Perinatal women's experiences of access to expertise, information and appropriate medical attention in prison

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Introduction

The Birth Companions 'Birth Charter'[1] states that it is estimated that around 600 pregnant women are held in prisons in England and Wales and some 100 babies are born to women in prison every year. However, there is limited research and information on the number and experiences of perinatal women in prison in England, there are no women's prisons in Wales. There are 12 female prisons in England, of which six have Mother and Baby Units (MBU's), where mothers can be housed with their babies up to 18 months old. Prior to NHS England taking responsibility for prison healthcare in England and Wales in 2013, Price[2] argued, there were significant challenges in the provision of equitable care that is both accessible and effective given the specific vulnerabilities, risks and extent of disenfranchisement of this population. Against the backdrop of NHS England taking responsibility for the commissioning of prison healthcare, Edge[3] conducted a scoping review of policy and provision of perinatal healthcare in prisons and found that imprisoned women experience significant levels of emotional and psychological distress during their perinatal period, with two-thirds experiencing depression. Women's experiences of pregnancy, childbirth and early motherhood in prison were generally negative, where they reported feeling unsafe, uncared for, uncomfortable and hungry. In a 2018 study[4] across three prisons involving semi-structured interviews with 28 pregnant women in prison, it was found that women were unable to access basic comforts, acceptable nutrition and fresh air. Moreover, they feared for their child's safety and the possibility of being separated from them.

There have been significant developments in the last few years in policy and guidance in relation to the specific needs of women in prison and perinatal women. In 2018, Public Health England (PHE) published 'Gender Specific Standards to Improve the Health and Wellbeing for Women in Prison'[5]. The implementation and achievement of the standards is a joint objective of Her Majesty's Prison and Probation Service (HMPPS), NHS England and PHE. The standards highlight the need for a whole systems approach to improving health and wellbeing for all women in prison. The public health standards have 12 specific standards that relate to pregnant women and babies in the prison setting. The 2018 Female Offender Strategy[6] sets out the Government's commitment to a new programme of work with female offenders, with three key priorities: early intervention, an emphasis on community-based solutions, and an aim to make custody as *'effective and as decent as possible for those women who do have to be there'*[7]. An accompanying document is the HMPPS Guidance on Working with Women in Custody and the Community[8], which contains specific guidance on the care of perinatal women in prison. Further, the Birth Companions Birth Charter has been an influential document in stimulating valuable discussion and review of the care provided to pregnant women in prison.

1. Kennedy A., Marshall D., Parkinson D. et al (2016) Birth Charter for women in prisons in England & Wales. Birth Companions, London.
2. Price, S. (2005) Maternity Services for Women in Prison: A Descriptive Study, British Journal of Midwifery. Vol 13 (6) 362–368.
3. Edge, D. (2006) Perinatal Healthcare in Prison: A Scoping Review of Policy and Provision, The Prison Health Research Network. Department of Health, London.
4. Abbott, L (2018) The Incarcerated Pregnancy: An Ethnographic Study of Perinatal Women in English Prisons.
5. Peden, J., McCann, L., O'Moore, E., Phipps, E., Ford, T., Plugge, E., Leaman, J., Sturup-Toft, S. and Connolly, AM. (2018) Gender Specific Standards to Improve the Health & Wellbeing for Women in Prison. Public Health England, London.
6. Ministry of Justice (2018). Supporting data tables: Female offender strategy. Available at: https://www.gov.uk/government/publications/female-offender-strategy accessed on 20 October 2019.
7. See n.6. p.3
8. Her Majesty's Prison & Probation Service, The Women's Team (2018) Guidance on Working with Women in Custody and the Community. HMPPS, London.

NHS England outline their commitment to improve the health and care outcomes for those in secure and detained settings and narrowing health inequalities between those in the Criminal Justice System (CJS) and the general population, in the document 'Our Strategic Direction for health services in the Justice System 2016-2020'[9]. NHS England Health and Justice teams commission to the principle of equivalence, meaning that the health needs of a population constrained by their circumstances should receive an equitable service to that offered to the rest of the population. However, Abbott, Scott, Thomas and Weston[10] have highlighted the challenges women imprisoned face during pregnancy compared to women in the community, commenting:

> *'Women imprisoned during pregnancy and/or childbirth clearly experience more intense challenges to their choices than their non-incarcerated sisters. The circumstances of pregnant prisoners contrast starkly with best midwifery practice where current practice regarding empowerment, continuity of care, partnership models, support of physiological birth and choice of birth location should be guiding principles.'*[11]

The midwife played the primary and pivotal role in the ante-natal care of women and, therefore, their ability to work within prison is central to the question of equivalence.

In October 2019, a woman in Bronzefield prison was reported as being found in her cell having given birth unattended; tragically the baby was dead[12]. In response, the Royal College of Midwives called for an urgent review and their statement echoed the principle of equivalence and concern that in practice some imprisoned women were not receiving adequate healthcare during pregnancy[13]. In June 2020, another tragedy was reported to have occurred when a woman at Styal Prison gave birth to a stillborn baby.[14] These cases have intensified focus on the care of perinatal women in prison, a recognised gap in the evidence base[15], that this article provides new insight into.

The current study, which was commissioned by NHS England (East), had several aims which included obtaining the views of women who were either pregnant or had given birth in the past 12 months or had their babies with them in the MBU whilst serving a sentence in a prison in England. The interviews with 10 women took place within the prison environment in September 2019[16]. The interviews were analysed thematically, following six steps: 'familiarisation' through reading and re-reading transcripts, 'code generation', 'theme identification', 'review' of themes and codes, 'labelling themes', and 'report writing'[17]. This paper discusses the experiences of the pregnant women in the prison and the challenges they faced in accessing the expertise, care and support that they needed. It highlights that high quality care is not being achieved due to systematic and cultural challenges within the prison environment. It concludes with a discussion and recommendations on areas of focus to remove blockers to women's ability to access equitable care.

Access to the expertise and support of the midwife

The midwife played the primary and pivotal role in the ante-natal care of women and, therefore, their ability to work within prison is central to the question of equivalence. In the prison, women saw the midwife regularly for appointments. It was clear that the midwife was a highly valued and primary source of information, expertise and support for the women:

9. NHS Commissioning (2016) Strategic Direction for Health Services in the Justice System: 2016-2020, Care not Custody, Care in Custody, Care After Custody. NHS England, Leeds.
10. Abbott, L., Scott, T., Thomas, H. & Weston, K. (2020) Pregnancy and Childbirth in English Prisons: Institutional Ignominy and the Pains of Imprisonment. Sociology of Health & Illness Vol. 42, No. 3, 2020 ISSN 0141-9889, pp. 660-675 doi: 10.1111/1467-9566.13052
11. See n 10. p.660.
12. Guardian (4 October 2019) Baby dies in UK prison after inmate 'gives birth alone in cell' available at https://www.theguardian.com/society/2019/oct/04/baby-dies-in-uk-prison-after-inmate-gives-birth-alone-in-cell
13. The Royal College of Midwives (November 2019) Position Statement: Perinatal womein in the Criminal Justice System. RCM, London.
14. Guardian (19 June 2020) Death of baby in Cheshire Prison prompts investigation available at https://www.theguardian.com/society/2020/jun/19/death-baby-cheshire-prison-prompts-investigation
15. See n.4.
16. The project was reviewed by the University of Northampton, Faculty of Health and Society Research Ethics Committee and the HM Prison & Probation Service National Research Committee (HMPPS NRC).
17. Braun, V. and Clarke, V. (2006) 'Using thematic analysis in psychology', Qualitative Research in Psychology, 3 (2), 77-101.

'She is lovely I couldn't ask for better support. She always chases stuff up, but she is the only one that does.'

However, women expressed there were barriers to contacting the midwife as and when they needed to. An important issue impacting women's access to the midwife was the convoluted processes of communication:

'The big problem is that the information about appointment bookings and medication has to go through from the officer to the nurse and then from the nurse to the midwife, it is a three-way process and it takes a long time and often the information is just not passed on.'

The women also talked about being assessed by nurses and doctors, and not necessarily having direct access to the midwife. One commented:

'When I have a problem, I have to ask the officer who tells the nurse who tells the midwife.'

In addition, there were other barriers in women having direct access to the midwife. The prison has in-cell telephony, so there is the opportunity for women to phone approved numbers at any time. Women reported that they had the midwife's number and that they could obtain information from and message her on the touchscreen kiosk. Women also had access to a 24-hour maternity helpline. However, women noted that a barrier was they did not have credit on their phone or needed to prioritise what they used it for (e.g. family, solicitor, social worker etc). One woman commented that some officers will allow you to use the office phone, but it is 'hit and miss'; she also reported that early in pregnancy she missed two midwife appointments because she was not released from her cell.

Systematic issues such as these hinder women in prison having the same unrestricted access to the care and expertise of the midwife as their non-incarcerated counterparts. Their limited access to appropriate healthcare support and expertise 24/7 undermines the principle of equivalence.

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Awareness of, and access to, ante-natal classes

Ante-natal classes are held at the prison weekly and the charity who run the classes is one of the women's key sources of information. Seven of the women interviewed had attended the classes and were generally very positive about them, considering them extremely useful and informative:

'The wealth of knowledge is unbelievable…my whole experience would have been completely different without it.'

The level of care provided by the charity was arguably greater than that experienced in the wider prison environment:

'First helped with what to expect, advice, leaflets and paperwork, brought in pregnancy books. They were really helpful and I still see them now. They help you out as much as possible. If they don't know something or you ask them to find out something they will always come back to you.'

However, women talked about a delay in hearing about ante-natal classes provided in the prison, commenting that they heard about it from other women prisoners or at their first appointment with the midwife:

'Only knew about it because one of the other girls told me about it. When you first come here, they don't tell you anything, didn't know for at least a month or two.'

'Didn't know about the classes until a few weeks before giving birth. Should be given information about them.'

Lack of information between staff members around prisoners' health conditions prevent adequate support and access to services. For example, one woman reported asking to leave the education wing to attend an ante-natal class. The staff on that wing were not aware of her pregnancy and by the time that they verified the information, the class had finished.

A woman also outlined issues that the provider had in getting through security meaning that they lost valuable time:

> *'(The provider) also struggles with things like access so they get held up at the gate and then we get a shorter time with them.'*

The provider reported that limited awareness of the class' existence was frustrating, as it did not allow them to support all the women that were eligible for their support. This was due to wider systems issues of the whole prison, such as relying on particular individuals to pass on the details of perinatal women and the establishment having limited data (for example not collecting information of women who had miscarried, had a termination or having a baby in the community).

Lack of information or systematic barriers to women receiving the classes is restricting women's rights to access equivalent care to that in the community and enabling them to care for themselves and know their rights within the prison environment.

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Access to assistance in an appropriate time frame

There were several cases where women didn't consider themselves to have received appropriate clinical support in an acceptable time frame. Here, the lack of perceived urgency and lengthy delays to receive support from a trained professional impacted their mental wellbeing. For example, one woman shared how she had not felt her baby move overnight. She alerted the wing officer in the morning who she described as being very good and acting quickly. However, she was not taken to the hospital until the evening, which she felt was an unacceptable delay and frightening for her. Another woman reported that after experiencing bleeding, she was seen by the nurse, but was told that she could not see the midwife until the next day.

Women talked about having conditions or health episodes that had left them very concerned about themselves, their baby, as well as being in considerable discomfort. For example, one woman reported that she had been suffering from a Urinary Tract Infection (UTI) and that her parent had to ring the prison themselves to push for it to be dealt with. Once seen, she was told the infection was very bad. Three weeks afterwards, at the time of the interview, she stated she still had not received the antibiotics that had been prescribed.

Two women complained of having very severe tooth pain whilst pregnant and felt unsupported in getting it treated and resolved appropriately:

> *'During pregnancy they didn't support me when I got really bad toothache and officers offered painkillers that I shouldn't have (taken) during pregnancy, and said that I should have them or nothing.'*

The other woman had a tooth abscess and reported the difficulty in getting dental appointments in prison. This was also reported in a survey involving over 2700 prisoners[18], where over 70 per cent of prisoners described it as very difficult to see a dentist, with just over 50 per cent reporting similar problems in accessing a GP.

Also indicated as being problematic were the timings within the establishment that women take medication were not aligned with the times that they need to take these types of medication, so for example morning sickness and indigestion medications.

Within a prison-environment, women are reliant on the system and the staff to provide them with the treatment and medication they need at the appropriate time. It is clear from the women's accounts that this does not always happen, which impacts both their physical and mental health and their sense of safety for their child. Particularly concerning is the reporting of incidents by women in which they do not believe that the healthcare professionals had sought advice from the midwife or allowed them to see a midwife immediately despite them presenting with symptoms that they perceived as a threat to their baby.

Communication about medical treatment and test results

Women often did not feel communicated with about their treatment and care. A woman described how she had asked to see the nurses because she had

18. User Voice (2018) Service Users Views on Prison Healthcare. For the Health and Social Care Committee's Prison Healthcare Inquiry. User Voice, London.

stomach pain. As they were unsure around the nature of the issue, they booked her in for a GP's appointment the next day. However, the GP cancelled the appointment without consulting her and prescribed laxatives:

> *'(I) felt shoved to one side and all I am is just a number'.*

One woman gave an example where she received misinformation about the medical attention she would receive. She described herself as being tachycardic, having a high heart rate, and she was told that the doctor would come back and check on her, but they never did. The misinformation about if, and when, they will receive attention compounded their levels of anxiety.

Another woman described how it took her three weeks to receive urgent blood test results, and in the case of certain tests, she never received the results. She reported that in the end you 'just give up asking'. It was clear from other comments that women became disfranchised and worried about speaking out or complaining:

> *'If you complain too much you get known as a person that complains and they won't even bother with you, they won't deal with you at all.'*

> *'I just don't bother with them. Don't feel like you can ask because you don't get nowhere.'*

> *'If you need anything you are told to stop nagging.'*

Women in prison are in a difficult position as they need to weigh up the perceived benefits and costs of speaking out and asking questions or making requests. It was clear from the interviews that women became disempowered and, in some cases, gave up on asking for information or things that they needed in relation to their pregnancy not to be labelled as a complainer or troublemaker and receiving even less support. A couple of women had made complaints about particular incidents but reported that they had received no response.

Access to mental health support

Women prisoners have a notably higher prevalence of mental health problems than male prisoners and the general population[19][20]. Moreover, there is an increased likelihood of mental health problems in the perinatal period: between 10 and 20 per cent of women will suffer from mental health problems during pregnancy and birth[21]. Evidence now demonstrates *'that maternal mental health problems are associated with a variety of adverse outcomes for women and children'*[22]. Three of the women interviewed stated that they needed counselling, one of which was receiving it and described it as 'really good'. She had been referred by the midwife and reported that the midwife had to make a strong case for it, which took a long time to be approved. Only after having suicidal and self-harm thoughts did she receive counselling:

> *'Unless you are actually self-harming you are not taken seriously.'*

Two other women stated that they needed counselling, one had been referred by the midwife but had not yet been seen at the time of the interview. She felt that she really needed counselling as she described herself as suffering from Post-traumatic stress disorder (PTSD). The third woman had been under the Mental Health Team but they had closed her case despite her still feeling she needed counselling— *'they just said that they couldn't help me'*. She said that no information as to why her case had been closed was provided.

It is also important to note that social support is an important factor in mental health[23]. However, women are imprisoned further from home and receive fewer visits than men[24]. Some of the women reported having no support network 'on the outside', and those that did have an external support network did not have free access to them, hindered by geographical distances, lack of credit on phones, and restrictions on and delays in the postal system:

> *'This is not my allocated jail and my family are far away so they can't visit. I'm on a waiting list to be moved but being told different dates for when I will be going home.'*

19. Light, M., Grant. E. and Hopkins, K. (2013) Gender differences in substance misuse and mental health amongst prisoners. Ministry of Justice, London.
20. McManus, S., Meltzer, H., Brugha, T., Bebbington, P., and Jenkins, R. (2009) Adult Psychiatric morbidity in England, 2007 Results of a household survey. The NHS Information Centre, Leeds.
21. Ayers, S. and Shakespeare, J. (2015). Should perinatal mental health be everyone's business? Primary Health Care Research and Development, 16(4), 323-325.
22. See n. 20, p.323
23. Harandi, T.F., Taghinasab, M.M. and Nayeri, T.D. (2017) The correlation of social support with mental health: A meta-analysis; Electron Physician. 2017 Sep; 9(9): 5212–5222.
24. Prison Reform Trust (2017) Why focus on reducing women's imprisonment, Prison Reform Trust Briefing. Prison Reform Trust, London.

'No facilitation for support with outside family. Asked for a visit with my partner who is in another prison. You get one weekly letter and have to pay if want more which can be a problem if you don't have a job.'

Women lack family support at key moments in their pregnancy, such as appointments and scans, for security reasons and short notice:

'We are not allowed to take any family with us, especially because we just don't know the day that we are going to be taken to hospital, they just tell us on the day so there is no time to contact our family.'

Mental health provision was consistently highlighted as an area of concern by all professionals, both internal to the prison and external service providers. In particular, they noted the lack of a perinatal mental health specialist, which they felt was much needed due to the high level of vulnerability amongst the women. This may be an issue of equivalence to the community as there are an increasing number of perinatal community mental health specialist services. It was also suggested that within the context of the prison, there are different perceptions of what constitutes a significant mental health issue in a prison setting as opposed to the community as mental health issues are much more prevalent. Women who are separated from their babies were highlighted as a group that the professionals (including the midwife, the outside providers of ante-natal classes and prison staff involved in the care of perinatal women) were particularly concerned about, with there being no formal package of mental health support for them through this traumatic event in their lives.

Perinatal women in prison are particularly at risk of experiencing mental health problems, which evidence now demonstrates could have significant negative consequences for themselves and their babies[25][26][27].

Women lack family support at key moments in their pregnancy, such as appointments and scans, for security reasons and short notice:

Women experienced difficulties accessing mental health services unless they indicated harm or suicidal thoughts, possibly being deemed as lower risk and/or need to residents in the wider population. In addition, women either had no support network to rely on, which can be a protective factor, or had limited access to it.

Healthcare needs and dignity

Women in this study, at times, outlined that they had degrading experiences when attending hospital appointments or scans. Three women described having been handcuffed. One woman described it as 'absolutely degrading'. She reported having to stand in the maternity unit for the appointment with other parents staring at her whilst handcuffed and under guard. Another woman outlined how she was handcuffed and under guard throughout the whole scan visit. Finally, a third woman reported that when taken to an appointment for an internal scan, the female officer refused to leave the room when asked. The Birth Charter[28] recommends that where scans or appointments need to happen in hospital officers should observe prison guidance which specifies that they should not be present during medical consultations. One woman recounted that a male and female officer had been present throughout her labour. She reported that the female officer was extremely supportive, but the male officer did not leave the room and was situated at the bottom of the bed during the entire labour. She described that she was in too much pain to ask him to leave, whilst her partner was afraid to challenge it for fear that he himself would be made to leave thereby missing the birth of his child.

Additionally, women do not always have the option of speaking to an appropriate person about their needs, which can be sensitive at times. One woman reported that she didn't feel comfortable to speak to officers about her specific health needs but had no other option:

25. Grote, N., Bridge, J., Gavin, A., Melville, J., Iyengar, S and Katon, W. (2010) A Meta-analysis of Depression During Pregnancy and the Risk of Preterm Birth, Low Birth Weight, and Intrauterine Growth Restriction. Arch Gen Psychiatry, Oct; 67(10): 1012– 1024.
26. Staneva., A, Bogossian, F., Pritchard, M. & Wittkowski, A .(2015) The effect of maternal depression, anxiety, and perceived stress during pregnancy on preterm birth: A systematic review, Women and Birth, vol. 28 (3) 179-193. https://doi.org/10.1016/j.wombi.2015.02.00
27. Talge ,N. & Glover, V. (2007) Antenatal maternal stress and long term effects on child neurodevelopment : how and why?, J Child Psychol Psychiatry, 2007 Mar-Apr (3-4) 245-61.
28. See n.1

'I don't feel comfortable talking to officers. I have a bladder weakness problem since pregnant and asked for towels, they gave me adult nappies which is not what I needed. Didn't really want to speak to a male about my bladder weakness problem.'

One woman recounted that she was in the chapel for Sunday service and she desperately needed to go to the toilet but the officers would not let her go — *'I thought I was going to wet myself'*. It was only because her fellow women protested saying that she was pregnant that officers relented. The officer then said she would take her to the toilet but would not bring her back to the chapel. The woman said that she wanted to go back to church because it was her faith.

Another woman reported that she had to walk around in clothes that didn't fit her:

'I had to walk round in t-shirts that are too short, with my belly hanging out. I felt trampy and embarrassed.'

These testimonies illustrate that during their pregnancies women in prison endure humiliations and a degradation of their dignity. The prison regime can be unsympathetic to the specific needs of pregnant women, with their status as a prisoner being given priority.

Discussion

This article highlights the experiences of women in prison who are pregnant or have given birth, providing important and previously unheard dimensions to understand the access to care and the quality of treatment provided. The accounts of women demonstrate challenges in their ability to access appropriate services and treatment as and when they needed it, which in some cases was a potentially high risk to their safety and that of their baby. Pregnant women as with all those incarcerated are in a position of powerlessness: their testimonies illustrate that they are not always listened to, which can leave them feeling disempowered and some suggested that they 'give up' on asking for their needs to be met. Lines[29] outlines in his paper the long-standing principle that the State owes a higher standard of care to those it imprisons than it does to those outside of prison because they have complete control over the day to day lives of the detainee and responsibility for their wellbeing.

We argue that to achieve equivalence in care for perinatal women in prison, or as advocated above an enhanced service, requires that systematic and cultural challenges are identified in the prison environment in which the pathway for the perinatal care of women is embedded. Wider evidence suggests that many of the issues experienced by perinatal women are symptomatic of wider issue of quality of healthcare to prisoners. In the Prison Health: Twelfth report of Session 2017-19[30], it was reported that prisoners *'often struggle to get health concerns acted upon in a timely way', 'prisoners can experience problems getting help in an emergency', 'prisoners report having to convince prison staff that they need urgent help'* and *'prisoners' complaints often go unanswered'*. In evidence to the Prison Health Report Her Majesty's Inspectorate of Prisons commented that consistent themes of health care provision include the adverse impact of staff shortages and insufficient training (both of healthcare and prison staff) have on health outcomes for prisoners as well as the adverse impact of restricted regimes.

Wider evidence suggests that many of the issues experienced by perinatal women are symptomatic of wider issue of quality of healthcare to prisoners.

It is important that perinatal care in prison takes into consideration the pregnant woman's whole experience in the system and how that impacts on her health and wellbeing and that of her babies. As stated in the National Partnership Agreement for Prison Healthcare in England 2018-2021[31], *'Improving overall health and wellbeing may be as much about changes to regime, custodial staffing levels, food, accommodation, access to exercise, training, employment etc. as delivering specific health services. There is an inter dependency of health and custodial service'*.

Conclusion and recommendations

It is important to acknowledge that this paper reflects the experiences of 10 women in one prison and

29. Lines, R. (2006) From equivalence of standards to equivalence of objectives: The entitlement of prisoners to health care standards higher than those outside prisons. International Journal of Prisoner Health, 2(4) p. 269-280.
30. House of Commons Health & Social Care Committee (2018) Prison Health. Twelfth Health Report of Session 2017-19. Ordered by the House of Commons, London.
31. HM Government and NHS England (2018) National Partnership Agreement for Prison Healthcare in England 2018-2021

therefore caution should be exercised over generalisability. Future studies should seek to explore and compare womens' experiences of healthcare between different prison settings, to enable consideration of contextual and policy influences. It is important to note in this study that the women were generally very positive about the care provided by the midwife and the support provided by the charity who deliver the ante-natal classes. In addition, other innovative practices were highlighted by professionals in the prison such as the provision of weekly 'pregnancy packs' that contain extra nutritionally valuable foods. However, the findings presented in this paper echo and build upon other recent research that highlights that women's ability to access support, care, information and maintain their dignity is compromised by aspects of the prison regime. Key areas of focus should include:

Access to appropriate expertise in a timely manner — There were instances where women described having concerning symptoms such as bleeding or not feeling their baby move overnight in which they felt that they had not received appropriate treatment and access to the expertise of the midwife in a timely manner. Similar concerns that healthcare staff and officers are taking decisions that a qualified midwife should take is an issue that has been previously identified in research[32] and raised in a joint submission, by The Royal College of Midwives and Birth Companions, to the prison healthcare inquiry, Health and Social Care Committee in May 2018[33]:

> *'Healthcare staff and officers may currently be making decisions for which they are unqualified, putting women, babies and themselves at risk.' (p.4)*

It is important to ensure clear communications and protocols between prison healthcare teams and midwifery teams, as there is the potential to put mothers and babies at significant risk. It is also essential that women are communicated with to ensure that they are fully aware of who is making the decisions regarding their care and the expertise of the midwife is sought as appropriate and in a timely manner. The Royal College of Midwives released a position statement on Perinatal women in the criminal justice system[34], with recommendations including, full implementation of the Birth Companions Birth Charter[35] and there should be a specific Prison Service Instruction for perinatal women taking a first 1001 days approach. Birth Companions have produced a toolkit to assist prisons in the implementation of the Birth Charter recommendations.[36]

It is essential that women are empowered from the beginning of their sentence with information about their rights, where they can access support and information about perinatal care, birth and options after birth.

On July 31st 2020, the Ministry of Justice announced a new policy to improve the care for pregnant women and mothers in prison. The reforms follow a review of Mother and Baby Units (MBUs) in prison[37] and will mean that every female prison will have a resident mother and baby specialist to act as a single point of contact to women their families and staff; there will be training rolled out for staff on looking after pregnant women and an advisory group will be established, which will include women who are currently or have formerly been in prison, to ensure the monitoring of these reforms, and that learning.

Empowerment of women through information — It is essential that women are empowered from the beginning of their sentence with information about their rights, where they can access support and information about perinatal care, birth and options after birth. In this study many of the women were told little on entry and were dependent on other prisoners for information provision. Ford[38] also found

32. See n.4
33. The Royal College of Midwives and Birth Companions (May, 2018) Royal College of Midwives and Birth Companions Joint Submission to the prison healthcare inquiry, Health and Social Care Committee. p.12
34. Royal College Of Midwifery (2019) Position Statement: Perinatal Women in the Criminal Justice System. The Royal College of Midwives, London.
35. See n.1
36. Birth Companions (2019) The Birth Charter Toolkit, Birth Companions, London.
37. Ministry of Justice (2020) Review of operational policy on pregnancy, Mother and Baby Units and maternal separation: Summary report of the review of PSI 49/2014 and operational policy on pregnancy and women separated from children under 2 in prison. Ministry of Justice, London.
38. Ford, J (2009) Information needs of women in prison with mental health issues. Nacro, London.

this to be the case in relation to information regarding mental health issues in female prisons. The study highlighted that the format of information is very important due to lower levels of literacy within the prison population and English not being the first language for a high proportion of female prisoners. Leaflets were seen as a good means of imparting information as they are something women can refer back to.

Availability and access to support — Women who are pregnant in prison can feel isolated, they often do not have support networks on the outside or have limited access to them and although there are some internal support networks, their access to them can be time specific and intermittent. Special attention needs to be paid to unblocking access to these key support networks — particularly the midwife — but also internal and external providers of specialist support. Further, there needs to be a wider cultural shift in which all staff are encouraged, trained and supported in meeting the needs of perinatal women to ensure continuous access to support. Abbott et al.[39] discussed how officers would talk about pregnant women using dehumanising terms such as 'the pregnants'. Women in this study relied on the support of a small number of individuals and felt less able to seek support from officers, recounting experiences where they felt that they had been treated unfairly or felt dehumanised.

Care cannot rely on a small number of individuals and a pathway specific to perinatal women but must be embedded in the wider system and constantly prioritised.

As noted above, the Ministry of Justice[40] have committed to rolling out training to increase knowledge across the Women's Estate of how best to care for perinatal women in custody. This training will be mandatory for the proposed pregnancy and mother and baby liaison officers and the wider staff network *'based on the needs of the prison'*. It is important that this training is monitored and evaluated in terms of its content, targeting and impact.

Wider prison issues impact on perinatal women's care — One of the National Prison Healthcare Board's priorities between 2018—21[41] is to *'develop and apply a whole prison approach to health and wellbeing that ensures that the regime, activities and staffing facilitate an environment that promotes good health and wellbeing and reduces violence for all prisoners, including those with protected characteristics.'* A study looking at the use of peer support health interventions in prison highlighted the extrinsic factors that affect the successful implementation of a health initiative, which included institutional buy in, security factors, staff support and resistance, prisoner preferences, awareness and prison turnover[42].

A valuable research avenue would be to consult with staff and officers within prisons around perinatal care in prison and their own confidence in addressing the needs of perinatal women. In addition, prison staff also need support, they may feel uncomfortable in supporting perinatal women, in particular in roles such as escorting a woman who will be separated from their baby. It is important to determine the extent to which they feel that the establishment culture prioritises the protection and support of perinatal women. Care cannot rely on a small number of individuals and a pathway specific to perinatal women but must be embedded in the wider system and constantly prioritised.

Catering for the specific needs of perinatal women and the prioritisation of their needs within the prison environment — It is important to reflect that pregnancy and maternity is a protected characteristic in the Equality Act 2010. The National Partnership Agreement for Prison Healthcare in England 2018-2021[43] makes particular reference to meeting *'the need for valid, reliable, timely and sensitive data to describe health needs among people in prison, the effectiveness of health service providers and health outcomes, how well services meet identified needs, including the needs of diverse groups, and the impact of policy decisions on health and social care provision for all people in prisons, particularly those with protected characteristics'* . However, there is no mention of pregnancy or maternity

39. See n.9
40. See n.29
41. See n.20
42. South, J., Woodall, J., Kinsella, K. and Bagnall, A-M. (2016) A qualitative synthesis of the positive and negative impacts related to delivery of peer-based health interventions in prison settings. BMC Health Serv Res 16, 525 (2016). https://doi.org/10.1186/s12913-016-1753-3
43. See n. 9

in 'Her Majesty's Prison and Probation Service Offender Equalities Annual Report, 2017/18[44] apart from the demographic breakdown of Mother and Baby Unit assessments and entries.

This lack of monitoring in relation to whether perinatal womens needs are being met is likely as a result of them being largely invisible at a National level due to the lack of centrally collated data. This is acknowledged in the Ministry of Justice's[45] Review of operational policy on pregnancy, Mother and Baby Units and Maternal Seperation which comments:

> *'The feedback via national publications such as the JCHR report on the Right to family life and the Royal College of Midwives' Position Statement consistently refer to the need for published datasets on births and pregnancy, as a minimum. The revised policy and guidance will, therefore, be accompanied by publication of a wider range of data in the MoJ Annual Digest. This will meet the need for greater transparency that stakeholders have called for, and that we agree is necessary to demonstrate an understanding of our prison demographic, and therefore the scale and type of support they might require. For the first time, we plan to extend published national data to include a quarterly snapshot of the pregnant population and the annual number of births taking place during women's sentences.'*[46]

The collection and publication of this data will undoubtedly be a step forward in understanding the scale of perinatal needs in prison. However, data monitoring needs also to provide insight into the extent to which perinatal womens needs are being met by the system and a better understanding of the perinatal outcomes for these women.

In this study women gave examples, where they felt that their pregnancy and related needs had not been considered. In two cases women had to persuade prison officers that they were, in fact, pregnant. Crawley and Sparks[47] highlighted the concept of 'institutional thoughtlessness', which refers to the prison system not catering for the specific health needs of a particular group. Abbott et al.[48] noted that this term can also apply to perinatal women and commented that the *'distinct status afforded to mainstream society was mainly absent in prison…their pregnancy afforded no special treatment'.*

The provision of appropriate mental health care for perinatal women is essential and critical to good health outcomes — Imprisoned perinatal women have significant risk of suffering from mental health issues, and research demonstrates that mental health issues, even when mild to moderate, can have significant negative outcomes for mother and baby. Therefore, it is important that mental health assessments processes take into consideration the specific risks to a pregnant woman and her baby even if they have mild to moderate mental health needs that may go untreated in the wider prison population. Her Majesty's Chief Inspector of Prisons highlighted the gap in mental health services commissioned in prisons[49], particularly in relation to services catering for people with mild to moderate mental health needs (e.g. psychological services, counselling etc). In addition, the system needs to be able to cater for the specific needs of perinatal women in prison for example, that they may be separated from their child and are likely to need specialist counselling and support. Specialist perinatal mental health services are emerging in communities and therefore this is an issue in equivalence.

44. Ministry of Justice (2018) Her Majesty's Prison and Probation Service Offender Equalities Annual Report, 2017/18. Ministry of Justice, London.
45. See n. 29
46. See n. 39, p. 13
47. Crawley, E. snd Sparks, R. (2005) Hidden Injuries? Researching the experiences of older men in English Prisons, The Howard Journal of Criminal Justice, September 2005, Vol.44 (4), No.4, p.345-56.
48. See n. 9. p.5
49. Her Majesty's Chief Inspector of Prisons (2018) Written Evidence from Her Majesty's Chief Inspector of Prisons to the Health and Social Care Committee's Inquiry on Prison Healthcare, London.