

Pregnant Women and the Use of Corrections Restraints and Substance Use Commitment

Ryan C. H. Hall, MD, Susan Hatters Friedman, MD, and Abhishek Jain, MD

Recent evolving trends in the United States legal system regarding how policies and laws are applied to pregnant women include concerns over the use of restraints or shackles in pregnant inmates and forced treatment or commitment of pregnant women for substance abuse. These topics raise many questions, such as: how violent are women, particularly pregnant women; what are the informed consent and treatment implications; and who is at risk of harm? In addition, questions have been raised regarding maternal versus fetal rights, especially when the mother uses substances during a pregnancy. We review legal decisions and organizational position statements and highlight ethics-related concerns.

J Am Acad Psychiatry Law 43:359–68, 2015

In the United States and internationally, women are increasingly becoming incarcerated or involved with the legal system for violent and nonviolent crimes.^{1–4} This trend leads to questions about whether different policies and regulations are needed in the correctional system for female inmates than for male inmates. Two areas where this debate has been playing out over the past 20 years are the use of restraints or shackles on pregnant inmates and what actions, if any, should be taken for women who abuse substances during pregnancy (e.g., criminal sanctions, voluntary or involuntary civil treatment, or combination of both).^{5–11} Although these topics have been addressed by medical ethics and case law in the past, recent societal changes (e.g., the increased number of incarcerated women), passage of new state and federal laws (e.g., Wisconsin's forced treatment

for pregnant women habituated to substances), and case law based on the interpretation of these new laws raise new ethics and legal conundrums.^{3,9,10,12–14} The purpose of this article is to inform forensic psychiatrists about these concerns, discuss positions taken by various medical groups, and discuss the legal actions that have occurred or are under way in these areas.

Use of Restraints on Pregnant Inmates

The use of restraints in correctional facilities for pregnant female inmates has been an evolving trend over the past two decades. Five percent of female inmates are known to be pregnant at jail intake and three to four percent at prison intakes.¹⁰ Currently, most states either allow the practice of shackling pregnant inmates or have no clear law placing restrictions on when such inmates may be restrained.^{10,11} Eight states have some statutory limitations and 10 states fully prohibit the practice.^{10,11} (These include Arizona, California, Colorado, Delaware, Florida, Hawaii, Idaho, Illinois, Louisiana, Pennsylvania, New Mexico, Nevada, New York, Rhode Island, Texas, Vermont, Washington, and West Virginia.) Most of these laws have been passed since 2008.^{10,11} The Federal Bureau of Prisons, U.S. Immigration and Customs Enforcement, U.S. Marshals Service, and other branches of the federal government have also placed limitations on the use of restraints during

Dr. Hall is Assistant Professor of Psychiatry, University of Central Florida College of Medicine, Affiliate Assistant Professor, University of South Florida, St. Petersburg, FL and Adjunct Professor, Barry University School of Law. Dr. Hatters Friedman is Associate Professor of Psychological Medicine, University of Auckland and staff psychiatrist Mason Clinic, Auckland Regional Forensic Psychiatry Services, Auckland, New Zealand. She is also Associate Professor of Psychiatry, Case Western Reserve University, Cleveland, OH. Dr. Jain is Assistant Professor of Psychiatry, University of Pittsburgh School of Medicine, Pittsburgh, PA. The authors report no conflicts of interest. Portions of this article were presented at the 2014 AAPL annual meeting in Chicago. Address correspondence to: Ryan Hall, MD, 2500 West Lake Mary Road, Suite 219; Lake Mary, FL 32746. E-mail: dr.rcwhall@live.com.

Disclosures of financial or other potential conflicts of interest: None.

pregnancy since the United States Congress passed the Second Chance Act (P.L. 110-199) in 2008.^{10,15} Parts of this law require federal correctional facilities to document justification (e.g., specific security concerns or flight risk) for use of restraints on pregnant women during childbirth.^{10,15} In addition, the United Nations (UN), in its Twelfth UN Congress on Crime Prevention and Criminal Justice (a.k.a. Bangkok Rules) passed in 2010, took the position that “instruments of restraint shall never be used on women during labor, during birth and immediately after birth” (Ref. 3, p 16). Although the UN and many other common law countries including Canada prohibit shackling pregnant women during labor and generally discourage the use of shackles during pregnancy, they do not necessarily fully prohibit the practice during all stages of pregnancy.^{3,4,16} This practice at times can create a dilemma, because it may or may not be reasonable to expect that corrections officials will know when an inmate has entered labor until after she is evaluated by medical professionals. For example, a woman who is five months pregnant and having abdominal pain could be experiencing premature labor, appendicitis, or food poisoning.

These recent events may be considered an evolving cultural decency standard regarding coercion and punishment, similar to how *Atkins v. Virginia*¹⁷ and *Roper v. Simmons*¹⁸ deemed that the death penalty for intellectually disabled individuals and minors, respectively, was “cruel and unusual punishment” under the Eighth Amendment. Interestingly, the case of *Weems v. United States*,¹⁹ which was referenced in *Atkins* and *Roper* as a precedent for the notion of evolving standards and for punishment “be[ing] proportioned to [the] offense,” (Ref. 19, p 367) involved an individual who was sentenced to “12 years in irons at hard and painful labor” for lying on a customs form (Ref. 17, p 311).

Various medical associations, including the American Congress of Obstetricians and Gynecologists (ACOG), the American Medical Association (AMA), and the American Public Health Association (APHA), have taken a position against the general use of restraints on pregnant inmates, citing health concerns for the mother and fetus (Refs. 10–12, 20 and Appendix A). From a psychiatric perspective, there is a general question of when and if restraints and shackling are medically needed to reduce risk of harm to self or others and, if generally used, whether they could exacerbate certain mental conditions.^{21,22}

Studies demonstrate higher rates of all mental disorders, except obsessive–compulsive and alcohol-related disorders, in incarcerated women compared with their community counterparts.^{2,23} In a recent study, Lynch *et al.*²⁴ found in an American population ($n = 491$) that 91 percent of female prisoners met lifetime criteria for any mental disorder, and 32 percent met criteria for a serious mental illness (e.g., major depressive disorder, bipolar disorder, and schizophrenia spectrum disorder) within the past year.²⁴ Similarly, an Australian study ($n = 103$) found that 84 percent of female prisoners met criteria for mental illness; when substance use disorders were removed, 66 percent of the women still met the criteria.²³

Particularly common in the women’s prison population and relevant to the discussion about restraints is posttraumatic stress disorder (PTSD).² The aforementioned American study found that 29 percent of women in prison met current PTSD criteria, and 14 percent had current comorbid severe mental illness with PTSD.²⁴ The Australian study found that 36 percent of female prisoners had PTSD in the past year,²³ and a New Zealand study found 17 percent of female prisoners had PTSD in the past month.²⁵ Thus, the PTSD rates of female prisoners are higher than those of male prisoners (approximately 10% in incarcerated males) and twice the rate of their female community counterparts.^{2,24–27} Although the 2006 American Psychiatric Association (APA) resource document on Restraint and Seclusion in Correctional Mental Health Care addresses many subjects, such as worsening of illness, it does not directly address pregnancy and the use of restraints in mentally ill female inmates.²¹

In addition to physical and mental health concerns, ACOG noted that the practice is “demeaning and unnecessary.”¹² The AMA, although generally against the use of restraints in pregnant inmates, notes that their limited use may be appropriate if “the woman is an immediate and serious threat to herself or others or a substantial flight risk.”²⁰ Some court opinions have noted that the AMA position is not an absolute prohibition, which was an important consideration for the legal standard of “deliberate indifference” and violations of the Eighth Amendment.²⁸

This raises a question about the actual risks involved in the practice. Those opposed to restraints cite concerns that shackling pregnant inmates puts them at risk for falls (because the center of balance is changed in pregnancy), increases risk for miscarriages and internal

bleeding secondary to falls, reduces ability to receive appropriate medical care, limits ability to reposition during delivery which can lead to distress or injury, interferes with mother–infant bonding, and can physically cause harm to extremities, especially during active labor.^{6,10–12,22,29} Proponents of use of restraints note that there is a general need to maintain protocols for safety of a facility (e.g., transferring multiple individuals at once) and that restraints may prevent escape, harm to corrections officers, harm to other inmates, harm to self, and harm to the fetus. As noted in the case of *Haslar v. Megerman* which dealt with the general question of shackling a male pretrial detainee in renal failure:

[shackling] serves the legitimate penological goal of preventing inmates awaiting trial from escaping [the hospital's] less secure confines, and is not excessive given that goal. A single armed guard often cannot prevent a determined, unrestrained, and sometimes aggressive inmate from escaping without resorting to force. It is eminently reasonable to prevent escape attempts at the outset by restraining hospitalized inmates to their beds [Ref. 30, p 180].

The arguments for and against use of restraints also raise the question of what period actually constitutes pregnancy for this debate. Although pregnancy has a straightforward medical definition, regarding institutional concerns, not all points of pregnancy are equal. Maternal health risks (e.g., falls) are much higher in the second and third trimesters, and correctional institution safety concerns are probably similar to those for other female inmates during the first trimester. In addition, the “condition of pregnancy” from an institutional standpoint may last longer than the actual physiologic medical state of pregnancy, to include the postpartum period.

Legal Actions: Restraints

Legal cases regarding shackling of pregnant inmates are beginning to be raised as 42 U.S.C. § 1983 claims. Many lawsuits cite the traditional landmark cases of *Estelle v. Gamble* and *Farmer v. Brennan*, in regard to the “deliberate indifference” displayed by the prison systems or individual guards.^{10,31,32} Lawsuits also cite the cases of *DeShaney v. Winnebago County Dep't of Social Services*³³ and *Helling v. McKinney*³⁴ which found, “When the State takes a person into its custody, and holds [her] there against [her] will, the Constitution imposes on it a corresponding duty to assume some responsibility for [her] safety and well-being” (Ref. 34, p 32).

In *Women Prisoners of D.C. Department of Corrections v. District of Columbia*,³⁵ the Federal District Court found the use of restraints on pregnant inmates during labor and delivery unconstitutional and found the actions of officials involved to be contrary to the Eighth Amendment prohibition against cruel and unusual punishment. The court ruled, “During the last trimester of pregnancy up until labor, the defendants [Department of Corrections] shall use only leg restraints when transporting a pregnant woman prisoner, unless the woman has demonstrated a history of assaultive behavior or has escaped from a correctional facility” (Ref. 35, p 682). It must be noted that much of this original case was overturned or vacated on appeal; however, findings that shackling during pregnancy violates the Eighth Amendment were not reheard, because the appellants did not challenge the use of physical restraints on pregnant women, which the court had found violated the Eighth Amendment.

The federal case of *Nelson v. Correctional Medical Services*³⁶ involved an appeal of a summary judgment for dismissal due to qualified immunity of a § 1983 claim brought after a nonviolent offender went into labor during her second trimester and sustained injuries from being shackled. The court in this case had two general findings. The first was that restraining a woman during labor could harm the mother and fetus and might interfere with responses required by medical personnel (in part based on the *Women Prisoners of D.C. Department of Corrections* case and expert testimony provided in the record).^{10,36} The court also ruled that there is no apparent safety or security reason that compels the use of restraints during labor in the fact pattern presented. The court then concluded “that a jury could find that a reasonable official would have known that shackling [Ms. Nelson's] legs to a bed post while she was in labor, without regard to whether or not she posed a security or flight risk, violated her Eighth Amendment rights” (Ref. 36, p 527). In the dissenting opinion, it was noted:

The United States Supreme Court has not addressed the constitutionality of the use of restraints on a pregnant inmate during labor, nor have any circuit courts, nor have any district courts in our circuit. Other than a single district court opinion from outside of our circuit, later vacated on various other grounds, no other court has considered the constitutionality of such a use of restraints The D.C. district court found that shackling a woman during labor “violate[d] contemporary standards of decency,” was “inhumane,” and violated the Eighth Amendment. The D.C.

district court discovered this constitutional right and its violation without citing any authority for its holding Based upon this single vacated district court opinion, the majority proclaims Nelson had a clearly established constitutional right to be free from restraints during labor [Ref. 36, p 537].

Since *Nelson*, there have been two more cases on this matter: the U.S. district court case of *Brawley v. Washington*³⁷ and the Sixth Circuit court of appeals of *Villegas v. The Metropolitan Government Of Nashville And Davidson County*.²⁸ In *Brawley*, the Supreme Court case of *Hope v. Pelzer*, 536 U.S. 730,(2002) (a case regarding shackling an inmate to a hitching post and qualified immunity, which was also discussed in *Nelson*) was referenced: “[U]nnecessary and wanton infliction of pain constitutes cruel and unusual punishment forbidden by the Eighth Amendment Among unnecessary and wanton inflictions of pain are those that are totally without penological justification” (Ref. 38, p 737).

In *Brawley*,³⁷ the district court found that there was a medical need to have the restraints removed during pregnancy and discussed deliberate indifference factors, such as whether the guards knew that the inmate was in active labor at the time she was transported (she was five months pregnant). In addition, in the court’s opinion, there was no documentation of Ms. Brawley’s being a flight risk during the transport or time at the hospital, despite her classification as medium security because she had two outstanding warrants for felonies.

In *Villegas*,²⁸ the Sixth Circuit’s tone was more favorable to the correctional institution than in previous cases when it reversed a summary judgment in the plaintiff’s favor. The court commented “the law on the shackling of pregnant women is underdeveloped, and this Court has not previously decided a deliberate indifference claim based on the practice” (Ref. 28, p 569). The Sixth Circuit noted: “A shackling claim does not necessarily involve the denial of or interference with medical treatment; rather, it may be premised on the notion that the shackles increase Plaintiff’s risk of medical complications” (Ref. 28, p 570). In regard to *Nelson*, the majority opinion in *Villegas* noted: “*Nelson* is informative with respect to the appropriate framework to apply; the majority would not go as far . . . [as] making *Nelson* dispositive of this case” (Ref. 28, n 3). In addition, the *Villegas* court found that the plaintiff could be considered a flight risk because she had an immigration detainer and was a medium-security inmate. This case is also interesting, because the court considered testimony

from a psychiatrist for the plaintiff regarding PTSD and major depression. In conclusion, the court stated:

In light of the material factual disputes surrounding whether Plaintiff was shown to be a flight risk, whether Defendant’s officers had any knowledge about a no restraint order, and the conflicting expert testimony about the ill effects of Plaintiff’s shackling, we conclude that the district court improperly granted summary judgment to Plaintiff on her shackling claim. On remand, a jury will need to determine whether Plaintiff was a flight risk in her condition and whether Defendant had knowledge of the substantial risk, recognized the serious harm that such a risk could cause, and, nonetheless, disregarded it [Ref. 28, p 578].

Risk Imposed on and by Pregnant Women

Clarke and Simon asserted: “The practice of shackling pregnant women and women in labor is principally a remnant of protocols designated for male institutions and is not based on genuine security concerns” (Ref. 6, p 780). However, there may be quite appropriate security concerns, especially during the earlier phases of pregnancy. In many ways, it is sexist to assume that women cannot be violent or dangerous. Although men are arrested for the large majority of violent crimes (an estimated four-fifths), women engage in violence, both while free and incarcerated, with approximately 60,000 to 70,000 women arrested a year in the United States for violent crimes (e.g., murder and manslaughter, forcible rape, robbery, and aggravated assault).^{1,39–41}

Those who have raised questions about the unnecessary use of restraints on pregnant women note that many of the concerns that may justify the need for restraints can be resolved by other means. For example, in the states where restraints cannot be used, additional personnel, with or without guns, are often assigned to the prisoner, either in the room or just outside, to reduce the flight risk. However, besides the points made in *Haslar*,³⁰ one might also consider that the presence of an armed guard is as demeaning as restraints and can still potentially interfere with or change the nature of medical treatment. In addition, being physically detained, tazed, pepper sprayed, bated, or shot by guards may be just as harmful, if not more so, than restraints. There may also be more ambiguity and variation among the correctional systems (e.g., training, staffing concerns, or level of force allowed) and what course of action individual

guards would take, heightening the potentiality for risk.

Key questions bearing consideration are: when restraint measures are used, what are the justifications for use and what are the demographics of the women they are used on? Although there is a dearth of research available on this topic, Pennsylvania Senate Bill 1074 which passed in 2010 stated:

The restraint of a pregnant prisoner is considered an extraordinary occurrence and is permissible only when the prisoner or detainee presents a substantial flight risk or if there are extraordinary medical or security risks to: the prisoner, the staff of the correctional institution or medical facility, other prisoners, or the public . . . Restraints shall not be used during any stage of labor, any pregnancy-related medical distress, any period of delivery, any period of postpartum, or for transport to a medical facility after the beginning of the second trimester of pregnancy [Ref. 42, p 1].

A review from 2012 through 2013, undertaken as part of this bill, revealed that 5 of 62 (8%) county jails had used restraints on pregnant prisoners or detainees (with it being unknown whether other jails had no incidents or failed to report).⁴² During that year, there were 109 incidents of restraint use on 15 detainees with a mean age of 25 years. The most common reasons given for use of restraints was security risk (93/109) followed by flight risk (11/109). (Four reports did not identify a reason for restraints, and one incident was due to misconduct.) When restraints were used during transportation outside the facility, 69 incidents were during transport to methadone clinics, 35 to or within a medical facility, and 2 to court. The reason for incarceration among the pregnant detainees was most commonly parole/probation violations, but also included writing bad checks, retail theft, theft by unlawful taking, forgery, and criminal conspiracy. Despite limited reporting, most of the women were incarcerated for nonviolent offenses. However, it must be pointed out that this review was only of jail populations, which usually contain pretrial detainees or postconviction misdemeanants.

Federal Recommendations for Shackling

The Justice Department, in a publication entitled *Best Practices in the Use of Restraints with Pregnant Women and Girls Under Correctional Custody*, currently advises:

The use of restraints on pregnant women and girls under correctional custody should be limited to absolute necessity. The use of restraints is considered absolutely necessary only when there is an imminent risk of escape or harm (to

the pregnant woman or girl, her fetus/newborn, or others) and these risks cannot be managed by other reasonable means (e.g., enhanced security measures in the area, increased staffing, etc.) [Ref 10, p 8].

The present recommendations are nonbinding on the states and may change in the future, depending on events or political change. Given the different tones with the *Nelson* ruling in the Eighth Circuit and the *Villegas* ruling in the Sixth Circuit, the use of restraints on pregnant prisoners may ultimately be settled by the Supreme Court.^{28,36}

Forced Treatment for Substance Abuse

The other emerging trend regarding pregnant women is forced treatment for substance abuse. In many ways, the general concept of informed consent and decision-making capacity in pregnancy is similar to informed consent and decision-making capacity in other areas of medical care. The art of engaging patients, understanding key medical problems, weighing ethics principles such as autonomy and beneficence, and being aware of legal precedent and limitations have to be incorporated in approaching these cases. However, the presence of another stakeholder, the fetus, creates an added layer of considerations, especially in medical scenarios that place (or seemingly place) the interests of a pregnant woman and her fetus at odds.⁴³

Historically, court holdings in cases involving pregnancy have varied, at times favoring the autonomy of the pregnant woman and at other times favoring the perceived protection of the fetus. In the landmark case of *In Re: A.C.* (1990), the D.C. Court of Appeals stated, “. . . in virtually all cases the question of what is to be done is to be decided by the patient—the pregnant woman—on behalf of herself and the fetus” (Ref. 44, p 1237). However, other examples include a 2004 Pennsylvania decision in which the court ordered a “medically necessary” Caesarian-section of a woman’s macrosomic (large) fetus, despite her refusal and preference for vaginal delivery, as she had successfully had in six previous pregnancies, some of which were also “large babies.”⁴⁵ She eventually underwent successful vaginal delivery at a different hospital after checking out against medical advice from the hospital seeking the court order.

Recent changes in federal entitlement laws have aimed to provide further protection of the rights of fetuses and newborns, especially in cases involving

prenatal substance use.^{9,46-48} For example, to qualify for welfare funds under the Keeping Children and Families Safe Act of 2003 (which was incorporated into the Federal Child Abuse Prevention and Treatment Act (CAPTA)), each state must have policies and procedures that require health care providers to notify child protective services when delivering or caring for an infant affected by prenatal drug exposure or a fetal alcohol spectrum disorder.^{9,46-48} (A review of individual state laws is available at the Child Welfare Information Gateway [https://www.childwelfare.gov/pubPDFs/drugexposed.pdf#page=2&view=Prenatal Drug Exposure](https://www.childwelfare.gov/pubPDFs/drugexposed.pdf#page=2&view=Prenatal%20Drug%20Exposure). Managed by Children's Bureau, Administration for Children and Families, and U.S. Department of Health and Human Services). Although these notifications under CAPTA were not intended to constitute child abuse or to result in criminal prosecution, many states have adopted harsher legal consequences for prenatal substance use since this change.^{9,46,48}

Another legal trend which has greatly influenced fetal rights is the patchwork of various feticide laws passed by 38 states.⁴⁹ In homicide or manslaughter cases, these laws often classify fetuses as persons. The laws were originally passed for various reasons, including the idea of protecting pregnant women against violent crimes (e.g., considered a deterrent because the murder of a pregnant woman results in two counts of murder), discouraging domestic violence, protecting infants from public health concerns (e.g., fetal alcohol syndrome), and, by some, to discourage abortions.⁴⁹ In addition, many of these laws were passed after a heinous act had been committed against a pregnant woman. For example, the federal government passed the Unborn Victims of Violence Act of 2004 which recognized fetuses as legal victims if they were harmed or killed during the commission of certain federal crimes in response to Lacy Peterson's murder.⁴⁹ As an offshoot of these laws, 18 states currently have laws allowing women to be charged with some form of child endangerment or abuse if they use substances while pregnant.^{46,48,50} Three states (Wisconsin, Minnesota, and South Dakota) have laws granting authorities the specific power to confine or commit pregnant women and force them into medical treatment.^{48,50} In 2014, Tennessee was the first state to pass a law that criminalized drug use during pregnancy as an assault.⁴⁸ Statue 39-13-107, Fetus as Victim, notes:

(c)(2) Notwithstanding [lawful medical or surgical procedures], nothing in this section shall preclude prosecution of a woman for assault under § 39-13-101 for the illegal use of a narcotic drug, as defined in § 39-17-402, while pregnant, if her child is born addicted to or harmed by the narcotic drug and the addiction or harm is a result of her illegal use of a narcotic drug taken while pregnant. (3) It is an affirmative defense to a prosecution permitted by subdivision (c)(2) that the woman actively enrolled in an addiction recovery program before the child is born, remained in the program after delivery, and successfully completed the program, regardless of whether the child was born addicted to or harmed by the narcotic drug.⁵¹

ACOG's Committee on Ethics opined that coercion and punishment in prenatal medical care may fail to recognize the bodily integrity of pregnant women; ignore limitations of medical knowledge; treat addiction and psychiatric illness as moral failings; discourage prenatal care; single out vulnerable women; and potentially lead to criminalization of legal maternal behavior.¹³ The Women's Health and Education Center has also taken the position that a "pregnant woman who has decision-making capacity has the same right to refuse treatment as a non-pregnant woman" and that "statutes that prohibit pregnant women from exercising their right to determine or refuse current or future medical treatment are unethical."⁵²

Legal Action to Force Treatment

The National Advocates for Pregnant Women reported that from 1973 through 2005, roughly 413 pregnant women in 44 states were forced into some sort of treatment through criminal laws or civil commitment.⁸ Currently, there are cases being brought by the National Advocates for Pregnant Women challenging Wisconsin's Law on forced treatment.⁵³⁻⁵⁵ Wisconsin Statue 48.133, passed in 1997, states:

The court has exclusive original jurisdiction over an unborn child alleged to be in need of protection or services which can be ordered by the court whose expectant mother habitually lacks self-control in the use of alcohol beverages, controlled substances or controlled substance analogs, exhibited to a severe degree, to the extent that there is a substantial risk that the physical health of the unborn child, and of the child when born, will be seriously affected or endangered unless the expectant mother receives prompt and adequate treatment for that habitual lack of self-control. The court also has exclusive original jurisdiction over the expectant mother of an unborn child described in this section.¹⁴

The initial challenge case was that of Alicia Beltran, who revealed to a physician's assistant at a preg-

nancy appointment that she had recently stopped abusing prescription narcotics and had done so by using Suboxone^{53,54,56}. The physician's assistant advised her to continue using Suboxone to prevent potential relapse, despite her reporting no current use. Because she refused to take the medication, she was arrested and taken to court, rather ironic given the earlier part of this article, in handcuffs and shackles.⁵³ She was court ordered to a drug treatment program where she remained for over two months until she filed a *habeas* petition and was eventually released.⁵³ One of the unusual aspects of the case was that Alicia Beltran was denied a lawyer at the initial hearing, even though one was appointed for her fetus.^{54,56} Her initial challenge against the law was found moot in September 2014 because the state dropped all the child-in-need-of-protection-services (CHIPS) charges, and she was released before the *habeas* hearing (but after its filing).⁵³ The court noted that if Ms. Beltran's allegations were true, they were "deeply disturbing" even though the point was moot from a legal perspective under the 28 USC § 2241 (writ of *habeas corpus*) claim brought before it. The court noted that there may be additional actions Ms. Beltran can undertake, such as bringing a 42 U.S.C. § 1983 civil rights case. Since this ruling, another Wisconsin woman, Tamara Loertscher, with a similar fact pattern as Ms. Beltran's has filed a 42 U.S.C. § 1983 case.⁵⁵

Depending on the outcome of these cases, more states may try to enact laws similar to those of Wisconsin and Tennessee. Given that certain medical organizations have already declared these types of laws unethical, the rulings in these cases may place medical societies squarely in the middle of high profile legal and political fights. Although ACOG, based on existing statements, appears to be very supportive of the mother's rights, other organizations (such as neonatology groups, pediatric organizations, and the American Academy of Child and Adolescent Psychiatry; AACAP) may have various positions and rationales. Although the authors at this time are unaware if AACAP has taken an official position on the topic of forced treatment of mothers who are using substances, one might be inferred from their information regarding fetal alcohol syndrome: "Exposure to alcohol during pregnancy causes damage to the brain and affects the child's behavior, these effects can be prevented 100 percent" (Ref. 57, p 1). Considering that the harm is 100 percent preventable, AACAP

may or may not have a differing ethical view from ACOG. Because some of these laws are based on the notion of civil commitment and treatment of a mental disorder (i.e., substance abuse), psychiatric organizations are more than likely to have to take some sort of position.

There may also be a question of whether these laws will be seen as creating a "status event/crime" such as in *Robinson v. California*,⁵⁸ in which the condition of drug dependency was seen as a disease state or based on past action (e.g., drug habituation, but not necessarily current use, as seen with Ms. Beltran), or whether substance use while pregnant is more of a directly controllable act such as in *Powell v. Texas*,⁵⁹ where a person chose to become intoxicated in public.⁵ Given that jurisdictions may vary on how they view the question, this matter may also have to be decided by the Supreme Court.

Conclusions

Medicine and psychiatry are embarking on important legal (and political) debates regarding how states and correctional institutions address pregnancy-related questions. Although psychiatrists are not usually involved in delivery rooms, given the high frequency of substance abuse in the general population and co-occurring mental illness in incarcerated female populations, forensic psychiatrists are likely to be involved at some level in these debates, as seen in the *Villegas* and *Beltran* cases. In addition, forensic psychiatry may bring a unique perspective to the debate, because many of these cases will be heavily influenced by forensic landmark case law and psychiatric concerns, such as commitment. At this time, it is important for forensic psychiatrists to be aware of the concerns, the laws in their states, the policies at their institution, and the professional, national, and international trends and standards, to effectively participate in the debate and serve this patient population.

In general, whether serving as a forensic or general psychiatrist, it is important for physicians to identify and document clearly the unique or important factors for the individual case, the risks and benefits of actions taken, and the thought processes leading to those actions. When in doubt, physicians should seek guidance from peers, ethics committees, or organizational treatises. As the law evolves and the cases work their way through the courts, the best advice for physicians to follow

during this period of transition may be *primum non nocere*.

Appendix A: Positions on Use of Restraints in General and Use During Pregnancy (the following texts are quoted from the sources identified)

United Nation Standard Minimum Rules for the Treatment of Prisoners

33. Instruments of restraint, such as handcuffs, chains, irons and strait-jacket, shall never be applied as a punishment. Furthermore, chains or irons shall not be used as restraints. Other instruments of restraint shall not be used except in the following circumstances:

(a) As a precaution against escape during a transfer, provided that they shall be removed when the prisoner appears before a judicial or administrative authority;

(b) On medical grounds by direction of the medical officer;

(c) By order of the director, if other methods of control fail, to prevent a prisoner from injuring himself or others or from damaging property; in such instances the director shall at once consult the medical officer and report to the higher administrative authority.

34. The patterns and manner of use of instruments of restraint shall be decided by the central prison administration. Such instruments must not be applied for any longer time than is strictly necessary (Ref. 60, p 5).

Specific Recommendations From the UN Bangkok Rules

The Standard Minimum Rules for the Treatment of Prisoners apply to all prisoners without discrimination; therefore, the specific needs and realities of all prisoners, including of women prisoners, should be taken into account in their application. The Rules, adopted more than 50 years ago, did not, however, draw sufficient attention to women's particular needs. With the increase in the number of women prisoners worldwide, the need to bring more clarity to considerations that should apply to the treatment of women prisoners has acquired importance and urgency.

Rule 22

Punishment by close confinement or disciplinary segregation shall not be applied to pregnant women, women with infants and breastfeeding mothers in prison.

Rule 24

Instruments of restraint shall never be used on women during labor, during birth and immediately after birth.

Rule 64

Non-custodial sentences for pregnant women and women with dependent children shall be preferred where possible and appropriate, with custodial sentences being considered when the offense is serious or violent or the woman represents a continuing danger, and after taking into account the best interests of the child or children, while ensuring that appropriate provision has been made for the care of such children (Ref. 3, pp 6,15,25).

Correctional Services of Canada; Commissioner's Directive 567-3: Use of Restraint Equipment for Security Purposes (in effect 2013)

Pregnant Inmates

13. If time and circumstances permit, assessment and approval by a Physician will normally be sought by the escorting officers to determine the safest and most appropriate restraint option.

14. Restraints will only be used as a last resort with pregnant inmates. If restraint equipment is used on a pregnant inmate, extreme caution must be exercised to ensure that both the woman and fetus are protected from injury (e.g., supported by staff on each side while walking).

15. Pregnant inmates will not be restrained during labor and delivery.

16. When pregnant inmates are being transported, body belts, if required, must be applied in such a way so as to ensure that no pressure is exerted on the inmate's stomach or torso.¹⁶

AMA position on general use of restraints and use in pregnant inmates

Ethics Opinion 8.17—Use of Restraints

All individuals have a fundamental right to be free from unreasonable bodily restraint. Physical and chemical restraints should therefore be used only in the best interest of the patient and in accordance with the following guidelines:

(1) The use of restraints, except in emergencies, may be implemented only upon the explicit order of a physician, in conformance with reasonable professional judgment.

(2) Judgment should be exercised in issuing pro re nata (PRN) orders for the use of physical or chemical restraints, and the implementation of such orders should be frequently reviewed and documented by the physician.

(3) The use of restraints should not be punitive, nor should they be used for convenience or as an alternative to reasonable staffing.

(4) Restraints should be used only in accordance with appropriate clinical indications.

(5) As with all therapeutic interventions, informed consent by the patient or surrogate decision maker is a key element in the application of physical and chemical restraints, and should be incorporated into institutional policy.

(6) In certain limited situations, it may be appropriate to restrain a patient involuntarily. For example, restraints may be needed for the safety of the patient or others in the area. When restraints are used involuntarily, the restraints should be removed when they are no longer needed.⁶¹

AMA Policy H-420.957 Shackling of Pregnant Women in Labor (adopted 2010)

1. Our AMA supports language recently adopted by the New Mexico legislature that

[A]n adult or juvenile correctional facility, detention center or local jail shall use the least restrictive restraints necessary when the facility has actual or constructive knowledge that an inmate is in the 2nd or 3rd trimester of pregnancy. No restraints of any kind shall be used on an inmate who is in labor, delivering her baby or recuperating from the delivery

unless there are compelling grounds to believe that the inmate presents:

An immediate and serious threat of harm to herself, staff or others; or a substantial flight risk and cannot be reasonably contained by other means.

If an inmate who is in labor or who is delivering her baby is restrained, only the least restrictive restraints necessary to ensure safety and security shall be used.²⁰

Women Prisoners of D.C. Department of Corrections v. District of Columbia (877 F. Supp. 634 (1994))

The Defendants shall develop and implement a protocol concerning restraints used on pregnant and postpartum women which provides that a pregnant prisoner shall be transported in the least restrictive way possible consistent with legitimate security reasons. Specifically, the protocol shall provide:

a. The Defendants shall use no restraints on any woman in labor, during delivery, or in recovery immediately after delivery.

b. During the last trimester of pregnancy up until labor, the Defendants shall use only leg shackles when transporting a pregnant woman prisoner unless the woman has demonstrated a history of assaultive behavior or has escaped from a correctional facility (Ref 35, p 682).

References

1. Friedman SH, Hall R, Sorrentino R: Commentary: women, violence, and insanity. *J Am Acad Psychiatry Law* 41:523–8, 2013
2. Friedman SH, Collier S, Hall R: PTSD Behind Bars: Incarcerated Women and PTSD, in *Comprehensive Guide to Post-Traumatic Stress Disorder*. Edited by Martin C, Preedy V, Patel, V. London: Springer Reference, in press
3. Resolution 2010/16 United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules). Available at <http://www.un.org/en/ecosoc/docs/2010/res%202010-16.pdf>. Accessed January 1, 2015
4. Handbook on Women and Imprisonment (ed 2), with reference to the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (The Bangkok Rules). Available at http://www.unodc.org/documents/justice-and-prison-reform/women_and_imprisonment_-_2nd_edition.pdf. Accessed January 1, 2015
5. Proehl K: Pregnancy crimes: new worries to expect when you're expecting. *Santa Clara L Rev* 53:661–91, 2013
6. Clarke J, Simon R: Shackling and separation: motherhood in prison. *virtual mentor. AMA J Ethics* 15:779–85, 2013. Available at <http://journalofethics.ama-assn.org/2013/09/pdf/pfor2-1309.pdf/>. Accessed January 1, 2015
7. Flavin J, Paltrow L: Punishing pregnant drug-using women: defying law, medicine, and common sense. *J Addict Dis* 29:231–44, 2010
8. Paltrow L, Flavin J: Arrests of and forced interventions on pregnant women in the United States, 1973–2005: implications for women's legal status and public health. *Health Pol Pol'y & L* 38:299–343, 2013
9. Christian S: Substance-exposed newborns: new federal law raises some old issues. Washington, DC: National Conference of State Legislatures, Children's Policy Institute, September 2004. Available at <http://www.ncsl.org/print/cyf/newborns.pdf/>. Accessed January 10, 2015
10. Best practices in the use of restraints with pregnant women and girls under correctional custody, 2014. U.S. Department of Justice, Bureau of Justices Associates, Center for Effective Public Policy, 2014. Available at <http://cjininvolvedwomen.org/sites/all/documents/best-practices-use-of-restraints-pregnant.pdf/>. Accessed January 10, 2015
11. ACLU Briefing Paper: The shackling of pregnant women & girls in U.S. prisons, jails and youth detention centers. New York: American Civil Liberties Union, ACLU National Prison Project, 2013. Available at https://www.aclu.org/files/assets/anti-shackling_briefing_paper_stand_alone.pdf/. Accessed January 10, 2015
12. American College of Obstetricians and Gynecologists Committee on Health Care for Underserved Women: Opinion: Health care for pregnant and postpartum incarcerated women and adolescent females, November 2011, reaffirmed 2013. ACOG: Washington, DC, 2013. Available at <http://www.acog.org/resources-and-publications/committee-opinions/committee-on-health-care-for-underserved-women/health-care-for-pregnant-and-postpartum-incarcerated-women-and-adolescent-females/>. Accessed January 18, 2015
13. American College of Obstetricians and Gynecologists Committee on Ethics. Maternal decision making, ethics, and the law. ACOG Committee Opinion No. 321. *Obstet Gynecol* 106:1127–37, 2005
14. Wis. Stat. Ann. § 48.133 (1997)
15. Second Chance Act. Available at <http://csgjusticecenter.org/nrrc/projects/second-chance-act/>. Accessed January 10, 2015
16. Commissioner's Directive: Use of Restraint Equipment for Security Purposes Commissioner's Directive Number: 567-3. Ottawa, ON, Canada: Correctional Service Canada. Available at <http://www.csc-scc.gc.ca/politiques-et-lois/567-3-cd-eng.shtml#s6/>. Accessed January 10, 2015
17. *Atkins v. Virginia*, 536 U.S. 304 (2002)
18. *Roper v. Simmons*, 543 U.S. 551 (2005)
19. *Weems v. United States*, 217 U.S. 349 (1910)
20. AMA Policy H-420.957: Shackling of Pregnant Women in Labor, Enacted in 2010. Chicago: American Medical Association, 2010. Available at <https://www.ama-assn.org/ssl3/ecommerce/PolicyFinderForm.pl?site=www.ama-assn.org&xuri=/resources/html/policyfinder/policyfiles/HnE/H-420.957.htm>. Accessed June 6, 2015
21. American Psychiatric Association: The Use of Restraint and Seclusion in Correctional Mental Health Care Resource Document. Approved by the Joint Reference Committee, December 2006. Arlington, VA: APA, 2006. Available at <http://www.bing.com/search?q=The+Use+of+Restraint+and+Seclusion+in+Correctional+Mental+Health+Care+Resource+Document&q=The+Use+of+Restraint+and+Seclusion+in+Correctional+Mental+Health+Care+Resource+Document&qs=n&form=QBLH&pc=U157&pq=the+use+of+restraint+and+seclusion+in+correctional+mental+health+care+resource+document&sc=0-0&sp=-1&sk=&cvid=64bf7717643e4e8abd185705f2fba969/>. Accessed January 10, 2015
22. Recupero P, Price M, Gravey K, *et al*: Restraint and seclusion in psychiatric treatment settings: regulation, case law, and risk management. *J Am Acad Psychiatry Law* 39:465–76, 2011
23. Tye C, Mullen P: Mental disorders in female prisoners. *Aust N Z J Psychiatry* 40:266–71, 2006
24. Lynch S, Dehart D, Belknap J, *et al*: A multisite study of the prevalence of serious mental illness, PTSD, and substance use disorders of women in jail. *Psychiatr Serv* 65:670–4, 2014
25. Simpson A, Brinded P, Laidlaw T, *et al*: The National Study of Psychiatric Morbidity in New Zealand Prisons: An investigation of the prevalence of psychiatric disorders among New Zealand inmates. An Epidemiology Study commissioned by the Depart-

Use of Restraints and Commitment in Pregnant Women

- ment of Corrections and co-sponsored by the Ministries of Health and Justice, 1999. Available at http://www.corrections.govt.nz/_data/assets/pdf_file/0007/671821/nationalstudy.pdf/. Accessed January 14, 2015
26. Goff A, Rose E, Rose S, *et al*: Does PTSD occur in sentenced prison populations? A systematic literature review. *Crim Behav Ment Health* 17:152–62, 2007
 27. Fazel S, Baillargeon J: The health of prisoners. *Lancet* 377:956–65, 2011
 28. *Villegas v. Metro. Gov't of Nashville*, 709 F.3d 563 (6th Cir. 2013)
 29. Dignam B, Adashi E: Health Rights in the Balance: The case against perinatal shackling of women behind bars. *Health Hum Rights* 16:2014 Available at <http://www.hhrjournal.org/2014/09/23/health-rights-in-the-balance-the-case-against-perinatal-shackling-of-women-behind-bars/>. Accessed January 10, 2015
 30. *Haslar v. Megerman*, 104 F.3d 178 (8th Cir. 1997)
 31. *Estelle v. Gamble*, 429 U.S. 97 (1976)
 32. *Farmer v. Brennan* 511 U.S. 825 (1994)
 33. *DeShaney v. Winnebago County Dep't of Social Services*, 489 U.S. 189 (1989)
 34. *Helling v. McKinney*, 509 U.S. 25 (1993)
 35. *Women Prisoners v. District of Columbia*, 877 F. Supp. 634 (D.D.C. 1994)
 36. *Nelson v. Correctional Medical Services*, 583 F.3d 522 (8th Cir. 2009)
 37. *Brawley v. Washington*, 712 F. Supp. 2d 1208 (W.D. Wash. 2010)
 38. *Hope v. Pelzer*, 536 U.S. 730 (2002)
 39. FBI Uniform Crime Report: Crime in the United States, 2011, Table 33. Washington, DC: U.S. Department of Justice, Federal Bureau of Investigation. Available at <http://www.fbi.gov/about-us/cjis/ucr/crime-in-the-u.s/2011/crime-in-the-u.s.-2011/tables/table-33/>. Accessed January 17, 2015
 40. FBI Uniform Crime Report: Crime in the United States, 2012, Table 33. Washington, DC: U.S. Department of Justice, Federal Bureau of Investigation. Available at <http://www.fbi.gov/about-us/cjis/ucr/crime-in-the-u.s/2012/crime-in-the-u.s.-2012/tables/33tabledatacoverviewpdf/>. Accessed January 17, 2015
 41. FBI Uniform Crime Report: Crime in the United States, 2013, Table 33. Washington, DC: U.S. Department of Justice, Federal Bureau of Investigation. Available at <http://www.fbi.gov/about-us/cjis/ucr/crime-in-the-u.s/2013/crime-in-the-u.s.-2013/tables/table-33/>. Accessed January 17, 2015
 42. 2012–2013 Fiscal Year Summary of Senate Bill 1074 Restraining Pregnant Females Pennsylvania Department of Corrections. Available at <http://www.cor.pa.gov/Administration/Statistics/Documents/Reports/Pregnant%20Women%20in%20Restrains.pdf/>. Accessed January 10, 2015
 43. Chervenak F, McCullough L, Brent R: The professional responsibility model of obstetric ethics: avoiding the perils of clashing rights. *Am J Obstet Gynecol*: 205:e1–5, 2011
 44. *In re A.C.*, 573 A.2d 1235 (D.C. Cir. 1990)
 45. Collier L: Could you be forced to have a c-section? *Baby Talk* May 2005. Available at http://advocatesforpregnantwomen.org/main/publications/articles_and_reports/could_you_be_forced_to_have_a_csection_1.php/. Accessed January 17, 2015
 46. Child Welfare Information Gateway: Parental Drug Use as Child Abuse. U.S. Department of Human Services, Administration for Children and Families, 2012 Available at [https://www.childwelfare.gov/pubPDFs/drugexposed.pdf#page=2&view=prenatal drug exposure/](https://www.childwelfare.gov/pubPDFs/drugexposed.pdf#page=2&view=prenatal%20drug%20exposure/). Accessed January 10, 2015
 47. Child Abuse Prevention and Treatment Act (CAPTA), Pub. L. No. 111-320 (2010)
 48. Guttmacher Institute: State Policies In Brief As of July 1, 2015 Substance Abuse During Pregnancy. Available at http://www.guttmacher.org/statecenter/spibs/spib_SADP.pdf. Accessed July 23, 2015
 49. Graham R: For pregnant women, two sets of rights in one body: a new wave of fetal-protection measures creates a collision in American law and exposes a moral conundrum. *Boston Globe*, February 16, 2014. Available at <http://www.bostonglobe.com/ideas/2014/02/16/for-pregnant-women-two-sets-rights-one-body/5Pd6zntlViRBZ9QxhiQgFJ/story.html/>. Accessed on January 10, 2015
 50. Child Welfare Information Gateway: State laws on issues related to child abuse and neglect. Washington, DC: U.S. Department of Health & Human Services, Administration for Children and Families. Available at <https://www.childwelfare.gov/topics/systemwide/laws-policies/can/related/#sss/>. Accessed January 17, 2015
 51. *Tenn. Code Ann.* § 39-13-107 (2010) (Fetus as victim)
 52. Women's Health and Education Center: End-of-life decision making. Springfield, MA: April 19, 2012. Available at <http://www.womenshealthsection.com/content/heal/heal022.php3/>. Accessed May 28, 2015
 53. *Beltran v. Strachoto*, No. 13-C-1101. (E.D. Wis. 2014)
 54. Press Release: Wisconsin Alicia Beltran Case Federal District Court Avoids Ruling on Constitutionality. New York: National Advocates for Pregnant Women, September 30, 2014. Available at http://advocatesforpregnantwomen.org/blog/2014/09/wisconsin_alicia_beltran_case.php/. Accessed January 17, 2015
 55. Press release: Pregnant woman files civil rights lawsuit against State of Wisconsin challenging Wisconsin law that permits jailing pregnant women who seek medical help. New York: National Advocates for Pregnant Women, December 16, 2014. Available at http://advocatesforpregnantwomen.org/blog/2014/12/pregnant_woman_files_civil_rig.php/. Accessed January 17, 2015
 56. Eckholm E: Case explores rights of fetus versus mother. *New York Times*, October 24, 2013. Available at <http://www.nytimes.com/2013/10/24/us/case-explores-rights-of-fetus-versus-mother.html?pagewanted=all> Accessed January 10, 2015
 57. American Academy of Child and Adolescent Psychiatry: Drinking alcohol in pregnancy (fetal alcohol effects). No. 93; New York: AACAP: December 2011. Available at http://www.aacap.org/aacap/families_and_youth/facts_for_families/facts_for_families_pages/drinking_alcohol_in_pregnancy_fetal_alcohol_effects_93.aspx/. Accessed January 10, 2015
 58. *Robinson v. State of California*, 370 U.S. 660 (1962)
 59. *Powell v. State of Texas*, 392 U.S. 514 (1968)
 60. United National High Commissioner for Human Rights: United Nation Standard Minimum Rules for the Treatment of Prisoners. Adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held at Geneva in 1955, and approved by the Economic and Social Council by its resolutions 663 C (XXIV) of 31 July 1957 and 2076 (LXII) of 13 May 1977. Available at <http://www.ohchr.org/EN/ProfessionalInterest/Pages/TreatmentOfPrisoners.aspx/>. Accessed May 26, 2015
 61. AMA Ethics Opinion 8.17: Use of restraints, issued 1992. Available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion817.page?/>. Accessed June 6, 2015