



POSITION STATEMENT

Women's Health Care in Correctional Settings

Introduction

Women represented 9% of the correctional population in 2012; proportionally, this is a substantial increase over the last 30 years (Carson & Golinelli, 2013; Minton, 2013). Women have unique, gender-specific health needs. Incarcerated women report histories of alcohol and drug abuse, sexually transmitted infection, sexual and physical abuse, and mental illness, with rates of these conditions higher than those of incarcerated men, according to numerous studies. Moreover, the majority of incarcerated women are younger than 50 (Guerino, Harrison, & Sabol, 2011) and therefore have specific reproductive health issues, including pregnancy. This position statement is intended to guide the correctional administrator in the management of women's health care.

Background

Gynecological

Research on the provision of gynecological services for women in correctional settings has consistently indicated that current services are inadequate (Weatherhead, 2003). Gynecological exams are not performed upon admission, nor are they routinely provided on an annual basis. Appropriate initial screening questions about a woman's gynecologic history often are not asked. Furthermore, many jails and prisons lack health providers who are trained in obstetrics and gynecology, which leads to inadequate and inappropriate gynecologic care. As a result, women in prison are at risk for having some diseases, such as breast and ovarian cancer, or abnormal Pap smears go undetected.

Pregnancy

Sexually active women remain at risk for pregnancy until they go through menopause (complete cessation of menses for greater than 12 months) either naturally (average age in the United States is 51) or surgically (hysterectomy or removal of both of their ovaries). At any given time, approximately 6% to 10% of incarcerated women are pregnant (American College of Obstetricians and Gynecologists [ACOG], 2011). Many women first learn they are pregnant when they enter a correctional facility. At the time of their arrest and incarceration, many pregnant inmates lack prenatal care and need considerable support to improve the clinical outcomes of their pregnancies. Research has demonstrated that these women are not consistently provided counseling on options or access to termination services (Roth, 2004; Sufrin, Creinin, & Chang, 2009). Owing to their past medical histories and high rates of substance use disorders, incarcerated women tend to have complicated and high-risk pregnancies. For example, fetal alcohol spectrum disorder creates psychological, neurological, and physical impairments in affected children (Pruett, Waterman, & Caughey, 2013). Pregnant women with opioid use disorders must not be detoxified and must be offered opiate substitution therapy, yet this is not uniformly available in jails and prisons. Despite these high-risk pregnancies, a 2008 Bureau of Justice Statistics report documented that only 54% of pregnant prisoners received prenatal care (Maruschak, 2008). Pregnant inmates have high levels of psychological distress, yet often do not receive counseling and support services. Restraints are still commonly applied in childbirth despite the medical risks (ACOG, 2011).

Postpartum

As many as 19% of women in the United States experience postpartum depression within 3 months of delivery, with 7% having a major depressive episode (Gavin et al., 2005). The general lack of attention to postpartum mental health issues has serious consequences. Postpartum incarcerated women are at higher risk for postpartum depression and psychosis owing to their high prevalence of underlying mental health disorders and the emotional trauma of being separated from their newborns. Nonetheless,

screenings for postpartum physical and psychiatric complications often are not routinely performed for women who deliver while in custody and for women who enter custody and have recently given birth. Mother–infant attachment is crucial for the infant’s psychological development and the mother’s mental health, especially in the immediate postpartum period. However, most women who give birth while in custody are forced to separate from their infants within 1 to 2 days of giving birth. Contact visits with the newborn can enhance mother–infant bonding and have a positive impact on the inmate’s well-being. Several correctional facilities have instituted nursery programs that allow the infant to live with the mother in a specially supervised wing, with parenting support for the inmate. Such programs have been shown to improve women’s feelings of attachment to their children, and to reduce recidivism; one study found that 86% of women in a prison nursery program remained in the community 3 years after release (Goshin, Byrne, & Henninger, 2013).

Breast milk is known to have numerous benefits for newborns and for mothers, but incarceration makes it difficult for infants and postpartum women to receive those health benefits (ACOG, 2011).

Parenting Services

Many women in correctional facilities have young children, ranging from 56% in federal prisons to 70% in local jails (Glaze & Maruschak, 2010). Female inmates generally do not receive appropriate parenting and child custody services. Entering a correctional facility is very stressful, but for women with children it is even more intense because of the separation from their children.

Sexual and Physical Abuse

It has been estimated that 43% to 57% of state and federal women prisoners and 67% to 79% of women in jail have been physically or sexually abused (Fickensher, Lapidus, Silk-Walker, & Becker, 2001; Greenfeld & Snell, 1999). Such abuse can lead to lifelong psychological problems such as depressive disorders, stress disorders, anxiety disorders, learning problems, substance abuse (with its attendant physical health problems), and behavioral disorders of violence and impulsivity. Furthermore, being victimized can have serious consequences. One third of all female inmates serving time for a violent crime had victimized a relative or intimate, and of these inmates, two thirds had victimized either their spouse or a family member such as a sibling or even their own child (Snell & Morton, 1994). Prior sexual abuse or assault may also make women reluctant to undergo gynecologic exams.

Alcohol and Drug Abuse

A U.S. Department of Justice (1999) study revealed that more than 40% of female prisoners were under the influence of drugs at the time of their offense. Sixty-nine percent of women entering jails met criteria for substance dependence or abuse (Karberg & James, 2005). Because of this abuse, many women prisoners are at much greater risk of becoming HIV positive from having had unprotected sex or having used dirty needles. Drug counseling, by itself, is not enough: The track record shows that people with addiction almost always relapse.

Sexually Transmitted Disease (STD)

Women entering correctional facilities have high rates of STDs resulting from limited access to preventive health services; from risky behaviors with substances, unprotected sex, and commercial sex work; and from being victims of sexual assault. A Rhode Island study found that 33% of women tested positive for an STD at admission (Willers et al., 2008) and 26% of all women had trichomoniasis. The Centers for Disease Control and Prevention (CDC; 1999) reported that 27% of incarcerated women had chlamydia and 8% had gonorrhea, compared with 0.46% and 0.13% in the community. In 2008, 2% of women in prison were known to have HIV (Maruschak, 2010).

Family Planning

Incarcerated women generally have had poor access to contraceptive services in the community (ACOG, 2012a; Clarke et al., 2006a) and have experienced high rates of prior unintended pregnancy (Clarke et al., 2006a). A study in Rhode Island showed that only 28% of sexually active women had consistently used birth control in the 3 months prior to incarceration; 85% of these women planned to be sexually active upon release, yet only 9% had a positive attitude about being pregnant (Clarke et al., 2006a). In this same setting, nearly half of the pregnant inmates had become pregnant in between incarcerations (Clarke, Phipps, Tong, Rose, & Gold, 2010). Moreover, more than 75% of women wanted to initiate or continue their method of birth control while in custody (Clarke et al., 2006b). Indeed, offering birth control in a correctional facility resulted in a 12-fold increase of a woman initiating contraception than when she was instructed to follow up in the community (Clarke et al., 2006b). In another study, nearly one third of women entering jail had had unprotected sex within the last 5 days and could therefore be candidates for emergency contraception (Sufrin, Tulskey, Goldenson, Winter, & Cohan, 2010). Incarceration is also a time to help women plan for healthy pregnancies upon release, offering preconception counseling that focuses on the risks of substance use, improving nutritional status such as folate supplementation, and optimizing physical and mental health (ACOG, 2012a).

Mental Health

It is well known that people who are incarcerated have higher rates of mental health diagnoses than the general population. However, rates of mental health disorders are even higher among incarcerated women than men. As reported in a 2006 Department of Justice study, the comparative prevalence of mental health problems in jail was 75% for women and 63% for men, in state prison 73% vs. 55%, and in federal prison 61% vs. 44% (James & Glaze, 2006). A study of Texas inmates found that 10% of women had major depressive disorder and 5.7% had bipolar disorder, compared to 3.5% and 2.3%, respectively, among men (Baillargeon et al., 2009).

Aging

Many prisons may be failing to recognize and prepare for the specialized physical, preventive health, social, and psychological needs of the older female inmate (Reviere & Young, 2004). For example, older female inmates may experience menopausal hot flashes, which can be challenging for women to manage in the correctional environment.

Nutrition and Diet

Correctional institutions should ensure that women receive a healthy diet consistent with federal dietary guidelines (U.S. Department of Agriculture [USDA], 2010). Recommendations for females aged 19 to 50 are 1,800 to 2,400 calories per day, depending on activity levels, with no more than 300 mg cholesterol, less than 10% saturated fat, and limited trans fats. Sodium intake should not exceed 2,300 mg for healthy females aged 19 to 50 and 1,500 mg for those 51 and older or with certain health conditions such as hypertension, diabetes, and chronic kidney disease. Fiber recommendations are 14 g per 1,000 calories or 25 g per day. To maintain bone health, women aged 19 to 50 should consume 1,000 mg of calcium (1,200 mg for those over age 50) and 600 IU of vitamin D daily (ACOG, 2012b). Women capable of becoming pregnant should consume adequate iron and 400 mcg of folic acid. Pregnant women have additional caloric and nutritional needs, including iron supplements and 600 mcg of folate per day. Women 50 years and older should consume foods high in, or fortified with, vitamin B12 (USDA, 2010).

Standards

NCCHC recognizes the need to view women as a special population and to provide appropriate treatment. The *Standards for Health Services* (the basis of NCCHC's accreditation program for jails,

prisons, and juvenile detention and confinement facilities) contain several standards that impact women's health care, including the following:

- Receiving Screening (E-02) suggests inquiry into current gynecological problems and pregnancy for women and female adolescents.
- Initial Health Assessment (E-04) recommends that clinical practice guidelines be followed for pelvic examinations and Pap smears.
- Intoxication and Withdrawal (G-07) acknowledges the special management of pregnant inmates with opioid use disorders.
- Contraception (G-08) recommends that women be provided with nondirective contraception counseling, access to emergency contraception, and continuation of current contraceptive method while incarcerated.
- Counseling and Care of the Pregnant Inmate (G-09) specifies that comprehensive counseling and assistance are given to pregnant inmates in keeping with their express desires in planning for their unborn children, whether they desire abortion, adoptive service, or to keep the child. It also addresses prenatal care and the nonuse of restraints during childbirth.

Position Statement

NCCHC recognizes that the number of female inmates is large and growing annually, presenting unique and increasing issues for health services in correctional facilities. Therefore, NCCHC recommends the following:

1. Correctional institutions need to be required to meet recognized community standards for women's services as promoted by standards set by NCCHC.
2. Correctional health services and women's advocacy groups need to collaborate to provide leadership for the development of policies and procedures that address women's special health care needs in corrections.
3. Correctional institutions need to implement intake procedures that include histories on menstrual cycle, pregnancies, gynecologic problems, contraception, current breastfeeding, sexual and physical abuse, and a nutritional assessment (ACOG, 2012a).
4. Correctional institutions provide comprehensive services for women's unique health issues:
 - A. Considering women's special reproductive health needs, the frequency of repeating certain tests, exams, and procedures (e.g., Pap smears, mammograms) needs to be based on guidelines established by professional groups such as the American Cancer Society, the U.S. Preventive Services Task Force, and ACOG, and should take into account age and risk factors of the female correctional population.
 - B. Correctional institutions need to provide intake examinations that include a breast exam and, depending on the female's age, sexual history, as well as past medical history, pelvic exam, Pap smear, and baseline mammogram (ACOG 2012a; Anno, 2001).
 - C. All women at risk for pregnancy should be offered a pregnancy test within 48 hours of admission. Sexually active women remain at risk for pregnancy until they go through menopause.

- D. Considering the high levels of victimization (sexual and physical) among the female inmate population, and considering the circumstances of incarceration of violent female offenders (i.e., many have committed interpersonal altercation violence against a family member or intimate), counseling to resolve issues of victimization and perpetration of violence against intimates (such as conflict resolution skills or parenting skills) needs to be available.
 - E. Considering the large number of incarcerated women who have dependent children, counseling on parenting and child custody issues needs to be available.
 - F. Considering the unique needs of pregnant women, women need to have access to options counseling and pregnancy termination when desired, to routine prenatal care from a qualified health professional, and to specialty and emergency obstetrical care when indicated (ACOG, 2011).
 - G. Because of their high risk of postpartum depression and psychosis, women who deliver while in custody and who enter a facility within 1 year of childbirth should be screened for and educated about these conditions.
 - H. Considering the known benefits of early mother–infant attachment, correctional facilities need to facilitate contact visits for mothers with their infants.
 - I. Given the benefits of breastfeeding and breast milk, correctional facilities should make arrangements for postpartum women to either breastfeed their infants or to pump, freeze, and transport breast milk for their infants (ACOG, 2011).
 - J. Considering the high rates of mental health issues women report upon incarceration, counseling needs to be available.
 - K. Considering the high rates of alcohol and/or drug problems women report upon incarceration, counseling and treatment need to be available to address this issue.
 - L. Considering the high risk of unintended pregnancy upon release, correctional facilities need to offer contraception services in a noncoercive manner while women are in custody, and allow women to continue methods they are already on, especially if their incarceration is short term or if the method is for medical reasons. Emergency contraception also needs to be made available to women, especially at intake (ACOG, 2012a).
 - M. Correctional institutions should conduct laboratory testing for chlamydia and gonorrhea on all women up to age 25, and when possible age 35, and among pregnant women regardless of age, unless the inmate is transferred from a facility where testing was done. Because many STDs are asymptomatic, all females should be screened for risk factors for chlamydia and gonorrhea according to CDC guidelines (e.g., new sexual partner, multiple partners, previous STD) and tested if risk factors are present regardless of age. Syphilis screening protocols should be determined based on local prevalence and in consultation with local public health departments, in addition to screening all pregnant women. The CDC recommends routine opt-out testing for HIV in correctional settings, and such testing should be performed on all pregnant women.
 - N. Considering the aging of the prison population, correctional institutions need to address the unique health care needs of older women including symptom management and treatment of menopausal hot flashes.
5. Correctional institutions need to provide pre- and postrelease services for women reentering the community. Strong partnerships are encouraged between public health, community, public

assistance, and correctional agencies. Programming such as employment and vocational training, health education, and parenting education also should be available.

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