National Resource Center on Justice Involved Women (NRCJIW)

- Funded by the U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Assistance in partnership with the National Institute of Corrections.

- **Primary Goal:** *Provide resources and tools to professionals to equip them to be more successful in their work with justice-involved women.*

- Administered by the Center for Effective Public Policy in partnership with Orbis Partners, University of Cincinnati, Women’s Prison Association, CORE Associates, The Moss Group and SAMHSA’s National Center on Trauma-Informed Care.
Primary Activities

- Targeted Technical Assistance
- Training and Webinars on Key Topics
- Policy and Practice Briefs
- Innovator Series
- E-newsletter

See our website at:

www.cjinvolvedwomen.org
Today’s Agenda

- Discuss the reproductive characteristics and health needs of women in custody
- Review evidence-based and best practices around pregnancy care and the non-use of restraints
- Look at some models for care and innovative programs
- Hear about upcoming research
- Q&A
Carolyn Sufrin, M.D., Ph.D.

- Ob/Gyn and Ph.D in Medical Anthropology
- Has worked extensively on reproductive health issues affecting incarcerated women
- Assistant Professor, Department of Gyn/Ob, Johns Hopkins School of Medicine, and in the Department of Health, Behavior and Society, Johns Hopkins Bloomberg School of Public Health
- Board member of the NCCHC
- Principal Investigator of new research project focused on pregnancy in prison
29 yo African American woman, 32 weeks pregnant and in jail for the 3rd time this pregnancy.

Pregnancy history: 2 other pregnancies, children are not in her custody

Medical and gyn history: Seizure disorder; previous chlamydia infection; multiple sexual partners

Social history: marginally housed; unemployed

Uses crack and heroin

Molested as a child; placed in foster care then juvenile facilities then in and out of jail/prison her adult life
Patient case: Evelyn

29 yo African American woman, 32 weeks pregnant and in jail for the 3rd time this pregnancy.

Pregnancy history: 2 other pregnancies, children are not in her custody

Medical and gyn history: Seizure disorder; previous chlamydia infection; multiple sexual partners

Social history: marginally housed; unemployed
Uses crack and heroin
Molested as a child; placed in foster care then juvenile facilities then in and out of jail/prison her adult life

What can we learn from Evelyn about the health needs of incarcerated women and how facilities can meet those needs?
What do we know about the health characteristics of women in custody?
Women are a small but growing proportion of incarcerated population...

- 2.6 million arrests of women/year
- 213,000 behind bars
- Most are mothers with young children
- Disproportionately affected by war on drugs
- 757% increase since 1977

Racial disparities:

- White ♀: 49/100,000
- Hispanic ♀: 64/100,000
- Black ♀: 115/100,000

US DOJ/FBI, 2008
USDOJ BJS, Correctional Population 2010
Clarke & Adashi JAMA 2011
Frost Women’s Prison Assn 2007
US DOJ BJS Prisoners 2012 admissions
Britton At Work in the Iron Cage 2006
Greenfeld & Snell. Women Offenders 2000
Doris et al 2006 USDOJ BJS
Women are a small but growing proportion of incarcerated population...

- 2.6 million arrests of women/year
- 213,000 behind bars
- Most are mothers with young children
- Disproportionately affected by war on drugs
- 757% increase since 1977

70% arrested for non-violent offenses

Racial disparities:

<table>
<thead>
<tr>
<th>Race</th>
<th>Arrest Rate per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>White ♀</td>
<td>49/100,000</td>
</tr>
<tr>
<td>Hispanic ♀</td>
<td>64/100,000</td>
</tr>
<tr>
<td>Black ♀</td>
<td>115/100,000</td>
</tr>
</tbody>
</table>

US DOJ/FBI, 2008
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Frost Women’s Prison Assn 2007
US DOJ BJS Prisoners 2012 admissions

Britton *At Work in the Iron Cage* 2006
Greenfeld & Snell. Women Offenders 2000
Doris et al 2006 USDOJ BJS
Number of Women in State and Federal Prisons, 1980-2012

- Federal prisons
- State prisons

<table>
<thead>
<tr>
<th>Year</th>
<th>Federal</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980</td>
<td>13,258</td>
<td>0</td>
</tr>
<tr>
<td>1985</td>
<td>23,099</td>
<td>0</td>
</tr>
<tr>
<td>1990</td>
<td>43,845</td>
<td>0</td>
</tr>
<tr>
<td>1995</td>
<td>68,468</td>
<td>0</td>
</tr>
<tr>
<td>2000</td>
<td>93,234</td>
<td>0</td>
</tr>
<tr>
<td>2005</td>
<td>107,518</td>
<td>0</td>
</tr>
<tr>
<td>2010</td>
<td>112,797</td>
<td>0</td>
</tr>
<tr>
<td>2012</td>
<td>113,605</td>
<td>0</td>
</tr>
</tbody>
</table>


National Resource Center on Justice Involved Women
Rates of disease in incarcerated populations are higher than in the community\textsuperscript{1,2}

<table>
<thead>
<tr>
<th>Disease</th>
<th>Rate Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV</td>
<td>x 5</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>x9-10</td>
</tr>
<tr>
<td>Syphilis (in women)</td>
<td>x1000</td>
</tr>
<tr>
<td>TB (active)</td>
<td>x23\textsuperscript{3}</td>
</tr>
<tr>
<td>Cervical Cancer</td>
<td>x4\textsuperscript{4}</td>
</tr>
<tr>
<td>Chronic disease?</td>
<td>39-43% new dx DM, Htn, Asthma\textsuperscript{3}</td>
</tr>
</tbody>
</table>

1. Dumont 2012 Ann Rev Public Health
2. Binswanger 2010 AJPH
3. Baussano 2010 PLoSMed
4. Binswanger 2009 J Epidemiol Comm Health
... and for incarcerated women, there are higher rates of STIs, substance dependence, abuse, and mental illness

<table>
<thead>
<tr>
<th>Condition</th>
<th>Incarc. ♀</th>
<th>Non-incarc. ♀</th>
<th>Incarc ♂</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlamydia $^{1,2,3}$</td>
<td>8.9%-14%</td>
<td>4.7%</td>
<td>10%</td>
</tr>
<tr>
<td>Trichomonas $^{2,4}$</td>
<td>26%</td>
<td>3.1%</td>
<td>-</td>
</tr>
<tr>
<td>HIV $^{5,6}$</td>
<td>2.4%</td>
<td>0.18%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Prior physical or sexual abuse $^{7,8,9}$</td>
<td>Up to 80%</td>
<td>Up to 44%</td>
<td>Up to 16%</td>
</tr>
<tr>
<td>Symptoms of psych illness $^{7,8,10}$</td>
<td>73%</td>
<td>20%</td>
<td>55%</td>
</tr>
<tr>
<td>Substance dependence $^{11,12}$</td>
<td>52%</td>
<td>6.9%</td>
<td>44%</td>
</tr>
<tr>
<td>Hepatitis C $^{13}$</td>
<td>41%</td>
<td>1.5%</td>
<td>41%</td>
</tr>
</tbody>
</table>

2. Willers 2008 Sex Transm Dis
3. MMWR 2014 63(38)
4. Sutton 2007 Clin Inf Dis
5. Macalino 2005 Clin Inf Diseases
6. CDC HIV Surveillance
7. Harlow 1999 USDOJ BJS
8. Fickenscher 2001 Public Health Reports
9. CDC 2014 NISVS
10. MMWR 2011, 60(03)
11. Clarke 2010 JAMA
12. SAMHSA 2012 13-4795
13. CDC, Corr Facilities and Viral Hepatitis
Incarcerated women are mothers and are at risk for unplanned pregnancies

<table>
<thead>
<tr>
<th>Pre-Incarceration</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Median age</td>
<td>32-36 (jail vs. prison)</td>
</tr>
<tr>
<td>Prior pregnancy¹</td>
<td>84%</td>
</tr>
<tr>
<td>Prior unplanned pregnancy¹</td>
<td>84%</td>
</tr>
<tr>
<td>Prior abortion</td>
<td>35%¹-55%²</td>
</tr>
<tr>
<td>Median # pregnancies¹</td>
<td>6 (1-17)</td>
</tr>
<tr>
<td>Median # deliveries¹</td>
<td>2 (0-9)</td>
</tr>
<tr>
<td>No regular birth control in prior 3 mo¹</td>
<td>72%</td>
</tr>
<tr>
<td>Sexually active in prior 3 mo¹</td>
<td>84%</td>
</tr>
<tr>
<td>Unprotected sex in last 5 days²</td>
<td>29%</td>
</tr>
<tr>
<td>Mother to children &lt;18 yo</td>
<td>62%³</td>
</tr>
</tbody>
</table>

1. Clarke 2006 AJPH
2. Sufrin 2010 J Urban Health
3. Rebecca Project 2010

National Resource Center on Justice Involved Women
A Public Health Perspective

**Pre-incarceration**
- Poor health status
- Poverty, malnutrition, homelessness, unemployment
- Medically underserved

**While incarcerated:**
- “opportunity”
  - New diagnoses
  - Transmission of ID
  - Preventive health care

**Release, Re-entry, Re-arrest**
- Continuity of care, competing priorities
- Mortality risk:
  - 12.7 x risk of death w/in 2 wks
- Perpetuates disparities

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1. Clarke AJPH, 2006
2. Dumont et al JHCPU 2013
3. Wang Public Health Reports 2010
Challenges of providing women’s healthcare services in correctional facilities

- Generally, research has found inadequate health services provided for women (in prisons and jails)
- There is limited attention to gender-specific needs
  - Women are a small part of a larger population
  - Males as “default inmates”
- However, most women are of reproductive age

Weatherhead 2003 Jnl Law and Medicine
Mullen 2003 Fam Comm Health
What are best practices for caring for pregnant and postpartum women in custody?
How common are pregnancy & childbirth in custody?

- 6-10% of incarcerated women are pregnant
- 5% of women in jail, 4% state prison, 3% federal prison reported being pregnant at intake
- 1400 births per year

- 1999 BJS report on women in custody
- 2004 and 2005 BJS inmate surveys Self-report Representative sample
- 1997 ACA survey of 43 state prisons
How common are pregnancy & childbirth in custody?

- 6-10% of incarcerated women are pregnant
- 5% of women in jail, 4% state prison, 3% federal prison reported being pregnant at intake
- 1400 births per year

We don’t know!

1999 BJS report on women in custody

2004 and 2005 BJS inmate surveys
Self-report
Representative sample

National Resource Center on Justice Involved Women
Pregnancy and Incarceration

- Many first learn of their pregnancy on entry
  - Importance of options counseling

- High risk pregnancies
  - Coexisting substance and mental health issues
  - Poor nutritional status

- Pregnancy outcomes

  - Vs. general population: higher
  - Vs. similarly disadvantaged women: lower

1. Knight 2005 BJOG

Preterm birth
Low birth weight
Stillbirth
Pregnancy and Incarceration: Prenatal Care

- Provided onsite vs. transport to facility
- Women in state prisons were more likely to receive an obstetric exam (94%) than women in jails (48%) and other pregnancy care services (54%) than were women in jails (35%).

- 38 states deemed to have inadequate prenatal care in prisons
- “Special privileges”
  - Bottom bunk
  - Light duty work assignments
  - Extra sandwich and a carton of milk

1. Maruschak 2006
2. The Rebecca Project 2010. Mothers Behind Bars
Best practices for prenatal care

- Follow community guidelines for care
- Qualified personnel providing prenatal care
- Prenatal vitamins, adequate nutrition including snacks
- Arrangement with hospital for specialty care and delivery
- Social support throughout pregnancy, delivery and postpartum
- Longer stay in hospital when possible
Best practices for pregnancy care: Require Access to Care for Pregnant Women

- Options re: counseling and abortion services
- Prenatal care and safe environment
- Support during and after childbirth
Best practices for prenatal care
www.ncchc.org

- Mental Health Considerations for Segregated Inmates (pdf)
- Nurses’ Scope of Practice and Delegation Authority (pdf)
- Pregnancy and Postpartum Care (pdf)
- Psychological Autopsy or Reconstruction (pdf)
- Quality Guidelines for Hospice and End-of-Life Care in Correctional Settings
- Standards of Care for the Addiction Specialist Physician: American Society
Pregnancy and Incarceration: Labor and Delivery

- Correctional staff as triage for medical complaints
- Usually not allowed to have visitors
  - Doula support enhances birth experiences
- Conflict over use of restraints in labor
  - “Safety & security”
  - Human rights
  - Medical safety

1. Schroeder & Bell 2005 Public Health Nursing
Health risks of restraints:
Prenatal and labor and delivery

- Risk of falls → separation of placenta → Preterm labor, stillbirth and bleeding
- Interference with pregnancy changes
- Unpredictability of obstetrical emergencies
  - Seizures, bleeding, preterm labor, fetal distress
- Labor and delivery - fetal monitoring, movement to relieve pain, baby getting stuck in birth canal, emergencies, c-section
- Transport

National Resource Center on Justice Involved Women
Health risks of restraints: Prenatal and labor and delivery

- Risk of falls → separation of placenta → preterm labor, stillbirth and bleeding
- Interference with pregnancy changes
- Unpredictability of obstetrical emergencies
  - Labor and delivery
  - Transport

Health care staff need unimpeded access to evaluate and treat patients

National Resource Center on Justice Involved Women
Health risks of restraints: Postpartum

- Interference with safe holding of the newborn
  - Importance of mother-infant bonding
  - Breastfeeding

- Post-partum emergencies

- Increased risk of falls, interferes with healing after vaginal delivery or c-section
Position Statement (2010)
http://www.ncchc.org/restraint-of-pregnant-inmates

“Restraint of pregnant inmates during labor and delivery should not be used. The application of restraints during all other pre-and postpartum periods should be restricted as much as possible and, when used, done so with consultation from medical staff.”

Committee Opinion 511 (2011)

“Shackling during transportation. . .and during receipt of health services should only occur in exceptional circumstances for pregnant women and women within 6 weeks postpartum after a strong consideration of health effects of restraints by the clinician providing care. . . . If restraint is needed, it should be the least restrictive possible.”

Standard J/P-G-09 (2014)

Restraints are not used during active labor and delivery.
Discussion: Restraint during transport. . . Should not be used except when necessary due to serious threat of harm. . . . Restraint during all other pre- and postpartum periods should be restricted as much as possible and used only in consultation from medical staff”
22 States Have Laws Prohibiting Restraints in Labor

**Federal Bureau of Prisons**

Source: ACOG (9.2014)
http://www.acog.org/About_ACOG/ACOG_Departments/State_Legislative_Activities/Shackling_of_Incarcerated_Pregnant_Inmates

National Resource Center on Justice Involved Women
The National Task Force on the Use of Restraints with Pregnant Women under Correctional Custody

Co-sponsored by the U.S. Department of Health and Human Services and the U.S. Department of Justice

A set of principles to guide corrections agencies in the development of policies and practices......

*Designed to maximize safety and minimize risk for pregnant women and girls, their children, and correctional and medical staff*
Best Practices in non-use of restraints:

1. Abdominal, leg/ankle, wrist behind the back and four-point restraints are expressly prohibited under all circumstances.
2. Restraints should never be used during labor and delivery.
3. The use of restraints should be avoided during the post-partum period.
4. When transporting a pregnant woman or girl, restraints should not be used except where absolutely necessary.
5. SOPs should outline a clear process and frequency for reassessing the use of restraints when they have been deemed absolutely necessary.
6. SOPs should be in place to address emergency and non-emergency decisions around the use of restraints.
7. All uses of restraints should be documented thoroughly.
8. Correctional staff should universally receive training on restraint policy, procedures, and specific variations for use with pregnant women and girls in custody.

What happens to mom and baby after delivery?

Mother and infant separated:
- Infant to pre-designated guardian
- Foster Care
- Supervised family visits in jail

Mother and infant together:
- Mother-infant care programs
  - 4 weeks – 2 years
- Family-based alternative sentencing
- Lower rates of recidivism

Prisons only (n=8) + Rikers Island

1. Goshin 2013 Public Health Nursing
Post-partum care

- Breastfeeding
  - Pumping arrangements?
  - Contact visits with newborn?

- Mental health
  - Post-partum depression

- Contraception
  - Preventing unplanned pregnancies
  - Preparation for release
  - Limited access in jails and prisons
Opportunities for re-entry: Family Planning in Correctional Facilities
Providing Contraception to Women in Custody

**Consider:**
- Population is predominantly of reproductive age
- High risk for unintended pregnancy
- Family planning → comprehensive gyn care
- Work release and furloughs
- Jail stays can disrupt and limit contraceptive effectiveness
  - ALLOW WOMEN TO CONTINUE A METHOD!!
- Medical indications
- Barriers to contraception access outside

1. Sufrin 2010 J Urban Health
Preparing for release: Unmet need for family planning

<table>
<thead>
<tr>
<th>Women want to access contraception...</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior unplanned pregnancy(^1)</td>
<td>84%</td>
</tr>
<tr>
<td>Plans to be sexually active when released(^1)</td>
<td>85%</td>
</tr>
<tr>
<td>Wanted to initiate BCM in custody(^2)</td>
<td>60%</td>
</tr>
<tr>
<td>Positive pregnancy attitude</td>
<td>9%(^1)-23%(^3)</td>
</tr>
<tr>
<td><strong>BUT. . . limited availability(^3)</strong></td>
<td></td>
</tr>
<tr>
<td>Provide BCM in facility</td>
<td>38%</td>
</tr>
<tr>
<td>Birth control pills</td>
<td>22%</td>
</tr>
<tr>
<td>Depo provera</td>
<td>18%</td>
</tr>
<tr>
<td>Intrauterine device</td>
<td>2%</td>
</tr>
<tr>
<td>Not allowed to continue BCM</td>
<td>55%</td>
</tr>
</tbody>
</table>

BCM = birth control method

1. Clarke et al 2006 AJPH
2. Sufrin et al 2010 J Urban Health
3. Sufrin et al 2010 Contraception
Many benefits to offering family planning services to women in custody

- Help plan for healthy pregnancies or prevent unwanted pregnancies to optimize successful re-entry
- Continuing current method of birth control
- One less thing for women to worry about
  - Access issues
- Birth control is cost-effective
  - Every $1 on FP saves $5.68\(^1\)
  - 43% of pregnant inmates became pregnant within 1 year of a prior incarceration\(^2\)

1. Guttmacher Institute
2. Clarke 2010 J Corr Health Care
Innovations in Health Services for Women in Custody
Innovation: Doula support for pregnant and postpartum women

What are doulas?

- Non-medical, trained support people for pregnant women
- Provide services throughout pregnancy, during childbirth, and after
  - Emotional support
  - Information about nutrition, breastfeeding, bonding
  - Pain management and support during labor
Innovation: Doula support for pregnant and postpartum women

- Women who deliver in custody lack support persons
- Doulas have been shown to improve birth experiences, shorter labor, reduce C-section rates
- Doula support for pregnant inmates has many benefits
  - Antepartum, childbirth, post-partum
- Research has shown high satisfaction among women
- Several model doula programs exist:
  - WA, MA, MN, San Francisco

1. Hodnett Cochrane Review 2003
2. Schroeder PHN 2005
3. The Prison Birth Project [www.theprisonbirthproject.org](http://www.theprisonbirthproject.org)
Innovation: Screen and offer women emergency contraception at intake

- Emergency contraception (EC) reduces risk of getting pregnant when taken within 5 days of unprotected sex
- Safer than Tylenol
- Available in the U.S. without a prescription
Innovation: Screen and offer women emergency contraception at intake

- Emergency contraception (EC) reduces risk of getting pregnant when taken within 5 days of unprotected sex
- Safer than Tylenol
- Available in the U.S. without a prescription

Women entering jail:
- 29% have had unprotected sex within 5 days of entry
- 48% of these women wanted to take EC
- Train intake medical staff to screen and administer EC
Innovation: Pre-release contraception

- Integrate into women’s health care visits
- Pre-release contraception clinics
- Group or individual counseling sessions
Is it feasible to provide contraception in custody?

- Partner with community providers
- Title X funded clinic at Rhode Island Facility
  - 12 x greater chance of starting a method if contraception onsite vs. referral post-release\(^1\)
- San Francisco County Jail
  - Available on-site:
    - 55 IUDs and 34 implants\(^2\)
  - Available in booking: Emergency contraception

1. Clarke 2006 AJPH
2. Sufrin in press PSRH
Nuances of providing contraception in custody

- Balance access, choice and autonomy with potential for perceived coercion
- Separate counseling and insertion visits for provider-controlled methods (IUD and implant)
- Access to a range of methods, not just one
- Focus counseling on reproductive life goals, not on pushing contraception
- Desire for and timing of pregnancy
- Preparing for a healthy pregnancy
Summary

- Providing contraception including EC to women in custody is an important preventive health measure.
- Incarcerated women have an unmet need for contraception services.
- It is feasible and potentially cost-effective to provide contraception in correctional facilities.
- If not able to establish services onsite, refer.
- Contraception should be provided in a non-judgmental, non-coercive manner which balances women’s family planning goals.
Learning more about how to best serve pregnant women in custody

- Importance of up to date information
  - Very outdated data on pregnancy and deliveries (1990s!)
  - No comprehensive information on pregnancy outcomes “vital statistics”

**New project!!**

**Pregnancy in Prison Statistics (PIPS)**

- Collaboration between Hopkins, NIC, NRCJIW
- Establish system for ongoing reporting of pregnancy and outcomes in correctional facilities
Be a part of PIPS!
Help improve care for pregnant women in custody!

- We are seeking facilities to report monthly pregnancy outcomes for 1 year to a central database
- Starting in March 2016
- Aggregate, de-identified data
- Eventually will become national, routine reporting process

If your facility is interested, please email one of us!
Carolyn Sufrin: csufrin@jhmi.edu
Rachelle Ramirez: rramirez@cepp.com
A few take-aways.....

- Incarcerated women have unique health needs, including access to pregnancy and family planning services.
- Prisons and jails are important venues for the delivery of clinical and preventive health services.
  - Short term "opportunities" to address health disparities.
- Improving reproductive health care at correctional facilities has benefits at the individual and community level.
- Criminal justice system reform is a public health issue.
Select Resources


For More Information…
or to Express Interest in PIPS Project…
Contact Us

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  Rachelle Ramirez, rramirez@cepp.com
- Carolyn Sufrin, MD, PhD, Johns Hopkins School of Medicine and Bloomberg School of Public Health, csufrin@jhmi.edu