GETTING IT RIGHT?

Services for pregnant women, new mothers, and babies in prison

Jenny North

THE MATERNITY ALLIANCE

Contents

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About the author

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Closure of The Maternity Alliance

After nearly 25 years campaigning for women's rights and benefits for pregnancy and child care, the Maternity Alliance was forced to close due to lack of funding on 19th December 2005. The work of the Maternity Alliance included an impressive array of achievements over the past 25 years of which this report is one. The former Council of Trustees and the staff involved in the project are grateful to the National Childbirth Trust for their assistance in helping disseminate this report. If you require further information please contact the Lankelly Chase Foundation on www.lankellychase.org.uk or email Sally Marchant, former Chair of the Council of Trustees of the Maternity Alliance: editor@midirs.org

Executive summary

Introduction

This report addresses the needs of pregnant women, mothers, and babies in prison - a group about whom relatively little is known. Her Majesty's Prison Service (HMPS) have published no reports on Mother and Baby Units (MBUs) since 1999. In this year, it produced a Response & Action Plan, which responded to, and in the majority of cases, accepted, the recommendations of a working group, commissioned by HMPS, that had examined MBUs in England. The Maternity Alliance was a member of this working group.

HMPS have released no follow-up reports, making it very difficult to know what life is like for mothers and babies, or how it has changed since 1999. HMPS have published no work at all on the lives of pregnant prisoners, and very little has been produced by the academic and voluntary sectors either.

To rectify this lack of knowledge, the Maternity Alliance has carried out consultations with a variety of health practitioners, prison officers, and HMPS policymakers, as well as with representatives from voluntary and campaigning organisations. We also examined available relevant literature. A seminar brought together representatives from many different prisons and areas of work to hear about examples of good practice, and to discuss where and what changes were needed.

These methods gave us a good insight into conditions in prison today, as well as into the effects of current HMPS policy. By recording the experiences of those who work with pregnant women and mothers, we are able to go beyond the remit of official reports.

In carrying out our research, and drawing up our recommendations, we were guided by three principles:

- It is crucial that prisoners have access to antenatal care of the same standard as that available in the community, and that prisons do all they can to facilitate a healthy pregnancy and birth.
- It is equally important that Mother & Baby Units are well-equipped, happy places that promote healthy child development.
- HMPS policy must ensure all pregnant women, and mothers, are treated fairly, with decisions made in their best interest.

Women in Prison

The female prison population is around 4600 and rising faster than the male prison population. By 2009, it is predicted that there will be 9000 women in custody. Most imprisoned women serve sentences of less than a year.

The female prison population has high rates of drug use, self-harm, mental illness, and suicide. Over half have experienced domestic violence or sexual abuse. Although there is very little statistical information on prisoners in MBUs specifically, it is has been shown that they are more likely to suffer from depression than other prisoners.

No official figures are released on the number of pregnant women in, or on the number of mothers and babies passing through prisons each year. However, research figures estimate that over 600 women receive antenatal care in prison each year, with over 100 actually giving birth during their sentences. As the female prison population grows, so will these figures. There are over 80 Mother & Baby places in units in England, spread between seven establishments.

It is recognised that prisoners can be a difficult group to deliver services to, partly because of the nature of prison, but also due to the char-

acteristics of the prison population, which can be challenging for health professionals. However, it is vital that the health and welfare of pregnant women, mothers, and babies are not compromised by the fact of their imprisonment, and that they are treated fairly by the system.

Policies & Procedures

In April 2000, HMPS and the National Health Service (NHS) entered a formal contract that commissioned the NHS to provide prisoners with the same standard of health care as that provided in the community. As part of this, the NHS took over the provision of maternity services. Antenatal clinics and classes may be held on site in prisons, but more complex care - such as obstetric consultations and ultrasound scans - is usually delivered outside the prison. Prisoners give birth in hospital, where since 1996, they should not be shackled during labour.

There is no Prison Service Order (PSO) relating to the treatment of pregnant prisoners. PSOs are very common in prison - they set out what Prison Officers and professionals should do in certain situations, and specify ideal practice. The lack of a pregnancy PSO is problematic, as this report will show.

There is an MBU PSO, which lays out the process of applying for an MBU place, and the criteria a woman must meet to gain admission. If she does, her baby will stay with her, until the end of her sentence, or until the baby is nine months (in five prisons), or 18 months (in two prisons), whichever comes first. The PSO also lays out the procedure for separating a mother and baby, either at birth, or during a mother's sentence.

Our research has shown that there is a great deal of inconsistency in practice between prisons, and a lack of communication at all levels. In addition to this, HMPS does not collate any figures on pregnancy and birth outcomes in prison. Health professionals mentioned all these factors as things that frustrated them in their attempt to deliver quality services.

Pregnancy

Consultation revealed a high level of variation in the quality of antenatal care between prisons. The good practice found in some establishments was not replicated in others. In one prison, women can access a drop-in antenatal three times a week; in another there is only one, about which women are sometimes not informed by Prison Officers.

The lack of a pregnancy PSO is the cause of much of the variation. Each prison fills the 'gaps' left in policy in a different way, leading to a real inequality of services across the country. The writing of a PSO would result in the creation of a set of minimum standards laying out what pregnant prisoners were entitled to, and advising staff on how they can facilitate this entitlement. It would also detail which situations are acceptable, and would recognise the specific and complex needs of pregnant prisoners.

The funding of prison antenatal care is problematic. Primary Care Trusts (PCTs) are funded to provide healthcare to prisoners in local establishments. However, it is Acute Trusts that manage the majority of prison antenatal care (Price, 2003), and they receive none of this allocated money. Therefore, these trusts must try to meet the diverse and complex needs of pregnant prisoners from budgets not calculated with them in mind.

This has led to inadequate funding of prison antenatal care - poor, unhygienic facilities were mentioned by midwives, as well as a lack of telephone lines to book outside appointments. Some practitioners mentioned that, without additional funding, they were unable to provide the number of midwifery hours they thought necessary. More money must be found if prisoners are to receive the care they normally provide in the community. Bringing funding of antenatal services into line with that of

other prisoner healthcare would also be an overdue recognition of the fact that pregnancy is a specific condition that deserves quality care.

Staff shortages are a well-known problem in many areas of prison life, and this is also true regarding pregnant prisoners. Prison Officers must accompany women to ultrasound scans, and other appointments, outside the prison. However there is often a shortage of Officers to perform this duty - leading to the cancellation of appointments that can take some time to reschedule. In some cases the rescheduling of the scan will delay the detection of serious conditions. This can be problematic where these are not identified prior to 24 weeks gestation as this is the legal limit for terminations and reduces the options for the women.

All of the health professionals we interviewed found the movement of prisoners a barrier to delivering quality services. It is very common for prisoners to be released or relocated at very short notice. Midwives are not promptly or routinely informed of these movements, and there is no established network of contacts between prison midwifery teams. All women are given hand held notes but these do not always survive prison moves. Midwives often attempt to contact colleagues in other prisons but this can be time-consuming and difficult.

It is even harder to trace a released woman's location, and alert health services in the area to her circumstances. Better communication is essential between prisons, probation services, and the courts to ensure that antenatal care is not overly disrupted when a women moves between prisons, or is released.

Consultation revealed that both HMPS, and individual prisons, can be slow to make important decisions about a mother's future, which can result in a great deal of stress and worry for pregnant women. There is more than one example of mothers being separated from their baby at birth not because they had been refused a place in the MBU, but simply because a decision had not yet been made. This resulted in unnecessary stays in foster care for the babies before they could be reunited in the MBU with their mothers. It is essential that Admissions Boards recognise that these decisions are urgent, and that the first few days and weeks after birth are a crucial time for mother-baby bonding, and that they operate more quickly to decide whether or not a mother will have an MBU place.

HMPS maintains very few statistics on pregnancy and birth outcomes. Records of birth weights of babies born in prison are not kept, neither are the incidences of miscarriage, birth complications, or stillbirths. All of these things can be affected by poor pregnancy health and inadequate antenatal care. Any large discrepancies between the statistics of prisoners and those of women from similar social backgrounds outside prison would be useful information to those devising and delivering services for pregnant prisoners. The collation of these statistics would also indicate a real interest in, and commitment to, the welfare of this group.

Mother & Baby Units

Research revealed that there are some poor facilities in MBUs in England. Common complaints from reports by Her Majesty's Inspectorate of Prisons (HMIP) include furniture inappropriate or unsafe for breastfeeding mothers, unhygienic, unmodernised kitchen facilities, and lack of educational materials for both mothers and babies. However, in general, it should be noted that facilities appear to have improved since 1999.

A 1999 recommendation was that all Prison Officers working in MBUs should have requested this role, and should not have simply been assigned to it. With a few exceptions our consultations showed this to be the case, which is very positive, although there was less evidence that this was so in private prisons.

Prison Officers working on MBUs are also required to attend three days of training to prepare them for their new responsibilities. This training consists mainly of understanding the details of the MBU PSO and infant safety and resuscitation. Some voluntary sector campaigners and health professionals would like to see this training strengthened and diversified.

Among the subjects that training could offer are providing breastfeeding support, and understanding and facilitating healthy mother-baby interaction. During consultation, it was decided that although training on the latter could have benefits, there was also a risk that it could lead to Prison Officers taking on inappropriate roles or even trying to impose a prescriptive style of parenting. However, this report recommends that HMPS consider the desirability of including training on the support and facilitation of breastfeeding.

Prison Officers also commented that they would like existing training on postnatal depression (PND) to be strengthened, as they did not feel they were able to recognise this condition, which affects around 15% of all new mothers.

It is clear that Prison Officers are not the right people to provide prisoners with parenting support. However, this conclusion raises the question of who is to do this. Only 62% of prisons deliver any parenting education at all, and our consultation revealed that none is specifically targeted at pregnant prisoners or women in MBUs. Furthermore, there is almost no parenting support available that addresses the psychological and emotional difficulties that can accompany bonding and parenting in prison.

One course that does address these issues currently runs in two prisons, and was developed and delivered by workers from the voluntary and academic sectors. It has been evaluated, and it has been shown that mothers who attended the courses had improved interactions with their babies, a better understanding of their babies needs, and gave more sensitive and competent care to their babies. Funding for this course is, at the moment, short-term and limited. All MBUs should commit to offering such a course, as it is clear they can have a significant positive effect on women.

Separation

Separation of a mother and baby in prison may happen for one of several reasons. It may occur at birth, if a mother has been refused a MBU place, or did not apply for one; if a mother is required to leave a MBU due to a breach of rules, of it a baby reaches the MBU's upper age limit before its mother is released.

The question of where a baby will go when separated from its mother is, of course, crucial. The mother should be involved in this decision, and some efforts are made to facilitate this, for example, every mother that enters a MBU must have a 'separation plan', which details two alternative carers, nominated by the mother. If she does not nominate anyone, or if these carers are deemed unsuitable by Social Services, the baby's default carer becomes its local authority.

Our consultation and research revealed that prisoners often do not feel fully involved in, or happy with, decisions made about their baby's future. We also heard about some unsatisfactory care arrangements. If a mother is in prison far from her hometown - which is very common - this can cause problems, as decisions will be taken by Social Services in her home town. This can make it logistically difficult for a mother to be involved, and it was commented that, in such cases, her needs are often forgotten or disregarded.

Even if a mother is happy with the care arrangements for her baby, separation can still be a stressful, difficult process. Consultation showed that those mothers who are separated from their baby soon after birth often miss out on postnatal care, usually because they are not motivated to receive it, and deliberately

avoid it. Mothers leaving the MBU often find it hard to adjust to 'normal' prison life after the more supportive, and communal, world of the unit. These problems come in addition to the emotional effects of being separated from their babies.

Problems with separation raise the question of why the upper age limits for babies in prison are set at nine months (five prisons), and 18 months (two prisons). The MBU PSO is vague as to the reasons for why these precise limits were set. Consultation found a view amongst HMPS officials that being in prison past 18 months jeopardised a baby's development, although no research on this was quoted during interview. However, in 2001 a court of appeal ruled that these upper age limits were arbitrary, and could be challenged, although this has been done rarely since.

During consultation, it was suggested that open prisons could be suitable for children up to 36 months - a limit that would allow the majority of mothers to leave prison with their babies. In addition to this, it was also felt that capacity for MBU places in open prisons should be increased to facilitate a move for any mother deemed suitable for open conditions at any time during her status as a MBU resident. There is little proof available to back up HMPS claims that too few of the female prison population are suitable for open conditions.

Leaving Prison

Female prisoners leaving prison risk homelessness, unemployment, drug misuse and abuse. Pregnant women, and women leaving prison with their baby, or to be reunited with their baby, face these things too, but they also have specific concerns due to their status as mothers. For example, many worry about how they will provide for their child, and how they will find decent and affordable childcare.

These women are not well-supported on the 'outside'. Many women fall through the cracks of probation services, and some are not even obliged to have any contact with them. Women are not required to leave contact details with health, or other professionals, within the prison, even though, for many, this might be helpful.

An initiative in one prison has been to allow mothers who are nearing their release date to make a day trip to a Sure Start or Children's Centre in their hometown. This shows mothers where to access services, and allows her to make the first crucial contact. Such an initiative should be facilitated by other prisons whenever possible, as part of a prisoner's 'resettlement plan'. These plans should also address such central questions as where a mother will live, how she will use health services and childcare, and where she may find the support necessary to prevent re-offending.

Conclusion

There are reasons to be positive about services for pregnant women, new parents, and babies in prison. This report highlights specific examples of good practice, and there was consensus during consultation that policy had improved somewhat since 1999.

However, improvements are uneven - MBUs are certainly better, but provision for pregnant prisoners lags behind. The lack of a Pregnancy PSO, the inequities in funding, and the variations in antenatal services all illustrate this. The needs of many pregnant prisoners go unmet, unless they are lucky enough to be in a prison that - due to the initiative of its midwives - offers good antenatal care.

There are also problems with MBUs. Most worrying is the lack of support available to women on the units, particularly in the light of their increased levels of depression and anxiety. The fact that some women do not feel fully involved in the decisions about their baby's future is also cause for concern - it is vital that a mother's needs and views are respected during this process.

Quality services are necessary for pregnant women, mothers and babies - not only because HMPS has a duty to provide them - but also because they can play a major role in a prisoner's rehabilitation. Pregnancy and motherhood are reasons for a woman to address offending behaviours, and high quality care can give her the opportunity and support necessary to do this. Women in prison will benefit disproportionately from good care and support - and these services will have effects that will last not only for the rest of a mother's life, but also that of her baby.

Recommendations

- HMPS must facilitate improved information sharing and networking. This is important both for HMPS employees working with pregnant women, new mothers, and babies, and mothers etc, also for midwives, health visitors, nursery nurses, and others who come into contact with these groups.
- HMPS must undertake a new review of policy and services for pregnant women, new mothers and their babies in prison.

PREGNANCY

- A Pregnancy PSO must be created, to ensure a high standard of care across the women's estate.
- Additional funding must be provided for antenatal care.
- Decisions as to whether a pregnant woman or mother is to gain an MBU place must be treated as priority, and reached as soon as possible.
- 'Pregnancy wings' should be created in all prisons.
- Better communications between prisons, probation services, and the courts, concerning the movements of pregnant women, are essential.
- More preparation for parenthood must be offered, particularly preparation that focuses on the emotional aspects of pregnancy and parenting in prison.
- HMPS must centrally collate, analyse and publish numbers and locations of pregnant prisoners, records of birth weights of babies born to women in prison, as well as incidences of miscarriages, birth complications, and stillbirths.

MOTHER & BABY UNITS

- All MBUs should provide a course that supports mothers in bonding with, and caring for, their babies.
- Staff training should be strengthened on the symptoms of postnatal depression.
- Mothers found using drugs on an MBU should, where possible, undergo detoxification and rehabilitation without being separated from their baby.
- HMPS should reconsider the current low number of MBU places in open prisons, and consider greater movement of MBU prisoners from closed to open prisons, where possible.

SEPARATION

- Mothers should be fully involved in decisions about where their baby is placed in the community. This is currently HMPS policy, but it must become practice too.
- HMPS should consider raising the maximum age limit to 36 months for children in open prisons.

LEAVING PRISON

- Resettlement plans must be strengthened and extended to take a woman's status as a mother into account.

Introduction

In 1999, the Maternity Alliance was part of a working group which formulated Her Majesty's Prison Service's (HMPS) Report of a Review of Principles, Policies and Procedures on Mothers and Babies/Children in Prison. This led to a Response and Action Plan, within which HMPS accepted 48 of the Report's recommendations, identified 11 for further consideration, and turned down four as recommendations upon which HMPS could not act.

HMPS have published no further reports on Mother and Baby Units since 1999, and they have published no work on pregnant women in prison. The very limited information available means it is very difficult to assess how, or if, life has changed for mothers in prison since 1999, and how many of the Report's recommendations have actually been implemented. Indeed, it is very difficult to get any understanding of the lives of pregnant women, mothers, and babies in prison. Evidence on conditions for these women is limited to inspections of individual prisons by Her Majesty's Inspectorate of Prisons (HMIP), and anecdotal reports.

This report aims to fill in some of the gaps in our knowledge. The Maternity Alliance has consulted with a variety of health practitioners, HMPS officials, prison officers, and the voluntary sector to gain a fuller picture of the quality of care and services available to pregnant women, new mothers and babies in prison.[1] This report presents the results of these consultations, as well as evidence from the available literature. It also makes recommendations based on this evidence, designed to improve the existing situations.

Our research was guided by three principles. It is crucial that prisoners have access to antenatal care of the same standard as that available to other women, and that the prison does what it can to facilitate a healthy pregnancy and birth. It is also important that MBUs are well-equipped, happy places that promote good mother-baby interaction and child development. Part of this should include social support for the mother. Finally, prison policy should ensure that all pregnant women and mothers are treated fairly, and that all decisions should be genuinely in her interest, and that of her child's. We were also keen to identify and publicise examples of good practice in these areas.

It should be noted that this report does not deal with the question of whether pregnant women and the mothers of very young babies, should be in prison at all. While it was not the remit of the MA to comment on the pattern of sentencing for women, custodial in preference to community or other forms of sentencing, this report advocates for better services on behalf of the women currently imprisoned, and their babies.

Methodology

Research started from the assumption that it would not be possible to conduct a systematic review of provision and policy in every women's prison, not least because we would be unable to secure such comprehensive access. However, we were keen to carry out research that reflected the realities of the lives of pregnant women, and new mothers, in prison, as well as of those who work with them. This was achieved through consultation with key policymakers and practitioners - interviews were held with representatives from central HMPS, the Home Office, Prison Officers, and the voluntary and campaigning sector, as well as with midwives and health visitors working in prisons (for a full list of interviewees see Appendix A).

In addition to this, a review of the literature surrounding pregnant women, and mothers and babies in prison, was undertaken. This literature is extremely limited, with most of it consisting of reports by Her Majesty's

[1] A full list of those who took part in consultation can be found at Appendix B

Inspectorate of Prisons (HMIP). We could identify no published studies presenting prisoners' views on, or experiences of, pregnancy in prison, or MBUs. However, a handful of midwives have carried out research in this field, and have published their results. In addition, there is a more substantial body of work on the experiences of all women within the prison system, and some of this has been relevant when examining the specific experiences of pregnant women and new mothers.

Finally, a seminar was held, bringing together representatives from many different fields to hear three different examples of good practice, which had been identified during consultations. The aim of the day was to publicise these examples, and to encourage networking amongst those who devise and deliver services to pregnant women and new mothers in prison. There was also a 'round table' discussion on the strengths and weaknesses of current policy and provision in the UK which identified things not uncovered during consultation, and provided a chance to 'test' initial research findings, and conclusions (for an agenda, and list of attendees, see Appendix B).

There are, of course, both advantages and disadvantages to a methodology that is so reliant on consultation. There is very little qualitative or quantitive analysis within this report, and much of the evidence is anecdotal. Some interviewees, unsurprisingly, were only familiar with one prison, and were unable to speak authoritatively about conditions in another. Others were only able to talk about the Prison Service in general, and not about specific incidents or policies.

However, the results of our consultations have given us a real insight into life for pregnant women, and mothers and babies in prison. Official reports cannot capture the experiences of those who work with these women, nor do they take account of the voices of the voluntary sector, many of which are in contact with prisoners themselves. In many instances, our research has identified problems that are outside the remit of HMIP reports, and which are not addressed in any of the literature.

Consultation has also given us the chance to find, and draw attention to, examples of good practice in provision for pregnant women, mothers and babies. This highlighting of expertise and sharing of initiatives is something many practitioners felt was not facilitated by HMPS.

Women in prison

The female prison population is around 4,600 and rising (HMPS, 2005). Between 2001 and 2002 this population rose by 15%, compared to a 5% increase in the male prison population (Counsell, 2002). It is predicted by the Home Office that there will be around 9000 women in custody by 2009 (Counsell & Simes, 2002). This rise can be attributed, in part, to the Courts increased enthusiasm for custodial penalties for women (up from 31% of offenders in 1994 to 44% in 2002) (Ash, 2003).

Many women serve very short sentences (70% receive a sentence of less than one year, and 60% of those on remand do not receive a custodial sentence when they are tried). The most common crimes are theft and handling, drugs offences, and violent crime. Foreign nationals are estimated to make up around 20% of the female prison population, and 80% of these are held for drugs offences. Around 30% of the female prison population is from an ethnic minority background (Ash, 2003).

The female prison population is considered to be more 'troubled' than their male equivalent. Proportionally fewer women test positive - around 50% - for drug use than men, but a higher proportion of positive tests are for opiates (Ash, 2003). It is estimated that over half of convicted female prisoners could be diagnosed as suffering mental illness. Over half have experienced domestic violence, and one in three has been sexually abused (Smart

Justice, 2005). Twenty percent of women prisoners were in care as children, compared to 2% of the general population (Fawcett, 2004). The suicide rate amongst female prisoners is higher than amongst men, as is the rate of self-harm (Ash, 2003).

Clearly, less than 5000 female prisoners represents a tiny proportion of a total prison population of 75,000. Because of this disparity, there is a danger that the specific needs of female prisoners are ignored. It has also been posited that because prison is a patriarchal system originally designed for men, in which women are overwhelmingly in the minority, female prisoners are fundamentally disadvantaged (Price, 2003). Within this framework, women come second in terms of creating prison policy and allocating resources, and pregnant prisoners are barely considered at all.

There are many examples within the prison service of how the needs of women are overlooked, or sacrificed to meet the needs of men. After riots, 'strikes', and escapes at male prisons in the 1990s, security was tightened across the entire estate, despite the fact that women prisoners very rarely cause these types of disturbances. This disadvantages women - as a 2004 report puts it, 'Women...suffer if security issues take priority when resources are distributed.' (Fawcett, 2004). Women's prisons also have fewer levels of categorisation (open, semi-open, and closed) than men's - leading to fewer opportunities for women serving longer sentences to progress through the system as they rehabilitate.

Clearly there can be no direct comparisons drawn between the treatment of male and female prisoners regarding pregnancy or parenting in prison. However, our consultation and research did point to there being inequalities within the system, with pregnant and parenting prisoners being disadvantaged firstly because they are incarcerated, and doubly, because they are incarcerated in a system designed for males, in which male needs are the norm.

It is difficult to assess how many women give birth during a custodial sentence, or spend a part of their pregnancy in prison. Figures on the number of pregnant prisoners, and on how many women are in Mother & Baby Units (MBUs), have only recently begun to be collated, and are not publicly available. However, a recent survey indicated that, over the course of one year, more than 620 women received maternity care in prison, with 169 giving birth before their sentence ended (Price, 2003). A written parliamentary answer also revealed that 114 women gave birth in prison in 2004 (Hansard, 2005). Because of the short length of most women's sentences, many pregnant prisoners will leave prison before their baby is born. Others will choose not to apply for a place in the MBU (or be denied a place), and they will be separated from their baby after birth.

Currently, there are over 80 places for mothers and babies in prisons across the UK (A full list of establishments and numbers can be found at Appendix C). In 2001, funding was secured to extend and renovate many of the existing MBUs. However, recently, 20 places were 'mothballed' at HMP Askham Grange, leaving just ten. HMP Askham Grange is an open prison, and it was decided by HMPS that too few female prisoners are suitable for open conditions to justify Askham Grange having so many places. Provision at HMP Holloway has also been reduced, and these places redistributed between other prisons, including the two newest private prisons, HMPs Bronzefield and Peterborough.

Although quite a lot is known about the 'characteristics' of female prisoners in general, there is very little evidence on the 'characteristics' of pregnant prisoners, or prisoners in MBUs. Among the limited evidence available is a 2004 study by the University of Southampton of the mental health and treatment needs of women in MBUs. Researchers identified mental

health problems (anxiety, depression, and/or personality disorders) in around 60% of the 55 women interviewed. Many had more than one type of mental health problem. None had a severe mental illness like schizophrenia. Although none of the mothers had attempted suicide while in prison, 24% reported having attempted it in the past. Ninety-eight percent said they did not need treatment for any mental health problems. Nearly 60% of women identified by researchers as having a mental health problem had no mention of it on their inmate mental health records (Birmingham, 2004).

These results suggest that mental disorder is in general less common amongst women in MBUS than in the rest of the prison population (using the criteria for mental disorder chosen by the researchers). This may be because women with severe mental illnesses are not considered competent to care for their child, and fail the admission process for MBUs. However, the specific condition of depression was more common in MBUs than in the rest of the prison population.

There is no doubt that the health - mental and physical - of pregnant women, and that of their babies, could be compromised by imprisonment. Pregnant women are unable to choose the provider of their antenatal care, and may be unable to access the varied diet, antenatal classes, and support they could in the community. New mothers could also be disadvantaged in that they may miss out on some postnatal care, and parenting education. They may also be depressed by imprisonment, and unable to interact with their babies in a way that promotes healthy development. They will not be able to see their baby's father, their wider family, or their older children, if they have them, or at least not regularly. Finally, prison can be a stressful environment, which can have an effect on a mother's mental health.

This report will attempt to assess to what extent these factors exist in prisons in England and Wales, and what are their effects. It should be stated that this report recognises that prisoners can be an extremely difficult group to safeguard, and to deliver services to. Pregnant prisoners may well smoke throughout their pregnancy, or use drugs. They may be ambivalent about the arrival of their baby, or unconcerned about the effect prison may have on it. This can be frustrating for health professionals, as well as potentially detrimental to the outcome of a pregnancy.

The challenges practitioners and prison officers face were taken into account during consultation, and they also inform the writing of this report and its recommendations. However, it should be noted that there is plentiful research showing that pregnant women and new mothers with the most risk factors for poor outcomes benefit the most from high-quality, intensive services, and interventions (North, 2005). The majority of prisoners are undoubtedly 'high-risk', and therefore represent an excellent opportunity for policymakers and practitioners to have a real impact on their lives, and that of their children. As a 'captive audience' this is, in some ways, more achievable than with similarly vulnerable women in the community. However, the services must be truly high quality, if pregnancy and motherhood in prison are to be real opportunities to improve the health and life chances of women and children, and to prevent re-offending.

Policy & procedures

Currently, women in prison on remand, or who are serving custodial sentences, are identified as being pregnant on reception, and are referred to the visiting midwife or midwifery team which serves the prison. Antenatal care will be provided by midwives, with any other appointments (including for scans) being arranged with external providers.

In April 2000, a formal partnership was established between HMPS and the National Health Service (NHS) that required the NHS to provide prisoners with the same standard of healthcare as that provided to the rest of the population. As part of this new partnership, the NHS took over the provision of maternity services from HMPS, which had previously employed doctors, and other health professionals directly (Price, 2003).

As part of this, it was expected that midwives would implement Department of Health standards set out in 'Changing Childbirth' (1993), although this has now been superseded by the 'National Service Framework for Maternity Services' (2004). 'Changing Childbirth' emphasizes the importance of a pregnant woman being able to make an informed choice on a variety of issues; for example, the chance to choose their lead professional, and their place of birth.

Antenatal classes may be available within a prison. When a woman goes into labour, she will be escorted to hospital to give birth. Most prisoners will be attended at birth by at least two Prison Officers. The practice of shackling women during labour was overturned in 1996, although women may still be shackled in the very earliest stages of labour, as well as on antenatal visits to hospital.

Much of this information has been garnered during the consultation process. This is because there is no Prison Service Order (PSO) relating to the treatment of pregnant prisoners. There are many PSOs within HMPS, and they relate to numerous aspects of prison life, from the mundane to the unusual. They set out what Prison Officers, and other professionals, should do in certain situations, and detail ideal practice. It will be shown later in this report that the lack of a Pregnancy PSO causes many problems, both for pregnant prisoners, and those who provide their care.

There is a PSO (Prison Service Order 4801) pertaining to Mother & Baby Units, and it lays out in some detail the process of, and criteria for, gaining admission. Women who will still be in prison when their baby is born may apply for a place on an MBU, which may require a transfer to another prison. Pregnant women, or women with very young babies should be given a Mother & Baby Booklet on reception, containing an application form for a place. This application form - which must be completed with the help of a Prison Officer, should include:

- A Social Services Report, detailing any child protection issues, any existing Care Orders, and information about alternative care arrangements if the application is unsuccessful.
- A Security Report, detailing previous convictions, projected release dates, and any offences of violence.
- Medical Reports for both mother and child, including whether the mother is breastfeeding.

The application will then go to an Admission Board, comprising an Independent Chair, the relevant Prison Governor, or MBU Manager, the mother, plus a friend or personal officer if desired, and/or a Social Services representative, or Probation Officer. Many other professionals may attend if appropriate, including drugs workers, and mental heath staff.

The PSO sets out the following criteria for admission:

- It is in the best interests of the child/ children to be placed in a Mother & Baby Unit.
- The mother is able to demonstrate behaviours and attitudes which are not detrimental to the safety and well-being of other Unit residents.
- The mother has provided a urine sample which tests negative for illicit drugs.
- The mother is willing to remain illicit drug-free (this does not include prescribed Methadone or Subutex withdrawal

or maintenance programme).

- The mother is willing to sign a standard compact, which may be tailored to her identified individual needs.
- The mother's ability and eligibility to care for her child is not impaired by poor health or for legal reasons such as the child being in care or on the Child Protection Register as the result of the mother's treatment of that child, or other children being in care

If these criteria are viewed as fulfilled, a mother and baby may be granted a place on the MBU. If an application is denied, the baby will have to go to its father, another relative, or into care.

If a mother does gain a place, she may remain there with her baby until the child turns 18 months, or nine months, depending on individual prison policy. At this point, the baby must be placed in the care of a relative or Social Services, and the mother must return to the main body of the prison.

There are further guidelines for separation of a mother and baby in prison, and these are detailed in the chapter headed 'Separation'.

A factor that influences policy and procedure in prison is the degree of separation between individual prisons, and between prisons and central HMPS. Many of our interviewees commented on the fact that each prison has different ways of doing things. Obviously this is most pronounced when there is no PSO, and therefore no centrally determined policy - each establishment 'fills the gaps' differently - this will be seen in more detail later in the report.

However, this lack of consistency across the estate is visible in most areas of prison life. There is very little communication between prisons, and only limited amounts with HMPS. One example of this, from our consultation, is that the central team at the Home Office were unaware that midwives at a large women's prison collated birth weights of babies born to mothers in prison, and rates of breastfeeding on MBUs, and passed these important figures to the governor. The central MBU team are not required to maintain these figures, but it was telling that they were unaware of their existence.

Many practitioners working with both pregnant prisoners and mothers and babies commented on the frustrating lack of communication between prisons. This can mean that those with 'good news' stories, and initiatives, have no way to share them, and those trying to improve services have few resources on which to draw. This can be demoralising for staff, and also works against quality services in prisons. Initiatives at local level should be encouraged - and some will be highlighted in this report - and it is not the intention of this report to argue for decision-making powers to be removed from governors. However, in some fundamental areas, the lack of centrally determined policy compromises the care of pregnant prisoners.

Pregnancy

During our research, we found that some midwives were frustrated in their efforts to deliver an antenatal service comparable to that on offer 'outside'. It must be recognised that prisoners can be a particularly challenging group to work with, and this can compromise the quality of care they receive. However, more frequently, it was the nature of prisons, and the Prison Service, that midwives identified as causing the problems that follow.

Variation in Health Services

Frequently mentioned during our consultations with health professionals was the high level of variation in services between prisons. This prevents equal access to antenatal services amongst prisoners. Midwives comment that

individual prisons tend to run to their own rules, and that health care for pregnant women is often provided in an inconsistent and ad hoc manner. An example is that in one Category C prison, a women may have her partner attend an ultrasound appointment with her, and in another she cannot.

In HMP Holloway, pregnant inmates are able to visit a 'drop-in' clinic on one of the landings three days a week - a service which is very well-used. But this service exists only because of the initiative of the midwifery team working in that prison. In HMP Styal, it was reported in a 2004 HMIP report, prisoners have access to only one weekly clinic. Some prisons offer antenatal classes, others do not.

HMP Holloway also makes some effort to accommodate all pregnant prisoners together on one wing (although Prison Officers admit that operational constraints mean that non-pregnant prisoners are sometimes also on the wing). The great majority of pregnant prisoners do wish to be on this wing, although some do not, and their wishes are respected. However, other establishments do not accommodate pregnant prisoners together.

Accommodating pregnant prisoners together makes it easier for midwives and others to deliver services more easily, and provides the women with support during their pregnancy. Residence on this wing should not be compulsory, but it should be an option. Where possible, antenatal clinics should be delivered on this wing. Non-pregnant prisoners should be kept to a minimum on this wing, as far as operational constraints will allow.

Prisons also failed to offer women the choices stipulated in 'Changing Childbirth'. Work carried out in 2003 showed that less than 10% of prisoners were given a choice in where to give birth, and less than 40% had a choice of lead professional (Price, 2003). However, results for choice of birth partner, birth positions and pain relief were positive, if not universally so.

The lack of a PSO relating to the treatment of pregnant prisoners means there is no description of a minimum standard service they should receive. This is frustrating for both practitioners and Prison Officers. It has been commented that, within the prison system, no PSO equates to no policy, and that this is true of pregnancy in prison. Staff and practitioners are 'flying blind', and what happens in one prison may bear no resemblance to what happens in another. It is particularly disappointing that there is no Pregnancy PSO, given the complex needs that pregnant prisoners often have.

It was posited during consultation that the lack of a PSO stems from a desire to not treat pregnant prisoners differently, or give them any special privileges, and to avoid 'medicalising' pregnancy. The latter aim may be commendable, but the former must be misguided. One clear example in which pregnant prisoners differ from their non-pregnant peers, and where this should be recognised, is morning sickness. A voluntary sector worker in one prison reported that she had seen pregnant prisoners suffering from morning sickness being reprimanded for being late for education, and threatened with a loss of privileges. Doubtless, in other prisons, Prison Officers use their discretion to avoid punishing sick women. But a PSO would provide rules that would give consistency across the estate.

The creation of a Pregnancy Prison Service Order would require HMPS to consider the needs of pregnant women, and would result in a 'minimum standard' stating what prisoners should be entitled to, and laying out how health professionals and Prison Officers can facilitate this entitlement. A PSO would ideally recognise that pregnant prisoners are likely to have needs over and above those of the general population, and that, arguably, the services they receive should be more intensive, and of a higher standard than those accessible in the community. In response to concerns raised by Prison Officers during our consultation, the PSO should also include guid-

ance on how to safely restrain an agitated or aggressive pregnant woman.

Funding

Since 2000, funding for prison healthcare has been the responsibility of the Department of Health, and has been apportioned amongst relevant Primary Care Trusts (PCTs). This is appropriate for funding the majority of prisoners' health needs. However, Acute Trusts manage most prison antenatal services, and they receive none of the money allocated for prisoner's healthcare. This means that maternity care for a group of women with diverse and complex needs comes from budgets not calculated with them in mind. This again seems to indicate that antenatal services are not seen as prison 'business' but dealing with pregnancy is an inevitable result of imprisoning women.

Direct funding for prisoner antenatal services would allow improvements to be made, and different prisons and midwifery teams would make different improvements. Some midwives we consulted mentioned poor facilities as a barrier to good services. The lack of an available telephone made it impossible for midwives to schedule external appointments for their patients during consultations. Consulting rooms were sometimes dirty and inadequately furnished. This is obviously not 'equal' to conditions outside of prisons. In other prisons, more money could be used to offer more antenatal visits and classes. It could also be used to extend the amount of time a midwife can spend with a woman during a visit, helping her to prepare for labour and parenting - or separation.

It is mooted that this inequality in funding is due to the gender bias within HMPS (Price, 2003). Prisons are overwhelmingly filled by men. Male prisoners are, of course, a disadvantaged group, but they have advantages over female prisoners in that the system in which they exist was designed for them. The needs of female prisoners are overlooked in this male-dominated world - the fact that pregnant prisoners receive no share in the money allocated for prisoner healthcare is perhaps the clearest demonstration of this.

The funding situation is different in private prisons, which are run by private sector companies (the two private prisons which house women - HMPs Peterborough and Bronzefield, are both managed by UKDS). These establishments do not have a contract with the NHS, which would specify delivery of healthcare of an equal standard to that in the community. However, secondary services (including the provision of antenatal care) are provided and funded by Acute Trusts.

Health professionals working in private prisons comment that they do not feel they are providing the same level of services they provide to the community. In addition, they do not feel that they are providing as good a service as that provided by their colleagues in state-run prisons. For example, they are able to offer very few antenatal services in the prison, and must arrange for nearly all care to be delivered at external appointments. However, a lack of escorts necessary to take women to these appointments means that quite routine care is often missed. To make 'best' use of the limited escorts, midwifery staff must prioritise certain cases, which requires difficult decisions, and certainly does not bring about equal access to services for prisoners. A PSO should prohibit medical staff being placed in such a situation by prioritising escorts for antenatal appointments.

Additional funding must be found if HMPS are to meet their commitment of guaranteeing services equal to those found within the community. Managers within HMPS and the NHS must reach agreements that recognise the complexities of providing antenatal care to prisoners, and that provide funding sufficient to meet these needs, and bring about quality services in all prisons.

Staff Shortages

During our research, the factors which most seriously compromised the standard of antenatal care were all related to the nature of the prison service itself. Although these factors might have been mitigated by additional funding, or a systematic approach to maternity care in prison, they do not arise from the quality of care provided, but from issues separate from, but intrinsic to, this care.

One of the most frequently mentioned problems is an ongoing lack of Prison Officer escorts to accompany prisoners to ultrasound scans, and other external appointments, due to staff shortages within HMPS. These appointments often have to be cancelled as a result, and rescheduled, which can take some time. This is not only stressful for the woman involved; it can also jeopardise her ability to make decisions about the future of her pregnancy. The upper limit for terminations is 24 weeks. If fetal testing at 21 weeks is cancelled, it may well take three weeks to reschedule the appointment. By this time, they may not be able to terminate the pregnancy if a scan reveals a serious condition.

A Pregnancy PSO must set out what situations are unacceptable and should be avoided as far as possible - one example is the cancellation of ultrasound scans due to a lack of escorts, whether in state or private prisons.

Security concerns can also mean that midwives are unable to tell patients when an external appointment has been booked. This can obviously lead to great worry for a pregnant woman, as well as meaning she may not be prepared for an appointment. Many midwives comment that they find it very difficult to deliver effective services in an environment where security and safety are so strictly controlled. This is, of course, the nature of prison, but it seems that, in some instances, prison staff are needlessly obstructive. The 2004 HMIP report on HMP Styal commented that officers frequently did not tell pregnant women when and where they could access the weekly antenatal clinic - leaving the midwives to attempt to locate the women throughout the prison. A Pregnancy PSO should detail several ways in which pregnant prisoners can be made aware of the time and location of clinics.

Movement of Prisoners

It is very common for prisoners - pregnant or not - to be released, or relocated to another prison, at very short notice. And a woman appealing, or on remand, may go to court and be released, or imprisoned elsewhere, without first returning to her original prison (see box).

Both these situations can obviously cause problems with her antenatal care. Midwives are not promptly or routinely informed of which prison a patient may have been moved to. They have no duty to inform the midwives at the new prison of any relevant patient history, but if they choose to try, the burden is entirely on them to make contact. This can be time-consuming as there are no networks in place to help health professionals contact colleagues at other establishments. All pregnant women are given hand held medical notes that they should carry with them when they relocate, or go to court, so they can hand them onto their next midwife. However, it is inevitable that this system fails at times, and many midwives would prefer to alert colleagues in other prisons to a patient's details, and any possible concerns.

It is even more complicated when a woman is released from prison. Currently, a prisoner serving a sentence of less than 12 months (70% of female prisoners) is not required to give a residential address to HMPS or to the Probation Service. Therefore, it is virtually impossible for a midwife to trace the women's new location (which may be hundreds of miles from where the midwife works), or to alert local health services. This is very frustrating for the health professionals involved. More important-

ly, it jeopardises the women's pregnancy health - if she does not have her hand-held notes, she may neglect to tell her new care provider important details about her medical history. In a worst-case scenario, she will not make contact with local health services at all, until she goes into labour.

Better communication between prisons, the Probation Service, and the courts, is essential. Hand held notes are not sufficient to ensure that antenatal care is not disrupted when pregnant women are released, or moved between prisons, at short notice. Improved networking and communication between prison midwifery teams is necessary to ensure future care providers are aware of a woman's circumstances. This must be enabled, and facilitated by, HMPS. Where possible, Probation Services can work with midwifery teams to alert a released prisoner's local health services.

A 16 year old girl was pregnant for the duration of her six month sentence for being a passenger in a stolen car - a sentence against which she was appealing. She was in her 'local' women's prison, around 80 miles from her home town. She discovered she was around six weeks pregnant when tested on her reception into prison.

When she informed her boyfriend, he was very concerned, as he had a family history of Huntington's Chorea - an incurable genetic condition, which typically develops in middle age, and affects the brain, with a gradual loss of movement, memory and mental ability. The boyfriend knew that genetic screening would reveal whether the baby was a carrier, but he also knew that if it was, it would mean he too was a carrier. This was something he had previously made a decision not to find out.

This was obviously a difficult situation for the girl. The midwifery staff offered to make a specialist appointment for her to discuss genetic screening in more depth, but she did not wish to proceed without her partner's support. This was complicated by her inability to have a face to face discussion with him, since he was not in a position to afford the travel expenses to visit her.

The midwifery priority was to arrange an ultrasound scan to date the pregnancy because any decisions related to the next steps in her care would depend on the gestation of the fetus. Scan appointments were frequently missed by women in prison because of the lack of officers to escort them to appointments - this concerned the midwives and they stressed to the staff how important it was that she attend.

When the woman missed her appointment the midwife assumed that staff shortages at the prison had meant she was unable to attend. However, this proved not to be the case - the woman had attended court some days earlier regarding her appeal and had not returned to the prison. No one within the prison seemed to know where she had gone so no follow up care was available to her.

It later transpired that her appeal had been successful and she was released directly from court. Through informal professional networks the midwives later discovered that she did not receive any specialist counselling to help her decision-making and continued with the pregnancy, without genetic testing.

Delays in Decision-Making

HMPS is a large, bureaucratic organisation, and it is frequently slow moving in its decision-making. For pregnant women this can be a problem, as pregnancy is a finite condition, and, as we have seen with the 24-week abortion limit, it has time-sensitive milestones within it. Some of the experiences we heard about that related to HMPS's slowness in making decisions did not impact the quality of maternity care. The majority were decisions taken by a prison about a mother and baby's future. However, the fact that they caused a great deal of stress and worry during pregnancy explains their inclusion in this section.

A fairly common example of such a problem is of MBU Admissions Boards delaying a final decision. In one case, this resulted in a prisoner giving birth before a decision had been made. Her baby was placed in foster care for two weeks, before they were reunited in an MBU. This was most definitely not in the best interests of either mother or baby. To separate a newborn from its mother, if the mother is not a danger to the baby, is cruel, and can interfere with the vital bonding process. It can also have a profound and negative effect on a mother's mental health.

In another instance, a baby was to be placed in foster care for ten days between its birth and its mother's release date. Upon this date she was to be reunited with her mother. In this case, medical complications ensured that she could not leave hospital until after her release date, and as a result she did not have to be separated from her baby. Both these situations show a fundamental lack of understanding on the part of HMPS of the realities of pregnancy, birth, and motherhood, as well as an attitude lacking in compassion towards prisoners and their babies.

It is essential that Admissions Boards operate quickly to avoid unnecessary separations of a mother and baby after birth, and to facilitate women accepted onto the MBU being able to take up residence in the unit while they are still pregnant.

Nutrition & Comfort

Practitioners reported difficulties in addressing issues of prisoner comfort and nutrition. For example, the fresh fruit that pregnant prisoners receive is reported to be of poor quality, such that the midwives themselves said they would not eat it. A voluntary sector worker in one prison commented that she had not seen pregnant women offered any fruit other than apples or oranges. Pregnant prisoners should also be entitled to a pint of milk a day but in one large prison, shortages resulted in six pints being shared between 15 pregnant women. Midwives commented that other nutritional advice - such as that pregnant women in the community receive - is pointless, as prisoners cannot control what is provided to eat.

Missed meals were also a reported problem. If a woman is nauseous she will miss meals - unsurprisingly, pregnant women suffering morning sickness can miss many meals. There are no opportunities for second servings in prison. Some prison officers make bowls of cereal and milk available at their discretion, but there is never any extra fresh food. It is also not uncommon for prisoners to eat their evening meal at 4.30 pm, which is followed by 'lockdown', after which there is no more food until breakfast. This is a long time for a pregnant woman to go between meals.

One midwife reported asking for extra pillows so that a pregnant prisoner with swollen ankles could sleep with her legs raised. This request was turned down, with no explanation of what operational or security problems the extra pillows would pose. Bathing and showering was also mentioned as a problem. This is normally done during 'Association' time - however, due to staff shortages, this can be cancelled at no notice, sometimes for several days. This means that a pregnant woman may

have to go some time without washing, even if she is due for a physical examination. This is confirmed by an HMIP report on HMP Holloway in 2002. It was suggested by one interviewee that pregnant prisoners should be allowed, during lockdown, to shower one at a time, accompanied by a Prison Officer.

Terminations

Throughout consultation, it was very difficult to determine how easy it was for a pregnant prisoner to secure a termination, or whether there was anyone she could talk to in reaching a decision about this. HMPS officials had very little information on the subject, and midwives also had little knowledge about it, as they may never see a woman who has decided to terminate. A midwife in one prison commented that the possibility of termination is always raised by the mother, not by the staff, while an officer in another said that it was not 'entirely' left to the mother to bring up.

It is, of course, right that no women should be pressured into having a termination; however, it is equally important that her legal right to do so is not affected by being in prison. We heard of one woman who discovered she was pregnant while in prison, and wanted to have a termination. She was given no advise or support, and indeed was told not to by other prisoners, and prison officers. She was also scared off by 'horror stories' about terminations, and no correct information was given. Her only source of support was a voluntary sector worker, who put her in touch with a Marie Stopes clinic.

Pregnant women should be offered counselling - whether by a health professional, or support worker, on their options. Termination should be one of these, as it is for any woman seeking advice about pregnancy. HMPS should work with PCTs and voluntary sector agencies to ensure that pregnant prisoners have access to advice, and easy access to terminations if they decide they want one. A Pregnancy PSO should lay out ways in which this may be best facilitated. Bearing in mind the example above, it is important that Prison Officers are involved in this process as little as possible. They are not appropriate people to advice on such situations, and may bring undue pressure to bear on prisoners.

Data Collection & Monitoring

HMPS maintains very few statistics on pregnancy or birth outcomes. As previously mentioned, there are no publicly available figures on the number of pregnant women in prison each year, or of the numbers who give birth at some time during their sentences. This in itself is problematic because it makes it hard to plan services, or to assess whether services and funding are adequate.

There are other figures, which HMPS do not keep, which make it hard to assess the quality of these services, and the effect of prison on pregnancy and birth. The most important are records of the birth weights of babies born to women serving prison sentences. The weight at which a baby is born is a rough measure of whether or not a pregnancy was healthy. It is also an indicator of some future health and development outcomes for a baby. Low birth weight babies are more likely to die before their first birthday, and are also more likely to develop diabetes, heart disease, and other illnesses later in life (North, 2005). Birth weight is chiefly determined by a woman's pre-pregnancy health, her diet during pregnancy, and whether or not she smokes.

HMPS does not maintain records of miscarriage, birth complications, or stillbirth either (or on the incidence on childhood illnesses and accidents on MBUs). All of these things can be in part caused by poor pregnancy health or by inadequate antenatal care (although they can also be unrelated to these factors). It would also be desirable for HMPS to maintain figures on terminations administered to pregnant pris-

oners to observe any variations in percentages from the rest of the population.

It has been suggested that HMPS are unlikely ever to collect figures on these outcomes voluntarily, but without such measures, we cannot know the effects of prison on pregnancy, nor the quality of services on offer. Birth weights for 'prison babies', as well as the other indicators mentioned above, would give policymakers and practitioners some idea of whether women in prison have more or less healthy pregnancies than women from similar social backgrounds outside of prison. A Pregnancy PSO should mandate their collection, and publication, as well as regular analysis.

HOLLOWAY GOOD PRACTICE

In 1998, a team of midwives from the Whittington NHS Trust took over maternity care in HMP Holloway, which has one of the most 'troubled' prison populations In the UK. Forty-one percent of inmates are current drug users, with heroin and crack cocaine the most frequently used. Thirty-four percent have a history of psychiatric problems, and 15% are foreign nationals - who can often speak little English, and are without friends or family in the UK.

The midwives working in Holloway have, over the past seven years, effected many changes to improve the quality of care and support they are able to offer pregnant women. Three days a week, midwives hold 'drop-in' clinics on one of the prison landings. One is always held on a Saturday to ensure women do not need to miss education or work to attend. Pregnant women are - as much as possible - accommodated on one wing, which makes it far easier for midwives to ensure they are delivering care to all who need it.

A pager system is operated which allows prison doctors, nurses, and officers to contact midwives directly, and immediately if there are any problems or concerns about a pregnant woman. Midwives them with questions and worries without having to go through a Prison Officer. This is particularly important during 'lockdown' hours - when a prisoner is not allowed out of their cell. The mobile phone can be passed through the hatch in the door. Every six weeks, a consultant obstetrician holds a clinic, within the prison, which removes the need to find escorts.

The midwives coordinate monthly breastfeeding workshops, and liase with external agencies such as Birth Companions, and the National Childbirth Trust, to ensure that pregnant prisoners get extra support in preparing for birth and parenthood. They also offer an improved level of postnatal care of up to 28 days, followed by a handover to Health Visitors.

The team have also put in place better communications systems with other agencies, and improved strategic planning within the prison. They have access to all prisoner lab results, and are informed of all appointments made for prisoners, including those made by drugs workers, mental health staff, social services and health visitors.

Four times a year, a multi-disciplinary team meets to discuss successes, failures, and initiatives in antenatal care. This allows the team - including health professionals, prison management, detox and mental health workers, and social services representatives - to plan for foreseeable problems, as well as debate ways forward. Monthly meetings with prison officers facilitate open communication over specific issues, and have helped to resolve conflicts of interest over the years.

A notable success of the Holloway midwifery team has been the Breastfeeding Initiative, for which the midwives sought, and secured, funding in 2001 and 2004. This funding was used to guarantee all pregnant women and new mothers in prison access to information about breastfeeding, and support for those who wished to initiate and maintain breastfeeding. This was done through the purchase of teaching aids and breast pumps, the training of prison staff in breastfeeding management techniques, the introduction of dietary and nutrition services, and the funding of additional midwifery hours. This resulted in an increase in rates of exclusive breastfeeding from 28% in 1998-99 to 61% in 2003-04. This is a higher rate than the national average, and is extremely impressive.

This midwives stress that their jobs are often difficult - prison is a stressful environment in which to work, and the women there are often challenging. They experience the problems mentioned elsewhere in this report, relating to prison bureaucracy, funding, and a lack of prison policy on pregnancy. However, they have worked within and around the system to provide a high standard of care that could serve as a blueprint for prison antenatal care across the UK.

Mother & baby units

Facilities

Her Majesty's Inspectorate of Prisons (HMIP) reports give insight into conditions within MBUs. However, due to the large number of prisons in the UK, reports can be up to three years out of date. It should not be assumed that things have not improved since the most recent report.

Available reports are, in general, positive about MBUs, and comment on improvements in the last few years, particularly in terms of the quality of childcare, and staff attitudes. However, there are several references to inadequate physical facilities. A report on HMP New Hall from 2004 remarks that furniture in the MBU lounge was 'not appropriate' for pregnant women or nursing mothers (HMIP, 2004). The unit's grounds had not been developed to allow mothers to take their babies outside.

An HMP Styal report, from the same year, noted a lack of 'information posters' for mothers around the unit, and a lack of toys and learning materials in the communal areas. This area was also 'dilapidated', with 'unhygienic, unsuitable furniture'. The kitchens were in need of 'significant modernisation' (HMIP, 2004). Indeed, almost of all the facilities at HMP Styal were criticised for similar reasons - beds and baths were broken, unsafe, and dirty. It was also noted that there was no Senior Officer responsible for the management of the MBU, and that this duty was being carried out by the overworked residential Senior Officer. At the time of the inspection, the governor had not visited the unit in over a week, and a request for refurbishment funding has been turned down.

Staff Training

One of the 1999 recommendations accepted by HMPS was that all Prison Officers working in MBUs should have requested this role, rather than be assigned to it. Our consultation with Prison Officers has shown this to be the case, although it may not be so universally - HMPS admit that staff 'rotation' is policy, and understaffing may also require some forced deployment. It is very important that this is rarely necessary. Prison Officers do not join HMPS to work with mothers and babies. Therefore it is crucial for the welfare of both staff and

inmates that officers working in MBUs do so by choice.

When a Prison Officer requests a transfer to an MBU, she receives training to prepare her for the new environment, and responsibilities. However, this training is arguably inadequate preparation, consisting as it does of three days addressing mainly the details of the MBU PSO, and infant safety and resuscitation. It has been suggested, during consultation, that Prison Officers working on MBUs should receive more diverse training.

Some campaigners argue for training to include guidance on facilitating mother-child interaction and bonding. Such training might include an understanding of the importance of healthy interaction in promoting cognitive and emotional development, and other basic elements of 'attachment theory'. However, practitioners point out that this could lead to a confusion of roles for Prison Officers, and a prescriptive approach to parenting in prison i.e. Prison Officers attempting to impose a 'right way' of interacting upon mothers and babies, that might not respect cultural differences. HMPS have a commitment to ensuring mothers have total responsibility for their babies, and it is vital than any changes to training do not endanger this. Although there is support for training on 'healthy parenting', there is no clear understanding of what this training would include, and such a change should be approached with caution.

The question of whether training on breastfeeding should be included is also problematic. As with training on 'parenting', concerns were voiced during consultation that facilitating breastfeeding could overstep the bounds of a prison officer's role, and be unwelcome to both mothers and officers. Although staff in MBUs often develop closer, warmer, relationships with inmates than they might do in the rest of a prison, they are still authority figures who must maintain discipline and security on the unit, Such a person may not be the ideal figure to deliver breastfeeding support.

Nevertheless, there will be times on an MBU when there are no more appropriate figures to help a mother who is struggling to breastfeed, particularly at night. It seems likely, that, on these occasions, prison officers assist mothers anyway, at their discretion. HMPS should consider whether this is a desirable situation. If so, then they should consider whether training should be updated to include breastfeeding support - the right process for this is during a Review of provision for mothers and babies.

A final point on training is that, as it stands, it does not seem adequate for staff working with a group of prisoners disproportionately vulnerable to depression. Training on the symptoms of, and treatment for, Post-Natal Depression (PND) must be strengthened. Although the training syllabus includes 'the identification of PND', the Prison Officers we consulted with did not feel that they knew much about the condition, or could identify it in a prisoner. It was felt by the officers that this lack of knowledge had led to unsympathetic treatment of depressed mothers in the past.

In general, HMIP reports are complimentary about Prison Officers working in MBUs, although there are exceptions. However, there are question marks over the performance of Prison Officers in private prison MBUs. Very little is known about this area as neither HMP Bronzefield nor HMP Peterborough has yet received a full inspection from HMIP. But previous publications have raised concerns about the private workforce. An HMIP report in 2003 commented on 'a worrying lack of experience and confidence amongst a young, locally recruited staff, few of whom had any previous prison experience, and who were operating with low staffing levels and high staff turnover.' (Prison Reform Trust, 2005)

The average basic wage for a prison officer in a private prison is nearly a third less than the average wage of their state-employed counterpart. They work longer hours, and receive fewer days' annual leave. Turnover amongst

the staff in private prisons runs at 25%, compared to 2.5% in the state sector.

Babies in prison are a vulnerable group, as are their mothers, who deserve a high standard of care from sensitive, experienced, well-trained Prison Officers. Continuity of care is also important for a stable, secure, and well-run unit. It will be essential that eventual HMIP reports on Peterborough and Bronzefield give good attention to the attitudes, performance, and turnover of staff in the MBUs.

Parenting Education & Support

Most prisoners have access to educational courses and training - the range of options is quite diverse. 'Parentcraft' is one of the optional units of the Social & Life Skills programme which forms part of the 'core curriculum' for prisons.

However, only 62% of prisons delivered parenting courses last year. There is no further information recording what percentage of women's prisons delivered such courses. During consultation, we did not find evidence of parenting education or preparation being specifically offered to pregnant prisoners or mothers in MBUs. The provision of such education was not routine, and was often neglected in favour of basic skills education. Some voluntary sector campaigners commented that what was on offer was 'unimaginative', and that best practice on parenting education was not shared between prisons.

This is a missed opportunity. Many prisoners are parents and would benefit from support in this area of their lives. Pregnant women and new mothers are particularly likely to gain, and may be more receptive at this point in their lives. Parenting education should be creative, and interactive, allowing prisoners to reflect on how they were parented, and the kind of parents they want to be. One such course has been running at HMP Holloway since March 2004 (and has recently begun at HMP Bronzefield), thanks to the joint working of the Anna Freud Centre and the New Bridge Foundation.

'New Beginnings' is based on attachment theory, and psychoanalytic research and clinical findings, and is the first psychologically-based course to be offered to mothers and babies in prison. It aims to foster a strong and loving bond between mother and baby, and to increase a mother's knowledge of infant development, her capacity to understand her baby's needs, and her confidence in her ability to parent her baby. The course is structured so as to promote attachment and interaction, even in the face of possible separation.

The course comprises eight sessions, delivered over a month. Mothers are invited to analyse their feelings about certain situations, and what they think their baby's feelings might be. They are also encouraged to talk about their own childhood, and to learn about their baby's developmental milestones. Facilitators all have a 'psychological' professional background, but the most important requirements are a non-judgmental, empathetic personality.

Evaluation of the course has shown that in 75% of cases, there is an increase in positive mother-baby interaction, and increased attempts on the mother's part to initiate interaction. Significant numbers of mothers show an increased capacity to attribute thoughts and emotions to their children, and understand how their own feeling may affect the baby. These are extremely positive results - all point to a stronger mother-baby bond, and more sensitive and competent care.

One mother was asked, during her pre-course interview, whether she felt guilty as a mother. She responded that she had nothing to feel guilty for. Following the course, she spoke honestly about her feeling of guilt for being in prison, and having her daughter with her. She maintained she would not return to prison, because of the effect it would have on her daughter. Another mother was unable to see how her emotions might affect her baby, prior

to taking 'New Beginnings'. Afterwards, she spoke about his independent emotions, and how some of her feelings had visibly affected him. A mother who had another three children outside prison said she had learned how to look at how her adult relationships affect her relationship with her children.

Women in prison tend to be from socially and economically deprived backgrounds. They are more likely to have been abused, and to misuse drugs. In short, they have many risk factors for poor parenting. Ironically, prison can give them an opportunity to overcome these risk factors away from the stresses of 'outside' life, and give their babies an opportunity to develop ahead of their peers outside prison. However, for this to happen, women in MBUs need quality support and education - 'New Beginnings' is an excellent example of a course that combines the two, and makes a substantive difference to the quality of parenting. However, it is a voluntary sector initiative, and not an assured part of prisoner education, meaning that its future is not guaranteed. Although HMPS can recommend that individual prisons offer certain courses, the creators of 'New Beginnings' consider it very unlikely that they will get long-term funding to deliver the course.

There are no other examples of similar courses in UK prisons. A mother's state of mind is arguably the most important factor in her baby's development, and 'New Beginnings' speaks directly to this. HMPS are missing an opportunity that would be seized upon by community practitioners working with a similar population - to provide vulnerable mothers with intensive help in a controlled environment, and facilitate a mother-baby bond that will improve a mother's mental health, and promote good development for the baby.

All MBUs should aim towards soon providing a course that helps mothers bond and interact with, and care for, their babies. Like 'New Beginnings' the course should be accredited so that it can be counted as part of a prisoner's education. Such courses should be in accordance with research and clinical findings, and should be provided, at least in part, by mental health professionals.

Separation

According to HMPS, it is policy to facilitate a mother leaving prison with her child, if at all possible, thereby avoiding any separation. For example, a woman serving a four year sentence who enters prison with her baby can probably expect to be paroled when her baby is 18 months old, if she meets the conditions for parole. However, under existing policies, some mothers do have to be separated from their babies while in prison. PSO 4801 sets out the separation policy for pregnant prisoners who will not be entering an MBU, mothers who are required to leave an MBU for a breach of rules, and mothers whose babies have reached the upper age limit, and must leave prison without them.

For a minority of pregnant prisoners, Social Services will have determined that it is in the baby's best interests to be separated from its mother at birth (in extreme cases, it may be considered unsafe to tell the mother this before the birth). In other cases, the mother may have been refused an MBU place, or decided not to apply. She may nominate a friend or relative to care for her baby, but Social Services have a responsibility to assess the suitability of the carer. In some cases, a baby may have to be placed in foster care if there is no suitable alternative.

For mothers who are admitted to an MBU - even those serving short sentences - a 'separation plan' must be drawn up. A mother must nominate two people to care for her child in the event of separation. Both must be assessed and approved by Social Services, who are the default nominee in the absence of a suitable carer.

When a mother is in danger of exclusion from an MBU, a Separation Board is convened. Reasons for exclusion include use of illicit drugs on the MBU, bullying towards others mothers and/or children, and aggressive behaviour. The Separation Board must consider the likely effects of separation on both mother and child, the good of the MBU as a whole, and the possibility of a move to another MBU as opposed to exclusion. A mother has the right to be present at the Board, and respond to any allegations made against her. However, once a final decision to separate has been made, the PSO stipulates that the separation should take place without delay.

It also sets out various ways that separation may be facilitated. These include extended visits to the MBU by the new carer before the final separation, as well as day visits (where possible) out to see the baby afterwards. With children who have not been separated from their mothers on grounds of child protection, the prison should facilitate contact between mother and baby. All recently separated mothers should be offered counselling.

In a best-case scenario, every mother would be fully involved, and happy with, the decisions made about her baby's future. However, our consultation has shown that this is not always the case. Often pregnant women and mothers are imprisoned many miles from their hometowns. But it is the Social Services from this area that will be involved in decisions about a baby's care, and the baby will probably go to live in that area. This can make it very difficult, logistically, for a mother to be fully involved in the process. As one practitioner commented, a mother's needs and opinions, as well as her right to be consulted, 'go by the wayside'.

One report told the story of a mother who had been refused a place in the MBU, and whose baby had been taken into foster care. Just a week after the birth of her baby, this mother did not know where he was (Birth Companions, 2005). Another example of inadequate communication is that of a woman with a three year old who was taken into care (and subsequently adopted) because of her mother's crack addiction and mental health problem. While in prison, the mother has come off crack and she now does not understand why she cannot see her son. Social Services have not explained the situation to her in a way she can understand, and neither has anyone connected to HMPS.

There are also reports in the literature of inadequate checks being carried out by Social Services, and of carers being nominated without the mother's full consent. A 2003 report recounted the story of a young mother encouraged, despite her reservations, to send her baby to her own mother, who was a heroin addict. The report concluded that 'large numbers of children [of imprisoned mothers] are in ad hoc, informal care arrangements...seldom checked by any statutory authority.' (Katz, 2003).

An example of this uncovered during consultation is that of three month old twins, who went to live with their paternal grandmother when their mother was imprisoned. The mother has not been able to contact her partner or his mother since she went to prison, and is worried the babies have been taken to Jamaica without her consent. She does not know how to get in touch with Social Services, and they have not contacted her about her children's care. Another case concerns a woman who gave birth in prison and handed out the baby to her mother to care for until her release. However, the grandmother was served with an eviction order, and the mother is very worried that she and her daughter will be homeless, which could lead to her daughter being taken into care.

There is little redress for mothers who want to challenge Social Services' decisions, as well as little support and advice. A prisoner whose five week old baby was in interim care wanted to fight this decision. However, being in prison, she had not been informed of the court date

details, and was worried she would not get the chance to go to court. She had no way of getting in touch with her social worker.

There is also some evidence that Social Services may be too quick to assume a mother, or her family, is unfit. In one such case, a pregnant woman was refused an MBU place due to traces of cannabis in her system, and having been in a fight. As a result of this, Child Protection workers were present in the delivery suite in the hospital, and threatened the mother with arrest if she tried to leave with the baby. She was also pressured to meet the baby's proposed foster parents one day after giving birth. The prisoner was adamant that she did not want her baby to be fostered, and after several meetings and home checks, Social Services agreed that the baby could live with its grandmother.

Even if a mother is satisfied with the childcare arrangements put in place outside prison, separation is still a stressful, and difficult process, for both a mother, and those who work with her. Consultation revealed the quality of care received by a post-partum mother separated from her baby varied between prisons, and depended upon the midwives responsible. Postnatal care can be difficult to deliver in these scenarios - prisoners are often not motivated to see a midwife or health visitor when they do not have a baby to look after. They are then not only missing out on healthcare, but also on the opportunity to talk about the separation with someone not connected to the prison. However, if a mother is unhappy about the separation she may feel anger and resentment towards the midwife who may have been a confidante during pregnancy, but who may also have been involved with the separation. Midwives describe this conflict - and the hurt it causes many mothers - as one of the hardest parts of their jobs.

Mothers leaving MBUs after their baby has left prison can also experience difficulties. They are not only losing their baby, they also have to leave the MBU, where they may have been for over 18 months (if they entered the unit during pregnancy). MBUs are very different from other parts of a prison, particularly a closed prison. Bedroom doors are rarely, if ever, locked; there are comfortable communal kitchen and living areas; and the nurseries attached are usually bright and cheerful places. They are also generally supportive places, where mothers may be together for a long time, and know the staff well, on a more personal level than other prisoners. To go back to a regular 'wing' will mean losing this structure, and support, and returning to what may be a far tougher environment.

Separating a baby from its mother when the mother is not a danger to the child, or a disruptive presence in the unit, raises the question of why the upper limit for a child in prison is set at 9 months (in five prisons), or 18 months (in two). The PSO seems to admit that there are not very clear reasons for this - noting that babies can develop normally in prison up to about nine months, but also that after two months, the bond between a mother and child is so strong that separation will always cause some distress to both parties. It also notes that, in the majority of cases, and for a variety of reasons, a child is best off with its mother, and that they will both benefit from the time spent together.

A court of appeal noted, in 2001, that the upper age limits imposed by prisons were not absolute, and could be challenged, although this has happened very rarely since (The Guardian, 2004). However, it is an acknowledgement that the upper age limits are not based on specific research, and are, to a large extent, randomly chosen. It should be noted that in the Netherlands, babies are allowed to stay in prison until they are four, in Switzerland, Portugal, and Denmark, they may still until they are three (Vis, 2000).

During consultation, one senior prison officer working in an open prison remarked that her establishment would be suitable for babies up to three years old, and the upper age limit

should be increased. This would mean the great majority of new mothers would not have to be separated from their babies. She feels strongly that babies are better able to handle a change in carer, if necessary, at three than at 18 months. She also questioned the wisdom of taking babies from, in general, deprived backgrounds, out of quality childcare.

Leaving prison

Resettlement into the community can be a difficult and risky time for any prisoner. Home Office figures show that 38% of female prisoners expect to be homeless on release. Sixty-six percent say that they were drug dependent, or drinking excessively, prior to imprisonment (Home Office, 2003). Many women have nowhere to go on release but back to partners who are very likely to have involved them in crime in the first place. It is difficult to overstate how vulnerable many women are when they leave prison - to homelessness, poverty, unemployment, drug misuse, and abuse.

Women released from prison with babies face all these problems too, as well as some specific to their situation. In one prison visited, one inmate resident in the MBU and coming up to release, told us that she was not looking forward to it. This was not only because she feared she would not be able to complete the education she had begun in prison, but also because she would not be able to find, or afford, childcare of the quality available in prison. Prison Officers comment that these fears are common amongst mothers. Some will have never been 'on the outside' with a baby before, and are justifiably worried about how they will cope.

Furthermore, there is real vagueness about who is responsible for resettlement of prisoners and their babies. The National Probation Service (NPS) is involved, but many women fall through the cracks in this system, particularly those who are deemed not to be at a high risk of re-offending. In addition, women who are released from remand, and women serving sentences of less than 12 months, currently do not have Probation Officers [2]. As with pregnant prisoners who leave prison before giving birth, they are not obliged to leave any contact details with health practitioners or nursery nurses who could alert colleagues on the outside, nor is there any system for practitioners to do this.

Many women, therefore, leave prison wholly unsupported, and with no knowledge of how to access health and other services, including childcare, parenting support, or employment and housing advice. One woman we heard of through consultation was due, on release, to be reunited with her baby, who had been living with its grandmother. However, she was extremely worried about this, as she and the baby had nowhere to live. She had contacted her local authority's Homeless Persons Unit to alert them to her situation, but they had told her they could not help until she was actually released. Mother & Baby hostels she contacted told her that she could only approach them through the Homeless Person's Unit.

One prison in the UK aims to put MBU prisoners in touch with their local Sure Start or Children's Centre before they leave prison. In most cases, a mother is able to make a day trip to the centre. This is a really useful initiative. It shows mothers not only where services can be accessed, and what's on offer, it also gives them a degree of familiarity with local services that she is unlikely to have had otherwise, which may give her the courage to make the initial contact on the outside. However, the prison that arranges these visits boasts a Family Centre managed by a Sure Start secondee - it is doubtful whether prisons without such strong links would know how to go about facilitating such a programme.

Continuity of support is crucial for women leaving prison, particularly those leaving to be

[2] 'Custody Plus', a new sentence for those serving under 12 months in custody, will soon change this situation. However women freed after custody on remand will still be unmonitored.

reunited with a small baby, or leaving from an MBU. Ex-prisoners with a low risk of re-offending are, for obvious reasons, not a priority for the National Probation Service, and, often, there are no other agencies available to provide this support outside of the voluntary sector. But women need a lot of support to go from an institutional environment like prison to a world where they must support their babies and themselves, and deal with a host of pressures and risks, from finding a job, childcare, and health services, to drug use, homelessness, and re-offending.

In the light of these needs, resettlement plans should be strengthened. These must take account of the prisoner's status, and responsibilities, as a mother. They should address central questions such as where a mother will live, how she will support herself and her child, and how she will access health services. They should also include consideration of how she might complete education begun in prison, how she might access, and afford, childcare, and how to obtain social support that could be key to ensuring she does not re-offend. Where possible, day-release visits to a Sure Start, or Children's Centre should be facilitated.

More responsibility must be taken by the National Offender Management Service (the new amalgamation of HMPS and NPS) for what happens to mothers outside of prison. Planning for this next stage, and anticipating potential problems, while they are still serving their sentence, will encourage rehabilitation, decrease the likelihood of re-offending, and increase the chances of positive outcomes for mother and baby on the outside.

ASKHAM GRANGE - GOOD PRACTICE IN ACTION

HNP Askham Grange is the only open prison in the UK to house a MBU. The standard of accommodation within the MBU is high with good facilities, attractive communal areas, lots of pleasant outside space, and a supportive atmosphere. But where Askham Grange excels is in its provision of childcare, early education, and services designed to support the mothers in the unit as they care for their children.

In 2004, Leeds City Council Early Years Services - a 'Beacon Service' for Early Years - entered into a contract with Askham Grange to set up and deliver quality childcare and other services. The manager of Askham Grange's Child and Family Centre is a Sure Start secondee, and a specialist practitioner on under threes, who has worked in Sure Starts and Children's Centres.

Askham Grange is determined to work within the DfES framework, 'Every Child Matters'. In practical terms this means ensuring that Sure Start-quality services are available within the prison, but that this does not take away responsibility for the children from the mothers - indeed mothers must be enabled to become 'First Educators'. They should become familiar with the language and concepts of 'Every Child Matters', so that they may be empowered to seek quality services when they leave prison.

Askham Grange has worked to help mothers fully engage with their babies. When mothers return to the MBU after a day of education or work, they are required to spend time playing with their babies in the nursery. It was previously found that, without this requirement, mothers watched TV in their rooms, leaving no opportunity for 'quality time' with their babies. The new rule changes this, and gives mothers ample time to watch nursery staff modelling interaction that promotes healthy development.

The childcare offered at Askham Grange is exemplary - their first OFSTED report

returned a verdict of 'excellent'. Its reputation is such that the nursery is attended not only by children resident in the prison, but also by fee-paying under-threes from the village of Askham Richard. Children are taken swimming, and to a playgroup outside the prison. Within the first 12 months of the Child and Family Centre, no staff have left - a rarity in any childcare setting, and one that provides continuity, and quality. Staff are well-paid, and have access to training to further their skills.

Away from the nursery, and within the MBU, the focus is more upon the mother, and a great deal of effort is put into supporting mothers and creating a 'home-like' atmosphere. Mothers are encouraged to learn about health, nutrition, and cookery. They are also encouraged to go on day trips, alone with their child. Many can be reluctant at first, but this is an important part of learning independence away from prison with their baby, and gaining skills to use after release.

Askham Grange has a different way of dealing with illicit drug use amongst mothers than that mandated in the PSO. One mother was found to be using heroin on the MBU. A decision was taken to not automatically send her back to the main prison and separate her from her baby. Rather a multi-disciplinary team met to discuss her situation, including representatives from Social and Probation Services, MBU staff, and members of the mother's family. It was decided that the best solution would be to find the mother an MBU place at HMP New Hall, which could offer more intensive detoxification and rehabilitation work than Askham Grange. The mother did this and was then able to return drug-free to Askham Grange with her baby. Subsequent to her release, this mother nominated the Mother & Baby/Nursery Team for a Butler Trust Award.

There have been challenges to setting up this level of provision. Security concerns were raised when the Child & Family Centre Manager requested that prison staff not wear belt radios in the nursery. This caused some discussion, but eventually belt radios were removed, and no problems have arisen from this. The biggest barrier has been the isolation in which prisons exist - there is no real way for Managers of Family Centres and Nurseries (or, indeed, Prison Officers working in MBUs) to contact each other. The result of this is that good practice, advice, and ideas are not shared. This seems to be an absurd situation in a nationally co-ordinated service. Askham Grange has a practitioner used to setting up and running services for disadvantaged families. Other prisons do not have that level of expertise - and unfortunately, there is no network to allow them to draw upon that of their colleague. Better communication will not only improve provision for mothers and babies in prison, it will also prevent duplication of work and 'reinventing the wheel'.

Askham Grange attribute their success to constant development and innovation, as well as a commitment to providing mothers and babies with services comparable to those on the outside. Arguably, they are better. Askham Grange is an open prison - this gives them the flexibility and freedom to offer some services that closed prisons could not, as well as a less challenging population. However, there is much that closed prisons could imitate about Askham Grange. And, as one senior officer commented, if closed prisons cannot offer excellent services for mothers and babies, should the mothers and babies not be in

an open prison. The question of why there is only one open prison with an MBU in the UK, and why its capacity was recently reduced by half, has not been satisfactorily answered.

Conclusion

This report intends to make it clear that there are many examples of good practice within prisons, and some of these examples have been highlighted. Work at HMPs Holloway and Askham Grange in particular is not only promising, but in some areas has created services better than those available to similarly disadvantaged women in some communities. In general it seems that the 1999 Report succeeded in improving conditions in MBUs, although as shown here, there are still areas in need of further improvement.

However, pregnancy in prison does not seem to have benefited in the same way, and remains the poor relation. This is most obviously reflected in the lack of a Pregnancy PSO, but can also be seen in the fact that antenatal services receive none of the money allocated for Prisoner Health Care. When this is added to the lack of interest in pregnancy health, it seems unsurprising that HMPS does not offer a universally good standard of antenatal care across the women's estate, and that pregnant prisoners are all but invisible in HMPS policy.

There are also problems within MBUs - many of these related to policy rather than practice. Certainly, a far greater amount of time and money has been spent in meeting the needs of mothers and babies in prison, compared to that spent on pregnant women. However, more effort is needed. Staff training remains an outstanding issue, as does the protocol for separation - or rather the practical delivery of this protocol. Our research showed there are prisoners who are not fully involved in the decisions about where their babies go, and that there is very little understanding within HMPS of who is responsible for resettlement plans.

Neither is there enough attention given to mothers and babies trying to bond in what can be a very stressful environment. It is essential that Prison Officers recognise the primacy of mothers, but if they are not the right people to facilitate healthy development, who is? Programmes like 'New Beginnings' are experimental and isolated, and many mothers are really without any emotional and psychological support for their parenting. This is particularly worrying, given what we know about the high levels of depression and anxiety amongst mothers in MBUs.

It is clear from consultation and research that there is a real lack of information available about every area of prison life for pregnant women and mothers. Central HMPS is often unaware of what is happening in individual prisons, and these prisons know little about what is happening in other parts of the estate. The dearth of published statistics about these groups, and the fact hat no review has been published since 1999, makes it very difficult to judge the quality of care provided.

HMPS must commission and complete a comprehensive review of provision for pregnant women, new mothers, and babies in prison. This review should examine policy for both mothers and babies and pregnant women, as well as their facilities and living conditions across England and Wales, and some analysis of outcomes for these groups. As with the 1999 review, a working group comprising representatives from HMPS, HMIP, health professionals, and the voluntary sector, should be established to investigate conditions, and make recommendations.

Pregnant women, mothers, and babies in prison not only deserve good services, they need them. It is vital that the health and development of babies who are carried, born, or live in prison, are not compromised by their surroundings. This means that HMPS must work

to ensure healthy pregnancies and births, as well as a stimulating, nurturing, and supportive environment in which babies can live. Their mothers also need this supportive environment where they can breastfeed and bond with their babies in as normal a way as possible. Later, they must be able attend work, or education, knowing that they are leaving their babies with competent and affectionate carers. If babies are to be kept in prison, all these things are essential.

It is clear that there are problems with separation, care arrangements, and resettlement too. Mothers - unless deemed a major threat to their child's safety - should be more fully involved in decisions about their children's future, and should be treated fairly and with respect. Mothers leaving prison must receive better support if they are not to re-offend, and if the well-being of the child is not to be compromised.

At the beginning of this report, it was recognised that women in prison can be a challenging group to deliver services to. However, these factors increase the need to provide them with high-quality support, at least the equal of what they might receive in the community. Women in prison are disproportionately likely to be poor, unemployed, mentally ill, socially excluded and the victims of abuse. Their babies are at risk of poor outcomes throughout their lives. These groups are poised to benefit the most from high quality antenatal care and postnatal support - they have the biggest strides to make. And, of course, they are genuinely a captive audience. Pregnant women and new mothers have, perhaps, more motivation than any other prisoner to rehabilitate. HMPS should seize the opportunity to help them do so.

The recommendations that follow address policy in the main. It is true that, over the course of the consultations, we discovered problems with practice, including protocols not being followed, and unsympathetic staff. However, it is changes to policy that will ensure pregnancy is taken seriously, that child outcomes are protected, and that mothers are fully supported in beginning their relationships with their babies.

Recommendations

A general recommendation that covers all aspects of this report is that the lack of information sharing, and dissemination of good practice across the woman's estate, must be addressed. There are several ways in which this could be facilitated, but the lead must be taken by HMPS. Providers of successful services, such as antenatal care in HMP Holloway, or family services in HMP Askham Grange, should be invited to talk to professionals and officers at other prisons. Visits should be made to watch quality services in action. It should be far easier for workers to share information at all levels, from central HMPS and governors to prisons officers, health professionals, and voluntary sector employees active in prisons.

- **HMPS must undertake a new review of policy, and services, for pregnant women, new mothers, and babies in prison.**

Pregnancy

- A Pregnancy PSO must be written, detailing a high minimum standard of antenatal care prisoners should receive, as well as instructions on how to deliver this care.
- Additional funding must be provided for antenatal services within prisons.
- When a pregnant woman has applied for an MBU place, the decision as to whether to admit her should be treated as a priority, and reached as soon as possible. It should also be possible for all pregnant women given an MBU place to be admitted to the MBU before the baby is born.
- It should be possible for all pregnant women who are not applying for an MBU place, or who are waiting for a decision

on their application, to reside with other pregnant inmates on one wing.

- Better communications between prisons, the Probation Service and the courts are essential. This will minimise the disruption to a women's antenatal care when she moves between prison, or is released, at short notice.
- Improving antenatal care is the priority in prisons, but preparation for parenthood must also be addressed. A focus on the more emotional and psychological aspects of pregnancy in prison could be more engaging, particularly for those facing separation from their newborn.
- HMPS must centrally collate, and publish, the numbers and location of pregnant prisoners in England and Wales. They must also collate, analyse and publish, the birth weights of babies born to women who give birth while still in prison, and well as any instances of infant, or maternal, mortality.

Mother & Baby Units

- All MBUs should provide a course - ideally accredited so that it can be counted as part of a prisoner's education - that helps mothers bond and interact with, and care for, their babies.
- Staff training should be revisited and strengthened. It is desirable that Prison Officers working on the MBU be better trained in how to recognise postnatal depression. The possibility and desirability of training Prison Officers in other areas, such as breastfeeding support, should also be considered.
- Mothers found using drugs while in MBU should be assessed on a case-by-case basis, and where possible, undertake detoxification and rehabilitation without being separated from their baby. Mothers should be offered ongoing support after they have completed this.
- Mothers who are suitable for open conditions should be moved, even if they are currently in a closed prison's MBU. This recommendation may involve the opening of more MBU places, or even units, in women's open prisons.

Separation

- Mothers must be fully involved in decisions about where their baby will be placed in the community. This is particularly relevant where there are not child protection issues, and where the baby is likely to be placed some distance from the prison.
- HMPS should consider raising the maximum age limit to 36 months for babies in open prisons, to avoid separation where possible.

Leaving Prison

- Resettlement plans must be strengthened. An inmate who is leaving prison with her baby must have a resettlement plan that takes her status as a mother into account.

Appendix A

Consultees

Tessa Baradon - Psychotherapist, The Anna Freud Centre

Ruth Britsch - Caseworker, Women in Prison

Frances Crook - Director, The Howard League for Penal Reform

Sinead Farrell - Team Midwifery Leader, Whittington Hospital & HMP/YOI Holloway

Eleanor Griffin - Principal Officer, HMP Askham Grange

Noreen Higgins - Family Services Manager, HMP Askham Grange

Denise Marshall - Birth Companions

Nick Montgomery-Potts - Mother & Baby Unit Team, Home Office

Sally Price - Consultant Midwife, North Bristol NHS Trust, and University of the West of England

Stephen Shaw - Prisons & Probation Ombudsman

Cathy Stancer - Director, Women In Prison

Kevin Venosi - Youth Justice Board

Appendix B

Seminar Attendees

Jenny Adams-Young - National Coordinator, Mother & Baby Units

Tessa Baradon - Psychotherapist, The Anna Freud Centre

Christine Bidmead - Trustee, Action for Prisoner's Families

Kirsten Bland - Psychologist, The Anna Freud Centre

Gail Bradley - National Offender Management Service

Barbara Burgess OBE - Babies in Prison

Krysia Canvin - Liverpool University

Hazel Cathcart - Whittington Hospital/ HMP Holloway

Noreen Higgins - Family Centre, HMP Askham Grange

Joyce King - Whittington Hospital/ HMP Holloway

Denise Marshall - Birth Companions

Sue McDonald - Royal College of Midwives

Susan Meyers - Head of Healthcare, HMP Bronzefield

Hilary Nailard - Health Visitor, HMP Bronzefield

Barbara Nutcher-Palmer - Probation Services, HMP Peterborough

Vanessa Predergast - MBU, HMP Eastwood Park

Jane Rochfort - Nursery Manager, HMP Eastwood Park

Diana Ruthven - Action for Prisoner's Families

Annie Souter - Whittington Hospital/ HMP Holloway

Cathy Stancer - Women in Prison

Alison Swift - HMP Peterborough

Heather Trickey - National Childbirth Trust

Tina Webb - HMP Holloway

Charlotte Wetton - Quaker Council

Angie Winterbottom - Deputy Head of Residence, HMP Holloway

John Wreford - Policy Advisor, MBUs

Appendix C

Mother & Baby Unit Locations and Capacities

HMP/YOI Askham Grange - 10 places

HMP/YOI New Hall - 9 places

HMP/YOI Styal - 12 places

HMP/YOI Holloway - 17 places

HMP Eastwood Park - 12 places

HMP Bronzefield - 12 places

HMP Peterborough - 12 places

All Mother & Baby Units have capacity for one set of twins, if necessary.

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