



NCCHC

National Commission
on Correctional Health Care

Standards for Health Services in Prisons

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essential

COUNSELING AND CARE OF THE PREGNANT INMATE

Standard

Pregnant inmates are given comprehensive counseling and care in accordance with national standards and their expressed desires regarding their pregnancy.

Compliance Indicators

1. Counseling and assistance are provided and documented in accordance with the pregnant inmate's expressed desires regarding her pregnancy, whether she elects to keep the child, use adoptive services, or have an abortion.
2. Prenatal care includes:
 - a. Medical examinations by a provider qualified to provide prenatal care
 - b. Prenatal laboratory and diagnostic tests in accordance with national guidelines
 - c. Orders and treatment plans documenting clinically indicated levels of activity, nutrition, medications, housing, and safety precautions
 - d. Counseling and administering recommended vaccines in accordance with national guidelines
3. Pregnant patients with active opioid use disorder receive evaluation upon intake, including offering and providing medication-assisted treatment (MAT) with methadone or buprenorphine.
4. Emergency delivery kits are available in the facility.
5. Custody restraints are not used during labor and delivery.
6. Custody restraints, if used, at other points of pregnancy and the postpartum period shall be limited to handcuffs in front of the body.
7. *Postpartum care* is provided and documented.
8. All aspects of the standard are addressed by written policy and defined procedures.

Definition

The postpartum period is the first 6 weeks after delivery. *Postpartum care* includes an examination at 2 weeks after cesarean delivery, 6 weeks after a vaginal delivery, or as specified by hospital staff. It addresses symptoms of breast engorgement and perineal or postoperative pain, provides lactation support for breastfeeding women, and includes screening for postpartum depression and discussion of family planning.

Discussion

The responsible health authority should ensure that pregnant inmates and their fetuses are provided every opportunity for healthy outcomes, and that the inmate is offered supportive comprehensive counseling and is not coerced into making any decision contrary to her expressed desires.

An arrangement should be established with a community facility as the site for delivery and for abortion care. Documentation of the patient's prenatal history should accompany her to the hospital; if a pregnant woman is released prior to delivery, efforts should be made to ensure community prenatal care and she should be given a copy of her prenatal records.

Due to the specialized nature of prenatal care, it may be provided off-site. Pregnant women who report bleeding or symptoms of labor such as pain or leaking fluid should be immediately evaluated by a qualified health care professional; when an appropriately trained health professional is not on-site, there should be consultation with or transportation to the hospital. Current recommendations are that all pregnant women should be vaccinated with the flu vaccine during flu season and tetanus, diphtheria, and pertussis during the third trimester, regardless of whether they were vaccinated outside of pregnancy. Women should be counseled on these recommendations and the vaccines must be available to them.

Before incarceration, many female inmates have limited access to prenatal care and have high-risk pregnancies because of chronic health concerns, including drug and alcohol use; tobacco use; HIV and other sexually transmitted infections; histories of abuse and mental illness; malnutrition; obesity; and stress and anxiety. As a result, specialized obstetrical staff and other resources are often needed. Medications should be reviewed by qualified providers to balance the benefit to the pregnant woman with the risk of harm for the fetus. Prenatal vitamins contain important nutrients such as folic acid and should be given to all pregnant women. Pregnant women must be given a bottom bunk or equivalent bed assignment to avoid the risk of falls. Women should be counseled on appropriate activity levels in pregnancy, such as recommendations that moderate exercise is healthy for most pregnant women. Diets should reflect national guidelines. When possible, additional food in between meal times should be provided as physiologic changes and nausea may create a need for more frequent meals.

Because alcohol exposure is harmful to the fetus, pregnant inmates should be counseled on the dangers of alcohol use while pregnant. Since withdrawal from opioids can be dangerous for the pregnancy and leads to high relapse, MAT with methadone or buprenorphine, along with counseling on benefits and risks, must be available to pregnant women who have opioid use disorder. Given the risks of opioid withdrawal in pregnancy, it is advisable that all pregnant women receive a urine drug screen in a timely fashion in order to initiate proper care.

Pregnant women have physical and physiologic changes throughout gestation that increase their risk of falls. In addition, obstetrical emergencies such as hemorrhage, eclamptic seizures, and preterm labor can arise at any point in pregnancy. Such emergencies require immediate medical intervention and/or movement of the woman. The postpartum period can involve exhaustion, dehydration, difficulty in urination or defecation, and complications such as hemorrhage.

The use of restraints is potentially harmful to the pregnant woman and fetus, especially in the third trimester and during labor and delivery. Restraint during transport to the hospital or during labor and delivery should not be used except when necessary due to serious threat of harm to the patient, staff, or others. If custody restraints are deemed necessary, abdominal restraints, leg and ankle restraints, and wrist restraints behind the back should not be used. Restraints are to be removed immediately when a medical professional who is responsible for the care of a pregnant inmate during a medical emergency, labor, delivery, or postpartum determines that removal is medically necessary. At a minimum, facilities must comply with state statutes or regulations limiting the use of restraints in pregnancy. Instances where restraints are used on pregnant women should be documented and reviewed.

Restraints at other times during pregnancy and postpartum are strongly discouraged and used under policies and procedures that are developed for the safety of mother and child and with consultation from medical staff. Abdominal restraints, leg and ankle restraints, wrist restraints behind the back, and four-point restraint should not be used, nor should pregnant inmates be placed in a facedown position. Postpartum, restraints should allow for the mother's safe handling of her infant and for mother-infant bonding, when appropriate.

To maximize compliance at the hospital, facilities should communicate their policies on restraints in pregnancy with the appropriate hospital units. To maintain privacy during childbirth, custody staff should be positioned outside the labor and delivery room.

Women should be informed of whether they have the option to breastfeed and/or express breast milk in the postpartum period. Consultation with a health professional knowledgeable about breastfeeding should be available to support lactating women. Appropriate nutrition and prenatal vitamins should be given to lactating women, and advice on symptom management for women who are not breastfeeding. Facilities should consider support for lactating mothers and those with breast engorgement who are not nursing.

Postpartum depression may manifest itself in different ways, particularly when the woman is separated from her newborn immediately after birth. Women who experience miscarriages, stillbirth, and other losses may also have difficulties. Medical staff should work with the mental health staff to address these issues and provide appropriate treatment.

Pregnancy care and outcomes should be monitored through the continuous quality improvement process.