." Throughout this chapter we have discussed nutritional education, prenatal education, and educational opportunities for correctional officers and medical personnel. It is important to increase education and awareness about this topic to these individuals but also more broadly to members of the community where these women live and these children will grow. Unfortunately, most individuals do not know or have never thought about what happens when a woman is pregnant and incarcerated. Through our work, we hope to educate, raise awareness and advocate for positive changes for these women and their babies.

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## Notes

1. The W&M HBP is a research and educational program which works with regional and local jails in Central and South Eastern Virginia to provide pregnancy tests, prenatal vitamins, nutritional counseling and support to pregnant incarcerated women. The first two authors of this paper are the program Principal Investigators.

2. Names of participants have been changed.