Review

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Pregnancy in incarcerated women: need for national legislation to standardize care

Abstract

Objectives: This review examined prenatal care provided to incarcerated women to identify areas where improvement is needed, and examined current legislative gaps such that they can be addressed to ensure uniform templates of care be instituted at women’s prisons.

Methods: Data were compiled from 2000-2021 citations in PubMed and Google Scholar using the keywords: prison AND prenatal care AND pregnancy.

Results: Although the right to health care of inmates is protected under the Eight Amendment to the United States Constitution, the literature suggests that prenatal care of incarcerated individuals is variable and would benefit from uniform federal standards. Inconsistency in reporting requirements has created a scarcity of data for this population, making standardization of care difficult. Although incarceration may result in improved access to care that women may not have had in their community, issues of shackling, inadequate prenatal diet, lack of access to comprehensive mental health management, and poor availability of opioid use disorder (OUD) management such as Medication Assisted Therapy (MAT) and Opioid Treatment Programs (OTP), history of post-traumatic stress disorder (PTSD) are just a few areas that must be focused on in prenatal care. After birth, mother-baby units (MBU) to enhance maternal-fetal bonding also should be a prison standard.

Conclusions: In addition to implementing templates of care specifically directed to this subgroup of women, standardized state and federal legislation are recommended to ensure that uniform standards of prenatal care are enforced and also to encourage the reporting of data regarding pregnancy and neonatal outcomes in correctional facilities.

Keywords: incarceration; legislation; pregnancy; prenatal care; prison.

Introduction

Prenatal care for incarcerated women is a topic that has not been extensively researched and therefore templates of care are typically based on standard prenatal care guidelines. This paper underscores the need for legislation regarding standardized prenatal care in incarceration while also providing an introduction of the NJ Commission on Women’s Reentry and the Commission’s focus. Current data suggest that establishing focused care guidelines for this subgroup of women and supporting legislation to uniformly incorporate these guidelines into the prison system, along with allocation of adequate funding resources, are necessary to optimally support maternal and fetal outcomes. Proper prenatal care is essential to perinatal health, and providing adequate care to incarcerated women will support healthy growth and development of the fetus. With an established standard of prenatal care, gaps in maternal health can be identified and addressed thereby improving the health outcomes of pregnancies during incarceration.

Data regarding maternal and fetal outcomes in incarceration are scarce, allowing few studies to explore a detailed account of maternal and fetal outcomes in incarceration. Requiring correctional facilities to provide data regarding maternal health data would allow for further research and analysis and the identification of gaps in

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Prenatal care in correctional facilities. It is our hope that this paper not only encourage further research into this topic, but also encourage legislative action to protect the healthcare needs of incarcerated pregnant women.

Incarceration of women in the US is increasing. While incarcerated pregnant individuals occur in many countries, there is a disproportionate occurrence in the US which houses one third of all such individuals in the world [1]. More than 66% of incarcerated women report having children under 18 years old, and about 6% of this population are pregnant at the time of arrest [2]. Policies governing jails and prisons in the United States are not dependent on gender, and thus, female and male prisons are operated in the same manner. Because of this standard, the unique needs of women typically are not addressed, which translates to an overall negative impact on women’s health. Further, states are not required to report data on pregnancy among incarcerated women, and as a result, there are large data gaps regarding prenatal outcomes. For this reason, it is difficult to determine the precise number of women who are affected by the lack of adequate prenatal care in US prisons and jails.

In 2004, only 54% of incarcerated pregnant individuals received prenatal care [3]. Many of these pregnancies are high risk due to the interaction of several adverse social scenarios, including barriers to accessing healthcare, poor education, drugs/alcohol use, and low socioeconomic status. For example, data suggest that the incarcerated woman’s pregnancy is often complicated by substance-use disorders, anxiety, depression, personality disorders, and other mental illnesses [4]. In addition to these factors, poor social support systems and abusive relationships also contribute to the increased perinatal and postnatal morbidity and mortality seen among incarcerated women and their children. After the child’s birth, interruption of a critical bonding period often occurs, as the newborn may be separated from the mother [5].

In addition to no national legislation mandating prisons to provide physical or mental health services to inmates, standards of care for pregnant inmates also have been inadequately addressed on national and state levels. As of 2011, 38 states have failed to create and uphold policies guaranteeing adequate prenatal care for incarcerated women [6]. Furthermore, for incarcerated pregnant women, 41 states do not require prenatal nutrition counseling or education and 48 states do not provide HIV screening [6]. In many states, the use of restraints such as handcuffs and shackles also are not restricted, despite data noting that this practice has negative physical effects on the physical and mental health of the mother and her child. In 13 states, shackle use is unrestricted, and can even be used during the vulnerable times of pregnancy and labor [7].

To address the needs of pregnant incarcerated women, as well as all incarcerated women, New Jersey legislated the NJ Commission on Women’s Reentry. This multidisciplinary group, that includes several women’s health care providers, is actively addressing women’s health care while in prison and afterwards, with reentry into their community. The Commission also is establishing templates of care to appropriately manage the unique needs of the expectant mother and her infant [8].

This review evaluated data on pregnancy issues that are prevalent in incarcerated women to highlight their special needs and to further support the passing of state and federally legislated standards of care.

Methods

Data were obtained from several sources that addressed prenatal care during incarceration. A literature search of several online databases such as PubMed and Google Scholar, compiled relevant citations from 2000 to 2021 using the keywords: prison AND prenatal care AND pregnancy AND incarceration.

Results

Mental health of incarcerated pregnant women

Incarcerated women are particularly at risk for problems with mental health, with nearly two thirds reporting a history of mental health problems [9, 10]. Although women may have improved access to behavioral health treatment while incarcerated as compared to their level of access prior to incarceration, this is due to their having received little to no treatment for mental illness in their communities prior to incarceration [11]. With pregnancy, women are particularly vulnerable to mental health problems and with the added stress of incarceration, their mental health status may be further compromised.

Mental health screening in the prison before, during, and after pregnancy allows for the early detection of mental health issues, the worsening of mental health status and its early management. Early intervention improves not only maternal, but also fetal outcomes, such as low birthweight and premature delivery [12]. There also
have been associations of adverse birth outcomes with maternal anxiety. After delivery, there is forced separation of child from mother, further maternal stress occurs, creating a high-stress environment conducive to mental trauma.

Physical/sexual trauma

Among female inmates, trauma, be it sexual, physical or both, is often a shared experience. A history of sexual or physical trauma may contribute to a high risk-pregnancy or pregnancy related complications, and providing therapeutic interventions for these individuals may positively impact their and their child’s health [13]. A trauma-informed approach by the prison health care team can reduce this negative impact on mental health. For instance, in the case of a pregnant patient with a history of sexual abuse, pelvic and breast exams may be traumatic and have to be done in a way that takes this issue into consideration. Physical exposure of the genitalia during childbirth also can cause traumatization in previously abused women and in some C-section may be the best option. Those who have PTSD may need to have special birthing accommodations as PTSD symptoms can be triggered by a high stress birth [14].

Opioid abuse/treatment

Up to 90% of the female prison population, inclusive of pregnant women, report drug addiction problems [14]. Currently, Medication-assisted treatment (MAT) is the treatment strategy for pregnant women with Opioid Use Disorder (OUD) [15] which correctional facilities should be legislated with the resources to provide. In the case of opioid misuse, a multifaceted approach incorporates many avenues of treatment and support, including cognitive behavioral therapy, support groups, MAT, and close monitoring for progress. Such programs in the women’s prison would not only benefit the mother, but also the newborn. In order to prevent withdrawal symptoms, newly incarcerated pregnant women should immediately be screened for substance abuse so there is no delay in their treatment. MAT medications, including methadone, offer many benefits to the pregnant mother with OUD. This treatment has been associated with decreased levels of drug use post-release, while withdrawal associated with discontinuation of opioid use without MAT is associated with a higher risk of relapse and later overdose post-release [16]. MAT is not offered by most correctional facilities and should be a part of the standard care in correctional facilities.

Peeler and Fiscella [17] describe several options that are currently used by jails and prisons to treat pregnant women with Opioid Use Disorder (OUD). The first option is to provide treatment for the pregnant incarcerated woman at a community Opioid Treatment Program (OTP) or hospital. However, daily transport might pose limitations regarding this option. The second is to partner with community OTP to provide in-house treatment within the correctional facility. An essential part of this option is the strict monitoring and documentation of dose transport, requiring all unused medication to be returned to the medical facility for further documentation. The third utilizes prescriptions from correctional clinicians holding buprenorphine licenses. Any inmates requiring this medication can obtain it through such prescriptions as recommended by the clinician. A fourth is for the correctional facility to obtain a facility license to have a unit operating as an OTP. Such a facility license would allow inmates to have the option of being prescribed methadone or buprenorphine. The last is unlocked if the health care services unit within the jail or prison obtains the necessary state and federal licenses in order to receive hospital level exceptions regarding the use of these MAT medications for treatment of OUD or the treatment of other health conditions. Each of these options present their own sets of benefits and drawbacks, however all result in the increased availability of treatment options for incarcerated women with OUD.

Diet and nutrition

Regarding nutrition, there are currently no federal regulations setting a national standard for inmate nutrition. As well, in many states, correctional facilities do not have strict minimum standards regarding appropriate prenatal nutrition and supplements for pregnant inmates. A maternal diet inadequate in folic acid can lead to neural tube defects in the child, along with other complications such as low birth weight and premature birth [18]. In order to protect the unborn child from developmental risks, a diet supplemented with necessary vitamins and minerals should be mandated for pregnant prisoners. Data have shown that incarcerated pregnant women are more likely to have babies of lower birth weight than control populations [19]. Furthermore, to ensure an adequate diet, women should have access to interventions that combat excessive nausea along with access to fluids.

While healthy diets are an important part of prenatal care, it is often costly for correctional facilities to provide
this. Thus, especially when faced with poor funding, dietary provisions provided to the pregnant inmates may be inadequate [20]. Shlafer and Stang outline six recommendations to improve the nutritional intake of pregnant inmates in correctional facilities [21]. These are: 1) take a pregnancy test upon intake, which is not the standard process in all prisons. Early identification of pregnancy can lead to earlier administration of prenatal care and supplements, minimizing any harm posed to the unborn child; 2) prescribe prenatal vitamins to those inmates who are diagnosed as pregnant [22]; 3) follow the nutritional guidelines set forth by the Academy of Nutrition and Dietetics for a healthy pregnancy. Adequate folic acid, iron, calcium, zinc, and Vitamin D should be a template of care for all incarcerated individuals who are pregnant; 4) provide additional food to pregnant inmates: 5) ensure regular access to fluids, especially water. Pregnant women require up to three liters of fluid a day, and dehydration during pregnancy can lead to increased risk of preterm labor and contractions [23]; 6) provide pregnant inmates with educational resources regarding nutrition and the importance of a balanced diet during pregnancy. This will assist with inmate compliance, and allow the pregnant inmate to understand the importance of her supplemented diet.

**Shackling**

In 2008, the Federal Bureau of Prisons ended routine shackling in federal correctional facilities, and state legislation also has begun to enact policies to end this practice. In the states of California, Colorado, Illinois, New Mexico, New York, Pennsylvania, Texas, Vermont, Washington, and West Virginia, pregnant women are prohibited from being shackled [24]. Currently, 24 states have policies that limit the use of restraints on pregnant women in correctional facilities, and of these states, 18 include room for broad exceptions to this rule [24].

Shackles can limit motility and range of motion, making medical intervention difficult when necessary. During labor, shackling can increase pain [25]. Furthermore, the use of shackles and restraints on pregnant inmates can increase the risk of falls along with the risk embolic conditions that can introduce risks into the pregnancy [26]. The use of restraints can also worsen pre-existing mental health conditions such as depression or post-traumatic stress disorder [27].

Internationally, the shackling of pregnant incarcerated women is a practice that violates several international human rights laws. The Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and the International Covenant on Civil and Political Rights are both treaties ratified by the United States that are violated by the United States’ tolerance of shackling pregnant inmates [28].

**Mother-Baby Units**

While only four nations separate incarcerated mothers from newborns (United States, Bahamas, Liberia, and Suriname), many other countries offer a system known as Mother-Baby Units (MBU). Data note that it is in the child’s best interest to not be separated from the mother after birth. MBU are offered by a quarter of the 50 US states. The National Women’s Law center noted that only three of the 13 existing prison nursery programs offered treatment and services for both the mother and child [29]. Within the existing American programs, mothers meeting specific criteria can cohabitate with their newborns up to 12 or 18 months [29]. MBUs should have the goal of promoting healthy child-rearing practices with a focus on parental education for all incarcerated mothers. Lessons and counseling regarding lactation, parenting, anger management, and substance use are especially important to these mothers. Parental education is key in this vulnerable time, and these units can facilitate the formation of a healthy mother-child bond. Furthermore, the implementation of such a project can actually decrease the recidivism rate. After participation in an MBU, the states of New York and Washington saw a decrease in recidivism rates. Furthermore, Nebraska observed a decrease in 10-year recidivism rates [30]. A study later found that mothers who participated in MBUs were less likely to return to prison when compared to mothers who were separated from their newborns shortly after birth [31]. While many states do not currently participate in an MBU, the implementation of this practice should be universal for it provides benefits to not only maternal and fetal health, but also provides a social and financial benefit to the state through lower readmittance rates.

**Pregnancy outcomes**

Clearly, incarcerated pregnant women have several risk factors, that may include drug use, alcohol use, and smoking [32]. However, when comparing the incarcerated population with a similarly disadvantaged but not incarcerated population, a meta-analysis found that incarceration may improve outcomes in pregnancy [19]. This appears to be due to separation from environmental risk
factors such as access to drugs, alcohol, and other high-risk behaviors. Furthermore, incarceration provides shelter, food, and other necessities, which some inmates might otherwise not be guaranteed outside of incarceration. Although women in a correctional facility have access to care, the unique deleterious effects of incarceration on pregnancy outcomes must be actively addressed.

**Study strengths and limitations**

This study analyzed the current relevant literature for gaps in prenatal care in order to ultimately call for legislation to ensure improvements in care for this population. By compiling and identifying several gaps in prenatal care seen in correctional facilities, this study provides a cohesive review of several areas of improvement that future literature and legislation can focus on.

The main limitation imposed on this study was the scarcity of similar literature and supporting data. As there is a lack of existing literature examining pregnancy outcomes in incarceration, analysis of current measures of prenatal care and the resulting health outcomes is limited. The scarcity of data in this field is a strong limiting factor for generating strong statistical evidence to support the adverse effects of inadequate prenatal care in correctional settings. Furthermore, as prisons are not required to report health data regarding pregnant inmates, it is difficult to make further conclusions regarding both the negative impacts that a lack of standardized prenatal care in correctional facilities could have on inmates and also the potential positive outcomes that this standardized prenatal care could bring.

**Discussion and conclusion**

Incarcerated pregnant women are a vulnerable population and enhancing their care appears to be dependent on legislation, education, provision of comprehensive healthcare, and establishment of MBUs post birth. Despite the eighth Amendment, federal and state legislation should be created in order to create a standard of care for pregnant and postpartum individuals who are incarcerated, based on guidelines set by professional organizations.

Women in correctional facilities have an over-representation of risk factors that complicate pregnancy and should be managed by templates of care that include screening for pregnancy on admission and then early interventions. Early screening in correctional facilities would also be beneficial in the detection of OUD. With over 90% of the female prison population reporting a problem with substance abuse, correctional facilities must anticipate the need for drug addiction treatment programs \[32, 33\]. Pregnant inmates would especially benefit from such an initiative, by preventing any adverse effects to the fetus. There are several avenues open for correctional facilities to supply MAT to inmates with OUD, each with their own benefits. In addition to MAT, behavioral therapy, and access to medical professionals should also be provided for inmates struggling with OUD. In addition to providing treatment for drug use, correctional facilities should also be held to a national standard regarding prenatal nutrition and adequate fluids and anti-emetic drugs, when indicated. It should be ensured that pregnant inmates are receiving prenatal vitamins, supplements, and adequate levels of essential vitamins and minerals that are vital during pregnancy. In order to prevent harmful effects to the mother and fetus, the dangerous practice of shackling must be eradicated. Not only does this pose danger to maternal and fetal health, but this practice is in violation with international human rights treaties, raising international alarm.

Additionally, correctional facilities should be required to provide data regarding prenatal outcomes and related health data. This would allow necessary further research and analysis regarding the effect of incarceration on prenatal outcomes and would assist with identifying current gaps in prenatal care in correctional facilities and how to address them. Historically, data regarding pregnancy during incarceration has been sparse, with no legislation requiring correctional facilities to report related data on this topic. In order to encourage further study and improvement regarding this vulnerable population, state and federal legislation should encourage and facilitate the collecting and reporting of data on health outcomes of pregnant inmates and involved risk factors. These data would allow correctional facilities to identify gaps in prenatal care and to address any resulting adverse effects, creating a higher caliber of healthcare for these women and their children.

MBUs are encouraged as they offer maternal-infant bonding and parental education that promote optimal child rearing behaviors. Furthermore, such a nursery program prevents the adverse mental effects of the mother being separated from the child and reduces readmittance of the mother to correctional facilities. Currently, such a
program is not available in the vast majority of correctional facilities. Lastly, more state legislated bodies, such as the NJ Commission on Women’s Reentry, is essential in ensuring that funding and support for the unique needs of women, especially during pregnancy, are being recommended. The Commission is identifying and then addressing women’s health issues as well as devising protocols and support structures to help women better adjust for re-entry into their communities [8].

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