



Incarcerating Pregnant and Parenting Women, the New Witch Hunt: A Policy Analysis

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Abstract

The mass incarceration of pregnant and parenting women is a serious problem in U.S. A policy focus is needed that takes a public health approach. This paper outlines the problems with health care delivery in correctional facilities. It is argued that correctional facilities are not the place for pregnant and parenting women. Alternative policies and programs are recommended that align with a public health approach and directly targets the pathways for imprisonment.

Keywords Women · Pregnant · Prison · Policy

Significance

This article is significant because it addresses the growing number of women that are being imprisoned. A majority of women entering prison are pregnant, parenting and primary caregivers resulting in a crisis for families. The U.S. incarcerates more women than any other country and these incarceration rates are growing. Mental health and substance use are pathways for imprisonment yet a criminal justice approach is being employed rather than a public health approach.

Background

The U.S. incarcerates more women per capita than any other country (Kraft-Stolar 2015). Approximately, 1.2 million women in the United States (US) were involved in the criminal justice system between 2013 and 2014 [National Resource Center on Justice Involved Women (NRCJIW) 2016]. Furthermore, it is estimated that up to 5% of women are pregnant at jail/prison intake (Hall et al. 2015), 65% of incarcerated women are parenting children under the age of 18 (Roth 2012), and most women entering jail are primary caretakers (NRCJIW 2016). The overall incarceration rate

for women is on the rise signaling mass incarceration (Hall et al. 2015; NRCJIW 2016; Roth 2012; Swavola et al. 2016).

Among incarcerated women, impoverished and minority women are over-represented in the criminal justice system. African-American families, women with incomes under the federal poverty level, and women receiving public assistance benefits are more likely to be imprisoned (Kraft-Stolar 2015; NRCJIW 2016). As many women entering prison are pregnant, parenting or primary caregivers, mass incarceration poses a crisis for families (Hall et al. 2015; Minton and Zeng 2015; NRCJIW 2016; Roth 2012).

The article is intended to highlight the mass incarceration of women and posits that prisons are not appropriate places for pregnant and parenting women. A public health approach is encouraged as opposed to a criminal justice approach. This paper will examine the factors that exacerbate this issue and the practice, policies and programs that serve to address this problem. The problem has implications related to inequality, health care and social justice.

Public Health Approach

A criminal justice response is used to address mental health and substance use needs of incarcerated women. The Future of Public Health defines public health as organized community efforts to prevent disease and promote health with the core functions of assessment, policy development and assurance (Schneider 2017). A public health approach applied to imprisoned pregnant and parenting women promotes disease

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prevention, health promotion, and wellness. Health care, mental health and substance use treatment are policy focus areas for women who are in correctional facilities or who are at higher risk for entry. It is imperative to support policy initiatives that expand access to public health services, reduce costs for these services, and improve the overall quality of these services to women before becoming involved in the criminal justice system.

As the incarceration rate for women is rising, a public health approach is needed to address health and mental health needs of women. Women in prison do not receive access to adequate health care (Roth 2012). Pregnant women have cited lack of food and water, sanitary products, prenatal care, postnatal care, counseling services, scant medical attention, and births in prison (Kraft-Stolar 2015; Roth 2012; Swavola et al. 2016). Substance use and serious mental health are pathways for prison entry for women (Kraft-Stolar 2015; Lynch et al. 2017). Consequently, many women in prison suffer from trauma, post-traumatic stress disorder (PTSD), and childhood victimization (Hall et al. 2015; Lynch et al. 2017). In fact, trauma (childhood and adult) is a precursor to significant offending histories for female inmates (Lynch et al. 2012).

Health Care Policy

The Eight Amendment offers protection for prisoners from cruel and unusual punishment. In 1976, the landmark case *Estelle v. Gamble* 429 US 97 upheld that prisoners have a right to adequate health care (King 2018). Therefore, “deliberate indifference” by prison officials to the serious medical needs of inmates is a violation of the cruel and unusual punishment clause. Although precedent is set requiring the provision of health care services, there is no national standard to oversee and implement inmates’ constitutional right to medical care (Roth 2012). As federal and local prisons develop their own policies, more regulation is needed ensure the access and delivery of appropriate health care.

Prisons are not developed for delivery of health care services and therefore are ill-equipped with the infrastructure required for interdisciplinary staff to address the needs of pregnant and post-partum women. One example is shackling policies in prison. Prison shackling policies are dangerous to the health of pregnant women and their unborn child. The Prison Birth Project (2016) states that most medical and professional organizations agree that restraining women during child birth and after is dangerous because it limits balance and mobility, increases the risks of falling (i.e. placental abruption, hemorrhage, still birth), blood clots, and interferes with the medical providers’ ability to provide care (standard and emergency). Although these risks have been identified by the health care community, many

states continue this harmful and potentially life-threatening practice.

Proponents of shackling posit that there is a need to prevent escape, avoid the use of armed force, and maintain safety for correctional staff, providers, inmate, other inmates, and the fetus (Hall et al. 2015). Although the American College of Obstetrics and Gynecology (ACOG), American Public Health Association (APHA), and American Medical Association (AMA) have position statements against shackling, AMA permits its use when a pregnant woman is a harm to herself or poses a significant flight risk (Hall et al. 2015). Some concerns seem less warranted when considering the physical limitations of pregnancy, debilitating state of active labor, and the desired need for health care services by the pregnant woman.

Most states either allow shackling or have vague laws restricting the practice (Hall et al. 2015). Many laws that limit and restrict shackling of pregnant women have emerged since 2008 after Congress passed the Second Chance Act in 2008 (Hall et al. 2015). Subsequently, the Federal Bureau of Prisons, US Immigration and Customs Enforcement, US Marshal Services and other agencies limit the use of restraints on pregnant women. In states that have adopted anti-shackling laws, there is evidence that prisons do not consistently enforce and comply with the provisions of the law (Kraft-Stolar 2015; The Prison Birth Project 2016; Swavola et al. 2016).

The Rebecca Project for Human Rights published a state-by-state report card examining federal policies on the conditions of confinement for pregnant and parenting women and its effects on their children (National Women’s Law Center 2010). The report card analyzes these key areas: prenatal care, shackling, alternative sentencing programs, prison nurseries and whether policies help or harm women. According to the report card, 21 states receive a D or F, 22 states are given a grade of C, 7 states obtain a grade of B and only one state (Pennsylvania) received a grade of A—(National Women’s Law Center 2010). This report card supports concerns that prisons generally do not provide optimal care to pregnant and parenting women.

There is a gap in administrative oversight for the delivery of health care and a need to develop and enforce health care policies in prisons. Correctional institutions are not equipped to deliver health care services and do not meet similar comparative oversight standards. A significant number of female inmates are not receiving appropriate medical and mental health care. In terms of pregnant women specifically, correctional facilities are inadequate and potential dangerous.

In 1981 the Standards for Health Services in Jails was published by the American Medical Associations (AMA) but provided limited guidance for pregnancy and abortion services (AMA 1981). Specifically, the 1981 Health Standards for Health Services recommended comprehensive

counselling and assistance for pregnant women to maintain their expressed desires for the unborn child (AMA 1981). In addition, the standards state that counseling should be made available by facility staff or community agencies. The NCCHC updated these standards in 2014 and developed Standards for Health Care in Prisons (NCHHC 2014). The NCHHC (2014) standards, revised again in 2018, include quality improvement, clinical performance enhancement, patient safety, initial health assessments, pharmaceutical operations and women's health. As a supplement to the health care standards, NCCHC (2018) also provides position statement for Restraint of Pregnant Women 2015, Breast-feeding in Correctional Facilities 2018, and Women's Health Care in Correctional Facilities 2014 to address areas not covered in the standards with additional policy guidance.

A limitation in these standards are lack of uniform access and application by prison staff. Since the NCCHC only accredits a small portion of correctional facilities, this may limit the use of these standards by non-accredited correctional facilities. This limits regulation, reduces the scope and delivery of health care practice standards for an overwhelming majority of individuals in correctional facilities. The low percentage of correctional facilities requesting accreditation may be another factor that explains substandard health care services experienced by women in correctional facilities. It should be noted, however, that correctional facilities may follow these standards without the rigor and oversight of seeking accreditation.

Practice and Policy Direction

There is minimal collaboration between the public criminal justice systems and the private–public system of medicine. Recent policy focuses more on recidivism for previous offenders rather than prevention of initial prison entry. The Second Chance Act (SCA) 2008 provides financial support to state, local tribal governments, and non-profit organizations in their efforts to reduce recidivism [Department of Justice (DOJ) 2018]. The SCA grant programs address mental health substance use, transitional mentoring/supervision services (DOJ 2018). A majority of the SCA programs do not solely address the needs of women. Although promising, these programs focus on intervention after incarceration. A public health approach focuses on prevention, as well as interventions, therefore policies need to target programs that prevent incarceration and initial imprisonment.

Pre-arrest crisis intervention programs offer specialty trained officers to direct people in crisis and experiencing trauma to community-based services instead of criminalizing the problem (Swavola et al. 2016). An Ohio based program implementing this model reported that 25% of cases

were transported to emergency services, 31% of cases were directed to a hospital or community treatment facility, 32% of cases did not need a police escort, and only 3% required arrest and imprisonment (Swavola et al. 2016).

Problem-solving courts are collaborations between criminal justice and social services designed specifically for persons with mental health, substance use, and homelessness issues to address the underlying reasons for offending (Swavola et al. 2016). A special assigned district attorney, trained, trauma-informed court and social service staff initiate screenings and treatment plans (i.e. community outpatient, residential treatment, case management). In 2016, initial guilty pleas were voided or dismissed and 30–40% of these cases represented women in (Swavola et al. 2016).

Pretrial supervision and release practices align with appropriate ethical and criminal justice practices. Pretrial custody and release decisions result in women receiving more leniency, obtaining releases on their own recognizance more frequently, and getting denied release less often (Swavola et al. 2016). While women tend to be given more leniency in the criminal justice system, they are less likely to afford the bail conditions for release. It is believed that court decisions are influenced on the perception that women are less of a threat to public safety and an integral part of family life (Swavola et al. 2016).

Trauma-informed care is critical in the criminal justice system. Trauma, along with mental health and substance use, is an identified pathway to incarceration and the criminal justice perpetuates and re-traumatizes women inmates increasing the risk for re-imprisonment (Kraft-Stolar 2015; Lynch et al. 2017). Furthermore, women are more likely to be sexually victimized in jail with 27% being victimized by inmates and 67% victimized by staff (Swavola et al. 2016). The needs of pregnant and parenting inmates specifically can be met with gender-responsive programs. The Trauma Informed Care Project, for example, educates and evaluates program and providers on policy, practices and structures that reduce re-traumatization of service recipients (traumainformedcare.org). Incarcerated women and correctional facilities can benefit from the evaluation of policies and services from a trauma informed lens.

These programs provide examples of more appropriate responses that align with a public health approach. This is important for women who are pregnant and cannot receive access to basic health care or appropriate prenatal health care in correctional facilities. These programs demonstrate a targeted approach to address the increasing rate of female incarceration. Until there is consensus that the criminal justice response does not adequately address issue, incarceration rates will continue to increase.

Conclusion

There is mass incarceration of women particularly those who are most vulnerable (i.e. poor, pregnant and women of color). A public health rather than a criminal justice approach is preferred to address the needs of women. Furthermore, a public health approach would improve health and mental health outcomes for women. A criminal justice response is not appropriate especially when prisons cannot provide basic necessities or appropriate prenatal–postpartum care that can put women and their infants at risk for poor outcomes. Prison policies further bolster concerns for the safety of pregnant women. There are promising models emerging that can help address this issue of mass incarceration and address the needs of women.

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