

# The Realities of Pregnancy and Mothering While Incarcerated

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Women of reproductive age may experience pregnancy and mothering in a correctional environment designed for men. Rates of incarceration for women in the United States are high by international standards, and they continue to rise. Mothers were often single mothers prior to incarceration, and they are often separated from their children for the first time upon entering prison. Pregnancy, delivery, lactation, and parenting each require special consideration. Outcomes of pregnancy in prison are better overall than for similarly disadvantaged women in the community. Breastfeeding, despite being recommended by medical groups, is problematic for most who are awaiting forced separation from their infant, due to a lack of mother-baby units in most U.S. states. Mother-baby units have crucial goals, including improved family relations and decreased recidivism. They should not discriminate against mothers with treated perinatal mental illness. Many barriers for visitation of incarcerated mothers exist, including that, because there are fewer women's prisons, there are greater distances between mothers and children. This article reviews data about pregnancy and motherhood in corrections, and it discusses the international state of mother-baby units, with implications for U.S. corrections.

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The United States has the second highest rate of incarcerating women internationally, second only to Thailand. In recent decades, there has been a dramatic increase in the U.S. correctional population, and women are a rapidly growing segment of this population.<sup>1-3</sup> In the United States, 64.6 women per 100,000 are incarcerated, with the highest rate of 142 per 100,000 occurring in Oklahoma.<sup>4</sup> Most women who are incarcerated are within their reproductive years, and many women are pregnant at reception.<sup>1,5</sup>

Approximately one in 40 (2.3%) U.S. children have a parent in prison.<sup>6</sup> Prior to incarceration,

women are often single mothers raising their children, in contrast to the experience of men. Lynch and colleagues<sup>7</sup> found that 75% of jailed American women had children who were under age 18. Although only 16 percent of these American women were incarcerated for a violent crime, incarcerated mothers are usually separated from their children. For the majority of mothers (85%), prison was the first time they were separated from their child.<sup>8,9</sup> Less than one third of these children are cared for by their father during their mother's incarceration. Most are cared for by another relative, whom they may begin to identify as the parent figure.<sup>10</sup> Prison mother-baby units (MBUs), common in the rest of the world, are rarely an option in America.

## Pregnancy and Delivery Behind Bars

### Prevalence

As the number of incarcerated women has increased, pregnancy during incarceration has become an important concern. Correctional facilities are not mandated to track or report pregnancy-related data,

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and most facilities do not have any routine process for collecting such information.<sup>11</sup> A Bureau of Justice report noted that four percent of women reported that they were pregnant at the time of admission to state prison, and three percent were pregnant at the time of admission to federal prison.<sup>12</sup> Other reports have higher estimates of 5 to 10 percent being pregnant at reception.<sup>1,5,13,14</sup>

### **Prenatal Care and Incarceration**

Caring for incarcerated pregnant women represents a unique challenge. Among incarcerated women, pregnancies are often unplanned and are complicated by lack of prenatal care, maternal trauma, poor nutrition, substance use, mental illness, chronic medical conditions, low socioeconomic status, and limited social support.<sup>15,16</sup> Under the Eighth Amendment, all inmates are entitled to care for “serious medical needs” as described in *Estelle v. Gamble*.<sup>17</sup> Meeting the health care needs of pregnant incarcerated women, however, can be difficult in a system originally designed for males. Perinatal care is usually shared among correctional medical staff and community obstetrics providers. Challenges may arise involving transportation of pregnant women to and from outside medical facilities, coordination of care among providers (including obstetrics), and time delays in accessing emergency obstetrical services. Corrections officers are often present during obstetrical appointments. Pregnant women lack control over their environment in prison, which can have a negative effect on sleeping times, naps, dietary requirements, and medication administration.

The American College of Obstetrics and Gynecology (ACOG) standards for perinatal care in correctional settings include pregnancy testing; access to pregnancy counseling and abortion services; assessing and treating for substance abuse, HIV, and depression; appropriate vitamins and diet; delivery in a licensed hospital with facilities for high-risk pregnancies; and postpartum contraception.<sup>18</sup> Other organizations, including the Federal Bureau of Prisons and the National Commission on Correctional Health Care, have proposed similar minimum standards.<sup>19,20</sup> Despite these guidelines, policies regarding pregnancy and the provision of perinatal care vary across institutions. The National Women’s Law Center<sup>3</sup> completed an analysis of confinement in pregnancy, considering prenatal care, shackling policies, and family-based

treatment alternatives in grading the states. Twenty-one states received Ds or Fs, while a single state, Pennsylvania, received an A–. Only 30 states received passing grades, with most states lacking prenatal care policies regarding routine medical examinations, nutrition counseling, treatment for women with high-risk pregnancies, HIV screening, and pregnancy outcomes reporting.<sup>3</sup>

### **Pregnancy Testing**

Early pregnancy detection is an important step in providing appropriate care to incarcerated women because it allows for timely initiation of prenatal care, counseling regarding pregnancy termination and adoption, and identification of women at risk for pregnancy-related complications such as bleeding or ectopic pregnancy. Both the ACOG and National Commission on Correctional Health Care Guidelines recommend offering pregnancy testing to women of childbearing age upon admission.<sup>8,20</sup> Additional testing may be required two weeks after intake or as needed for inmates who remain at risk of pregnancy. Despite these recommendations, pregnancy testing is not routine in correctional settings. In a survey of 53 jails across the United States, only 38 percent reported performing pregnancy tests on all women entering their facilities; 45 percent described relying on inmate self-report of pregnancy status and then performing confirmation testing as needed.<sup>21</sup> Medication treatment of pregnant women with mental illness in corrections has been reviewed recently elsewhere in *The Journal*.<sup>22</sup>

### **Access to Abortion**

Rates of unintended pregnancies are elevated among female inmates.<sup>23</sup> Incarceration does not preclude a woman’s right to access abortion<sup>24</sup>; however, heterogeneous policies and practices have led to variable and unreliable access to abortion services for inmates.<sup>25</sup> Some states have no official policy for inmates seeking abortion, whereas other states’ policies lack clear provisions for transportation, facilitation, and funding.<sup>26</sup> Although many states require comprehensive counseling for pregnant women, the nature of such counseling is rarely described.<sup>25</sup> Further, a survey of jail medical facilities found that, upon confirmation of pregnancy, fewer than a third informed women of options such as adoption or termination.<sup>21</sup> In a survey of 286 correctional health care providers, more

than two thirds (68%) reported that abortion services were available at their institutions.<sup>26</sup> Of these, 88 percent responded that transportation was provided, and only 54 percent indicated that inmates were assisted in arranging necessary medical appointments.

### **Childbirth Support and Education**

Childbirth can be a daunting experience even under the best of circumstances. For pregnant inmates, labor and delivery may be additionally anxiety-provoking, because of lack of control over the birthing experience, limited health education, absence of support from family or friends, mother–newborn separation following delivery, and concern about infant placement.<sup>27,28</sup> Additionally, high levels of stress in the perinatal period have been associated with maternal depression, preterm delivery, and low birth weights; therefore, childbirth support and education are particularly important for incarcerated women who are already at higher risk for complicated pregnancies.<sup>27,29</sup>

A variety of programs have been developed to provide pregnant inmates with health education, nutrition counseling, perinatal fitness, and support from peers, midwives, and doulas.<sup>29,30</sup> Examples include Motherhood Beyond Bars in Georgia and Women and Infants at Risk in Michigan. Doula birth support programs for incarcerated pregnant women have shown positive results in terms of delivery outcomes and satisfaction.<sup>29,31</sup> As a result, several states, including Washington and Minnesota, have passed legislation allowing doula and midwife support for incarcerated pregnant women.<sup>32,33</sup>

### **Use of Restraints and Shackling**

The use of restraints, or shackling, among pregnant inmates remains controversial.<sup>34</sup> Shackling involves the use of any mechanical device that limits an inmate's movement and may include handcuffs, ankle cuffs, belly chains, or soft restraints.<sup>35</sup> The purpose of restraints is to prevent incarcerated women from either escaping or from harming themselves or others. Most incarcerated women are not violent offenders, however, and there are no known escape attempts among inmates who were not restrained during childbirth, which raises doubts about the need for shackling in this population.<sup>18</sup> Numerous medical and legal organizations have opposed the routine use of restraints during pregnancy, including

the American Civil Liberties Union, ACOG, and the American Psychological Association.<sup>8,36,37</sup> ACOG describes shackling as demeaning, rarely necessary, and as compromising health care.<sup>18</sup> Potential negative health effects of restraints include increased discomfort, limited mobility, increased fall risk, delays in medical assessments during obstetrical emergencies, increased risk of blood clots, interference with normal labor and delivery, and interference with mother–infant bonding.<sup>18,34</sup> Currently, 22 states have some legislation restricting the use of shackles during pregnancy, with some of these banning shackling only during active labor and delivery.<sup>35</sup> In December 2018, Congress passed the First Step Act, which prohibits shackling of pregnant women in federal custody except where restraints are necessary to prevent serious harm or escape.<sup>38</sup> A Bureau of Justice Assistance best practices statement regarding the use of restraints with pregnant women under correctional custody recommends the use of restraints be limited to absolute necessity, defined as an imminent risk of escape or harm that cannot be managed with other reasonable means such as enhanced security measures or increased staffing.<sup>39</sup>

### **Pregnancy Outcomes**

Incarcerated women frequently have risk factors for poor pregnancy outcomes. Female offenders often neglected their own health in the community prior to incarceration.<sup>40</sup> Compared with the general population, incarcerated women are at higher risk for having premature delivery and low birth-weight infants.<sup>5,28</sup> When compared with similarly disadvantaged groups in U.S. communities, however, outcomes may be improved with increasing lengths of incarceration, including lower rates of stillbirth and higher birthweights.<sup>5</sup> Compared with women from similar social backgrounds who are not incarcerated, women in prison experience forced sobriety, regular nutrition, regular prenatal care, a lack of partner violence, and no homelessness.<sup>28,41</sup>

A recent examination of pregnancy outcomes of 1,396 women incarcerated in U.S. prisons reported that the proportion of preterm births (6%) was lower than the national average (10%), which could be related to certain aspects of confinement such as improved access to prenatal care, nutrition, and housing, as well as limited access to alcohol and drugs.<sup>11</sup> Preterm birth rates varied across institutions, however, with some facilities reporting

elevated preterm birth rates, which suggests that outcomes may be affected by facility-specific circumstances and other variables.<sup>11</sup> Pregnant women's knowledge that they will be separated from the infant soon after birth may add to their distress.<sup>1</sup> The mother may be happy until the birth and may find herself trying not to think ahead.<sup>2,28</sup> Mothers in the correctional population should be screened for postpartum depression, similar to their community counterparts.

### **Breastfeeding**

Benefits of breastfeeding for the infant have been well documented, and many health organizations often recommend exclusive breastfeeding. Breastfeeding may be important to incarcerated mothers themselves as well, even being seen as representative of good mothering.<sup>42</sup> Doula support may promote breastfeeding initiation in this population.<sup>43</sup> Barriers to breastfeeding include physical separation from the infant, lack of access to breast pumping and storage equipment, difficulties breastfeeding on visits in front of corrections officers (e.g., this may be triggering for sexual abuse victims), and demographics typically associated with lower rates of breastfeeding being more common in incarcerated populations.<sup>42-45</sup>

### **Mother-Baby Units**

Thirty years ago, the 1989 United Nations Convention on the Rights of the Child noted "in all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration" (Ref. 46, Part 1, article 3). In 2007, the United Nations Children's Fund (UNICEF) noted that infants should not be separated from their mothers due to incarceration because of the child's best interest and a right to family life. If the mother is to be incarcerated, it was noted that the infant should be present in prison if possible.<sup>9,47</sup> Many other nations offer Mother-Baby Units. Unique characteristics of international MBUs are noted in Table 1.<sup>9,14,40,48-57</sup> In fact, only four nations routinely separate inmate mothers from their newborns, including the United States, the Bahamas, Liberia, and Suriname.<sup>14</sup>

Only a quarter of American states offer an MBU. The National Women's Law Center's analysis gave

38 states failing grades in the category of prison nurseries, noting that only three of 13 existing programs offered therapeutic services for both the child and the mother.<sup>3</sup> The MBU cost is estimated at \$24,000 per infant per year of prison nursery; the annual cost of a child in foster care was similar at approximately \$22,000 per year.<sup>14</sup>

The Bedford Hills Correctional Facility Nursing Program in New York is the oldest in the United States.<sup>3</sup> It offers parenting classes, advocacy, and a daycare program operated by inmates who have completed an early childhood educational program.<sup>14</sup> California, Idaho, Illinois, Indiana, Ohio, Massachusetts, Nebraska, South Dakota, Tennessee, Texas, Washington, and West Virginia have programs in which infants may remain with their mothers for various lengths of time, depending on location.<sup>3,14</sup>

The programs that exist in the United States allow children to co-reside with their mothers in correctional facilities, until 12 or 18 months of age.<sup>58</sup> Specific criteria must be met for a mother to participate. In general, women must have no history of maltreating children and must be incarcerated for a nonviolent offense.<sup>14</sup> For example, Ohio's prison nursery program by statute indicates that an inmate may be eligible if she is pregnant at the time she is delivered into custody, has a prison term of less than three years, has never been convicted of a violent crime or any sort of child abuse or endangerment, meets medical and mental health criteria, and is the legal custodian.<sup>59</sup> One study reported that women who did not apply either had already lost custody, their child lived with a family member, they were unaware of their eligibility, or they felt prison was not the right environment for a baby.<sup>9</sup>

In a study of 55 women in four MBUs in the United Kingdom, Birmingham and colleagues<sup>52</sup> noted that many women had been sentenced for drug offenses and most pregnancies had been unplanned. Although approximately 60 percent of mothers in the MBU had a mental disorder, few had been identified as needing psychiatric treatment. Compared with the general female prison population, the authors reported less frequent personality disorder among MBU mothers (35%), less frequent drug use disorder (36%) and alcoholism (13%), and no psychosis.<sup>52</sup> Although these mothers had a higher likelihood of mental illness than the general population, this rate was lower than that for other incarcerated

**Table 1** International Mother-Baby Unit Characteristics

| Country     | MBU Characteristics  |
|-------------|--|
| Canada      | In Canada, children may remain with their mothers until age four on a full-time basis, or stay with their mothers on a part-time basis (such as weekends and holidays) until age 12. Uniquely, Canadian children have the right to request to stop living in prison. <sup>14,48</sup> Mother-child programs in federal prisons permit children up to age seven to live with their mothers. <sup>49</sup>   |
| England     | England's MBUs exist in seven of 13 women's prisons. Each has mother-baby officers and nursery nurses. There are no women's prisons in neighboring Wales. <sup>14,50</sup> The length of time that the infant can stay with the mother ranges from nine to 18 months. <sup>9,14,40,51</sup> Criteria for MBU admission include the following: it is in the best interest of the child; there is social services support; there is a strong likelihood that the mother will have custody after release; her ability to care for her baby is not impaired; her behavior and attitudes are nondisruptive and safe; she undertakes the targets in her custody plan; she is drug-free and agrees that the baby can be searched as necessary. <sup>52</sup>  |
| Australia   | In Victoria, children must be under school age to participate, whereas in parts of New South Wales extended holiday stays are possible up to 12 years of age. In Queensland, infants stay until 12 months of age and then are reviewed until they reach school age. <sup>48</sup>  |
| New Zealand | In New Zealand, mothers may have their child with them in the MBU for up to 24 months. The MBU is a self-care unit in the low-security section of the prison. The aim is to assist development of a relationship and minimize reoffending. Alternatively, feeding and bonding facilities exist for women who are on remand or under high security. They may have daily visits with their infant up to nine months old. The facility seeks to replicate a domestic lounge with a kitchenette, courtyard, and baby bedroom. Hohepa and Hungerford <sup>53</sup> note that, under New Zealand's Correction Act of 2008, consideration is given to whether the MBU is in the best interest of the baby. Purposes include bonding, feeding, and maintaining continuity of care. The entry criteria in New Zealand include a child under 24 months whose mother is the main caregiver before prison or is likely to be after release. The mother must have no history of sexual or violent offending involving children, must be drug-free, and must have no serious misconduct in prison. She must also pass a mental health screen, and child protective services is involved in a case review for each child. <sup>54</sup> |
| Ireland     | In Ireland, there are two women's prisons. The mother may be temporarily released for special occasions with her child. <sup>55,56</sup>   |
| Denmark     | In Denmark, co-location is seen as a right, even in maximum-security environments. Children are with their mothers until age seven years and may spend the weekend up to age 15. <sup>48</sup>   |
| Germany     | In Germany, at Preungesheim Prison, women who are in low-security environments can have their children with them up to age five; women in high-security environments can have their children up to age three. Mothers who have school-age children can travel daily to their home to complete their work as a mother (including waking the children, cooking for the children, and helping them with homework). <sup>14,48</sup> Another German correctional facility allows special housing for mothers and children up to age three, with parenting classes and babysitting available. <sup>57</sup>   |
| Mexico      | Mexico is the only nation in the world where it is mandatory for the child to stay with the mother until age six. There is no special environment because they rely on the inmates' collective mothering. <sup>14</sup>  |

MBU, mother-baby unit.

females.<sup>52</sup> Goshin and colleagues<sup>58</sup> similarly reported that, among 139 mothers in U.S. MBUs, nearly three quarters (74%) of them experienced depressive symptoms during their stay, and 79 percent had a history of substance dependence. They had a low three-year recidivism rate, with four percent returning to prison for new crimes and nine percent for parole violations.<sup>58</sup>

Good practices in an MBU include having a child-friendly and stimulating environment that is focused on the relationship between mother and baby. As during pregnancy, the correctional setting has protection from risk factors such as homelessness, illicit substance use, and intimate partner violence. But compared to being at home, prison offers less maternal control over the environment. MBUs should promote child development and provide parenting education. Parenting education and lactation consultants, as well as anger-management and substance-use treatment, are invaluable. Pediatricians or pediatric nurses may visit the MBU regularly and provide

routine care and follow-up. When needed, mothers and infants may be escorted to specialist or emergency department visits. Mothers should also be screened for postpartum depression and anxiety, and these illnesses should be treated for optimum function and parenting.<sup>22</sup>

In theory, goals for MBUs should include providing a supportive environment and training for improved parenting, improved attachment, and decreased recidivism related to the importance of the mothering role. Limited studies exist at present. Both New York and Washington have noted a decrease in reoffending rates over three years after participation in an MBU,<sup>53</sup> and Nebraska reported a decrease in 10-year recidivism rates.<sup>14</sup> Dolan and colleagues<sup>60</sup> found in a follow-up study in the United Kingdom that, among mothers who had been in the MBU with their infants, over three quarters (77%) had their children living with them at follow-up, which occurred at a mean of 4.5 years later. Among mothers who were separated from their infant in prison, how-

ever, only 20 percent lived with their children at follow-up. Those who had been separated from their infants were also more likely to have been reconvicted.<sup>60</sup> A meta-analysis confirmed that, compared with mothers separated from their infants, MBU participants were less likely to return to prison.<sup>48</sup>

New Beginnings is an attachment-based group intervention for incarcerated mothers and their infants that is brief and seeks to strengthen the early attachment bond.<sup>41</sup> Considering the risk factors commonly experienced by incarcerated women, such as childhood victimization, homelessness, substance abuse, and mental illness, these mothers are themselves at risk for insecure attachment. Slead and colleagues<sup>41</sup> reported that an intervention based on attachment for mothers who often had attachment problems themselves may help mitigate the risks for these pairs.

In an observation of attachment relationships with 30 infants in the MBU, 60 percent had secure attachment, with rates of 75 percent if the infant remained with the mother for a year. This occurred even when the mother's attachment was insecure.<sup>61</sup> Infants who remained with their mothers in the MBU were noted to have fewer anxious and depressive behavioral problems when they reached preschool age than infants who were separated from their mothers, although both groups are at risk of aggressive behavioral problems.<sup>62</sup>

Arguments against MBUs include violation of the child's Fourteenth Amendment rights, the concern of incentivizing pregnancy for inmates because of a nicer environment, and its being an unnatural environment for a child.<sup>14</sup> Other concerns with MBUs include: the baby may reach the maximum age prior to the completion of the maternal sentence with a looming separation; the mother still experiences a lack of control over the environment, over other mothers who are prisoners, and over correctional officers; risk management and custodial priorities for correctional institutions are at odds with supporting the needs of the child; and the need to balance the rights of the child against the seriousness of the mother's offending.

### Mothering at a Distance

As described above, MBUs are severely limited in the United States, and tens of thousands of children of incarcerated mothers need childcare at any moment in time.<sup>6</sup> Infants and older children generally

are placed either in kinship care (i.e., care of children by relatives or, in some jurisdictions, close family friends) or in foster care. Given that many women (42%) had been living in a single-parent household with their children in the month before their arrest, it is not uncommon for there to be a lack of paternal support when a mother is incarcerated. This is in stark contrast to fathers, where the vast majority (88%) of incarcerated men identify their child's mother as the primary caretaker.<sup>6</sup> As a result, grandparents are identified as the most common caregiver for children of incarcerated women, with mothers in state prisons identifying the child's grandmother as current caregiver 42 percent of the time and the other parent 37 percent of the time.<sup>6</sup> For those mothers for whom kinship care is not an option, the children are either placed in foster care or given up for adoption. Rates of placement in foster care highlight the uniquely devastating effects on a family when a mother is incarcerated, with 11 percent of children of incarcerated mothers placed in foster care in contrast to two percent of children of incarcerated fathers.<sup>6</sup> In the United Kingdom, only one in 20 (5%) children of incarcerated mothers were able to remain in their own home.<sup>8</sup>

This separation can lead to termination of parental rights for the incarcerated mother. The Adoption and Safe Families Act of 1997 (ASFA)<sup>63</sup> is intended to place children from foster care into permanent adoption more expeditiously. It requires termination of parental rights for children who have been in foster care for 15 months of the previous two years.<sup>1,14</sup> This act has significant consequences for some incarcerated mothers (i.e., those who do not have availability of kinship care and are incarcerated for more than 15 months) and their children. The U.S. Supreme Court decision in *Troxel v Grandville*<sup>64</sup> protected the constitutional rights of parents to make decisions concerning the care, custody, and control of their children afforded by the Fourteenth Amendment. It has been argued that these rights extend to incarcerated individuals.<sup>65</sup> In practice, the mere condition of incarceration, irrespective of the reason for incarceration or the ability to parent, can lead to a mother's losing her parental rights in several situations, such as the child being placed into the custody of the state and the state initiating proceedings to terminate parental rights; the child's father marrying and the new wife adopting the child; and the child living with a family member who initiates

adoption proceedings, which can be done without the mother's permission.<sup>66</sup> When a child is placed in foster care, it can be particularly hard for a mother to reunify with her child, with one Illinois study reporting that incarcerated mothers were half as likely to regain custody of children in foster care compared with nonincarcerated women.<sup>67</sup> This is partly because of the requirements placed on formerly incarcerated women to regain custody of their children, including proof of employment that can support their children, adequate housing for children, and participation in various parenting programs.<sup>65</sup> Although these may appear to be reasonable requirements, the mandate for formerly incarcerated women to demonstrate them represents a disparity compared with their nonincarcerated counterparts. Another study in Michigan reported that a large minority (42%) of infants born to incarcerated women were placed in foster care for some period of the incarceration, and that almost one third (31%) of the women had their maternal rights terminated, despite all of the women at the start of the study expressing the intent to parent upon release.<sup>67</sup>

Despite the difficulties maintaining parental rights, most incarcerated women keep in regular contact with their children while incarcerated. In state prisons, although most mothers reported some form of contact with their children, including exchanging letters, phone contact, or an in-person visit, over half (58%) of mothers never had in-person contact with their children while incarcerated.<sup>6</sup> Transportation challenges are significant, especially because there are fewer women's prisons, and thus they are likely farther from where the child may live compared to men's prisons. The relationship between the mother and the child's caregiver is important, as well, to ensure that visits keep occurring and to set the mother-child relationship up for success after leaving prison. Even for those mothers who are afforded in-person visits, many factors, such as geographic distance, a physical environment that is not child-friendly, security procedures, restrictions on physical contact, and short visitation appointments, can be problematic.<sup>56,68</sup> In a study of women incarcerated in a Massachusetts prison, of the 80 percent of women who reported contact with their children, most reported this was via mail (79%) or via phone contact (61%). Less than half (46%) reported that they had visits with their children. This is in contrast to the three quarters of women in the study who reported per-

sonal visits from some family member, the most frequent visitor being their own mother.<sup>69</sup> The most prominent barriers to contact noted by the inmates were prison regulations, financial constraints, and distance from family.<sup>69</sup> One proposed solution has been to use video-conferencing to address some of these barriers to traditional in-person contact, however various attempts at its implementation have been met with challenges. These have included technical difficulties and logistical concerns such as the families occasionally being required to travel to the correctional facility to use the equipment despite no in-person contact with the incarcerated mother.<sup>70</sup> Other programs have tried having parents record bedtime stories to send to their children, or having parents record DVDs for their children during parenting classes. These both suggest possible additional avenues for therapeutic communication.<sup>71</sup>

This limited contact may have a profound impact on both the women who are incarcerated and their children. Risks for children whose mothers are incarcerated include sleep disorders, depression, anger, and anxiety.<sup>69</sup> Children of incarcerated mothers have increased rates of psychiatric disorders, such as depression and anxiety, as well as higher rates of criminality.<sup>72</sup> Children of incarcerated mothers are 2.5 times more likely to be subsequently incarcerated themselves compared with children of incarcerated fathers, and three times more likely than children whose mothers have never been incarcerated.<sup>72</sup> Although these increased rates are likely attributable in part to the preincarceration environment and other risk factors, it has been suggested that contact between mothers and their children during incarceration, such as in MBUs, could be a protective factor against these outcomes.<sup>73</sup>

According to a survey of U.S. prison wardens, 90 percent of female correctional facilities offer a parenting program; however, the majority of these programs do not include visitation, and there is limited research regarding their outcomes.<sup>74</sup> In Australia, the Mothering at a Distance Program was designed with an aim to improve the relationship between children and their incarcerated mothers to break the intergenerational cycle of crime.<sup>75</sup> This program was instituted at a variety of correctional facilities throughout New South Wales and included orientation sessions when mothers were first incarcerated, supported play programs during visiting

times, a mothers group focused on parenting skills, and an education and support program for correctional staff.<sup>75</sup> The participants overwhelmingly found the program useful, particularly through increasing their self-esteem and confidence in their ability to parent.<sup>75</sup> This indicates that education about parenting is likely a powerful component to successful communication between incarcerated mothers and their children.

Contact during incarceration is a predictor of reunification.<sup>10</sup> Mothers need to be able to practice their new parenting skills. Given the potential benefits of improving the ability of incarcerated mothers to parent from a distance, a more systematic approach to enabling the implementation of programs similar to the Mothering at a Distance Program is vital. Not only does communication between families appear to improve outcomes for women and their children, and subsequently potentially reduce the burden on larger social systems (e.g., the foster care and criminal justice systems), but correctional administrators have also identified the value of meeting incarcerated individuals' basic human need for communication with family as key to maintaining a safe and secure correctional environment.<sup>76</sup> This suggests that many stakeholders would be invested in implementing programs to assist incarcerated mothers in cultivating relationships with their children. For example, at Bedford Hills Correctional Facility in New York, family visitation is encouraged by providing child-friendly waiting areas with books and toys, as well as an outdoor playground near the visiting area. A recent study in Minnesota considered a program to assist in this cultivation through enhanced visitation between incarcerated mothers and their children. This consisted of extending the length of the visit to four hours, providing a more child-friendly environment, and allowing more natural physical contact between mothers and their children.<sup>66</sup> These relatively low-cost interventions led to overwhelming satisfaction reported by both mothers and caregivers compared with standard visitation procedures and shed light on the types of small changes that could be made on a broader level to enhance the connections between incarcerated mothers and their children.<sup>68</sup>

## Discussion

Incarcerated women appear to have better pregnancy outcomes than women who have similar risk factors but are not incarcerated. Positive birth out-

comes in this population likely reflect broader social inequities and health care disparities within our society and the better treatment received in prison, rather than a therapeutic effect of incarceration itself. Rather, incarceration represents an important time for public health intervention in pregnancy, much as it does for those with mental illness.<sup>77</sup> Despite common medical recommendations for breastfeeding, significant barriers exist for incarcerated women as discussed above.

Discussion about mothering in correctional environments must also consider maternal mental health. In a study of 491 incarcerated women in the United States, many met current criteria for mental illness, including major depression (22%), bipolar disorder (8%), and posttraumatic stress disorder (29%). More than half (53%) met criteria for substance use disorder.<sup>7</sup> Women who are incarcerated are more likely than men to experience psychiatric disorders and to experience comorbidities. Fazel and Danesh<sup>76</sup> completed a systematic review of 12 nations' studies on prisoners and mental disorders and reported that four percent and 12 percent of female prisoners were diagnosed with a psychotic illness and major depression, respectively. Fazel and Danesh found that approximately 42% of female prisoners were diagnosed with a personality disorder (25% with borderline personality disorder and 21% with antisocial personality disorder).<sup>78</sup> Thus, pregnancies among women in prison, in addition to being complicated by the aforementioned risk factors, are more likely to be complicated by mental illness, substance-use disorders, and personality disorders. Perinatal screening for mental illness is certainly indicated in this population, and proper treatment must be made available. Maternal mental illness that is treatable should not bar a woman and her infant from participation in an MBU. Further, postpartum mental disorders should be anticipated in this at-risk population, who are also often grieving the impending loss of custody.

MBUs exist around the world and in about a quarter of U.S. states. There is debate about whether it is in a child's best interest to be with the mother while she is incarcerated. MBUs are potentially safe and supervised options, and they can help with better bonding and attachment for this at-risk group. Motherhood may give women a sense of purpose and reduce women's risk of recidivism. On the other hand, children of female inmates are five times as likely to be placed in foster care than are children of

male inmates, and prisons are sometimes not friendly environments for children to visit, even when it is possible.<sup>14</sup>

Whether or not MBUs are available in the correctional facility, incarcerated mothers often require mental health treatment and parenting education. Forensic and correctional psychiatrists should be knowledgeable about perinatal psychiatric treatment.<sup>22</sup> In light of high rates of maternal mental illness, women in the MBU should be screened for and treated for maternal mental illness. Child protection services can assist in determination of whether MBU placement is appropriate. Treated mental illness, however, should not be a bar *per se* to MBU acceptance. The reproductive health challenges, mental health concerns, substance misuse, and parenting concerns experienced by women in prison all merit exploration and treatment.

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