Caring for the Peripartum Patient Experiencing Incarceration

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INTRODUCTION

We have worked together for several years at a tertiary care maternity hospital and during that time have collaborated to advocate for peripartum patients experiencing incarceration. As a registered nurse (MP) and a registered social worker (RSW), we offer our interdisciplinary perspectives and insights to provide recommendations based on our experiences and available literature to improve the care experience for both patients and care providers.

In Canada, there is limited data available regarding the frequency with which patients are incarcerated during pregnancy. Through access to information and privacy requests, legal scholar Robin Hansen (in press) found 69 babies were born in provincial/territorial custody from 2011-2015: approximately 17 per year for four years. In a reproductive health survey among 89 people incarcerated in an Ontario provincial jail designated for women, Liauw and colleagues (2016) found 4 (5%) to be currently pregnant. Analysis of 102 people who engaged with a women's health clinic in an Alberta provincial jail, Besney and colleagues (2018) found 20 (21%) requested a pregnancy test and none were diagnosed with pregnancy.

No information is available from Correctional Services Canada regarding pregnancy or births in federal prison. Paynter and colleagues (2022) found 67 participants in the federal Mother Child Program from 2012-2019, or approximately 9.6 per year. However, it is not a requirement for the program that the child be born while incarcerated, and children may participate until five years of age. We generously estimate 30 births in custody per year in total in Canada. Furthermore, these 30 births take place across 14 different prison systems: each province, territory, and the federal system.

As a result of the small number of births, perinatal health care facilities and professionals working within them lack experience, policies, and procedures to care for pregnant patients experiencing incarceration. Although in 2021 the American Society of Obstetricians and Gynecologists published recommendations for the perinatal care of incarcerated women,

the Society of Obstetricians and Gynecologists of Canada, the leading publisher of evidence-based standards for care in the country, does not yet have guidelines for perinatal care for people experiencing incarceration. Reciprocally, health care professionals working in prisons and jails lack specialization in perinatal care. In the College of Nurses of Ontario disciplinary hearing for Rose Gyasi, who was working at the Ottawa Carleton Detention Centre when Julie Bilotta gave birth inside a cell in 2012, the adjudicators heard how little experience Gyasi had as a nurse (six months) and that she had next to no experience in perinatal care (Discipline Committee of the College of Nurses of Ontario, 2014). Research has found prison staff approve of integrating maternal child health protocols to guide actions in prisons (Pendleton et al., 2020).

Pregnant individuals who are experiencing incarceration are likely to require complex psychosocial supports due to reporting a higher number of adverse childhood events in their lives. (Felitti et al., 1998). Infants born to mothers with a history of incarceration in Canada are more likely to experience prematurity and low birth weight (Ramirez et al., 2020). Incarcerated people in Canada have complex health and social histories, including higher than average rates of chronic illness and pain, infectious disease, traumatic brain injury, obesity, mental illness, and substance use disorders (Kouyoumdjian et al., 2016). Most incarcerated women have a history of substance use disorder. Research has found that the babies of incarcerated mothers require longer lengths of stay in hospital and greater use of pharmacotherapy to treat newborn withdrawal. Furthermore, almost 50% of federally incarcerated women are Indigenous (Office of the Correctional Investigator, 2021). Racialized groups, newcomers to Canada, and members of the 2SLGTBQIA+ communities are also disproportionately criminalized and incarcerated. Patients may experience layers of health harms from stigma, incarceration, racism, homophobia and transphobia and other types of discrimination.

POLICY AND LEGISLATION

Health care providers are often not educated or receive training about care for people in prisons. Health care providers can familiarize themselves with key provincial, territorial, and federal documents and legislation pertaining to health care for incarcerated people. For example, the *Nova*

Scotia Correctional Services Act, and the provincial Correctional Health Services pamphlet. The federal system is governed by the Corrections and Conditional Release Act (Canada, 1992), as well as Commissioners Directives (CD). Relevant CDs include CD-800, governing Health, and CD-566-6, governing security escorts, including "medical escorts". All these documents are publicly available,

There are two international statutes that provide detailed guidance about health care and in particular perinatal care: The United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders, known as the Bangkok Rules (UN, 2011), and the United Nations Standard Minimum Rules for the Treatment of Prisoners, known as the Nelson Mandela Rules (UN, 2015). These documents clarify that the state is responsible for the medical and mental health care of the people it incarcerates; that health care provided to people in prison must meet professionally accepted standards, including respect for privacy and confidentiality; and prisoners are never to be held in shackles or restraints in labour and delivery.

Care can become confusing and complex when prisons employ the healthcare professionals and/or work with healthcare providers at the perinatal hospital. In the federal system, both health care staff and prison staff are employed by the same body, Correctional Services Canada, but this is not the case in most provinces and territories. We believe the clinical and mental health care needs of the pregnant individual who is incarcerated are best met by community-based health care providers in the community who have the structures, skills, and policies in place to provide appropriate care outside of the prison.

There is mounting evidence of the value of independent doulas for people experiencing incarceration during the perinatal period (Shlafer et al., 2015). Doulas provide non-clinical support and will "be on the patient's side" regardless of health care centre or prison policies.

Our aim is to provide some guidance based on our experiences and available literature with respect to best practices to optimize care.

PREPARATION

In our experience, caring for perinatal patients experiencing incarceration requires extensive preparation. Even with this preparation, the care demands

flexibility, creativity, and resolve, as well as extensive interprofessional collaboration.

An established agreement between the health centre and prison will improve patient access to health care and supports during the perinatal period. CD-566-6 states, "Where possible, a written agreement or protocol will be developed with the outside health care facility authorities as to their expectations with respect to procedures for maintaining and/or the removal of security equipment as well as the physical location of escort staff during medical procedures (e.g. operations)".

A memorandum of understanding (MOU) can be helpful to establish expectations of the health centre and of the prison before a pregnant individual is referred. The MOU can be reviewed on a regular basis by all parties to ensure it is kept up to date and includes the most recent information on best practices for perinatal care.

Health care institutions in proximity to prisons should prioritize efforts to create these agreements. Paynter and colleagues (2020) map out the distance from each of the 72 facilities designated for the incarceration of women and girls in Canada to the nearest perinatal care centre. Regional and tertiary health centres may receive patients from out of province prisons and should consider how they will address caring for patients arriving from out of province who are in carceral care.

In developing an MOU, it is necessary to connect with both those who manage "correctional" aspects of operations and with those who manage health services within the prison. Prisons and health centres both experience high rates of staff turnover; it is important to identify key roles, not specific individuals who happen to be in those roles at the time to begin collaboration about meeting the individual's perinatal care needs.

The Bangkok Rules recommend a complete reproductive health history be collected when an individual is admitted to the prison. All individuals should be offered the option of a confidential pregnancy test. The prison health care staff should then contact the perinatal health centre as early as possible after a patient discloses or learns of a pregnancy.

We suggest elements of an MOU be discussed in advance and cover at least these twelve areas. In general, we recommend also considering how each part will be managed in the event of an extended inpatient stay.

1. Escort practices
    a. Who will accompany the patient to the health care centre?
    b. What about different types of visits, for example ultrasonography and other diagnostic tests, versus clinical conversations with a social worker, etc.?
    c. What will the patient wear*? Consider that jumpsuits require exposure of the chest to access the abdomen for assessment; plain clothes would be recommended.*
    d. What will happen if there is insufficient prison staffing to escort a patient to the health centre?
2. Use of restraints during transport and appointments
    a. Restraints conflict with patient ability to provide uncoerced and continuous informed consent and performing care while a patient is restrained may violate professional codes of ethics. What is the procedure for care providers to request removal of restraints?
    b. Are all health care providers aware of their professional responsibilities about ensuring uncoerced care, and do they all know how to seek removal of restraints?
3. Privacy and confidentiality
    a. How will the patient's private health information be kept confidential from correctional officers and other prison staff?
    b. How will the patient's privacy and dignity be maintained during physical examinations, clinical assessments, and treatment? *Consider that it should not be left to the patient to speak up for their own right to privacy, as some may feel pressured to say "it is alright" for correctional officers to be present.*
4. Supplies
    a. Who will provide hygiene products, clothing, and newborn items?
    b. How will these be supplied in a timely manner if the individual is an inpatient?
    c. What is defined as clinical supplies? Do sanitary pads count? Nipple cream?
    d. What can health care staff give the patient outright, and what requires permission from prison staff?

   e. Consider the likely delay when staff onsite need to get approval from facility staff. How can this be made more efficient? There are many grey areas to this that may warrant further conversation.
5. Communications
   a. Who is the primary contact at the prison?
   b. Who is the primary contact at the health centre?
   c. How will the patient be supported to contact health care providers?
   d. How will they contact family members, friends, or doulas?
   e. How do communication and other plans change after-hours?
6. Doulas
   a. Does the health care centre already support doulas as members of the care team?
   b. What are the restrictions on where doulas can go in the health care centre?
   c. Does the prison support doula support?
   d. How will doula support be arranged?
7. Postpartum stay
   a. Is the patient allowed visitors/support people? Who?
   b. What about the baby? If the baby is admitted to the neonatal intensive care unit, who will be authorized to support the baby?
   c. Will the patient remain in hospital until the baby's discharge?
   d. If the baby requires care for neonatal withdrawal from opioids or other substances, will they be supported to participate in skin-to-skin and rooming in with their birth parent to optimize the infant's health?
8. Breastfeeding
   a. How will privacy be protected during breastfeeding at the health centre?
   b. How will breastfeeding and access to human milk be protected after discharge?
   c. What supplies and equipment are required/available?
   d. Who will obtain the necessary supplies to support breastfeeding?
   e. What procedures are in place with regards to transporting milk from the patient to the baby?

9. Care for the baby
    a. Has the patient applied to the federal Mother Child Program or the provincial Mother Baby Unit at Alouette Correctional Centre for Women in BC?
    b. Has the Department of Community Services completed their assessment to participate in these programs? C*onsider this should be started prenatally and completed in a timely manner.*
    c. Is the patient going to be the primary caregiver of the baby in hospital?
    d. What are the individual's goals around caring for the baby?
    e. What is the discharge plan for the patient as well as the baby?
    f. Who will have custody of the baby?
    g. Are the provincial child protection services involved or do they need to be?
    h. Is there a need for a referral to legal services? *Consider the role of the clinical Social Worker at the health centre and their counterpart at the prison. There may need to be ongoing discussions between the two roles on who does what as there may be overlap of these roles.*
    i. Can the patient be part of this discussion to respect their self-determination and self-advocacy?
10. Cultural considerations
    a. What measures are in place to protect the patient from institutional racism at the prison and the health care centre?
    b. What does the patient require in the perinatal period to affirm their cultural and spiritual traditions, beliefs, and practices?
    c. Which team member will speak to them about this?
11. 2SLGTBQIA+ inclusion
    a. Is the language for perinatal care services at the health centre gender inclusive? *Consider that perinatal health care centers often focus on supporting women and staff often lack education regarding how to use inclusive languag*e {REF}.
    b. What are the individual's best hopes for their perinatal period?
    c. Who is having these conversations with them?
12. Decision-making
    a. Who is the substitute decision-maker for the patient if they are not able to consent for themselves?

b. What happens in an emergency?
c. Who consents to clinical procedures on behalf of the infant if the birth parent is not permitted?
d. What role does another parent play?

The comprehensive care plan should be developed as early as possible, with consideration of the patient's best hopes and goals, their strengths, and areas in which they are seeking additional support. The expectations of prison staff and health care staff must be clear.

The care plan is likely to require extensive revision once a patient arrives at the health centre for the first time for a prenatal visit, and again if a patient is admitted in pregnancy, and again as the care team prepares for labour and birth and the postpartum stay. The care plan may need to be revised as the patient shifts between units of the health centre, such as from a birth unit to the postpartum unit.

It is important to create space to act prudently in case of an emergency. Prison staff must understand the need for them to interrupt surveillance and quickly step aside to allow for patient care. A discussion between the prison operations staff and health centre staff at both facilities should be conducted early in the perinatal period to avoid any issues arising at the time of an emergency.

HEALTH CARE PROVIDER PERSPECTIVES

To optimize the preparedness of the health centre for receiving the patient, health centre staff must be informed and knowledgeable about best practices. We recommend one or two key role(s) in nursing, social work and medicine/midwifery be identified to coordinate care, and those persons be kept fully informed and responsible for communications with other appropriate members of the team. Clear written instructions, printed and easily available in the patient's chart and Kardex (nursing plan of care), are helpful for both health care providers and prison staff.

Issues to consider include:

1. Does everyone on the care team – nurses, social workers, physicians, surgeons, anesthesia assistants and anesthesiologists, pharmacists, as well as housekeeping and nutrition services management-understand what is expected of them?

2. Does everyone on the care team know their responsibilities to treat the patient in the exact same manner as they would every patient, with respect for dignity, privacy, and confidentiality?
3. Does everyone on the care team feel safe and listened to about their concerns, and do they know who to contact if they have questions?
4. If members of the care team experience moral distress caring for patients in the context of carceral controls, how are they supported? What steps can they take within the health care centre? For example, is a consult with bioethics required?

ADVOCACY

People experiencing incarceration face layers of oppression and marginalization; providing services at the perinatal centre can be an opportunity to intentionally resist those forces with layers of support and care.

Health care providers are held to a high standard of professional conduct and code of ethics. Prison staff also follow their own policies and procedures. Conflict can arise when the two fail to align and the patient's best interests are lost. Health care provider codes of ethics stipulate that we must always do no harm, must advocate for the patient and work for social justice. Advocating for the patient – and for justice more broadly – may take many forms. Health care providers may educate prison staff about the clinical rationale for best practices in perinatal support. Care providers can maximize time parents and children spend together by prescribing skin to skin, rooming in and breastfeeding as therapeutic modalities. Care providers can help patients to have the best possible experience by supporting them to have visitors/support persons, necessary supplies, and equipment – from televisions to breast pumps – and high-quality meals. Further, care providers can optimize the inpatient postpartum stay as an opportunity to cluster specialized care that may otherwise be delayed, such as various medical consults, mental health counselling, and other types of allied care support.

In providing an environment for positive perinatal care, the patient and infant will have the best start in life. This is a necessary and basic step to interrupt persistent cycles of generational trauma and adverse childhood events stemming from systems of criminalization and incarceration.

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