# REPRODUCTIVE (IN)JUSTICE IN CANADIAN PRISONS FOR WOMEN

by

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## Table of Contents

## List of Tables

## List of Figures

## Abstract

**Introduction:** The population of people incarcerated in federal prisons for women in Canada increases every year. They experience barriers to reproductive health care and traumatic separations from children. The federal Mother Child Program (MCP) was created to address mother-child separation but has been the subject of little research. The aim of this study was to examine experiences of the federal MCP among participants and non-participants.

**Methods:** Case study design integrated multiple data sources and used a theoretical framework of prison abolition. Three scoping reviews foreground the study: 1) Maternal health outcomes among incarcerated women; 2) Health outcomes associated with mother child programs; and 3) Sexual and reproductive health outcomes among incarcerated women in Canada. An environmental scan mapped out facilities designated for the incarceration of women and proximity to perinatal hospitals. A theoretical framework of feminist prison abolition for nurses was developed. A quantitative study was conducted to generate descriptive statistics about MCP participation from 2001-2018. Finally, semi-structured interviews were conducted with 23 people with lived experience of federal incarceration during pregnancy and early parenting and with staff of Elizabeth Fry Societies.

**Results:** The scoping reviews found negligible maternal health research in Canadian prisons. There are 72 prisons for women and girls in the country**.** 133 mothers participated in the MCP from 2001-2018. In interviews, parents expressed ambivalence about the MCP due to exclusionary eligibility criteria. They experienced traumatic separation, mental distress was met with punishment, and they were subject to surveillance and violence. Parents navigated challenges through self-advocacy and peer support. Elizabeth Fry Societies' staff perceived the MCP as out of reach for most, resulting mother-child separation and trauma bonding. The MCP introduces additional surveillance and inequities. Both types of informants described systemic problems in health services including prioritization of security operations and clinician dual loyalty. They characterize prison as incompatible with maternal health.

**Conclusions:** Prison abolition provides a critical lens to the subject of the MCP, demonstrating failure to address health harms of incarceration to the parent-baby pair. With Elizabeth Fry staff support, parents strategically navigate federal incarceration to prioritize the best interests of their children. Alternatives to incarceration are recommended.

## List of Abbreviations and Symbols Used

| | |
|---|---|
| ACOG | American College of Obstetrics and Gynecology |
| ANA | American Nurses Association |
| ATIP | Access to Information and Privacy |
| BDI-II | Beck Depression Inventory |
| CES-D | Center for Epidemiological Studies-Depression Scale |
| CHRC | Canadian Human Rights Commission |
| COVID-19 | coronavirus disease of 2019 |
| CSC | Correctional Services Canada |
| HIV | human immunodeficiency virus |
| HPV | human papilloma viruses |
| IDU | injection drug use |
| JBI | Joanna Briggs Institute |
| MCP | Mother Child Program |
| MMAT | Mixed Methods Appraisal Tool |
| OCI | Office of the Correctional Investigator |
| P4W | Prison for Women, in Kingston, Ontario |
| Pap | Papanicolaou |
| PRISMA | Preferred Reporting of Items for Systematic Reviews and Meta-Analyses |
| PTSD | posttraumatic stress disorder |
| STBBI | sexually transmitted and blood borne infections |
| STI | sexually transmitted infection |
| TFFSW | Task Force for Federally Sentenced Women |
| WHC | Women's Health Clinic |
| UN | United Nations |
| UNODC | United Nations Office on Drugs and Crime |
| US | United States |

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# Chapter 1: Introduction

In September 2012, Julie Bilotta laboured unattended and uncared for in a solitary confinement cell at the Ottawa Carleton Detention Centre. Her baby was born footling breech, in respiratory distress, and she required emergency surgery. She was separated from her son on and off for his first year of life. Hearing about her experience at the time, as a birth doula, a new mother, and a longtime reproductive rights advocate, I was undone by the news stories about Julie, and even more so by her fierce resistance. Over the years that followed, Julie and I became friends, and I became embedded in community, clinical nursing, and political work to change how incarcerated patients receive sexual and reproductive health care. This dissertation project stems from and is informed by that work. It brings together multiple methods to consider the case of how pregnant people and parents of new children experience incarceration, focusing on the federal prison system's institutional Mother Child Program (MCP).

## 1.1 Reproductive Health of People in Prisons for Women

The number of people incarcerated in federal prisons for women has increased dramatically in the past three decades. Despite this, women still make up a small subset of the incarcerated population- only 6% overall (Correctional Services Canada, 2019).-. From 2006 to 2016, the number of non-Indigenous women in custody rose 44%; among Indigenous women, the number rose 76% (Department of Justice, 2018). Now, nearly 50% of women in federal prisons are Indigenous (Office of the Correctional Investigator, 2021). The increasing numbers of women, trans and nonbinary people in prison has profound implications for sexual and reproductive health especially when gendered experiences and needs are underappreciated and unaccommodated.

Incarcerated people begin custodial sentences with a complex health footprint that includes disproportionately high risks of childhood abuse, sexual assault, traumatic brain injury, chronic disease, sexually transmitted and blood borne infections (STBBI), mental illness and substance use disorder (Kouyoumdjian et al., 2016). While in prison, people face not only inadequate access to health services, but threats that worsen health: poor nutrition, lack of exercise, and the emotional battery of isolation, surveillance, and control. These issues- poor health on admission, health-deteriorating conditions, and barriers to care- intersect with gendered needs associated with reproduction.

Researchers in Canada have found women prisoners have higher rates of fertility and abortion than the general population as well as higher rates of unplanned pregnancy and unmet contraceptive needs (Liauw et al., 2016). They have higher rates of STBBI in comparison to incarcerated men and to women in the general population (National Collaborating Centre for Infectious Diseases, 2021), and were more likely to be overdue for cervical cancer screening (Kouyoumdjian et al., 2018). The little research available shows high rates of preterm delivery and low birth weight for babies born to mothers who experienced incarceration before or during pregnancy (Carter Ramirez et al., 2020). While under-researched, the physical reproductive health of incarcerated women in Canada and their newborns is an area of pressing concern. Less recognized still is their reproductive mental health needs, and the emotional toll of mother-child separation resulting from incarceration, particularly within the federal system where sentences are for two years or more and facilities are widely dispersed across the country. It is estimated at least two-thirds of  incarcerated women are mothers. Incarceration presents a threat not only to pregnancy prevention and health pregnancy, but healthy postpartum

and early attachment experiences for mother and child. Correctional policies remain largely silent on issues pertaining to this period and its associated health outcomes remain largely invisible in the research literature. This persists despite a 1990-era call for significant changes to federal corrections to account for gendered needs and experience.

### 1.2 Creating Choices

In 1990, the Taskforce on Federally Sentenced Women (TTFSW), a partnership between Correctional Services of Canada (CSC) and feminist non-profit organizations including the Canadian Association of Elizabeth Fry Societies (CAEFS) and the Native Women's Association of Canada (NWAC), published a landmark report called Creating Choices that aimed to transform federal corrections (TTFSW, 1990). At the time, the main federal facility for women was in Kingston, Ontario, the Prison for Women (P4W). For the small number of women incarcerated there, having a single central institution resulted in significant displacement from their families. *Creating Choices* recommended closing P4W and replacing it with a system of "cottages" intended towards rehabilitation and attentive to women's needs and lives, such as childrearing roles (TFFSW, 1990). The *Creating Choices* report acknowledged women's experiences of criminalization differed from the experiences of men and called for women-centred transformation of federal corrections based on five principles: empowerment, meaningful choices, dignity and respect, and support. It captured understanding of the intersecting trauma experienced by most women prisoners and their overall low security risk. It advocated for assessment and treatment over punishment and isolation.

*Creating Choices* also served as the basis for the eventual implementation of the federal residential Mother Child Program (MCP), arguing that "The most important

aspect of this [Regional Facilities] program is the opportunity for mothers and children to live together based on the rights and needs of the children, mothers and significant others in each individual case. Each Regional Facility must provide an appropriate environment to enable a child or children to live with the mother." (p.144). The authors also recommended that children who had to be removed by the state be placed "in specialized foster homes close to the facility so that visits between mothers and their children can be frequent." (p.145) and that CSC accept responsibility for costs associated with children who remained with their other family members to visit their mothers in prison regularly.

However, the implementation of *Creating Choices* strayed from its ideals (Shaw & Hannah-Moffat, 2000). Shaw and Hannah-Moffat (2000) described how CSC replaced the call for women-centred assessment of prisoners with an approach to risk classification that had been developed for use with male prisoners. A cascade of deviations from *Creating Choices* followed: gendered and racialized treatment needs, such as exposure to trauma, were conceived as security threats. The principle of empowerment was reconceptualised as individual responsibility (Shaw & Hannah-Moffat, 2000). The philosophical shifts and the building of six new facilities and expansion of physical capacity coincided with changes in the criminal justice system that increased the number of women receiving federal sentences. For example, more charges were laid for drug-related offences, there was increasing imposition of mandatory minimums, and the promotion of mandatory charges in domestic violence incidents.

The Prison for Women did close, and regional facilities were built to replace it: Nova Institution for Women, in Truro, Nova Scotia; Établissement Joliette, in Joliette,

Quebec; Grand Valley Institution for Women, in Kitchener-Waterloo, Ontario; Okimaw Ohci Healing Lodge, in Maple Creek, Saskatchewan, Edmonton Institution for Women, in Edmonton, Alberta, and Fraser Valley Institution for Women, in Abbottsford, British Columbia. There is also a small healing lodge called Buffalo Sage in Edmonton, Alberta. The closure of P4W and introduction of regional centres did not decrease the number of incarcerated women; indeed, the opposite occurred.

Creation of the regional facilities did not alleviate concerns about the treatment of incarcerated people. In 2003, the Canadian Human Rights Commission (CHRC) called for action to address continued discrimination against federally incarcerated women. Two years later, the United Nations Human Rights Commission reported on Canada's failure to implement the CHRC and Arbour's recommendations (Balfour, 2018). In 2007, Ashley Smith, a teenage girl imprisoned at the Grand Valley federal prison in Ontario, strangled herself in a segregation unit while under suicide watch by multiple guards. In 2013, the coroner's inquest into her death ruled it to be a homicide (Carlisle, 2013). Increased public scrutiny following these events and the on-going efforts of feminist advocates have resulted in minimal meaningful systemic change. Indeed, solitary confinement, use of force, and strip searching have remained carceral practice norms despite the optimism generated by *Creating Choices*. These persistent concerns with federal prisons must be centred in considerations of the potential health of mothers and children in prison spaces.

### 1.2 Mother Child Programs

In the literature, the infrastructure and eligibility requirements of prison mother child programs (MCP) vary considerably. An international policy review conducted by

Robertson (2012) asserts most countries allow children to live with their mothers in prison, the details on these arrangements are sparse. In the United States, which incarcerates more women than any other country in the world, there are few facilities and as the facilities are generally run independently by each state, there is a lack of national cohesion or collated reporting. According to the National Women's Law Center, in 2010 there were programs in just 13 states. The oldest of these, New York state's Bedford Hills Correctional Facility, opened in 1901.

Available research suggests there is wide variation in mother child program infrastructure, such as separate units and complementary day care. In a comparative study of programs in the United Kingdom and Australia, Farrell (1998) describes most of the English programs as operating in physically separate facilities from the main prisons. In New Zealand, the mothers and children live together in special facilities called "self care units" (Robertson, 2012, p. 22). Candelori and Dal Dosso (2007) describe the site of their observation study of one infant incarcerated with its mother in an Italian prison. They write, "The 'nursery' has all the features of a prison ward: barred windows, steel doors, locks, gates with iron bars. Even the garden-courtyard is surrounded by a high fence." (p. 61).

Some jurisdictions include day care facilities that relieve the pressure on participants from 24/7 responsibility and proximity to their children. Brazil required all prisons have rooms for breastfeeding babies up to age six months, special accommodations for pregnant women and on-site day care (Robertson, 2012). India provides day care within prisons for children up to age six (Robertson, 2012). Austria also provides day care (Robertson, 2012). In some places, the children of prison staff and

community members may attend the same facility. The Ohio Reformatory for Women includes a special wing for women to live with their babies, and they attend daycare in-house while the women perform prison duties (Inskeep, 2008).

Most jurisdictions place age or developmental restrictions on child participants. For example, Robertson (2012) states that in Ghana, once the child has weaned (from breastfeeding), they can no longer reside with their mothers. In Germany, they can live full-time inside until they are school age. In the United States and much of Europe including the United Kingdom, the age restrictions are much earlier, around 18 months.

### 1.3 Mother Child Program in Canada

In Canada, the federal residential Mother Child Program (MCP) is governed by Commissioner's Directive 768, which describes its purpose is "to foster positive relationships between women incarcerated in women offender institutions and units and their children and to provide a supportive environment that promotes stability and continuity for the mother-child relationship" (Correctional Services Canada (CSC), 2020, p.1). CD-768 sets out the responsibilities, eligibility, requirements, and processes for the program. Children may live full-time, on-site, up to the age of five. Mothers must not have been convicted of an offense against a child and must be classified as minimum or medium security risk.

There is very little published information about the federal MCP. Neither Public Safety Canada (the Ministry responsible for CSC) nor the Office of the Correctional Investigator regularly report on MCP participation, or the children of incarcerated people. Brennan (2014) investigated declining participation in the MCP from 2001-2012 through interviews with advocates working at Elizabeth Fry Societies. They described the main

reasons for declining participation as due to 1) Changes to eligibility criteria enacted under the Harper government in 2008 that made participation more exclusive and elusive; 2) Overcrowding in the prison facilities, a result of increasing use of mandatory minimum sentences, particularly for non-violent drug offences; 3) Limitations of the physical prison environment and 4) The increasingly punitive nature of corrections. Miller (2017) explores barriers to participation for Indigenous women. She finds Indigenous women are disproportionately classed at higher security levels, made ineligible for participation. The CSC policy for single-occupancy (i.e., one person per room), in the context of ever-rising numbers of incarcerated women, results in lack of space for MCP participants. Fayter and Payne (2017) tell the story of a woman, "Kendall," who wanted to participate in the MCP at Grand Valley Institution for Women. Despite "being a model prisoner" (p.16), and having received approval from the Children's Aid Society, CSC denied Kendall the necessary security reclassification.

With little research available about experiences of the MCP and discouraging findings about eligibility and participation in those articles, the health implications of participation, or of not participating, remain uninvestigated. That the program persists with so little evaluation is hard to justify considering the associated financial cost. While the budget for the MCP is not known, federal prisons for women in general are startlingly expensive: it costs taxpayers $83,861 per person per year, and $259,894 for each increase in capacity by one bed (Office of the Parliamentary Budget Officer, 2018).

### 1.4 Prison Abolition

Prison abolition critiques investments to improve prison systems, such as the investment the MCP constitutes, because they displace public funding for upstream

services to protect people from the experience of criminalization in the first place. At the same time as there is increasing spending on prison infrastructure and correctional services, funding for social programs that benefit marginalized people is inadequate, or even decreasing. For example, while the number of Indigenous women in federal prison rises year over year, the National Inquiry into Missing and Murdered Indigenous Women and Girls Truth-Gathering Process (2018) heard testimony from Indigenous women who had been subjected to childhood sexual and physical abuse but could not seek treatment due to economic barriers to access services. Untreated trauma is a significant determinant of young women's criminalization (Saar, Epstein, Rosenthal, & Vafa, 2014; Simkins, Hirsch, Horvat, & Moss, 2004).

Abolition acknowledges that despite the emphasis on security, prisons are dangerous and violent spaces. Self-injurious acts in the prisons designated for women tripled from 2008-2013, with Indigenous women accounting for 45% of incidents (Office of the Correctional Investigator, 2013 Risky Business). From 2006-7 to 2015-16, 553 federal prisoners died in custody (OCI, 2017, p. 21). Of these deaths, 15.7 per cent were suicides (OCI, 2017, p. 69). The rate of suicide among federal prisoners is six-fold higher than in the general population; the rate of homicide is ten times higher (OCI, 2017). The OCI concludes "applying a security-driven intervention model to medical or psychological distress is an inherently risky approach to managing a population that overwhelmingly presents with substance use or dependence, mental health and behavioural issues" (2017, p.26).

From a feminist perspective, abolitionism demands consideration of not only how prison creates barriers to reproductive health care, but the broad reproductive health

repercussions of prison excluding parents and children from parenting and being parented (Davis, Gent, Meiners & Ritchie, 2022). Abolition reflects on the possibility of alternatives outside of the prison walls to keep parents and children together.

### 1.5 Research Problem, Purpose and Significance

The purpose of this research was to understand the experience of federally incarcerated pregnant people and parents of young children with respect to the institutional Mother Child Program. The qualitative case study at the heart of this project relied first on collecting and in some cases generating multiple data sources, including scoping reviews of the literature, an environmental scan of prison facilities designated for women and the presence of mother child programs, a framework for abolition feminism in nursing, descriptive statistics about participation in the federal program, as well as publicly available policies and legislation relevant to the issue.

The case study addresses the primary research question: *What are pregnant people and new parents' experiences of the federal MCP?*

To address this overarching question, the following investigative questions were explored:

1. What is known about the maternal health outcomes of incarcerated women?
2. What is known about the health outcomes associated with mother child programs in prisons?
3. What is known about the sexual and reproductive health of people incarcerated fin prisons designated for women in Canada?
4. What facilities in Canada are designated for the incarceration of women and girls, how close are they to maternity services, and do they have mother child

programs?

5. What would a feminist abolitionist framework for nursing research, practice, policy and education look like with respect to care for parents experiencing incarceration?
6. How many people have participated in the federal Mother Child Program, and what is known about them?
7. How do pregnant people and new parents experience the federal MCP?

In exploring the research questions, this study addresses several significant issues for people experiencing incarceration, their children, health care providers in prisons and in community, and policy decisionmakers. First, the scoping reviews demonstrate the gaps in evidence about reproductive health outcomes in prisons generally in Canada and in relation to mother child programs specifically. Second, the environmental scan creates the first ever comprehensive picture of where women and girls are incarcerated, their physical proximity to maternity care, and their access to mother child programming across the 14 correctional systems operating in Canada. Third, the theoretical framework of abolition feminism proposes approaches for transformative nursing engagement with prisoner health. Fourth, the quantitative analysis demonstrates the rarity of federal Mother Child Program participation. Finally, the qualitative interviews provide insight into how the Mother Child Program is experienced both for those who are able to participate and for those who were not and were separated from their children. This complex portrait provides a strong foundation for identifying theory and evidence-informed next steps to address the escalating problem of parental incarceration and its impact on children and families.

### 1.6 Overview of the Dissertation

This dissertation includes eight published or in-press manuscripts positioned in nine chapters. In Chapter 2, three scoping review manuscripts form a comprehensive literature review addressing research questions 1, 2 and 3. The literature review is followed by five manuscripts. *Manuscript 4* (Chapter 3) is the environmental scan of facilities designated for incarceration of women and girls in Canada, addressing research question 4. *Manuscript 5* (Chapter 4) develops the theoretical foundation for the approach used in this case study, a framework for feminist prison abolition for nurses, responding to research question 5. *Manuscript 6* (Chapter 5) addresses research question 6 by analysing available data about participation in the federal Mother Child Program from 2001-2018. *Manuscript 7* and *Manuscript 8* (Chapter 7 and 8) build on the findings from the earlier manuscripts and focuses on research question 7 from the perspectives of both people with lived experience of pregnancy or parenting young children from federal prison, and of Elizabeth Fry Society staff who support these parents while inside and outside of prison. Finally, Chapter 9 summarizes the nursing practice, health and correctional policy and research implications of this study and offers recommendations for future directions in this field.

## Chapter 2: Literature Review

The following chapter provides an overview of the literature on the health and wellbeing of people who experience incarceration in pregnancy and when their children are very young. This literature review is divided into three sections, each of which is a published manuscript reporting a scoping review: (1) Maternal health outcomes for incarcerated women; (2) Mother child programs for incarcerated mothers and children and associated health outcomes; and (3) Sexual and reproductive health outcomes among incarcerated women in Canada. Please note that over time, the language used in this project evolved from a focus on pregnant women and mothers in prisons to the more inclusive terms "pregnant person", "parent," and "people incarcerated in prisons designated for women."

Each scoping review used the Joanna Briggs Institute methodology (Peters, Godfrey, McInerney, Munn, Tricco & Khalil, 2020). As such, for each review, a JBI-trained medical librarian, Shelley McKibbon, assisted with selection of search terms and development of the search strategy. In each review, records were independently reviewed by a peer. Each review specifies search strategy, inclusion and exclusion criteria, study selection, data extraction, and approach to data synthesis.

This chapter concludes with a summary of the literature and perceived gaps in research.

### 2.1 Maternal Health Outcomes for Incarcerated Women

This work in section 2.1 also appears in: **Paynter, M.J.,** Drake, E., Cassidy, C., & Snelgrove-Clarke, E. (2019). Maternal Health Outcomes for Incarcerated Women: A

Scoping Review. *Journal of Clinical Nursing, 28*(11-12), 2046-2060. Published online February 20. doi: 10.1111/jocn.14837

. Co-author Emily Drake was the second reviewer for all articles. Dr. Christine Cassidy supported the conceptualization and Dr. Erna Snelgrove-Clarke reviewed the manuscript.

Women's imprisonment is rising. Although the United States reports small decreases in overall imprisonment (Kaebel & Cowhig, 2018), the country incarcerates 30% of the world's population of female prisoners, at a rate of 133 per 100,000 population or at least eight times the rate of every other NATO country (Kajstura, 2018). The rate in the United Kingdom is 16 per 100,000 (Sturge, 2018). The number of women who are incarcerated in Australia increased by 53% in the past five years (Australian Bureau of Statistics, 2018). From 2005–2014, the number of women in federal prisons in Canada rose 66% (Office of the Correctional Investigator, 2014). Most of these prisoners are mothers. In 2007, the US incarcerated 65,600 mothers of 147,400 children (Glaze & Maruschak, 2008). In the United Kingdom, 66% of women prisoners are mothers (Epstein, 2014). The incarceration of women may present a significant risk to maternal health in pregnancy, labour and delivery, breastfeeding and postpartum recovery.

The United Nations *Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders* (“the Bangkok Rules”) specify the need to attend to “special problems women offenders encounter, such as pregnancy and child care” (United Nations Office on Drugs & Crime, 2010, p. 6). In this article, we review available research in English pertaining specifically to imprisoned women's health experiences during pregnancy, delivery and the first six months postpartum. The complex

health and socio-economic characteristics of women prisoners suggest greater risk of pregnancy and delivery complications, challenges with breastfeeding and peripartum depression. The context of imprisonment, including restraints, isolation, and shackling, may further impact women's experience. While neonatal infant outcomes are important, this review is unique in its centring of the experience of the women.

### 2.1.1 *Aims and Objectives*

The aim of this scoping review is to centre women in a synthesis of existing research on maternal health outcomes of incarcerated women. The research on the incarcerated women in the perinatal period is focused on nonmaternal outcomes, such as birthweight; nonhealth outcomes, such as recidivism; and risk factors that do not emerge from the perinatal experience specifically, such as substance use. By centring the question of this review on women, we call for greater attention to women's health and to how women would define meaningful, healthful outcomes. This review is based in a compassionate philosophy that considers incarcerated women worthy of healthful pregnancies, safe births, information, choice, breastfeeding and parenting experiences.

### 2.1.2 *Background*

**2.1.2.1 Rationale for Review Centring Women's Experiences.** Women prisoners experience complex health histories, including disproportionate exposure to violence and sexual abuse, poverty and development of mental illness and substance use disorders. In the United Kingdom, 53% of women prisoners report being victimised sexually, emotionally or physically as a child (Bulman, 2017). Although systematic review of the evidence has found methodological problems with and variations in prevalence counts, the rate of mental illness among prisoners in the US is decidedly

higher than the general population (Prins, 2014). In Canada, 63% of women in federal facilities are prescribed psychotropic medications (Kouyoumdjian, Schuler, Matheson, & Hwang, 2016). In Australia, one in four prisoners take a medication for mental health (Australia Institute for Health and Welfare, 2016). The experience of incarceration itself can be triggering and harmful to women's mental health (Mollard & Brage Hudson, 2016). The confining experience of incarceration may cause women to experience increased anxiety and depression (Ferszt, Miller, Hickey, Maull, & Crisp, 2015). Studies have found one in five imprisoned people in Canada attempt suicide (Kouyoumdjian et al., 2016). The rate of self-inflicted death is 58.6 times higher in United Kingdom prisons than in the general population (Prison Reform Trust, 2018).

Incarceration as a mother may be particularly difficult. Separation from children can cause incarcerated mothers to experience distress and anxiety (Shamai & Kochal, 2008). Chambers (2009) recount newly postpartum incarcerated mothers' feelings of loneliness, depression and pain from the separation from their infants experienced after birth. Fear of losing custody of their children is described as an "extreme concern" among incarcerated mothers (Luke, 2002, p. 934). Care for their children during incarceration is a significant preoccupation (Luke, 2002). Incarcerated women's own experiences of abuse and the foster care system during their childhoods place them at high risk of experiencing attachment disorders (Baradon, Fonagy, Bland, Lénárd, & Sleed, 2008).

Keeping the mother and child together and facilitating breastfeeding may have uniquely positive effects for incarcerated women in relation to these health histories. Breastfeeding is a protective factor against the development of peripartum depression (Watkins, Meltzer-Brody, Zolnoun, & Stuebe, 2011), to which women with a history of

mental illness are predisposed (Räisänen et al., 2014). Incarcerated mothers express lower suicide risk than incarcerated women without children, pointing to the potential mental health benefit to supporting mothers' parent role and contact with children (Krüger, Priebe, Fritsch, & Mundt, 2017). "Maternal therapy," whereby infants room-in with their mothers and practice skin-to-skin contact, enhances recovery from neonatal abstinence syndrome (Bagley, Wachman, Holland, & Brogley, 2014), a neonatal complication to which the infants of women with substance use disorder are predisposed.

Indigenous women and women of colour are significantly overrepresented in the carceral system. In the last ten years, the population of incarcerated Indigenous women in federal prison in Canada has increased by 42.9% and 37% of federally incarcerated women are Indigenous (Public Safety Canada, 2017, p.63). Twenty-eight per cent of prisoners in Australia identify as Aboriginal (Australian Bureau of Statistics, 2018). In the US, 38% of prisoners are Black (Federal Bureau of Prisons, 2019).

Ours is not the first review article to address maternal outcomes among incarcerated women; it is however unique in its women-centred approach. Bard, Knight, and Plugge (2016) conducted a rigorous and important systematic review of 18 studies in this research area. However, their inclusion and exclusion criteria differ from our approach. The outcomes of interest in their review are not restricted to women-centred health outcomes in the perinatal period and include infant outcomes, health services use, recidivism, child custody and HIV status. They also include studies conducted outside of the carceral setting and nonresearch. Foley and Papadopoulos (2013) conducted a review of the perinatal mental health needs of Black and minority ethnic women. They did not include a critical appraisal of included studies (Shaw, Downe, & Kingdon, 2015) aimed

to synthesise research about the experiences and outcomes for pregnant incarcerated women and their infants. The timeframe for their search is limited to 1992–2012, and they use only two search terms, "mother" AND "prison." Of the seven studies they include, one examines satisfaction with a doula programme, three examine infant outcomes (birthweight), and one is not specific to the perinatal period. Mukherjee, Pierre- Victor, Bahelah, and Madhivanan (2014) sought to conduct a systematic review of the prevalence and correlates of mental health issues among pregnant prisoners. However, none of the studies they include examine health outcomes, but rather focus on risk factors.

**2.1.2.2 Theoretical Framework.** This review uses intersectional feminist theory as a guiding framework (Crenshaw, 1989). Intersectional feminist theory moves beyond gender-based analysis to examine the overlapping layers of identities and discrimination, such as racism, ableism, homophobia, cissexism and class privilege, that impact social and economic experiences. Intersectional feminist theory presents not only an analytical tool for conducting research but aims to create solutions for advancing health equity.

Gender, race and class are key considerations in this research as maternal health, breastfeeding and newborn care are experiences that disproportionately affect women and carceral experiences are demonstrably raced and classed. There are interactions between the social and economic determinants of health, the health determinants of criminalisation and the relationships between health status and health futures. For example, breastfeeding success influences mothers' peripartum mental health (Figueiredo, Canario, & Field, 2014) and breastfeeding has long-term impacts on women's risks of developing chronic illness and noncommunicable disease (Dieterich, Felice, O'Sullivan, & Rasmussen, 2013). Breastfeeding is a rare topic in the carceral health research literature (Paynter &

Snelgrove-Clarke, 2017). Intersectional feminism centres women's experiences and considers women experts of their own experience. Incarceration compounds gender-based, race-based and classbased discrimination that marginalises the voices of women who experience criminalisation.

### 2.1.3 *Design*

This paper uses the systematic scoping review methods of the Joanna Briggs Institute (JBI). All authors are JBI-trained. Scoping reviews intend to synthesise the types of research and findings in an area using a systematic approach. They "have great utility for synthesizing research evidence and are often used to map existing literature in a given field in terms of its nature, features, and volume" (Peters et al., 2015, p. 141). A scoping review is appropriate for the topic of an intersectional feminist examination of the maternal health of incarcerated women as this perspective has not been comprehensively reviewed (Peters et al., 2015). This systematic scoping review followed the JBI method and began with the development of a protocol followed by an extensive search of the literature that was both rigorous and replicable through the following defining points of the study's design (Peters et al., 2015).

### 2.1.4 *Methods*

**2.1.4.1 Scoping Review Research Question.** The purpose of this review was to address the following research question: What is the state of knowledge pertaining to maternal health outcomes for incarcerated women?

**2.1.4.2 Data Sources and Search Strategy.** Support of an experienced JBI-trained medical research librarian was used to develop and implement our search strategy using MeSH and key terms (e.g., incarcera*, breast*) to investigate the current state of

knowledge of the maternal health outcomes of pregnant and incarcerated women. The developed search strategy was used to search the published literature available in CINAHL. It was then translated with help of the medical research librarian to search two additional electronic databases: PubMed and PsycINFO. These databases were searched in February of 2018 with no date limitations. Additionally, we supplemented this search by hand-searching the literature that was published between March of 2013–March of 2018 in three key journals: *The American Journal of Maternal Child Nursing, The Journal of Obstetrical, Gynecologic and Neonatal Nursing* and *The Journal of Forensic Psychiatry and Psychology.* These journals were chosen to capture international study in these areas and to cover the range of physical and mental health outcomes associated with the perinatal period for women. The reference lists of key articles were also scanned for pertinent articles. To search for relevant but unpublished literature, we searched ProQuest Dissertation and examined the first 100 hits of Google Scholar using the terms pregnant* OR perinat* OR prenatal* OR postpartum OR birth* OR breastfe* OR lactat* OR "peri nat*" OR "post partum" OR "breastfe*" AND carceral OR penal OR custody* OR jail OR prison* OR incarcerat* OR penitentiar* OR detention OR inmate* OR offender*. Please see Appendix A. The review adheres to the PRISMA-EQUATOR checklist for systematic reviews.

**2.1.4.3 Eligibility Criteria.**

**2.1.4.3.1** ***Study Design.*** We included empirical studies (qualitative, quantitative and mixed methods) in this review. Studies had to have been published in English or French, with no predefined date range.

**2.1.4.3.2** ***Population.*** The population of interest included women or transgender individuals who were incarcerated at any point during the perinatal period, which for the

purpose of this review was defined as pregnancy, labour, delivery and the postpartum period, defined as the six months post birth (Romano, Cacciatore, Giordano, & Rosa, 2010).

**2.1.4.3.3 *Concepts.*** The concepts of interest for this scoping review are studies that investigated the perinatal (the period before, during and six months after birth) health outcomes in our participant population. They include but are not limited to breastfeeding, postpartum depression, gestational complications (e.g., gestational diabetes and gestational hypertension) and operative deliveries.

**2.1.4.3.4 *Context.*** This scoping review concerned studies that have been conducted within carceral facilities, including jails, prisons, detention centres, police lock-up, immigration detention and juvenile detention.

**2.1.4.3.5 *Exclusion criteria.*** We excluded nonresearch, case studies and review articles. We excluded studies that examined infant outcomes and nonhealth outcomes, such as recidivism. Studies that examined nonoutcomes or outcomes nonspecific to the perinatal period, such as substance use, risk factors and access to services, were not included.

**2.1.4.4 Study Selection.** Following the search, we collated and uploaded all identified citations into RefWorks. We removed and deleted duplicates. We used a two-step screening process to determine citation eligibility based on the review's inclusion and exclusion criteria. Two independent reviewers screened titles and abstracts. In the second phase of the process, these reviewers then screened the full text of the selected studies from phase one. We excluded full-text studies that did not meet the inclusion criteria. We resolved disagreements through consensus discussions.

**2.1.4.5 Data Collection and Synthesis.** The reviewers developed a data extraction form in Microsoft Excel to extract key characteristics of the studies, which

included title, author(s), year of publication, country of publication, purpose, design, population, sample size, relevant outcomes and relevant findings. We extracted data from papers included in the review using McGill Mixed Methods Appraisal Tool (MMAT) (Pluye et al., 2011) by two independent reviewers. This tool can be used to appraise research of qualitative, quantitative and mixed-method designs (Pluye et al., 2011). The data extracted included specific details pertaining to the populations, study methods and outcomes of significance to the review's question and objectives. We resolved any disagreements between the reviewers through discussion, with a third reviewer available who was not needed. We used an excel spreadsheet table to organise data and expedite the mapping of major themes.

**2.1.4.6 Data Items.** Maternal health outcomes include breastfeeding, operative deliveries, gestational complications, depression and anxiety, stress, maternal experiences, bonding and attachment and sterilisation.

**2.1.4.7 Critical Appraisal.** Overall quality scores of 0, 0.25 (*), 0.5 (**), 0.75 (***) or 1.0 (****) were assigned to the individual research studies based on the quality criterion of the MMAT (Pluye et al., 2011).

### 2.1.5 *Results*

**2.1.5.1 Data Presentation.** Our search in the published literature databases retrieved 3,741 hits. Searching additional sources, including hand-searching key journals, reviewing review articles, Google Scholar and ProQuest Dissertations, retrieved 577 articles. Removal of duplicates resulted in 3,225 articles for title and abstract review. We independently screened the articles to identify those eligible for full-text review. We included 45 articles for full-text review, of which 13 met our inclusion criteria (Figure 1).

Reasons for exclusion of 32 articles include the following: outcome (9 studies); setting (2); population (4), not research (6), duplication (1), language (4); review (4); and lack of specification at outcome of maternal outcomes of interest (2).

**2.1.5.2 Study Characteristics.** The 13 studies were published between 1989–2014. Twelve were based in the United States and one in Australia. Study designs included three qualitative studies, four cohort or survey studies, four case–control studies and two using mixed qualitative and quantitative methods. Sample sizes varied from 12, as in both the qualitative studies by Chambers (2009) and Wismont (2000),–over 40,000, as in the retrospective cohort study by Walker, Hilder, Levy, and Sullivan (2014). The relevant outcomes using the intersectional feminist lens and centring on the women's experiences included infant feeding method, method of delivery, gestational complications, peripartum depression, maternal stress, maternal experiences and sterilisation (Table 1).

**Figure 1**

*PRISMA: Maternal Health Outcomes*

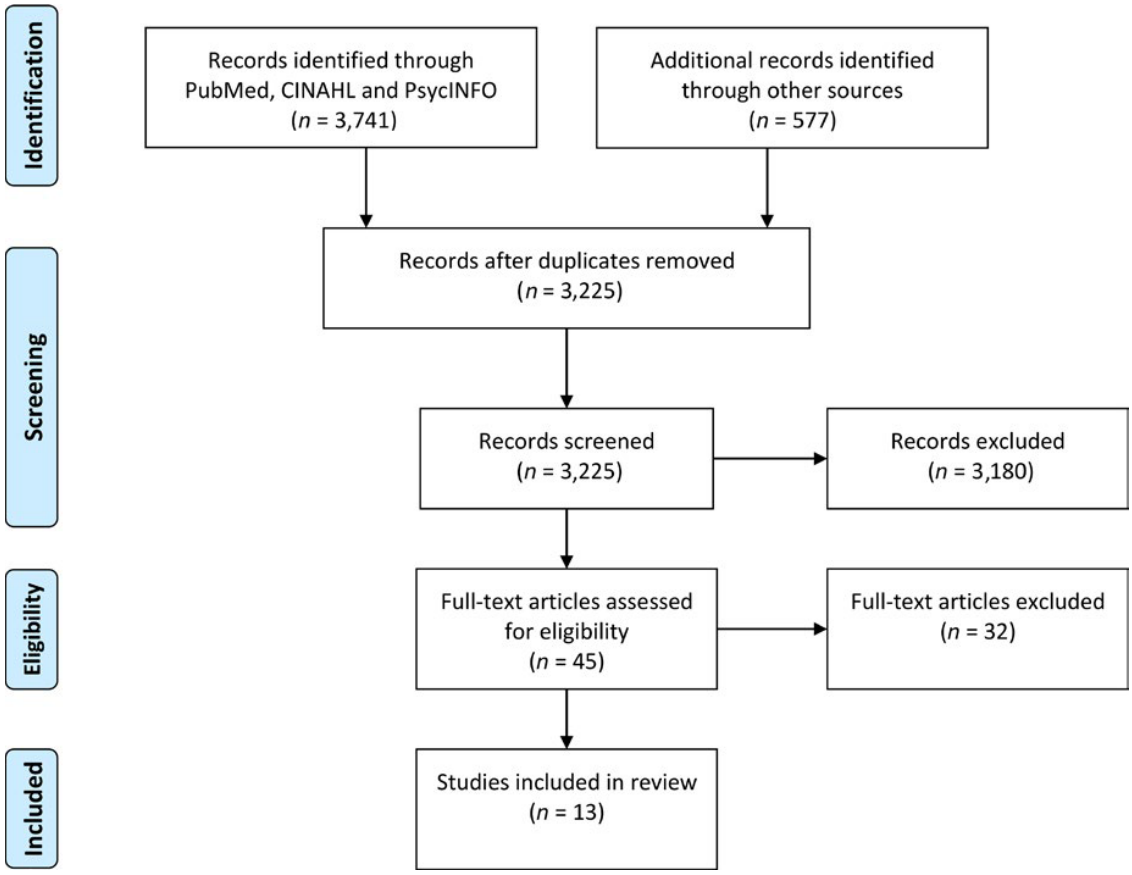


**Table 1**

*Included Studies and Maternal Health Findings*

| Journal | Authors, Year, Setting | Purpose | Design | MMAT score | Sample size and population | Maternal outcomes | Relevant findings |
|---|---|---|---|---|---|---|---|
| *Policy, Politics, & Nursing Practice* 10(3) | Chambers, A.N.<br>2009<br>USA | Examines the impact of the policy that separates mothers and babies immediately and during most of the postpartum period, by exploring the nature and meaning of the mother–infant bonding experience when the mothers know separation is coming | Qualitative | 0.75 | 12<br>Prison hospital patients who were 1–3 days postpartum and separated from their infants | Perceptions of the nature and meaning of the mother–infant bonding experience when the mothers know separation is coming; type of delivery; type of feeding (breast or formula) | 4 C-sections, 8 vaginal deliveries; 1 breastfed; 11 formula fed. Qualitative themes: “a love connection” to the foetus; “everything was great until I birthed” (and infant was going to be removed); “feeling empty and missing a part of me”; “I don't try to think too far in advance.”. |
| *Journal of Perinatology 12*(3) | Cordero, L., Hines, S., Shibley, K.A., Landon, M.B.<br>1992<br>USA | To determine whether adequacy of prenatal care received by high-risk prison population can impact perinatal outcome | Cohort<br>Quantitative<br>Descriptive | 1 | 233<br>Women who served time in a medium security prison and were pregnant from 1986–1990. All gave birth while imprisoned. | Gestational complications, operative deliveries. | 64 (27%) experienced prenatal complication such as preterm labour, gestational diabetes and hypertension; 194 (84%) vaginal deliveries and 29 (16%) by C sections. |

| Journal | Authors, Year, Setting | Purpose | Design | MMAT score | Sample size and population | Maternal outcomes | Relevant findings |
|---|---|---|---|---|---|---|---|
| *Journal of Reproductive Medicine 37*(2) | Egley, C.C., Miller, D.E., Granados, J.L., Ingram-Fogel, C.<br>1992<br>USA | To study prenatal and perinatal obstetric and medical problems in a cohort of pregnant prisoners during a 12-month period | Case–control<br>Quantitative<br>Descriptive | 1 | 138 (69 cases and 69 controls)<br>Inmates who delivered at a medical centre were matched with noninmates by race, age, parity and date on which they entered prenatal care | Antepartum hospitalisation, false labour, preterm labour and premature rupture of the membranes | No significant differences between populations except premature rupture of membranes: 2/69 prisoners versus 18/69 controls |
| *Journal of Obstetric, Gynecologic & Neonatal Nursing 22*(1) | Fogel, C.I<br>1993<br>USA | To document the risk factors and outcomes of pregnant women incarcerated in a maximum-security prison | Survey<br>Quantitative<br>Descriptive | 1 | 89<br>Pregnant incarcerated women in their third trimester | Gestational complications; depression (Center for Epidemiological Studies-Depression Scale (CES-D) and anxiety using the Spielberger State-Trait Anxiety Inventory Subscale for State Anxiety (STAI-S). | Prenatal complications: pregnancy-induced hypertension 3 (3.4%); anaemia 35 (39.3%); diabetes 3 (3.4%); psychiatric disorder 17 (19.3%), however, not clear if these conditions pre-dated pregnancy. Participants reported high levels of anxiety; mean anxiety score for the sample being 43.37 (SD = 7.03); high levels of depressive symptomatology; mean depression score was 27.26 (SD = 10.98). 77% reported depressive symptomatology above level indicative of clinical depression. |

| Journal | Authors, Year, Setting | Purpose | Design | MMAT score | Sample size and population | Maternal outcomes | Relevant findings |
|---|---|---|---|---|---|---|---|
| *MCN, The American Journal of Maternal/ Child Nursing 26*(1) | Fogel, C.I., Belyea, M.<br>2001<br>USA | To explore pregnant prisoners' experiences with childhood violence and substance abuse, their parenting attitudes and their psychological health | Survey (oral)<br>Quantitative<br>Descriptive | 1 | 63<br>Pregnant incarcerated women in their third trimester 1993–1995; women with convictions of child abuse or neglect were excluded | Depressive symptoms and stress using Center for Epidemiological Studies-Depressions scale (CES-D); General Stress was operationalised by the Perceived Stress Scale (PSS) | High levels of depressive symptomatology with a mean depression score of 24.14 (SD = 12.55) for the sample. More than 70% of participants reported depressive symptoms above the level considered indicative of clinical depression. High levels of current (in the past month) stress with the mean stress score of 27.2 (SD = 9.35) |
| *Psychology of Women Quarterly 32*(4) | Hutchinson, K.C., Moore, G.A., Propper, C.B., Mariaskin, A.<br>2008<br>USA | To understand the psychological experience of pregnancy during incarceration | Mixed: Qualitative and quantitative | 0.25 | 25 (21 were pregnant at the time, and 4 had given birth within the past 2 months)<br>Incarcerated and pregnant or had given birth in last two months | Psychological distress, bonding measured through Brief Symptom Inventory (BSI), Beck Depression Inventory (BDI-II), Parent Bonding Inventory (PBI). | Participants reported moderate depression. Depressive symptoms were positively correlated with themes of separation, attachment, visitation, jealousy towards interim caregivers and cognitive coping |
| Dissertation | Kaminer, A.D.<br>1992<br>USA | To identify relationships among stress from life events, social support and maternal–foetal | Case–control<br>Quantitative<br>Descriptive | 1 | 132 (70 imprisoned pregnant women and 62 pregnant women who | Maternal-Fetal Attachment Scale (Cranley, 1981); Life Events Stress Questionnaire (Norbeck, 1984); Personal Resource | Significantly higher levels of life events stress and lower levels of social support in the incarcerated group. Levels of maternal–foetal attachment were |

| Journal | Authors, Year, Setting | Purpose | Design | MMAT score | Sample size and population | Maternal outcomes | Relevant findings |
|---|---|---|---|---|---|---|---|
| | | attachment in incarcerated and nonincarcerated pregnant women. | | | were not imprisoned)<br>Incarcerated pregnant women and nonincarcerated pregnant women | Questionnaire (Brandt and Weinart, 1981) | similar in the incarcerated and nonincarcerated groups. Life events stress was not correlated with maternal–foetal attachment in either of the two subgroups. |
| Dissertation | Lin, C.H.<br>1997<br>USA | This study examined the patterns of care and outcomes for pregnant inmates and their infants in Texas state prisons between 1994–1996 | Mixed:<br>Case–control<br>Quantitative<br>Descriptive | 1 | 1,006 (20 pregnant inmates who delivered were interviewed; 202 pregnant women included in quantitative data set compared to 804 controls)<br>Pregnant inmates who delivered in a 2-year period and a randomly sampled comparison cohort of 804 women from general Texas population, matched on race and educational levels | Gestational complications, operative deliveries, sterilisation | Pregnancy-induced hypertension: inmate = 7% (14); comparison = 0.4% (3) p-value < 0.001; 16% of inmates were sterilised (no data on control) |

| Journal | Authors, Year, Setting | Purpose | Design | MMAT score | Sample size and population | Maternal outcomes | Relevant findings |
|---|---|---|---|---|---|---|---|
| *Journal of Obstetric, Gynecologic & Neonatal Nursing 18*(4) | Shelton, S.J., Gill, D.G.<br>1989<br>USA | To obtain detailed information on the ways in which women describe their feelings and perspectives on the circumstances of pregnancy in prison | Qualitative | 0.25 | 26<br>Pregnant inmates in their last trimester | Perceptions of circumstances of pregnancy in prison; prenatal complications | Pregnancy experience in prison perceived of as negative; all expressed anger, regret and depression. Of the 26 women, 20 were identified as having 72 complications during their childbearing cycles. Nine women had primary, and two women had repeat caesarean deliveries. Most frequent complications were infections of the reproductive tract. |
| *Journal of Maternal-Fetal Medicine 2*(5) | Terk, J.V., Martens, M.G., Williamson, M.A.<br>1993<br>USA | To assess the effect of incarceration on pregnancy outcome | Case–control<br>Quantitative<br>Descriptive | 1 | 193 (76 inmates and 117 controls)<br>Pregnant women imprisoned during their gestation were compared to a control group of nonincarcerated women | Operative or vaginal delivery | No significant differences between populations regarding rate of C-section (28% case, 27% controls) |
| *BMC Pregnancy and Childbirth 14* | Walker, J.R., Hilder, L., Levy, M.H., Sullivan, E.A. | To investigate whether imprisoned pregnant women in New South Wales, Australia, have | Cohort<br>Quantitative<br>Descriptive | 1 | 40,907 (birthing prisoners = 99; nonbirthing prisoners who were incarcerated at least 5 days of pregnancy = 203; | Premature onset of labour, method of birth | Pregnant prisoners did not have significantly better outcomes with respect to early onset of labour and method of birth compared with other similarly disadvantaged |

| Journal | Authors, Year, Setting | Purpose | Design | MMAT score | Sample size and population | Maternal outcomes | Relevant findings |
|---|---|---|---|---|---|---|---|
| | 2014<br>AUS | improved maternal and perinatal outcomes | | | prisoners who were incarcerated 5 days but not pregnant = 1,238; "community controls" = 39,367)<br>(1) Imprisoned pregnant women aged 18–44 years who gave birth between 2000 & 2006 with women who were (2) imprisoned at a time other than pregnancy and (3) community control | | women (with a history of imprisonment but not imprisoned during pregnancy). No association between imprisonment during pregnancy and improved perinatal outcomes for imprisoned women. |
| *Journal of Correctional Health Care 12*(2) | Williams, L., Schulte-Day, S.<br>2006<br>USA | To explore depression in pregnant incarcerated women | Mixed: Qualitative and quantitative | 0.45 | 120<br>Inmates who had recently given birth while incarcerated | Beck Depression Index | None of the participants found to be clinically depressed. |
| *Journal of Midwifery & Women's Health 45*(4) | Wismont, J.M.<br>2000<br>USA | To describe the childbearing experience as reported by pregnant incarcerated women | Qualitative | 0.75 | 12<br>Incarcerated pregnant women | Perceptions of the childbearing experience in incarceration | Essential themes related to the experience of childbearing in prison include the following: apprehension, grief, subjugation and relatedness |

**2.1.5.3 Breastfeeding.** Only one study in the review mentioned breastfeeding. Although not a major theme that emerged in her qualitative inquiry, Chambers (2009) noted that among the 12 participants in her study, one breastfed and 11 used formula. As eligibility for this study included only prisoners who would be separated from their infants within the first few days postpartum, that one breastfeeding experience is notable in the literature but limited in terms of information it provides.

**2.1.5.4 Operative Deliveries.** Six studies examined vaginal versus Caesarean-section deliveries (Chambers, 2009; Cordero, Hines, Shibley, & Landon, 1992; Lin, 1997; Shelton & Gill, 1989; Terk, Martens, & Williamson, 1993; Walker et al., 2014). In a qualitative study of 12 prisoners' maternal health experiences, Chambers (2009) notes that four (33.3%) delivered by C-section and eight (66.6%) by vaginal delivery. In their cohort study of 233 prisoners, Cordero et al. (1992) found 29 (16%) prisoners delivered by C-section and 194 (84%) by vaginal delivery. Comparing 202 pregnant prisoners with 804 randomly selected community-based controls matched for race and educational attainment, Lin (1997) did not find a significant difference in the Csection rates between groups. In their qualitative study of 26 prisoners in the third trimester, Shelton and Gill (1989) identified 11 (42%) women had caesarean deliveries, of which two were repeat C-sections. Terk et al. (1993) found no significant differences between the 76 members of the prisoner case group and 117 controls regarding rate of C-section (28% case, 27% controls). In their retrospective examination of 40,907 people, including 99 prisoners who gave birth while imprisoned (birthing prisoners), 203 people who were pregnant at some point during imprisonment (former pregnant prisoners), 1,238 people who had been imprisoned but not during pregnancy (prison controls) and 39,367 community controls,

Walker et al. (2014) found the C- section rate for cases (prisoners who gave birth while imprisoned) (28%) comparable to community controls (26%). However, former pregnant prisoners were significantly less likely to have a C-section when compared to birthing prisoners (adjusted OR 0.38 (0.21–0.70)), and the prison controls were also significantly less likely to have a C-section when compared to birthing prisoners (adjusted OR 0.60 (0.38–0.96)).

**2.1.5.5 Gestational Complications.** Six studies examined gestational complications Cordero et al., 1992; Egley, Miller, Granados, & Ingram-Fogel, 1992; Fogel, 1993; Lin, 1997; Shelton & Gill, 1989; Walker et al., 2014). In their cohort study, Cordero et al. (1992) found 64 (27%) prisoners experienced prenatal complications such as preterm labour, gestational diabetes and hypertension. Egley et al. (1992) found only one gestational complication to be statistically different between 69 prisoners who delivered at a hospital with 69 controls who delivered at the same medical centre. Premature rupture of the membranes was more commonly observed among the controls (Egley et al., 1992). Fogel (1993) found three (3.4%) of the 89 pregnant prisoners who participated in her survey experienced pregnancy-induced hypertension. Lin (1997) found a significantly higher rates (7%) of pregnancy-induced hypertension among the 202 pregnant prisoner participants compared to 804 controls, among whom 0.4% experienced pregnancy-induced hypertension ($p$-value < 0.001). Of the 26 participants in Shelton and Gill (1989)'s qualitative study, 20 were identified as having 72 different types of complications. Walker et al. (2014) found pregnant prisoners did not have significantly different outcomes with respect to early onset of labour compared with other similarly disadvantaged women.

**2.1.5.6 Stress.** Two studies examined stress (Fogel & Belyea, 2001; Kaminer, 1992). Fogel and Belyea (2001) used the Perceived Stress Scale (PSS) (Cohen, Kamarak, & Mermelstein, 1983) and found high levels of current (in the past month) stress with the mean stress score of 27.2 out of a possible total of 40 (*SD* = 9.35). Kaminer (1992) administered the Life Events Stress Questionnaire (Norbeck, 1984) and found significantly higher levels of life events stress among the 62 pregnant prisoners compared to the 70 participants in the control group.

**2.1.5.7 Depression and Anxiety.** As peripartum depression and anxiety are some of the most common complications of pregnancy, affecting approximately 15% of pregnant people (Robertson, Grace, Wallington, & Stewart, 2004), and incarceration is isolating and potentially triggering of mental illness (Mollard & Brage Hudson, 2016), peripartum depression and anxiety are key outcomes to examine in terms of incarcerated women's maternal health outcomes. Four studies in our review examined depression and/or anxiety, all using previously validated tools (Fogel, 1993; Fogel & Belyea, 2001; Hutchinson, Moore, Propper, & Mariaskin, 2008; Williams & Schulte-Day, 2006). The instruments used included the Center for Epidemiological Studies- Depression Scale (CES-DS), with possible scores from 0–60 (Fogel, 1993; Fogel & Belyea, 2001) and the Beck Depression Inventory (BDI-II) (Hutchinson et al., 2008; Williams & Schulte-Day, 2006). In a sample of 120 prisoners who had recently given birth, Williams and Schulte-Day (2006) found no participants to be clinically depressed using the BDI-II for measurement of depression. In a survey of 89 pregnant prisoners using the CES-DS, Fogel (1993) found a mean depression score of 27.26 (*SD* = 10.98) and 77% of participants reported depressive symptomatology above the level indicative of clinical

depression. In a later survey of 63 pregnant prisoners using the CES-DS, Fogel and Belyea (2001) found a mean depression score was 24.14 (*SD* = 12.55) and 70% of participants reported depressive symptoms above the level indicative of clinical depression. Of the 25 pregnant and postpartum prisoners who participated in Hutchinson et al. (2008)'s mixed-methods study, the authors found, on average, participants experienced moderate depression. Themes of qualitative studies of the women's experiences were largely based in the area of depression, grief and not wanting to think about it or having to keep one's distance to preserve mental health.

**2.1.5.8 Experiences.** Intersectional feminist frameworks centre women's experiences and explorations of power and oppression in those experiences. Three qualitative studies explored imprisoned women's experiences of health in the perinatal period (Chambers, 2009; Shelton & Gill, 1989; Wismont, 2000). Chambers (2009) interviewed 12 prisoners who were separated from their newborns within the first three days of the postpartum period. Themes in her study included feeling "a love connection" to the foetus; "everything was great until I birthed" (and infant was going to be removed); "feeling empty and missing a part of me"; and "I don't try to think too far in advance." Although Shelton and Gill (1989) interviewed 26 pregnant prisoners, they included narrative responses from only three, under the pseudonyms of Amy, Susan and Florence. Each of these participants expressed feelings of depression, anger and regret. For example, "If you think about it being a baby, it's depressing to the point where you wouldn't be able to do anything 'cause you know they're going to take it away from you when you have it. You can't get that attached to it before it's born; you got to kinda keep

your distance." (p.304). Wismont (2000) summarised the themes in her study of 12 pregnant prisoners as apprehension, grief, subjugation and relatedness.

**2.1.5.9 Bonding and Attachment.** Both Hutchinson et al. (2008) and Kaminer (1992) examined bonding. Hutchinson et al. (2008) used an established tool, the Parent Bonding Inventory. The dominant themes included the following: fear of separation and lack of attachment (58%), plans for reunification (71%), confidence in mothering ability (79%) and thinking of baby constantly (88%). Kaminer (1992) used an established tool, Maternal-Fetal Attachment Scale. Kaminer (1992) found levels of maternal–foetal attachment were not significantly different between the 70 pregnant prisoners and 62 pregnant women who were not imprisoned. These results suggest bonding and attachment are priority concerns among the imprisoned participants.

**2.1.5.10 Sterilisation.** Although no studies examined coercive practices like shackling, Lin (1997) included data regarding sterilisation of prisoners after delivery. Lin (1997) found 16% of the 202 pregnant prisoners in their case group were sterilised through bilateral tubal ligation. No data were available for the control group.

**2.1.5.11 Quality of Evidence.** The MMAT scores varied from one star (*) to four (****), or from 25%– 100% scores. We used MMAT types 1 (Qualitative), 4 (Descriptive quantitative) and 5 (Mixed methods). None of our included studies evaluated an intervention, and thus, we did not use MMAT 2 or 3. Of the three qualitative studies, two scored 75% and one scored 25%. None included a discussion of the researcher's role and influence, and thus, none received perfect scores. Of the eight descriptive quantitative studies, all scored 100%. Of the two mixed-method studies (Hutchinson et al., 2008; Williams & Schulte-Day, 2006), both scored 25%.

### 2.1.6 *Discussion*

In this scoping review, we found 13 studies that included examination of maternal outcomes for incarcerated women specifically investigating maternal health and experiences. The research on the perinatal period for incarcerated women is dominated by concern with infant outcomes, such as birthweight, health issues not specific to the perinatal period, such as substance use, and nonhealth outcomes, such as recidivism. Our review identifies gaps in research examination of maternal concerns, including patient satisfaction, an important and underappreciated maternal health outcome (Austin et al., 2014) and maternal mortality, which is rising overall and rising disproportionately among marginalised populations (Creanga et al., 2014).

Twelve of the 13 studies in this review were based in the United States (US). The US imprisons one third of the world's female prisoners (Kajstura, 2018) and has one of the costliest health systems in the world (Squires & Anderson, 2015). US research findings may have limited applicability to contexts with less extensive incarceration and differently organised and administered health systems. Furthermore, socio-political experiences of racism, misogyny, poverty and other types of oppression are contextdependent (Collins & Bilge, 2016 see ref list). None of the studies included in our review examined intersections of health outcomes with race, class and other identities. There is a need for disaggregated data and qualitative inquiry that attends to intersecting racial, class, sexual orientation and other identities in maternal outcomes of incarcerated women. Racism, gender-based discrimination and class oppression contribute to overincarceration of marginalised groups such as Indigenous people and people of colour

(Office of the Correctional Investigator, 2013) and likewise impacts maternal health outcomes (Jones et al., 2015 see ref list).

Among the included studies in this review, we found no examination of coercive carceral practices such as shackling, restraints and use of solitary confinement, and how these acts impact and are experienced by women in the perinatal period. Although the Bangkok Rules (2010) require accommodation of pregnancy and breastfeeding and guarantee protection of pregnant women from cruel and unusual punishment, including solitary confinement, no study considered adherence to these international requirements. As incarcerated women experience disproportionate rates of mental illness and histories of trauma, and coercive practices can retraumatise (Mollard & Brage Hudson, 2016), research examining maternal health outcomes of incarcerated women should critically examine the impact of coercive and punitive practices. Twenty-two US states have legislated protection for pregnant incarcerated women from shackling (Ferszt, Palmer, & McGrane, 2018); how, for example, has this practice affected maternal health?

Only one study, Lin (1997), examined sterilisation. It was not clear if the sterilisation procedures experienced by the pregnant prisoners were autonomously sought or involved coercion. Prisoners may be denied sterilisation requests. There is evidence prisoners do not have unfettered access to postpartum hormonal contraception. An Australian study found only two women prisoners out of 252 study participants were taking prescribed oral contraceptives (Sutherland, Carroll, Lennox, & Kinner, 2015). Postpartum contraception is an important variable in maternal health (Sridhar & Salcedo, 2017).

Mode of delivery (vaginal or C-section) was the most commonly measured outcome among the studies; this is a binary and likely easily-measured outcome. However, we learn little about the experience for the incarcerated woman through this measure alone. In the USA, the general rate of C-section delivery is currently 31.9% of all births (Center for Disease Control & Prevention, 2016); for many of the studies, the rate was lower than this average. An intersectional feminist framework examines how social and political identities and contexts affect decision-making, including in relation to operative deliveries. Restriction of access to operative delivery is as concerning as potential overuse among prisoners. Future research must investigate: What are the reasons for the operative deliveries? Are they planned or emergent? What are the reasons for planned operative deliveries? For example, to coincide with prison staff availability and prisoner transportation scheduling and administration?

Breastfeeding was only measured in one study in this review (Chambers, 2009), likely because the physical situation of incarceration usually precludes contact with the infant to participate in a breastfeeding relationship. Less than a dozen jails and prisons in the USA are believed to have “Mother Child” programs, where infants can co-reside with their mothers inside the carceral facility (Craig, 2009), which would potentially facilitate breastfeeding. Breastfeeding among incarcerated women is poorly studied (Paynter & Snelgrove-Clarke, 2017). Examining perceptions among pregnant incarcerated women through qualitative interviews, Huang, Atlas, and Parvez (2012) found participants generally wanted to be able to breastfeed and felt it could help in the development of agency and self-esteem. Given the complex health histories of most incarcerated women, breastfeeding is an important possible source of women's health promotion, as it has been

found to positively impact maternal health (Dieterich et al., 2013). For example, breastfeeding as a protective factor to prevent postpartum depression would be an important consideration for a population with high rates of mental illness, as is generally found among prisoners. Breastfeeding has significant impacts on women's physical and emotional health and its absence from research with incarcerated women in the perinatal period results in a noteworthy gap in understanding prisoner maternal health.

Among the studies that examined depression and anxiety, there is a lack of preconception and pre-incarceration baseline measures. Because pre-existing depression is the most significant risk factor for development of peripartum depression (Robertson et al., 2004), and most incarcerated women experience histories of trauma (Tam & Derkzen, 2014), and are admitted to prison with mental illness diagnoses (Farrell MacDonald, Keown, Boudreau, Gobeil, & Wardrop, 2015), it is difficult to determine the impact of incarceration on maternal mental health without these baseline measures. Of the four studies in this review that examined depression, one found *none* of the participants to have results indicative of clinical depression. This is starkly contrasting with the general rates of depression found among prisoners. Abracen et al. (2014) found rates of diagnoses of depression among Canadian parolees to be 25.4%. It also contrasts with the dominant themes in the qualitative studies: depression, grief and apprehension about the future.

The two studies (Fogel & Belyea, 2001; Kaminer, 1992) that examined stress levels found high results. Fogel and Belyea (2001) measured stress over the past month; how would that measurement change over the course of the perinatal period, for instance after birth and possible separation from the newborn? Kaminer (1992) compared the

pregnant prisoner case group to pregnant nonprisoners. Imprisonment is stressful; how would their results compare to a nonpregnant prisoner control group?

The results of this review point to the need to centre women and apply an intersectional lens to future research, to examine how the perinatal period differs from other prison-based stressors on women's health, and how complex health and illness backgrounds experienced by prisoners may shift perinatally. In addition to the research that has focused on infant outcomes, there is a need for research that examines the impact of incarceration during the perinatal period on women's physical, mental and emotional health. Next steps must include research that highlights women's voices in describing their healthcare priorities, which this review suggests may be psychosocial outcomes such as being together and relief from stress.

There is a similar need to bring consciousness of prisoner health complexity and context-specific concerns to clinical practice when caring for incarcerated women in the perinatal period. Perinatal clinicians working in and outside of carceral contexts with incarcerated populations can ask how they can advance the health and wellbeing of incarcerated women by considering the complexity of their identities, health histories, experiences and structural constraints: what access to education is provided? How is support offered and by whom is it provided? How do these women define their hopes for labour and delivery? What are their breastfeeding goals? What are their fears? What services do they need and who will provide them? Healthcare providers must consider the gaps in evidence: A lack of evidence about shackling does not mean it does not happen and does not impact perinatal health. Healthcare providers must be aware of the risks of separation, lack of opportunity to breastfeed, implications for elevated risk of peripartum

depression, and that this population may have additional risks for gestational complications and anticipate and create appropriate care plans.

Health policy-makers must be aware of the friction between corrections policies and optimal, evidence-based health policies. For example, it is a public health norm to describe “Breast is Best,” yet correctional procedures causing mother–infant dyad separation compromise breastfeeding success. Family-centred care policies in hospitals are inadequate for women without access to their families; other procedures may need to be developed to create social support systems for this patient population. Healthcare providers must use their positions to protect women and infants from harm and promote health, including the health outcomes of bonding and attachment. The dignity and humanity of incarcerated women must be preserved and promoted in their perinatal health experience.

**2.1.6.1 Limitations.** To examine a broad range of the published and unpublished literature concerning the maternal health outcomes of pregnant and incarcerated women, the developed search strategy explored three research databases, a hand-search of the past five years in three key journals relevant to the research question, dissertations on ProQuest and the first 100 hits on Google Scholar. While the titles, abstracts and articles of the relevant hits were reviewed independently by two reviewers who consulted after every phase of the process, it is possible that relevant literature was not included. Included studies also needed to have focused on the perinatal health outcomes of the mother and studies that instead focused on the health of the child were not included. We acknowledge however that the health of the child can be influenced by the psychosocial and physical context in which the mother experiences pregnancy and birth and this

limitation in our review limits the findings. Additionally, the review only included English and French-language studies, which narrowed the global investigation of relevant literature. This review used the MMAT (Pluye et al., 2011) to assess the quality of the included research studies. While the MMAT is designed to do so for a systematic mixed studies review, it was not developed to assess the quality of the author's reporting (Pluye et al., 2011). Within the studies themselves, there may be a host of methodological limitations associated with conducting research within the carceral settings. This review is limited by any publication bias and selective reporting within studies.

### 2.1.7 *Conclusion*

This scoping review presents a unique synthesis of the research pertaining to maternal health outcomes among incarcerated populations by focusing on outcomes necessarily stemming from the perinatal state and on those outcomes that impact women. The scoping review finds few studies take this women-centred approach. Through various study designs, researchers have examined method of delivery, a limited number of gestational complications, depression, stress and experiences. There is little research examining breastfeeding, despite the prioritisation of this maternal health outcome in the broader research literature. There is a concerning lack of research of the impact of carceral practices on maternal health. An intersectional feminist approach (Crenshaw, 1989) would examine the intersecting and overlapping social determinants of mental health (World Health Organization, 2014), such as race, class and gender. There is a need for women's voices to inform our understanding of their maternal health outcomes.

### 2.1.8 *Relevance to Clinical Practice*

Clinicians caring for incarcerated women in the perinatal period must be aware that gaps in evidence affect the expectations, options and lived experiences of incarcerated women during the perinatal period. A lack of attention to breastfeeding for this population should not mean it is excluded from the perinatal education and care for this population, but rather speaks to an amplified need to provide support. Healthcare providers must be conscious of intersecting layers of discrimination faced by this population. When patients from this population present with gestational complications, such as hypertension and diabetes, we must question how the context of incarceration contributes to negative health sequelae and make clinical recommendations that centre women's health. We must question birth and postpartum arrangements that fail to support women's health, and advocate for access to support people, to adequate time to labour and freedom of movement, and for skin-to-skin contact postpartum. An absence of research on strip-searching, shackling and segregation for this population does not mean incarcerated women do not face these conditions during incarceration. While promoting infant health, we must also centre women's perinatal experiences in our care to be healthful.

### 2.1.9 *Addressing Maternal Health Needs through Mother Child Programs*

The limited evidence of maternal health outcomes research among incarcerated people, and the findings of harm associated with incarceration vis-à-vis the perinatal period, raise the question of the extent to which programs that aim to keep mothers and children together may affect health. The next step was to map out the research examining the health outcomes associated with Mother Child Programs.

## 2.2 Mother–Child Programs for Incarcerated Mothers and Children and Associated Health Outcomes

This section also appears in: **Paynter, M.,** Jefferies, K., McKibbon, S., Martin-Misener, R., Iftene, A., Tomblin Murphy, G. Mother Child Programs for Incarcerated Mothers and Children and Associated Health Outcomes: A Scoping Review (2020). *Nursing Leadership. 33*(1)*,* 81-99. doi:10.12927/cjnl.2020.26189

Co-author Dr. Keisha Jefferies was the second reviewer for included studies. Shelley McKibbon developed the search strategy and retrieved the articles. Dr. Ruth Martin-Misener, Dr. Adelina Iftene and Dr. Gail Tomblin Murphy supported manuscript development and review.

In Canada, and globally, women are the fastest growing population in prisons (Sawyer 2018). Women face many threats to health during incarceration, such as disruption in therapies, isolation from support systems and restricted access to health services. Worldwide, it is estimated that over two-thirds of incarcerated women are mothers (Glaze and Maruschuk 2010; Kouyoumdjian et al. 2016; McCampbell 2005). The increasing incarceration of women disrupts fertility (Jones and Seabrook 2017), family formation (Sufrin 2017) and parenting and mother–child relationships (Poehlmann 2005). Correlated with high rates of physical and sexual abuse, incarcerated women are at an elevated risk of posttraumatic stress (Jones et al. 2018) and substance use (Farrell MacDonald et al. 2015) – factors that may destabilize any mother–child relationship. Recognizing the potential for nurse leadership in addressing the policies and practices of care for incarcerated mothers with young children, we sought to review what researchers

have studied with respect to programs that keep mothers and children together during the period of incarceration.

Separation of mothers from their children through incarceration poses additional threats and harms for mothers, including distress and anxiety (Shamai and Kochal 2008); loneliness, depression and pain (Chambers 2009); and fear of losing custody of their children and concern about their care (Luke 2002). Their children also face increased risks. Turney (2018) found that children with incarcerated parents are exposed to nearly five times as many adverse events as children who do not have this experience. Moreover, the children of incarcerated parents are at an increased risk of developing antisocial behaviours (Murray et al. 2012).

To reduce the harm of separation to both the mother and the child, some prisons allow children to co-reside with their mothers under the mother–child programs (MCPs) (Goshin et al. 2017). These programs have existed since at least the 1800s (Craig 2009) and are increasingly prevalent in North America (Goshin and Byrne 2009). MCPs may include parenting skills classes, counselling and prison nursery or off-site daycare services (Johnson 2017). The co-residential feature of these programs differentiates them from other didactic or visitation parenting programs that may also be offered in prisons (Tremblay and Sutherland 2017). Researchers have found that in facilities that promote co-residing, mothers may be more likely to initiate and maintain breastfeeding (Senanayake et al. 2001), maintain or develop healthy bonds with their children and develop positive feelings toward themselves, such as self-esteem and confidence (Carlson 2001).

The United Nations Office on Drugs and Crime (UNODC) (2011) *Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders*, known as the "Bangkok Rules," articulate principles for MCPs. They were unanimously adopted by the United Nations (UN) member countries, including Canada (UNODC 2011) (Figure 2). Many rules refer to children and suggest that prisons have a responsibility for monitoring and evaluating the health of mothers and children in co-residential programs.

The right to be parented is enshrined in the United Nations *Convention on the Rights of the Child* (United Nations Human Rights 1989).

Yet it appears that only a small portion of incarcerated mothers have access to, or participate in, MCPs. For example, although one third of all incarcerated women in the world are imprisoned in the United States, there are only nine MCPs in the country, located in eight of 50 states (Goshin and Byrne 2009; Goshin et al. 2017). There are six MCPs in England, with a total of 65 places, and yet, the program is rarely full (Dolan 2019).

Although each of the six federal prisons for women in Canada in theory has MCPs (CSC 2016), research has found only a small number of women per year use the program (Brennan 2014). Black women, women of colour and Indigenous women may be less likely to meet eligibility criteria, largely due to their disproportionate likelihood of being classified at higher security levels (Miller 2017).

**Figure 2**

*"Bangkok Rules" Regarding Mother–Child Programs*

| | | |
|---|---|---|
| **Rule 2:** "Prior to or on admission, women with caretaking responsibilities for children shall be permitted to make arrangements for those children, including the possibility of a reasonable suspension of detention" (UNODC 2011: 8). | **Rule 33:** "Where children are allowed to stay with their mothers in prison, awareness-raising on child development and basic training on the health care of children shall also be provided to prison staff, in order for them to respond appropriately in times of need and emergencies." (UNODC 2011: 4). | **Rule 42:** "The regime of the prison shall be flexible enough to respond to the needs of pregnant women, nursing mothers and women with children. Childcare facilities or arrangements shall be provided in prisons in order to enable women prisoners to participate in prison activities" (UNODC 2011: 15). |

### 2.2.1 *Literature Review*

Although most countries in the world allow mothers and children to live together in prisons (Warner 2015), MCPs are understudied and under-documented. Neither Correctional Services Canada (CSC) nor the federal watchdog for corrections, the Office of the Correctional Investigator, routinely collects health data among MCP participants. MCP programs are costly. The annual cost per woman (not accounting for children) in federal incarceration is $83,861. The cost per new bed expansion in women's facilities is $259,894 and for women in structured living environments is $533,765 (Office of the Parliamentary Budget Officer 2018). To justify continuation, changes or expansion, high-quality research must inform what types of MCPs exist, who is eligible to participate, rates of participation and to what extent MCPs make a difference to maternal and child health outcomes.

In our preliminary search in February 2019 of the Joanna Briggs Institute (JBI) (2019) Database of Systematic Reviews and Implementation Reports, CINAHL,

Cochrane Library, PsycINFO and MEDLINE, we found no existing scoping or systematic reviews specifically addressing health outcomes associated with MCPs in carceral facilities. Ward (2018) authored an unpublished systematic review on the impact of MCPs on mothers' recidivism. All five databases included studies that were based in the United States, and all suggested MCPs result in a reduction in reoffence (Ward 2018). A rapid review of MCPs by Shlonsky et al. (2016), prepared for the Victorian Department of Justice and Regulation in Australia, focused on child outcomes broadly, mothers' parenting skills and mothers' recidivism. Only one of the studies in the review demonstrated MCPs to be associated with differences in outcomes related to children's health or well-being.

Given the paucity of literature about MCPs, the aim of this scoping review was to systematically map what is known about MCP eligibility criteria, review MCP program characteristics and discern the health outcomes for mothers and children in research examining the health of MCP participants. The results were analyzed to determine: the implications for policy governing the services for incarcerated mothers and their children, nursing practice when caring for this population and future research to address the needs of this marginalized population.

### 2.2.2 *Methods*

**2.2.2.1 Research Questions.** The questions that guided this scoping review were as follows: (1) What are the characteristics of MCPs and carceral facilities, such as whether they are full-time or part-time and whether they are within the carceral facility or located in the community? (2) What are the eligibility criteria for mothers' and children's participation, such as non-eligibility for adult participants convicted of violent offences or

age restrictions for child participants? (3) What health outcomes have been studied among mother and child participants, such as peripartum depression and breastfeeding among adult participants and birthweight and feeding experience among child participants?

**2.2.2.2 Design.** We conducted a scoping review following the JBI (2019) methodology. The population of interest was MCP participants. The concept was MCP characteristics, eligibility criteria and participant health outcomes. The context was incarceration.

**2.2.2.3 Search Strategy.** The JBI method uses a three-step comprehensive search strategy to find both published and unpublished studies: First, an experienced medical librarian led a limited search of MEDLINE and CINAHL using keywords. She analyzed the text in the titles/abstracts and index terms to develop a tailored search strategy for each information source. Keywords included the following: carceral, penal, custod*, jail, prison*, incarcerat*, correction*, penitentiar*, detention, inmate*, offender*; baby, infant, child, newborn; co residential, residential, resid*, onsite, liv* with; mother*, maternal, antenatal, postpartum.

Second, databases were searched using the keywords and index terms identified from the initial limited search. The databases we searched included the following:

- MEDLINE,
- CINAHL,
- PsycINFO and
- Gender Studies Abstracts.

The search for unpublished studies included the following:

- Internet search engine (first 100 hits on Google Scholar) and
- ProQuest dissertations.

A full search strategy for CINAHL is detailed in Appendix B. Finally, to help identify any additional studies, the reference lists of all literature meeting the inclusion criteria of this review were examined for potentially relevant studies. The JBI method for scoping reviews does not include quality assessment of the studies, and as such, this was not performed.

**2.2.2.4 Inclusion Criteria.** This scoping review included studies with participants who met the following criteria: mothers and/or their children, regardless of age, who participated in an MCP during maternal incarceration. We included transgender women in the term "mother." Community-based and carceral facility-based programs were included. All adult (mother) participants must have been serving a custodial sentence during participation in the MCP. Studies conducted in the community or in carceral facilities, for example, jails, prisons, detention centres, police lock-up, immigration detention and juvenile detention, were included.

This scoping review considered studies of health outcomes associated with MCPs for incarcerated mothers. Deciding what counted as a "health outcome" was difficult and our judgments are a limitation. This review included experimental and quasiexperimental study designs as well as qualitative research, such as ethnographies, case studies and studies using grounded theory and phenomenology. Only studies or protocols published in English were included. No specific date range was used.

**2.2.2.5 Exclusion Criteria.** This review excluded fathers or parents not specified as "mothers." We excluded non-residential programs, such as parenting education

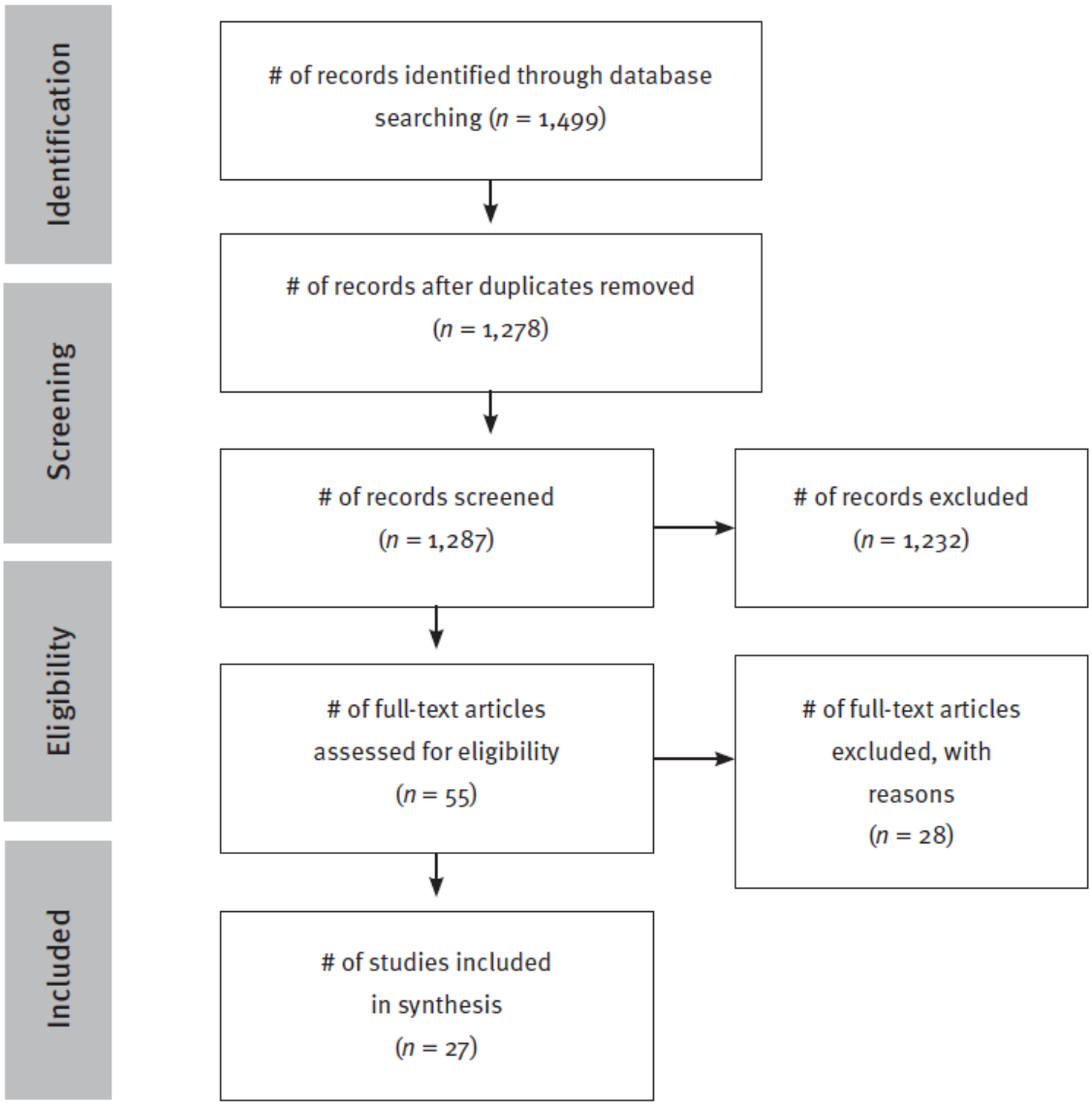
programs, and programs for formerly incarcerated people, such as those on parole. This review excluded residential drug treatment programs unrelated to criminal charges. As the focus on this review and the keywords addressed health, we did not consider studies that examined outcomes not described as health related, such as educational attainment of children or recidivism rates among mothers, although we recognize that these are likely to influence health experiences. The review did not include systematic reviews, literature reviews, commentaries or editorials and excluded all publications not available in full text in English.

**2.2.2.6 Study Selection.** Following the search, all identified citations were collated and uploaded on Covidence. Duplicates were identified and deleted. Two reviewers independently screened the titles and abstracts for assessment against the inclusion and exclusion criteria. Titles and abstracts that met the inclusion criteria were retrieved in full and assessed by two independent reviewers using the inclusion criteria. Where any conflicts occurred, a third reviewer was available to assist. Full-text studies that did not meet the inclusion criteria were excluded.

The search strategy retrieved 1,499 hits. Removal of 212 duplicates resulted in 1,287 articles for title and abstract review. Two reviewers independently screened articles to identify those eligible for full-text review. A total of 55 articles were included for full-text review, of which 27 met the inclusion criteria (Figure 3).

**Figure 3**

*PRISMA: Mother Child Programs*




*Note*. Adapted from "Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement," by D. Moher, A. Liberati, J. Tetzlaff, D. G. Altman, and The PRISMA Group, 2009, *PLoS Medicine*, *6*(7), Article e1000097. https://doi.org/10.1371/journal.pmed.1000097.

Reasons for exclusion of 28 articles included the following: not research (10), duplicate (seven), not focused on health outcomes (seven), not the population of interest

(two), not in English (one) and record could not be located (one). Please see Preferred Reporting of Items for Systematic Reviews and Meta-Analyses (PRISMA) in Figure 3, adapted from Moher et al. (2009).

**2.2.2.7 Data Extraction.** Data were extracted from included papers using Excel. The items extracted from the full text included study characteristics (e.g., year of publication, country), program eligibility criteria, program elements, study design and methods and health outcomes for mother and child participants (Table 2). Any disagreements that arose between the reviewers during data extraction were resolved through discussion.

### 2.2.3 *Results*

**2.2.3.1 Study Characteristics.** The 27 studies were published between 1989 and 2019. The settings included 12 countries: one study each in Brazil (Leal et al. 2016), India (Planning Commission 2006), Iran (Rahimipour Anaraki and Boostani 2014), Italy (Ferrara et al. 2009), Portugal (Freitas et al. 2016), South Africa (Eloff and Moen 2003), Spain (Jiménez and Palacios 2003), Sri Lanka (Senanayake et al. 2001), Turkey (Kutuk et al. 2018) and the United Arab Emirates (Al Salami et al. 2018); six in the United Kingdom (Baradon et al. 2008; Birmingham et al. 2006; Catan 1989; Dolan et al. 2013; Gregoire et al. 2010; Sleed et al. 2013); and 11 in the United States (Barkaukas et al. 2002; Borelli et al. 2010; Byrne et al. 2010; Carlson 2001; Cassidy et al. 2010; Condon 2017; Fritz and Whiteacre 2016; Goshin 2015; Goshin et al. 2014; Lennon 1992; Schehr 2003). None of the studies was based in Canada.

## Table 2

*Data Extraction*

| Authors, Year, Country | Inclusion Criteria | Program Characteristics | Sample Size & Design & Instruments | Child outcomes | Maternal Outcomes |
|---|---|---|---|---|---|
| Al Salami, Al Halabi, Hussein, Kowash (2018)<br>**United Arab Emirates** | Not described | Not described | 128 children in MCP, 254 controls, 45 staff caregivers<br>**Cross Sectional:** Clinical examination and interviews with staff | **Oral health:** Prevalence of caries was not significantly different between the two groups with 89.9%. Good oral-hygiene among 18.2% in the control vs. 6.2% in the study-group. | |
| Baradon, Fonagy, Bland, Lénárd, Sleed (2008)<br>**United Kingdom** | Child < 9 or 18 months (varies). | New Beginnings short term, experience-based supplemental programme in Mother and Baby Units of two prisons, to improve awareness of babies' needs | 15 mothers<br>**Qualitative:** Interviews and videos of interactions | | **Experiences, Reflective functioning:** Themes 1) Idealisation of baby and self-as-mother 2) Guilt 3) Wish for baby to have different, better experiences than their own; 4) Role of the infant as rescuer or comforter; 5) Anger and hostility. Reflective functioning changed over time. |
| Barkauskas, Low, Pimlott (2002)<br>**United States** | Pregnant; sentence < 2 years; nonviolent offences; history of drug or alcohol "abuse"; seeking to actively parent; not required to take psychotropics. Min stay of 4 mo postpartum. | Educational, therapeutic, employment, and substance abuse groups. On-site childcare. Greater access to counselling, childbirth instruction, rooming-in with infants, overnight visits with older children, birth control, after-care, financial stipend | 37 mothers in MCP, 40 controls (incarcerated mothers not in MCP) and their infants<br>**Case Control:** Chart review | **Birth weight, Breastfeeding**: Outcomes for both groups similar re birth weight, rate of C-section, preterm deliveries, APGARs. However, breastfeeding rate 19.4% in MCP vs. 2.9% in control, who were to be separated at 1-2 days postpartum. | **Mode of delivery:** Outcomes for both groups similar re rate of C-section, |

| Authors, Year, Country | Inclusion Criteria | Program Characteristics | Sample Size & Design & Instruments | Child outcomes | Maternal Outcomes |
|---|---|---|---|---|---|
| Birmingham, Coulson, Mullee, Kamal, Gregoire (2006)<br><br>**United Kingdom** | In the Best Interests of the Child; require social services support; adequate space; mother likely to care for child after release; no legal or medical impediment; urine drug screen negative; mother "drug free"; signs contract; baby can be searched; participates in prison regime; mother's behaviour is "not disruptive" | Not described | 55 mothers<br><br>**Mixed Methods:** Interviews and SCAN (Wing et al. 1990); CIS-R (Lewis & Pelosi, 1990); SCID-II (First et al 1995); AUDIT (Saunders et al. 1993); Severity of Dependence Questionnaire (Phillips et al. 1987) | | **Mental Health, Pregnancy intention:** 4 of 55 participants (0.7%) were pregnant; for 82% most recent pregnancy was unplanned. 35% had personality disorders, 35% neurotic disorder, 16% "hazardous drinking" and 36% drug use disorders. 31% have current need for mental health treatment. |
| Borelli, Goshin, Joestl, Clark, Byrne (2010)<br><br>**United States** | Not described | Not described | 69 mothers<br><br>**Longitudinal Cohort:** Adult Attachment Interview at T1 and 8.4 months later at T2t, CES-D (Radloff 1977), PSOC; Gibaud-Wallston & Wandersman, 1978), SSQ (Sarason et al 1983) | | **Attachment:** Using the four-way AAI classification system, 35% of participants were secure, 20% insecure-dismissing, 13% insecure-preoccupied, and 30% insecure-unresolved. Mother participants had higher rates of insecure attachment than previous low risk community samples. |
| Byrne, Goshin, Joestl (2010)<br><br>**United States** | Not described | Programs and personnel, prenatal and parenting classes, full-time civilian experts in child development and nursery management. | 30 infants<br><br>**Cross Sectional**: Strange Situation Procedure (Ainsworth et al., 1978) | **Attachment:** 60% of infants classified secure, 75% who co-resided 1 yr or >, 43% who co-resided < 1 yr. All within normal range. | |

| Authors, Year, Country | Inclusion Criteria | Program Characteristics | Sample Size & Design & Instruments | Child outcomes | Maternal Outcomes |
|---|---|---|---|---|---|
| Carlson (2001)<br><br>**United States** | Tentative release date < 18 months after birth; cannot be in segregation; no extensive history of violence or convictions of child abuse; is primary caregiver of child on release; complete prenatal and Lamaze classes; abide by institution rules; complete infant classes. | Mother responsible for care of child and to attend work programs. Half-time morning work assignment until the baby is 6 mo. Then may apply for full-time work. If not graduated from high school, required to participate in GED classes half time and nursery the other half. | 11 mothers<br><br>**Cross Sectional:** Survey | | **Attachment, Satisfaction, Self Esteem:** 8/11 reported stronger attachment with their child as a result of the MCP. 6/11 reported feeling better self-confidence and self-esteem, 100% felt that the parenting classes helped and that they should be required. 10/11 said they would repeat the experience if they could. |
| Cassidy, Ziv, Stupica, et al. (2010)<br><br>**United States** | Pregnant, nonviolent with history of substance abuse. Full "dosage" of "treatment" includes a residential-living phase from pregnancy to 6 mo postpartum; community-living to 12 mo postpartum. | Jail-diversion program; integrated network of prenatal care- substance abuse, mental health, psychotherapy, education, work skills, housing assistance, advocacy. Circle of Security Perinatal Protocol parenting education to promote sensitivity, attachment. | 20 mothers and their infants<br><br>**Cross Sectional:** Strange Situation Procedure (Ainsworth et al. 1978); NICHD mother–infant interaction scales (Owen, 1992) to code maternal responsive behavior and 7 other established tools to measure maternal mental health | **Attachment:** Program infants had rates of attachment security and attachment disorganization comparable to rates typically found in low-risk samples (and more favourable than those typically found in high-risk samples). | **Mental Health:** At enrollment in the MCP, 69% of the participants had BDI scores (depression) in the clinical range; only 38% did post-intervention (but not statistically significant). |
| Catan (1989)<br><br>**United Kingdom** | <9 or 18 months (varies) | Babies spend 13-19 wks in units. Mothers responsible for children's care, staff ensure health of baby not seriously affected | 74 infant cases, 33 controls<br><br>**Longitudinal Case Control:** Griffiths Mental Developmental Scale (Griffiths, 1954) | **Development:** No statistically significant differences in development or physical growth. | |

| Authors, Year, Country | Inclusion Criteria | Program Characteristics | Sample Size & Design & Instruments | Child outcomes | Maternal Outcomes |
|---|---|---|---|---|---|
| Condon (2017)<br><br>**United States** | Sentence < 30 mo; essay and written application; no outstanding warrants; no major infractions; no open children's protective services cases; no violent crimes or crimes against children or arson; in-person interviews with counsellors, corrections and EHS staff | Special unit segregated from general population, minimum-security. Mother and infant live in one room. Up to 20 dyads at a time. From 6 wks old, infants in on-site Early Head Start intervention program M-F while mothers are in school or work. Parenting classes, referrals, support. Dedicated paediatrician. | 17 infants<br><br>**Qualitative:** Observations | **Attachment:** The general context of the program was positive and remained that way throughout the course of the study. Infants lived, slept, and played in safe, pleasant indoor and outdoor spaces specially designed for infants, toddlers, and mothers | |
| Dolan, Hann, Edge, Shaw (2019)<br><br>**United Kingdom** | < 18 mo. Apply 3 mo before due date. Admissions board decides. | Not described | 85 pregnant women<br><br>**Cross sectional:** CAN, EPDS, SOD-Q, AUDIT and the Structured Clinical Interview for DSM-IV (SCID-II) | | **Mental Health:** 51% had depression and 57% had anxiety. Those working prior to imprisonment were more likely to be admitted to MBUs, those with a prior social services involvement, diagnosis of personality disorder or history of suicidality were less likely. Those who might benefit most from MBU placement are least likely to be admitted. |
| Eloff, Moen (2003)<br><br>**South Africa** | Pregnant women and women with children < 5 yr. | Communal mother–baby unit is separate. Dark, not child friendly; no privacy; some share a bed with their child. Each day, one walk is allowed in courtyard without any trees or grass. After 2:30pm units are locked. 2x/wk clinic services. | 4 mothers and their children<br><br>**Qualitative:** Interviews | | **Experiences:** Themes: 1) Restrictiveness of the prison environment; 2) In-exclusivity of the mother-child attachment process; 3) Mothers' inattention to situations that their children might experience as stressful; and 4) Absence of imaginative play |

| Authors, Year, Country | Inclusion Criteria | Program Characteristics | Sample Size & Design & Instruments | Child outcomes | Maternal Outcomes |
|---|---|---|---|---|---|
| Ferrara, Gatto, Nicoletti, Emmanuele, Fasano, Curro (2009)<br><br>**Italy** | < 3 years | "Nest areas" cells must be open, free movement. Each cell has 2 rooms including a sleeping place and a crib, bathroom and a store to allow mothers to cook. | 391 total children:150 in prison group, (G1);150 with parents, (G2); 91 with foreign parents, (G3)<br><br>**Case Control:** Chart review | **Breastfeeding, Gestational age, Infection, Immunization, Mode of delivery:** Gestational age (lower in G1 vs G2, lower in G1 vs G3,), time of weaning age earlier in G1 vs G2, ($p < 0.035$), number of respiratory infective disease (G1>G2, $p < 0.0001$, and G1>G3, $p < 0.003$). Immunization rates inadequate. No significant differences in mode of delivery or breastfeeding. | |
| Freitas, Inácio, Saavedra (2016)<br><br>**Portugal** | < 3 or 5 years (varies). Inmates in a "safety regime" are excluded. | The right to a cell designed to accommodate a minor, eat meals with their children instead of other prisoners | 20 mothers: 10 with children in prison, 10 without<br><br>**Qualitative:** Interviews | | **Experiences:** Themes: MCP women experience some advantages, but also increases suffering due to restrictions on liberty |
| Fritz, Whiteacre (2016)<br><br>**United States** | < 18 mo. Pregnant; release date <18 mo after projected due date; no violent crime or child abuse; have custody; meet medical and mental health criteria | Special housing unit | 27 mothers<br><br>**Qualitative:** Interviews | **Breastfeeding:** 33% of controls and 60% of MCP participants breastfed. | **Separation, Maltreatment/ restraints Pregnancy, Prenatal care, Satisfaction:** 20/27 described instances of negative prenatal care, Themes: communication, delay in care, expectation that pregnant women should have priority over other incarcerated women; 58% of controls and 47% of case group reported having no support from family or friends during labor. Both groups felt the use of restraints during childbirth was excessive. 40% of case group and 58% of controls reported negative emotions re use of restraints during labour, birth. Separation from |

| Authors, Year, Country | Inclusion Criteria | Program Characteristics | Sample Size & Design & Instruments | Child outcomes | Maternal Outcomes |
|---|---|---|---|---|---|
| | | | | | their child was the primary difference between the groups. |
| Goshin (2015)<br><br>**United States** | Charged with a felony; willing to plea; judicial approval for suspended sentence; have custody. Up to 3 minor children. With violent charges, crime cannot have resulted in serious injury, and victim must approve | Families have own apartments, with leases and tenancy rights. Enter and exit without approval during curfew hours. Women work, attend school and social events. Partners, family and friends can visit but not reside. Can remain housed there after completion of term of community supervision. | 28 participants: 8 adult tenants, 12 children, 3 staff, 1 administrator, 5 prosecutors<br><br>**Qualitative:** Interviews | | **Experiences**: Themes: 1) The Cycle; 2) This is My Home; 3) This Doesn't Go With That. |
| Goshin, Byrne, Blanchard-Lewis (2014)<br><br>**United States** | Not described | Not described | 47 children in prison nursery, 64 controls from national dataset separated from their incarcerated mothers<br><br>**Case Control:** Child Behavior Checklist for Ages 1 1/2 –5 (CBCL; Achenbach & Rescorla, 2000), Parenting Stress Index-Short Form (PSI-SF) (Abidin 1995), Parent-Child Conflict Tactics Scale (Straus, Hamby, & Warren, 2003) | **Development:** Ecological risks were high and not significantly different between the groups. | **Stress, Substance Use:** > 1/3 caregivers in both groups reported prenatal substance use/ problem drinking, 1/5 of caregivers of controls and ¼ of caregivers of former MCP residents reported current substance use/problem drinking. Parenting distress scores for both groups closely matched the range found in parents of preschool children in Early Head Start. |
| Gregoire, Dolan, Birmingham, Mullee, Coulson (2010)<br><br>**United Kingdom** | Women should be advised on intake it is possible to have their baby if in the best interests of the child. < 9 - 18 mos (varies). Suitability assessed by a multi-agency panel. Mental disorder not | Not described | 112 mothers in 7 prisons<br><br>**Cross Sectional**: CIS-R (Lewis & Pelosi 1990), SCID-II (First et al 1995), AUDIT (Saunders et al., 1993), SOD-Q (Phillips et al 1987) | | **Mental Health:** 90% had one or more of the 5 categories of mental disorder. 6 of the women had been "using drugs at levels of abuse or dependence and had no other mental disorder." |

| Authors, Year, Country | Inclusion Criteria | Program Characteristics | Sample Size & Design & Instruments | Child outcomes | Maternal Outcomes |
|---|---|---|---|---|---|
| | an exclusion criterion but criteria may exclude women with mental illness | | | | |
| Jimenez, Palacios (2003)<br><br>**Spain** | Mother's discretion | 'Mother units' in closed prisons with children < 3yrs. Completely secluded. Include pediatric medical services. If > 4-6 mo, children attend nursery school in jail, some attend nursery school outside jail. Prohibit toys from outside, play materials supplied by NGOs. Or 'Dependent units' shared by 4–5 women near end of sentence. Open, supervised by prison staff, integrated in community. Mothers work, children attend nursery schools nearby. | 127 children<br><br>**Cross Sectional:** HOME scale for 0–3-year-old children (Caldwell & Bradley 1984); Brunet–Lezine scale for development (Brunet & Lezine, 1978) | **Development:** Quality of prison context is extremely low according to HOME scale. Significant differences related to the mother's level of education, ethnic origins and the type of prison where they are serving their sentences. Re Brunet-Lezine scale, child development similar to that of the infant population in general | |
| Kutuk, Altintas, Tufan, Guler, Aslan, Aytan, Kutuk (2018)<br><br>**Turkey** | < 6 yrs. | Not described | 24 mothers and 26 children<br><br>**Cross Sectional:**<br><br>**Mothers:** SCID-I, BDI, BAI, MDSPS<br><br>**Children:** CTSQ-53, D-II-DST, K-SADS | **Breastfeeding duration, Development:** Most common diagnoses in children: adjustment disorder (26.9%) separation anxiety disorder (11.5%) and conduct disorder (7.7%). Mean duration of breastfeeding of 8.3 mos. D-II-DST abnormal in 33.3% of the children. | **Mental Health, Mode of Delivery, Substance Use:** Mode of delivery 75.0% uncomplicated 79.2% vaginal. All mothers scored in clinical ranges for emotional abuse, emotional neglect, and physical neglect. Most common diagnoses: nicotine abuse (70.8%), specific phobia (33.3%), alcohol abuse (29.2%) and substance abuse (20.8%). |

| Authors, Year, Country | Inclusion Criteria | Program Characteristics | Sample Size & Design & Instruments | Child outcomes | Maternal Outcomes |
|---|---|---|---|---|---|
| Leal, Ayres, Esteves-Pereira, Sánchez, Larouzé (2016)<br>**Brazil** | Transferred in 3rd trimester to mother baby units. Duration in unit btw 6 mo- 6 yrs. | Not described | 495 incarcerated women:206 pregnant, 289 mothers<br>**Mixed Methods:** Chart review and interviews | | **Maltreatment, Mode of delivery, Parity, Pregnancy intention, Prenatal Care, Satisfaction, Transport:** >33% had 4+ previous pregnancies, 20% had 5+. 8% had child during prior incarceration. 90% pregnant when incarcerated. 37% wished to become pregnant and 63% did not. 81% satisfied with course of pregnancy. 93% had 1+ pre-natal care visit. 32% had adequate prenatal care. >60% were assisted 30 min after the start of labor, 8% waited > 5 hrs. 61% transported in labor by ambulance; 36% by police car. 65% vaginal deliveries, 35% operative. 40% had 0 visits. 3% had companion at delivery, 11% had family visit in hospital. Reports of verbal/psychological maltreatment/violence during hospital stay: 16% at the hands of health staff, 14% from guards. 36% handcuffed in hospital, 8% during birth. 15% rated stay at hospital as excellent. 10% viewed respect for privacy/ intimacy as excellent |
| Lennon (1992)<br>**United States** | Babies born to inmates up to 12 mo, occasionally 18 mo. | Not described | 116 infants<br>**Cross Sectional:** Chart review | **Infection, Injuries, Infection, Development, Breastfeeding, Preterm delivery:** 3 most frequently encountered health problems. Incidence of accidents (221), upper respiratory infections (182) and otitis media (135). 8 | **Mode of delivery**: C-section rate 23%. |

| Authors, Year, Country | Inclusion Criteria | Program Characteristics | Sample Size & Design & Instruments | Child outcomes | Maternal Outcomes |
|---|---|---|---|---|---|
| | | | | children had developmental delay. 20% breastfed. 8% preterm. | |
| Planning Commission (2006)<br><br>**India** | Not described, appears to be maternal discretion | All jails arrange through district government hospitals for medical and health check-up, treatment, safe delivery of pregnancies etc. of women prisoners. In some jails, pregnant and lactating mothers get special diet. Children receive milk. Health check-up, immunization, nurturing facilities available in 3 districts. | 297 women prisoners<br><br>**Mixed Methods:** Survey and interview | **Breastfeeding, Immunization:** 20% breastfeeding. Immunizations available in a list of prisons. | **Pregnancy:** 45% of women in sample had their minor children are living with them. 3% were pregnant. 3% had delivered babies in jail. |
| Rahimipour Anaraki, Boostani (2014)<br><br>**Iran** | Not described | Mother child unit is separate. Use a single bed. Door opened 5am – 6pm or 7:30pm. Mothers in classes or workshops (tailoring, sewing, knitting). Kindergarten at tcentre open 8:30am-1:30pm. Toys provided. Small library. | 14 imprisoned mothers who were on leave.<br><br>**Qualitative:** Interviews | | **Experiences:** Themes: 1) Child as an emotional support of the mother; 2) Child as centre, prison as periphery; 3) Hope and will to favoured future; 4) Mother unit as a family; rehabilitation; 5) Other side of the coin: perceived risk for children; 6) Imprisoned mother–child interactions: learning to live by hope and fear. |
| Schehr (2003)<br><br>**United States** | Excluded if history of violence against children. | Segregated from the main population. Mothers care for babies 24/7. Drug counselling, parenting classes. | 3 mothers<br><br>**Qualitative:** Interviews | | **Experiences:** Themes: 1) We found safety in prison; 2) We began a new life together; 3) We were mothered and mothering at the same time; 4) We found a family in prison; 5) Our bond with our babies strengthened us. |

| Authors, Year, Country | Inclusion Criteria | Program Characteristics | Sample Size & Design & Instruments | Child outcomes | Maternal Outcomes |
|---|---|---|---|---|---|
| Senanayake, Arachchi, Wickremasinghe (2001)<br><br>**Sri Lanka** | 11 facilities accept pregnant women. Children < 5 yrs. admitted on a court order. | Special dormitory. Cheerful and "child-friendly." Other women prisoners had access. Children accompany mothers to work. No separate menu was available to the children. | 30 children and 200 mothers who had "left their children behind".<br><br>**Cross Sectional:** Survey | **Breastfeeding, Development, Infection, Nutrition:** 23% scabies, 10% pediculosis, and 7% impetigo. No severe malnutrition found. Screening for tuberculosis was negative. 8 children born while in custody. 70% breastfed. No vitamin deficiencies or severe protein, calorie malnutrition. Immunisation up-to-date. Growth of children satisfactory | |
| Sleed, Baradon, Fonagy (2013)<br><br>**United Kingdom** | 7 Mother Baby Units in in England and Wales; < 18 mo. | New Beginnings (NB) is attachment-based intervention developed for mothers and babies in prison. | 88 mother baby dyads in NB and 75 dyads in prison without it<br><br>**Cluster Randomized Control Trial:** Interviews and video. PDI semi-structured interview tool (Slade et al 2004) coded for Reflective Functioning (Slade et al. 2004), CES-D (Radloff 1977), MORS (Danis et al 2005), CIB scales (Feldman 1998). | | **Development, Mental health:** Mothers in control group deteriorated in level of reflective functioning and behavioral interaction with their babies over time, mothers in the intervention group did not. No significant group effects on levels of maternal depression or mothers' self-reported representations of their babies over time. |

Study designs included eight qualitative studies (Baradon et al. 2008; Condon 2017; Eloff and Moen 2003; Freitas et al. 2016; Fritz and Whiteacre 2016; Goshin 2015; Rahimipour Anaraki and Boostani 2014; Schehr 2003), 16 quantitative studies (Al Salami et al. 2018; Barkaukas et al. 2002; Borelli et al. 2010; Byrne et al. 2010; Carlson 2001; Cassidy et al. 2010; Catan 1989; Dolan et al. 2013; Ferrara et al. 2009; Goshin et al. 2014; Gregoire et al. 2010; Jiménez and Palacios 2003; Kutuk et al. 2018; Lennon 1992; Senanayake et al. 2001; Sleed et al. 2013) and three mixed-methods studies (Birmingham et al. 2006; Leal et al. 2016; Planning Commission 2006). Sample sizes varied from three, as in the study by Schehr (2003), to 495, in the mixed-methods study by Leal et al. (2016).

**2.2.3.2 Program Eligibility.** A total of 16 studies included information regarding eligibility criteria for participation in the MCP. Common criteria included child age limits or length of participation limits and ineligibility of mothers with a history of violent offences. Additional requirements included that applicants be pregnant when they applied, demonstrate the ability to parent and pass urine drug screens. Both Gregoire et al. (2010) and Birmingham et al. (2006), whose studies are set in the United Kingdom, reported subjective determination of the "best interests of the child" as a condition for participant eligibility.

**2.2.3.3 Program Characteristics.** The evidence in this review points to great variation in characteristics associated with the MCP. Nine studies did not include information about MCP characteristics. A few programs had multiple supplemental elements: Condon (2017) described monthly pediatrician visits, therapeutic childcare, support and coaching for mothers; by contrast, Senanayake et al. (2001) described

children accompanying their mothers to prison labour placements. One study (Sleed et al. 2013) compared groups within an MCP: the case group received access to an extra intensive parenting program, whereas the control did not.

**2.2.3.4 Health Outcomes.** A total of 14 studies examined child outcomes and 19 examined maternal outcomes. Common health outcomes among the child-focused studies were breastfeeding (six), development (five), neonatal outcomes (three), attachment (three), infection (three) and immunization (two). Studies examined more than one outcome. Common health outcomes among the mother-focused studies included mental health/stress (seven), qualitative experiences (six) and perinatal (six). Seven studies presented outcomes for both mothers and children.

**2.2.3.5 Child Outcomes.** In this review, seven studies mentioned breastfeeding. Lennon (1992), based in the United States, and the Planning Commission (2006), based in India, found that 20% of MCP participants breastfed. Both Senanayake et al. (2001), based in Sri Lanka, and Ferrara et al. (2009), based in Italy, found that 70% of MCP child participants were breastfed. Barkauskas et al. (2002), based in the United States, found that 19.4% of MCP participants breastfed at discharge from hospital, compared with 2.9% of controls who were incarcerated mothers unable to return to the prison with their infants. Fritz and Whiteacre (2016), also in the United States, found breastfeeding rates of 60% for MCP participants compared to 33% for non-participants. Kutuk et al. (2018) in Turkey found a mean duration of breastfeeding of 8.3 months for MCP participants.

All five studies that examined child development used an established tool. Four generated results that suggested no marked developmental harm associated with MCP participation (Catan 1989; Goshin et al. 2014; Jiménez and Palacios 2003; Lennon 1992).

However, Kutuk et al. (2018) found that 14 of the 26 children in their study experienced a developmental disorder.

Three studies examined neonatal outcomes. Barkauskas et al. (2002) found birth weights, gestational age and neonatal APGAR health scores among children in MCPs to be similar to those of children in the control condition. Ferrara et al. (2009) found a statistically significant difference in the gestational ages at birth of babies born to the in-prison group (lower) versus the control, as well as earlier time of weaning. Lennon (1992) found nine of the 116 infants in her study to be born preterm. All three studies that explored attachment found favourable or normal levels among the child participants in MCPs (Byrne et al. 2010; Cassidy et al. 2010; Condon 2017).

The three studies examining infection and two examining vaccination were less uniform in their findings. Ferrara et al. (2009) found higher rates of respiratory illness among the case group (MCP) than in controls and inadequate immunization among MCP children. Among the 116 infants in her study, Lennon (1992) found 182 incidences of respiratory illness and 135 of ear infection (children could be ill more than once). In a sample of 30 children, Senanayake et al. (2001) found that 23% had scabies, 10% had pediculosis and 7% had impetigo; all immunizations were up to date.

**2.2.3.6 Maternal Outcomes.** Each study in our review used established tools for measurement of maternal outcomes. As shown in Table 2, results varied. In their sample of 55 MCP participants, Birmingham et al. (2006) found that 35% had personality disorders, 35% had a neurotic disorder, 16% had a “hazardous drinking” disorder and 36% had drug use disorders. Of the participants, 31% had current need for mental health treatment. In their sample of 85, Dolan et al. (2013) found that 51% had depression and

57% had anxiety. Goshin et al. (2014) found that one third of the caregivers of the 47 infants in their study reported prenatal substance use or problem drinking. In their sample of 112, Gregoire et al. (2010) found that 90% had one or more of the five categories of mental disorder for which they surveyed. Kutuk et al. (2018) found that all 24 mothers in their study scored in clinical ranges for emotional abuse, emotional neglect and physical neglect. Cassidy et al. (2010) found that Beck Depression Inventory scores fell on average among the 20 mothers who participated in the MCP, but that the result was not statistically significant. Sleed et al. (2013) did not find any change in depression scores over time among the 88 MCP participants in their study.

Although a dominant theme across the qualitative studies is the mother–baby dyad as its own "home" and "family" and the MCP as supportive, some researchers uncovered mental and emotional distress among participants. For example, Freitas et al. (2016) remarked, "Women whose children live with them in prison experience some advantages, but motherhood also increases suffering due to restrictions on liberty" (p. 415).

Perinatal outcomes included pregnancy rate, pregnancy intention, parity and mode of deliveries. The rate of pregnancy among incarcerated women in MCPs was reported to be 0.7% in one study (Birmingham et al. 2006) and 3% in another (Planning Commission 2006). Leal et al. (2016) identified high rates of unplanned or unwanted pregnancy among their study participants but did not provide an overall rate of pregnancy among incarcerated women. Although the mode of delivery rates varied widely among the studies, no study identified the C-section rate among MCP participants as out of the ordinary for their context.

Importantly, two studies addressed carceral force: Leal et al. (2016) found that 36% of that respondents were held in restraints during labour. Fritz and Whiteacre (2016) reported that the use of ankle cuffs was a normal practice during birth, with 40% of the MCP participants reporting negative emotions regarding their use. The amount and the implications of carceral force remain curiously rare outcomes of study.

### 2.2.4 *Discussion*

This systematic scoping review aimed to create an international picture of what types of health outcomes researchers have examined among participants in MCPs in carceral settings and how MCPs differ in terms of program characteristics and eligibility criteria. Given the sparsity of synthesized information, the scoping review approach was appropriate to begin to understand the nature of existing MCPs and the types of health outcomes under scrutiny and how they have been studied.

In a third of the studies in our review, the eligibility criteria for participating in MCPs are not described. Indeed, in some, participation is presented as maternal choice (Planning Commission 2006). Between the studies, criteria contradict each other: in some, the applicant must be pregnant (Cassidy et al. 2010); in others, up to three children may come with the mother. Sometimes, only those with a history of substance use may apply (Barkaukas et al. 2002); in others, participants must have a negative urine drug screen (Birmingham et al. 2006). As Gregoire et al. (2010) noted, although mental illness may not be a criterion for exclusion, the other criteria may effectively exclude potential participants with mental health concerns. In general, the only restriction in terms of the children was their age, usually limited to the first year of life. These wide differences in

eligibility, and in the consequent differences in characteristics of participants, prevent any generalizations.

In Canada, the Commissioner's Directive 768 governs eligibility to the full-time federal MCP. Prospective applicants must have a child who is four years or younger, be classified as medium or minimum security and have no convictions for actions endangering a child (CSC 2016). Nurses may be able to directly support applicants by using their independent professional authority and leadership to influence expediting paperwork, supporting efforts for applicants to reach lower security classifications and by helping applicants frame their applications as in the best interest of the child.

The variability in MCP contexts impairs our ability to make comparisons among outcomes across multiple settings. The term "prison nursery," although used often, is obfuscating. It may refer to a unit in which mothers and children co-reside or to a nursery school/daycare option in addition to co-residence. The absence of day-care in settings where incarcerated women are required to work could be a deterrent to maternal willingness and ability to join the MCP. Baradon et al. (2008) found that mothers felt guilty about bringing their children into the prison environment. The potential negative implications for mother participants vis-à-vis other aspects of imprisonment and MCP participation must be disentangled from a presumption of benefit for all.

In Canada, there is no on-site day-care for the MCPs. Children are ineligible when they reach five years of age and are expected to attend school regularly (CSC 2016). Nurses who work in corrections in Canada must consider how balancing work and caregiving responsibilities and ubiquitous concerns for mothers is a strain for MCP

participants, who lack flexibility, have next to no income and are also trying to fulfill institutional requirements for their eventual release.

Given the stigma criminalized mothers experience, we expected a greater focus on outcomes of the child over those of the mothers and were surprised to find more studies focused on mothers. We also expected more studies to examine health outcomes among both the mother and the child, as the pair is strongly connected in their experiences of health. The range of outcomes introduced in this review speak of the enormous complexity of creating a healthful environment within an institution.

We anticipated breastfeeding and healthy attachment as likely key outcomes to study; this expectation was confirmed by the review. The strong interest in infant development buttresses concerns we often hear that the prison environment is sterile and inadequately stimulating for children. Although limited, findings in this review demonstrate that developmental delay is not an overarching concern for MCP participants and, rather, that separation may increase anxiety.

The research reporting on health outcomes for children reflected a broad view of child health and considered the impact of physical infrastructure in the prisons, resources for gross and fine motor skills development and the presence of stimulating play items and recreational equipment in the prison (Jiménez and Palacios 2003; Planning Commission, Government of India 2004). Nurses should consider the complexity of healthy child development in their care and advocate for MCP participants. Future research should be conducted in collaboration with colleagues in early childhood education, social work, recreation therapy and other health disciplines.

Eight of the 27 studies explored how MCPs affect maternal and infant health in the perinatal period, that is, pregnancy, labour, birth, postpartum and neonatal outcomes. We questioned whether to include these studies at all, as they do not address outcomes associated with a child *living* with their mother. Thus, it is not the MCP that likely influences these health outcomes but rather prenatal incarceration and institutional accommodations for pregnancy, labour and birth. However, including these studies allows us to note, with concern, the greater focus on pregnancy and neonatal outcomes than longer term health outcomes for both mother and child, in or out of MCPs. Although giving birth in ankle cuffs is an extraordinary trauma, separation from one's child for their infancy is likely far harder to endure.

As might be expected, MCPs may have a greater influence on postpartum well-being than antenatally or during labour and birth. Fritz and Whiteacre (2016) found that prenatal, labour and delivery outcomes do not differ significantly between mothers who participated in MCP versus those who did not but that the mothers had differing postpartum experiences. MCP participants were less likely to experience trauma with separation from the infant and were more likely to breastfeed.

We were pleased to find that about one quarter of the studies in this review mentioned breastfeeding; in our earlier scoping review of maternal health outcomes of incarcerated women (Paynter, Drake, Cassidy & Snelgrove-Clarke, 2019), we critiqued the lack of attention to breastfeeding. Breastfeeding is recognized as a key determinant of maternal and infant well-being (Victora et al. 2016). Breastfeeding initiation, exclusivity and duration would be expected to be mediated by proximity and co-residence with the

child. Although likely influencing breastfeeding outcomes among MCP participants, local cultural norms regarding breastfeeding were not examined in our scoping review.

Mental illness is both a common precursor to incarceration of women and a common complication of pregnancy and as such was unsurprisingly the most common outcome of study in the review. Seven studies examined indicators such as maternal depressive symptomatology, presence of psychiatric disorder and/ or receipt of treatment. Birmingham et al. (2006) noted that mothers who are deemed to have stable mental health may be more likely to be admitted to MCPs. However, high rates of depression, other psychiatric disorders and substance use found among MCP participants in the scoping review are unsurprising. In Canada, more than three quarters of federally incarcerated women have histories of mental illness, and two thirds have co-occurring substance use disorder or personality disorder (Office of the Correctional Investigator 2019). Almost half are prescribed psychotropic medication (Office of the Correctional Investigator 2016). Nurses can recognize not only the physiological value for infants to room in with their mothers during withdrawal from uterine substance exposure (Johnson 2020) but also for mothers to develop self-esteem and self-worth through uninterrupted bonding in the early infant period.

This review finds a lack of research related to MCPs in Canada, resulting in gaps in knowledge to inform policy making, clinical care and research. We recommend first and foremost a census. In Canada, neither CSC nor the Office of the Correctional Investigator systematically tracks or analyzes how many mothers and children are affected by maternal incarceration. To our knowledge, the health outcomes for

criminalized mothers and their children under community supervision have also not received substantial study. This oversight requires immediate attention.

The *Bangkok Rules* require (1) a comprehensive health history when a woman is admitted to custody, (2) state responsibility for child well-being and (3) provision of equal access to women's healthcare in prison as is available in the community (UNODC 2011). We suggest that the aforementioned three health system indicators are minimal requirements for researchers to assess in evaluation of MCPs. Our scoping review identifies many others (Figure 4).

**Figure 4**

*Key Health Outcomes for Participants in MCPs*

- Reproductive health history
- Current reproductive, physical and mental health needs
- Breastfeeding and infant feeding
- Child and mother nutrition
- Infectious disease and immunization
- Maternal mental health: presence of psychiatric disorder or substance use disorder, access to therapy, use of psychotropic medication
- Child development
- Child and mother attachment
- Accidental injury
- Carceral force, restraints and maltreatment
- Access to services: pediatric, perinatal, emergency, specialty, etc.
- Oral hygiene and dental care
- Maternal satisfaction with MCP
- Maternal self-esteem and self-efficacy

From the perspective of clinical practice, the health outcomes listed in Figure 4 inform what nurses must ensure are part of their support for incarcerated mothers and child health. Given that incarcerated women experience elevated rates of mental illness and substance use, nurses must ensure that MCP participants have access to comprehensive mental health and support for substance use disorder. Peripartum depression is a common complication of pregnancy and more predictable in a context of limited access to support, constant surveillance and restricted activities of daily living. Without adequate emotional support, MCP participants risk instability and challenges meeting institutional expectations and eligibility requirements. Nurses have a critical role to play in providing trauma-informed mental healthcare and in advocating for access to additional resources, such as opioid replacement therapy, counselling by elders and talk therapy. Nurse confidence in the value of mothers and children being together could be important to supporting prospective MCP applicants.

Policy makers and administrative stakeholders for prisons for women in Canada and internationally must observe the *Bangkok Rules* (UNODC 2011) and the UN *Convention on the Rights of the Child* (United Nations Human Rights 1989) and permit mothers to parent their children wherever possible. They must recognize that if children are to be co-incarcerated, their complex needs in early childhood must be reliably met. In geographically large countries with small incarcerated populations, such as Canada, this could be exceedingly resource intensive. Non-carceral options for mothers and children must be explored rather than using resource intensity as a rationale to separate the dyad. From a professional position of trust and expertise in the evidence of maternal and child well-being, nurses can advocate for alternatives to incarceration. For participants in

MCPs, nurses can advocate for respite and day care to support mothers' participation in required correctional programs and, training and employment to expedite release and facilitate community reintegration.

### 2.2.5 *Limitations*

This review has limitations. The studies included in this review span five continents, providing limited information about areas that require in-depth monitoring and research with attention to local contexts. This review was restricted to articles published in English. Some of the studies are over 30 years old; contexts have changed drastically in that time. We did not assess study quality. Although many social and economic factors are known to be determinants of health, this review only includes research studies in which outcomes are described as health related by the study authors. The authors of this review recognize that trans and nonbinary parents may be imprisoned in facilities for men or women, and "mother" is a problematic term. Future research must include trans and nonbinary parents.

### 2.2.6 *Conclusion*

This review maps the great variation in MCP eligibility criteria, program characteristics and outcomes of interest in studies examining maternal and child health associated with participation. It identifies key outcomes that nurses can apply to research, clinical practice and policy. We found no studies of health outcomes associated with the MCPs in Canada, and yet, every federal prison for women in Canada has an active program. To justify continuation of, changes in or expansion of MCPs, high-quality research must inform decisions. The rising incarceration of women in Canada and globally (World Prison Brief 2017) is driving increasing concern about the well-being of

affected children and consequent advocacy for MCPs. The paucity of evidence about the health benefits of MCPs suggests consideration should be given to alternatives to family incarceration and serious evaluation of variations among program options. Nursing leaders should advocate for not only creative and extensive research, comprehensive care and policy in line with the *Bangkok Rules* but also alternatives to research, care and policy of incarceration for mothers and children together. Nurses can promote a vision of future mother–child dyad-centred research, care and policy that breaks down the prison walls.

### 2.2.7 *Lack of Canadian Evidence*

Search strategies and criteria in the two previous reviews found no Canadian studies eligible for inclusion. To understand what was known about sexual and reproductive health for prisoners in Canadian facilities designated for women, the final scoping review looked specifically at Canadian evidence and broadly at sexual and reproductive health outcomes.

## 2.3 Sexual and Reproductive Health Outcomes Among Incarcerated Women in Canada

This work in section 2.3 also appears in: **Paynter, M.,** Heggie, C., McKibbon, S., Martin-Misener, R., Iftene, A., Tomblin Murphy, G. (2021) Sexual and reproductive health outcomes among incarcerated women in Canada: A scoping review. *Canadian Journal of Nursing Research.* https://doi.org/10.1177/0844562120985988

Co-author Clare Heggie was the second reviewer of all included articles. Shelley McKibbon developed the search strategy and retrieved the articles. Dr. Ruth Martin-

Misener, Dr. Adelina Iftene and Dr. Gail Tomblin Murphy supported manuscript preparation and review.

### 2.3.1 *Rationale*

At 112 people per 1,00,000 Canada has one of the highest rates of incarceration in the western world and women are the fastest-growing incarcerated population (World Prison Brief, 2020). The population of people in prisons for women increased 32.5%from 2009 to 2019 (Canadian Friends Service Committee, 2019). The increasing incarceration of women increases needs for sexual and reproductive health care from prison health services. The absolute numbers of women experiencing incarceration are relatively small: women represent 7% of the 14,742 people in federal prisons and 16% of the 25,405 people in provincial custody (Reitano, 2017). As a small subpopulation, the sexual and reproductive health service needs of women, trans and nonbinary people may be crowded out by those of the much larger populations of men. In a 2015 scoping review of Canadian prisoner health, Kouyoumdjian et al. found 86 of the 194 studies included only male participants and in another 35 studies, more than 2/3 of participants were male. Although women are named as a focal population for the OCI, the office has only published one recent study focused on the health of women, and it examined factors associated with self-harm. Correctional Service of Canada has never published a study about sexual or reproductive health.

Colonialism and racism are foundational to Canadian systems of policing, justice and corrections. In both the federal and provincial/territorial systems, Indigenous women are significantly over-represented: 42% of women admitted to provincial/territorial facilities are Indigenous (Malakieh, 2019), and 41.4% of women in federal prisons are

Indigenous (OCI, 2020). In Canada, Indigenous groups include First Nations, Inuit and Metis (Canada, 2017). The population of Indigenous women in provincial/territorial facilities varies from 76% in Saskatchewan to 5% in Quebec (Reitano, 2017). The number of Indigenous women detained in the federal system rose 60.7% from 2008–2018 (Public Safety Canada, 2019). Indigenous people are disproportionately likely to receive sentences at higher (medium and maximum) levels of security (Public Safety Canada, 2019), where it is less possible to participate in programming and access services.

The Corrections and Conditional Release Act (Canada, 1992) sets out the legal requirements that the federal prison system provide health services at professionally accepted standards of practice. Health service delivery is organized under the Correctional Service Canada's (CSC) Commissioner's Directive 800 (CSC, 2015). Health care staff are employed by the same body as correctional officers, namely CSC, and comprise 7% of CSC's 17,000 employees (Office of the Parliamentary Budget Officer, 2018). In the provinces and territories, the state is responsible for the health of incarcerated people, however health services for people in carceral facilities may fall under Justice or Health portfolios.

The United Nations Office on Drugs and Crime (UNODC) *Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders*, known as the Bangkok Rules (UNODC, 2011) stipulate international requirements pertaining to women's sexual and reproductive health. Bangkok Rule 6 specifies:

> The health screening of women prisoners shall include comprehensive screening to determine primary healthcare needs, and also shall determine: (a) The presence of sexually transmitted diseases or blood-borne diseases. . .(b) Mental health-care

needs. . .(c) The reproductive health history of the woman prisoner, including current or recent pregnancies, childbirth and any related reproductive health issues; (d) The existence of drug dependency; (e) Sexual abuse and other forms of violence that may have been suffered prior to admission. (UNODC, 2011, p. 9)

Rule 10 stipulates that "Gender-specific health-care services at least equivalent to those available in the community shall be provided to women prisoners" (UNODC, 2011, p. 10). Rule 17 states that "Women prisoners shall receive education and information about preventive health-care measures, including on HIV, sexually transmitted diseases and other bloodborne diseases, as well as gender-specific health conditions" (UNODC, 2011, p. 11). Rule 18 specifies "Preventive health-care measures of particular relevance to women, such as Papanicolaou tests and screening for breast and gynaecological cancer, shall be offered to women prisoners on an equal basis with women of the same age in the community" (UNODC, 2011, p. 11). Rule 47 states "Pregnant or breastfeeding women prisoners shall receive advice on their health and diet under a programme to be drawn up and monitored by a qualified health practitioner" (UNODC, 2011, p. 16).

The UNODC *Standard Minimum Rules for the Treatment of Prisoners*, known as the Mandela Rules (UNODC, 2015) also include international requirements for maternal health care. These include Rule 28, which states "In women's prisons, there shall be special accommodation for all necessary prenatal and postnatal care and treatment" (UNODC, 2015, p. 9) and Rule 48 "Instruments of restraint shall never be used on women during labour, during childbirth and immediately after childbirth" (UNODC, 2015, p. 15).

Pretrial incarceration and brief sentences are highly disruptive to the lives of people experiencing criminalization (Pelvin, 2019), and may impact continuity in health service use, housing, employment, and family (Elwood Martin et al., 2009). Most people in prison in Canada are in the provincial/territorial systems, where over two-thirds of prisoners are remanded to custody before trial (Reitano, 2017). Their average length of stay is one week (Malakieh, 2019). One third of those who are sentenced to provincial prisons spend less than a week in custody (Malakieh, 2019). In general, women spend less time in remand and sentenced custody than men (Malakieh, 2019). People in federal prisons have received a conviction and sentence for two years or more. Of these, approximately half will serve less than five years in custody (Public Safety Canada, 2018).

Some authors suggest improving prison health services would support incarceration as an opportunity for people to focus on their health (McLeod & Elwood Martin, 2018). Health care provision within carceral settings is fraught with the ethical dilemma of dual loyalty to patients and prison authorities (Pont et al., 2012). Furthermore, the "revolving door" (Padfield & Maruna, 2006) of incarceration poses logistical problems to health and rehabilitation service provision within carceral institutions.

Health-related matters are the most common type of complaint to the OCI (2019), the watchdog for federal prison services. Incarcerated people are disproportionately likely to experience structural determinants of ill health such as poverty, low educational attainment, unemployment, and racism (Public Safety Canada, 2018). Incarceration itself can be framed as a socialstructural determinant of health (Brinkley-Rubenstein & Cloud,

2020). Risks to health during incarceration include violence, segregation, and disciplinary sanctions in response to health experiences such as mental illness and substance use disorder (OCI, 2020). The experience of incarceration impacts health outcomes including physical wellbeing, mental health, infection, injury and pain (Kouyoumdjian et al., 2016).

Sexual and reproductive health is a dominant area of health service use for women and people with a uterus. Indeed, it is a broad concept:

> Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. (World Health Organization, n. d., p. 1)

Birth is the most common reason for hospitalization in Canada (Canadian Institute for Health Information (CIHI), 2020). Approximately 75% of Canadians have Human Papilloma Viruses (HPV), sexually transmitted infections that cannot be cured and are the cause of genital lesions and several types of cancers (Action Canada, 2020). An estimated 60% of women over the age of 18 have primary dysmenorrhea (painful periods) (Burnett et al., 2005). The prevalence of sexual assault among women in the general population is 30% (Cotter & Savage, 2019). For people in prisons for women, lack of adequate sexual and reproductive health care can result in significant harm. Given the increasing population in prisons for women in Canada, the legal requirements to provide adequate health services to women in prison, and the sparsity of knowledge about the health of this population, In this scoping review we asked, “What is known about the

sexual and reproductive health of people incarcerated in prisons for women in Canada?" This knowledge will be used to inform future research priorities, policy governing the health services for people experiencing incarceration, health care providers' practice when caring for this population, and the development of interventions to address the needs of this population.

### 2.3.2 *Methods*

We conducted a scoping review following Joanna Briggs Institute (JBI) (Peters et al., 2020) methodology. The protocol for this review was not registered. The population of interest was women experiencing incarceration. The concept of interest was sexual and reproductive health, very broadly defined, including sexually transmitted infections; contraception; pregnancy rates, intentions and complications; birth; maternal health; sexual assault; reproductive mental health, etc. The context was incarceration in Canadian prisons.

**2.3.2.1 Inclusion Criteria.** This scoping review included studies with participants who were or had been incarcerated in provincial, territorial and federal prisons for women in Canada and whose sex and or gender was identified as female, trans or nonbinary.

**2.3.2.2 Exclusion Criteria.** This review excluded studies conducted only with people in prisons for men. As the focus on this review and the key words addressed health, we did not consider studies that examined outcomes not described as health related. We did not include review articles, commentaries or editorials and excluded all publications not available in full text in English or published prior to 1992.

**2.3.2.3 Search Strategy.** We used a JBI method which includes a three-step comprehensive search strategy to find both published and unpublished studies: First, an experienced clinical librarian led a limited search of MEDLINE and CINAHL using keywords. She analysed the text in the titles/ abstracts and index terms to develop a tailored search strategy for each information source. Keywords included: carceral, penal, custod*, jail, prison*, incarcerat*, correction*, penitentiar*, detention, inmate*, offender*; health; women, woman; Canada and the names of each of the provinces and territories.

Secondly, databases were searched using the keywords and index terms identified from the initial limited search. The databases we searched included:

- MEDLINE
- CINAHL
- PsycINFO
- Gender Studies Abstracts.

The search for unpublished studies included:

- Internet search of reports published by Corrections
- Services Canada (CSC) and the Office of the
- Correctional Investigator of Canada (OCI)
- Google Scholar (first 100 citations)
- ProQuest dissertations.

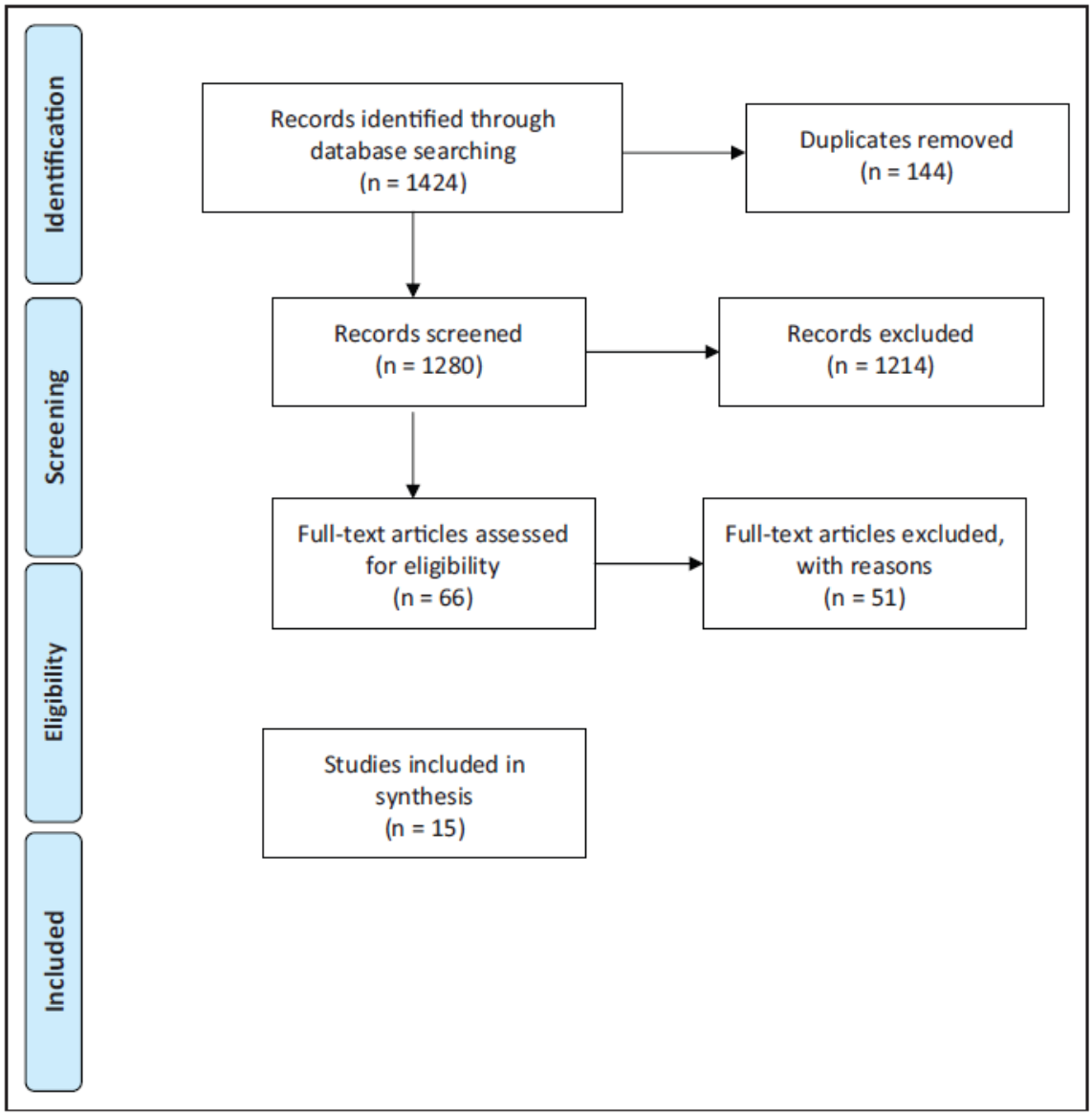
A full search strategy for CINAHL is detailed in Appendix C. Lastly, to help identify any additional studies, the reference lists of all literature meeting the inclusion criteria of this review were examined for potentially relevant studies. The JBI method for

scoping reviews does not include quality assessment of the studies and as such this was not performed.

**2.3.2.4 Study Selection.** Following the search, all identified citations were collated and uploaded into Covidence (Covidence systematic review software, 2020). Duplicates were identified and deleted. Two reviewers independently screened the titles and abstracts for assessment against the inclusion and exclusion criteria. Titles and abstracts that met the inclusion criteria were retrieved in full and assessed by two independent reviewers using the inclusion criteria. Where any conflicts occurred, a third reviewer was available to assist. Full text studies that did not meet the inclusion criteria were excluded. The search strategy retrieved 1424 hits. Removal of 144 duplicates resulted in 1280 articles for title and abstract review. Two reviewers independently screened articles to identify those eligible for full-text review. Sixty-six articles were included for full-text review, of which 15 met the inclusion criteria (PRISMA Figure 5). Reasons for exclusion of 51 articles included: Not focused on sexual or reproductive health outcomes (33); Not research (8); Not the population of interest (3); Duplicate (2); Outside the date range (2); Not the setting of interest (2); Not an included study design (1). Please see PRISMA diagram below, developed from Moher et al. (2009).

**Figure 5**

*PRISMA: Sexual and Reproductive Health Outcomes*




**2.3.2.5 Data Extraction.** Data were extracted from included papers using Excel. The items extracted from the full text included study characteristics (e.g., year of publication, province), number and types of participants and controls where appropriate, aim, study design and methods, sexual and reproductive health outcomes and results (see

Table 3). Any disagreements that arose between the reviewers during data extraction were resolved through discussion.

### 2.3.3 *Results*

**2.3.3.1 Study Characteristics.** The 15 studies were published between 1994 and 2020. The settings included five studies in provincial prisons for women in Ontario (Burchell et al., 2003; Carter Ramirez et al., 2020a, 2020b; Kouyoumdjian et al., 2018; Liauw et al., 2016); three in British Columbia (Elwood Martin, 2000; Elwood Martin et al., 2004, Rothon et al.,1994); two in Quebec (Dufour et al., 1996; Hankins et al., 1994) and one in Alberta (Besney et al., 2018). One paper was set in selected federal prisons for women (Ford, 1995); one included data from all the federal prisons for women (De et al., 2004), one included a small group of formerly incarcerated women who had been incarcerated in both federal and provincial facilities (Hutchison, 2020), and one included formerly incarcerated people living with HIV in Ontario, BC and Quebec (Gormley et al., 2020). Only Gormley et al. (2020) specified that the participants included trans and nonbinary people, and Hutchison (2020) specified that all five participants identified as cisgender women.

Study designs included 13 quantitative studies (Burchell et al., 2003; Carter Ramirez et al., 2020a, 2020b; De et al., 2004; Dufour et al., 1996; Elwood Martin, 2000; Elwood Martin et al., 2004; Ford, 1995; Gormley et al., 2020; Hankins et al., 1994; Kouyoumdjian et al., 2018; Liauw et al., 2016; Rothon et al., 1994), one mixed methods (Besney et al., 2018) and one qualitative (Hutchison, 2020). Sample sizes varied from 5 (Hutchison, 2020) to over 8,00,000 (Carter Ramirez et al., 2020a, 2020b). Four studies

included men and women participants, all four of which addressed HIV (Burchell et al., 2003; De et al., 2004; Dufour et al., 1996; Rothon et al.,1994).

Several papers addressed more than one reproductive health outcome (Table 3). Seven studies examined HIV (Burchell et al., 2003; De et al., 2004; Dufour et al., 1996; Ford, 1995; Gormley et al., 2020; Hankins et al., 1994; Rothon et al., 1994); four addressed Pap testing/cervical cancer screening (Besney et al., 2018; Elwood Martin, 2000; Elwood Martin et al., 2004; Kouyoumdjian et al., 2018); three studies looked at pregnancy or contraception (Besney et al., 2018; Carter Ramirez et al., 2020b; Liauw et al., 2016); one examined birth and neonatal outcomes (Carter Ramirez et al., 2020a); one addressed STIs (in addition to HIV) (Besney et al., 2018); and one addressed sexual assault (Hutchison, 2020).

**Table 3**

*Sexual and Reproductive Health Outcomes of People Incarcerated in Prisons for Women in Canada*

| Author, year, jurisdiction | Aim | Participants | Methods | Outcomes | Results |
|---|---|---|---|---|---|
| Besney et al. (2018); Alberta | To explore the impact of a Women's Health Clinic (WHC) on care at a provincial prison. | 109 women's charts reviewed; 11 women participated in focus groups. | Mixed. Retrospective chart review & focus groups with women and staff. | Intake tool measured socio-demographics, menstrual/reproductive history, social and personal risk history, sexual history, medical and surgical history, medications, allergies, addictions, housing status, and intimate partner violence (IPV) assessment. | Quantitative results: STI testing uptake significantly increased through the WHC compared with the 6 months prior to incarceration (17% to 89%, $p<.001$). Up-to-date Pap tests significantly increased through the WHC (15% to 54%, $p<.001$). Qualitative themes: A) Factors influencing use of women's health services: (1) Competing priorities impede access in the community; 2) Incarceration is opportunity to access; 3) Lack of access to comprehensive, gender-specific health services; 4) Mistrust of health care professionals; 5) Fragmentation of health care. B) Impact of WHC on accessing Women's Health Services: 1) Improved access to comprehensive, gender-specific services in a timely manner; 2) Knowledgeable and empathetic staff. C) Factors influencing the use of women's health services upon community transition: 1) Targeted community health resources; 2) Support navigating health and social services. |

| Author, year, jurisdiction | Aim | Participants | Methods | Outcomes | Results |
|---|---|---|---|---|---|
| Burchell et al. (2003); Ontario | To determine the prevalence and correlates of self-reported HIV testing among inmates in correctional centers in Ontario, Canada. | 597 incarcerated people (439 men and 158 women). | Quantitative. Cross-sectional survey delivered to inmates in a closed interview. | Previous HIV testing history, most recent HIV test specifics (e.g. date, time, location), risk factors (sexual activity, tattoos, drug use). | 58% of all participants had ever been tested for HIV; 21% had voluntarily tested in past year while incarcerated. Correlates of voluntary testing while incarcerate included being single/never married, without casual sexual partners, injecting drugs twice a week or more prior to incarceration, hepatitis history, and agreeing with mandatory testing. |
| Carter Ramirez et al. (2020a); Ontario | To examine antenatal care quality indicators for women who experience imprisonment and compare with the general population. | 529 women in prison during pregnancy; 1570 women with history of incarceration but not in prison while pregnant; 8,84,063 control/ general population women. | Quantitative. Linked correctional and health administrative data from women released from provincial prison and women in the general population with deliveries at 20weeks gestation or greater. | Receiving first-trimester visit, receiving first-trimester ultrasonography, receiving 8 or more antenatal care visits. | Women who experienced imprisonment were significantly less likely to receive adequate antenatal care than women in general population. |
| Carter Ramirez et al. (2020b); Ontario | To describe the population- level risk of infant and maternal outcomes for women who experience imprisonment. | 529 women in prison during pregnancy; 1570 women with history of incarceration but not in prison while pregnant, 8,84,063 control/ general population women. | Quantitative. Linked health and corrections data for women released from provincial prisons in 2010 compared to general population | Preterm birth rate, low birth weight, small for gestational age birth weight, NICU admission, neonatal abstinence syndrome, placental abruption, preterm prelabour rupture of membranes. | There was an increase of adverse outcomes in women who experience imprisonment (during or before pregnancy). Preterm birth risk rates were 15.5% (prison pregnancy) and 12.5% (prior incarceration); low birth weight risk rates were 13% (prison pregnancy) and 11.6% (prior incarceration) small for gestational age birth weight risk rates were 18.1 % (prison pregnancy) and 19.2% (prior incarceration). |

| Author, year, jurisdiction | Aim | Participants | Methods | Outcomes | Results |
|---|---|---|---|---|---|
| De at al. (2004); Canada | To investigates rates of testing and HIV among inmates in all 53 Canadian federal penitentiaries. | 385 "new admission" women, 347 "resident inmate" women; 7,285 "new admission" men and 12,079 "resident inmate" men. | Quantitative. Cross-sectional design using surveillance data on voluntary HIV antibody testing. | Seroprevalence rate of antibodies to HIV | 3.7% of women and 1.9% of men were HIV positive. A higher proportion of women than men underwent HIV testing. |
| Dufour et al. (1996); Quebec | To assess HIV prevalence and related risk factors at the Quebec Detention Centre. | 618 people at a Quebec detention Centre (499 men and 119 women). | Quantitative. Survey and HIV antibody testing of saliva. | HIV prevalence, sexual history, intravenous drug use (IDU) history, tattooing | There was a 2% HIV prevalence rate among men and an 8% prevalence rate among women. IDU was associated with HIV positivity. |
| Elwood-Martin (2000); British Columbia | To determine what factors are associated with increased willingness to undergo Pap testing while incarcerated. | 100 incarcerated women. | Quantitative. Survey. | Age, ethnic background, educational background, sentence length, knowledge of Pap testing, previous abnormal Pap, willingness to undergo Pap. | 75% of women were willing to undergo Pap testing. |
| Elwood-Martin et al. (2004); British Columbia | To examine the impact of a nurse-led Pap screening intervention at the Burnaby Correctional Centre for Women. | 650 incarcerated women. | Quantitative. Compare Pap screening rates before and during the 20-week intervention period. | Pap screening rates. The intervention included establishment of a nurse-led Pap clinic for one-on one education about cervical cancer and its early detection, Pap testing, reporting of Pap test results and arranging for appropriate treatment. | A higher proportion of inmates were screened during the intervention period (26.9%, 95% CI: 22.1%, 31.7%) than during the preintervention period (21.0%, 95% CI: 17.0%, 25.7%) but difference was not statistically significant (p¼0.06). Of 180 women incarcerated during the intervention period who had not had a Pap test in the preceding 2.5 years, 15.0% received Pap |

| Author, year, jurisdiction | Aim | Participants | Methods | Outcomes | Results |
|---|---|---|---|---|---|
| Ford (1995); Ontario | To determine the seroprevalence of HIV infection and hepatitis C among inmates of a federal penitentiary for women. | 113 women incarcerated at a federal penitentiary. | Quantitative. Pointprevalence study of voluntary, anonymous, linked HIV antibody testing. | Seroprevalence rate among participants of antibodies to HIV, age, length of sentence, place of residence. | The women had an overall seroprevalence rate of 0.9%. |
| Gormley et al. (2020); British Columbia, Ontario & Quebec | To determine associations between social determinants of health and HIV-related care outcomes among women living w HIV with recent incarceration experience. | 1422 women (inclusive of trans and non-binary women) over the age of 16 who live with HIV. | Quantitative. Selfreported Baseline surveys from a longitudinal cohort study of women living with HIV). | Recent incarceration, Sociodemographic factors, housing stability, HIV stigma, drug use, mental health diagnoses, Hep C diagnoses, Having ever been linked to HIV care or on ART, viral load. | Recent incarceration was associated with unstable housing, current sex work, IDU, lower income and sub-optimal ART adherence. Incarceration more than a year ago was associated with current sex work, IDU and experiencing violence. |
| Hankins et al. (1994); Quebec | To determine the relative contributions of pre-incarceration needle use and sexual practices to HIV antibody seropositivity among incarcerated women. | 394 incarcerated women. | Quantitative. Sociodemographic survey and test for HIV antibodies. | History of IDU, sex work, HIV seropositivity. | 6.9% were seropositive for HIV antibodies. Of women with a history of prior injection drug use (IDU), 13% were seropositive. Of those for whom sex work was their principal source of revenue prior to incarceration, 12.9% were seropositive. |
| Hutchison (2020); Canada | To report findings from qualitative interviews conducted with five formerly incarcerated women to provide empirical evidence that strip searching is sexual assault. | 5 formerly incarcerated women. | Qualitative interviews. | Thematic | Main themes: (1) “Sexual abuse is when you don’t have the choice to say no,” (2) “There’s nothing I could do about it and if I did, I would get a charge,” and (3) “Every time, it felt like the same experience.” |

| Author, year, jurisdiction | Aim | Participants | Methods | Outcomes | Results |
|---|---|---|---|---|---|
| Kouyoumdjian et al. (2018); Ontario | To determine cervical cancer screening rates for women in provincial prison in Ontario. | 4553 women in the prison group and 3 647 936 women in the general population group. | Quantitative. Retrospective cohort study used correctional and health administrative data from January 12,006 to December 31, 2013. | Whether women were overdue for cervical cancer screening at the time of admission to prison or on July 12,010 defined as not having been screened in the previous 3 years, and whether women who were overdue were still overdue after 3 years. | Women in the prison group had 2.20 times (95%CI, 2.08-2.33) odds of being overdue for cervical cancer screening compared with women in the general population. Women in the prison group had nearly twice the odds of still being overdue at 3 years. |
| Liauw et al. (2016); Ontario | To describe the rates of unintended pregnancy and contraceptive use for incarcerated women in Ontario. | 85 incarcerated women participants. | Quantitative. Survey | Prior unintended pregnancy, prior therapeutic abortion, contraception use, unmet need for contraception. | 82% of women been pregnant, and of these 77% had experienced an unintended pregnancy and 57% reported having undergone a therapeutic abortion. 80% of women were not using a reliable form of contraception. |
| Rothon, Mathias & Schechter (1994); British Columbia | To determine the prevalence of HIV infection among people entering provincial adult prisons in British Columbia and to study associations between HIV infection and specific demographic and behavioural characteristic. | 2483 adult inmates in provincial prisons (2332 male, 150 female). | Quantitative. Survey and HIV antibody testing of saliva. | HIV status, sex, Indigenous status, age, history of IDU. | HIV prevalence rate of 1.1% in the study population; HIV as. associated with history of IDU. |

**2.3.3.1 HIV and other STIs.** The most common area of research among the studies was HIV. Six of these eight studies were published from 1994–2004. The four studies that compared female and male subpopulations found higher rates of HIV among incarcerated women. Burchell et al. (2003) surveyed 597 people in Ontario prisons about HIV testing histories, of which 26% were female. Female participants were more likely than male participants to have experienced several risk factors: having had more than 50 sexual partners (24% versus 17%), participation in sex work (26% versus 1%) and injection drug use (IDU) (37% vs. 30%). Female participants were more likely than male participants to have been tested for HIV (69% vs. 58%). HIV seroprevalence was not measured. De et al. (2004) conducted a large Canada-wide study to determine seroprevalence of HIV among 732 women and 19,364 men. The authors found a higher proportion of women than men underwent testing, and 3.7% of women compared with 1.9% of men reported being HIV positive. Dufour et al. (1996) found higher seroprevalence of HIV among incarcerated women compared to men in Quebec (8% versus 2%). Rothon et al. (1994) also found higher rates of HIV among women than men in BC.

In their study of prevalence of HIV among women in a federal prison in Ontario, Ford (1995) found a rate of 0.9%. In a Quebec prison for women, Hankins et al. (1994) found a rate overall of 6.9%, which rose to 12.9% among those who disclosed a history of sex work, and 13% among those with injection drug use. Besney et al. (2018) included two women previously known to be HIV positive in their study, generating a prevalence rate of 2.04%.

One recent study, Gormley et al. (2020) surveyed 1422 women living with HIV who had histories of incarceration. The authors found recent incarceration to be associated with unstable housing, current sex work, IDU, lower income and suboptimal ART adherence.

Through a prison women's health clinic intervention, Besney et al. (2018) tested 98 participants for STIs including HIV, chlamydia, gonorrhoea and syphilis. They found 0 participants tested positive for HIV or syphilis, 11 tested positive for chlamydia and 5 for gonorrhoea. The authors found uptake for STI testing significantly increased compared with the six months prior to incarceration, from 17% to 89%. The authors estimate a lifetime prevalence for at least one STI (including HIV, chlamydia, gonorrhoea and syphilis) within the study population of 16.33%. Besney et al. (2018) also examined cervical health including Pap testing.

**2.3.3.2 Pap Testing/Cervical Cancer Screening.** Four studies examined Pap testing/cervical cancer screening. Elwood Martin (2000) surveyed 100 women at a BC provincial prison and found 75% expressed willingness to undergo Pap testing. Elwood Martin et al. (2004) measured participation among women at a provincial prison in BC in Pap screening during the implementation of a nurse-led clinic. Although the rate increased during the clinic intervention from preimplementation (26.9% vs. 21%), the change was not statistically significant. In an analysis of 4533 women in prison in Ontario compared to the general population, Kouyoumdjian et al. (2018) found women in prison were 2.2 times more likely to be overdue for cervical cancer screening.

Like Elwood Martin et al. (2004), Besney et al. (2018) measured the impact of a nurse-practitioner-led women's health clinic in a provincial prison in Alberta. However,

the latter intervention saw Pap tests significantly increase (15% to 54%). Of those tested, 3% had an abnormal Pap result.

**2.3.3.3 Pregnancy, Contraception, Birth, Neonatal Outcomes.** Besney et al. (2018) examined pregnancy testing and contraception use associated with the new women's health clinic. Of 109 women whose charts they reviewed, 21% either requested or required pregnancy testing, however none were diagnosed with pregnancy. Besney et al. (2018) found 67% of women described using a form of contraception, although it is not clear if the authors are referring to use during the period of incarceration. Liauw et al. (2016) surveyed 89 women in provincial prison in Ontario. They found 82.4% had ever been pregnant. Of those who had, 57.1% had previously sought an abortion and only 28% described their last pregnancy as planned. Furthermore, 80% reported an unmet need for contraception while incarcerated.

Carter Ramirez et al. (2020a) examined access to prenatal care for women experiencing incarceration in Ontario prisons, and Carter Ramirez et al. (2020b) examined labour and neonatal outcomes in this same population. The former study found women who had experienced imprisonment were significantly less likely to receive adequate prenatal care compared to the general population. The latter study found women who had experienced incarceration during pregnancy or prior to pregnancy were more likely to experience preterm birth and their infants were more likely to be low birthweight or small for gestational age.

**2.3.3.4 Strip Searching.** Hutchison (2020) conducted a qualitative study with five previously incarcerated women about the experience of strip searching. While strip searching is not a health outcome, the way in which participants responded to that

carceral protocol was as sexual traumatization. Hutchison (2020) found participants described the experience as degrading and dehumanizing, and revictimizing for participants with childhood histories of sexual assault.

### 2.3.4 *Discussion*

This systematic scoping review aimed to synthesize research in Canada pertaining to the reproductive health of women experiencing incarceration. Despite our generous definition of sexual and reproductive health outcomes, our review includes only 15 studies, with seven studies from the last five years and, curiously, none from 2004–2016. This is not surprising and is in keeping with the findings of Kouyoumdjian et al. (2015); their review called for more research in sexual and reproductive health. A scoping review approach proved appropriate for narrative organization of the few sexual and reproductive health outcomes that have been examined, and identification of gaps.

The predominant outcome of interest was testing for HIV or Pap testing/cervical screening: only five studies did not examine HIV or Pap screens. The studies showed variation in rates of HIV seroprevalence among women experiencing incarceration from 0.9% to 8%, in keeping with CATIE Canada's Source for HIV and Hepatitis C Information (CATIE) is current estimates of HIV prevalence in prisons at 1–8% (CATIE, 2020). The prevalence of HIV in the general population is estimated at 173 cases per 1,00,000 people (CATIE, 2018), or 0.01%: HIV is clearly disproportionately experienced by incarcerated people.

Much has changed in sexual and reproductive health in the 25 years between the first of the included studies pertaining to HIV and Pap testing and today. HIV infection can be prevented with pre-exposure prophylaxis (PrEP) and treated with anti-retroviral

medications. Screening schedules for cervical cancer start at later ages and it is now recommended to wait longer intervals (3 years) between normal Pap results (Canadian Taskforce on Preventive Health Care, 2013). Widespread HPV vaccination reduces transmission risk and risk of cervical cancer (Brisson et al., 2020).

In addition to the findings that women experiencing incarceration have higher rates of HIV and of abnormal and overdue Pap tests, our review found high rates of STIs (Besney et al., 2018) and of unplanned pregnancy (Liauw et al., 2016). Besney et al. (2018)'s measure of pregnancy rate of zero (0%) appears to be the only one available in the literature regarding incarcerated women in Canada, albeit with a very small sample size of 20 women who requested a test. The Bangkok Rules call for voluntary, confidential, and timely screening that is complemented with appropriate preventative or therapeutic care and education. STI, HIV, Pap and pregnancy screening/testing must be routinely offered to all people on admission to carceral facilities.

The Bangkok Rules, Mandela Rules and legislation in Canada require that people in prisons receive care consistent with at least professional standards. The recent studies by Carter Ramirez et al. (2020a), Kouyoumdjian et al. (2018) and Liauw et al. (2016), all found barriers and delays to reproductive health care in prisons.

Two studies measured the impact of introducing improved reproductive-health-focused service delivery. Although Besney et al. (2018) found significantly higher rates of STI and Pap testing when a women's health clinic was introduced at a provincial prison in Alberta, the earlier study by Elwood Martin et al. (2004) did not find significant increases in test seeking when a nurse-led clinic was introduced, despite very high rates of perceived acceptability of Pap testing (Elwood Martin, 2000). The dearth of evidence

allows few conclusions: it is surprising that in three decades, only two such initiatives have been studied.

The large retrospective studies by Carter Ramirez et al. (2020a) and Carter Ramirez et al. (2020b) are the only substantial quantitative evidence in Canada of the impact of incarceration on maternal and newborn health. Carter Ramirez et al.(2020a) compared the outcomes of 544 births to women who had been pregnant while incarcerated, 2,156 births to women who were incarcerated at some point before pregnancy, and 1,284,949 births among the general population. They adjusted for maternal age and parity. They found the odds of preterm birth to be 2.7 and 2.1 times more likely for these groups, respectively, in comparison to the general population. Preterm birth is the leading cause of death of children under the age of five (World Health Organization, 2020), places women at increased risk of ill-health (Henderson et al., 2016), increases hospitalization costs (Petrou et al., 2019).

Carter Ramirez et al. (2020b) found that of 626 pregnancies among incarcerated women, only 30.8% had a first trimester visit; less than half had the recommended eight prenatal visits; and 34.6% had a first-trimester ultrasound. The case and control groups were comparable in terms of maternal age and parity. Equitable access to prenatal care is critical to ensuring the health of pregnancies and early child health (Chief Public Officer of Health, 2009). These findings of harm point to the importance not only of measuring these outcomes among formerly/incarcerated people, but of responding to what is already known, and diverting pregnant people/people who may become pregnant away from incarceration to promote health and wellbeing in pregnancy, birth and infancy. Particularly in the time of COVID-19, during which prisons have become a key site of

Canadian outbreaks (Cousins, 2020), we must question the utility of trying to augment health services in a context that is simply inconducive to health (Paynter, Jerries & Carrier, 2020).

The lack of attention to maternal health of incarcerated people and to the health of adult and child participants in mother-child residential programs in Canada was demonstrated in earlier systematic scoping reviews (Paynter, Drake, Cassidy & Snelgrove-Clarke, 2019; Paynter, Jefferies, McKibbon, Martin-Misener, Iftene & Tomblin Murphy, 2020). Outside of Canada, mental health has been a key concern in examinations of maternal health outcomes among incarcerated women. Most people in prisons for women are mothers. Despite generous inclusion criteria and broad search terms, our review did not find any research pertaining to reproductive mental health. Given the disproportionate experience of mental illness among populations in prison, the lack of research in this area requires urgent attention.

We also note the lack of research addressing breast health. Besney et al. (2018) noted that 7% of their participants had ever noticed breast abnormalities, but their intervention, the introduction of a Women's Health Clinic, did not result in increased care seeking for breast health matters. There were also no studies addressing breastfeeding.

Bodily autonomy is critical to sexual and reproductive health. Security of the person is a constitutionally protected right in Canada (Canada, 1982). We found one study that speaks to how carceral practices, namely strip searching, violate that autonomy (Hutchison, 2020). Hutchison (2020) describes formulating their study as a response to the lack of empirical investigation of the gendered impact of strip searching. Carceral force could be expected to traumatize or re-traumatize people who had experienced

sexual violence and violations of their personal security. This aspect of sexual and reproductive health is under-studied.

We identify key gaps in basic data collection, including the data collection required by the Bangkok Rules when a person is admitted to a prison for women. To begin to address the complex health needs of people in prisons for women, comprehensive, confidential, voluntary assessment is required. The clinical intake assessment tool developed by Besney et al. (2018) with respect to the introduction of a women's health clinic at a provincial facility in Alberta presents a potential approach. At minimum, assessment must include serology for sexually transmitted and blood-borne diseases, screening for mental health-care needs, reproductive health history, substance use disorder, and experiences of gendered violence. Screening for these outcomes must be met with care including education, prevention, and treatment, and kept confidential. However, Besney et al. (2018) do not comment on the challenges to confidentiality posed by clinical assessment within a carceral setting. Silva et al. (2017) called for a national conversation and guideline development process for research involving incarcerated people because of the challenges of power imbalances and threats to privacy and confidentiality in the prison environments.

Finally, we must comment on the lack of research that takes an intersectional approach and explores the impact of racism, homophobia and other layers of social oppression in Canada (Hill Collins, 1989). In Canada, Indigenous women experience systemic barriers to reproductive health care (Smylie & Phillips-Beck, 2019). Lack of race-disaggregated data has long been a barrier in Canada to understanding the impact of anti-Black racism on the sexual and reproductive health of Black women (Nnorom et al.,

2019). An early study by Burchell et al. (2003) found 17% of their female participants identified as Black and 66% as Aboriginal but offer no further comment on how racism intersect with HIV. Fifteen years later, Besney et al. (2018) find 25% of their population identify as lesbian and 64% as Indigenous, however they too do not examine intersections between experiences of racism and homophobia and the outcomes of interest in their women's health clinic study.

### 2.3.5 *Limitations*

This review is limited by our interpretation of what to include as a sexual and reproductive health outcome. While we endeavoured to think broadly, it can be argued that every aspect of health implicates sexual and reproductive health, including pain, ability, and chronic illness. The studies included in this review are dominated by populations in Ontario and BC, potentially obscuring regional variations. This review was restricted to articles published in English. Some of the studies are over 25 years old and clinical recommendations and practices have changed significantly in that time. As per JBI methods, we did not assess study quality. Trans and nonbinary people may be imprisoned in facilities for men or women, but few of the studies are stated to be trans or nonbinary inclusive. The sexual and reproductive health experiences of trans and nonbinary people in prisons should be a priority for researchers.

### 2.3.6 *Conclusion*

The sexual and reproductive health of people in prisons for women in Canada is starkly understudied. The predominant outcomes studied were HIV testing and Pap screening, both of which have changed significantly over time with respect to screening/testing, treatment, prevention and risk identification. The sexual and

reproductive health of people in prisons is complex and fundamental to their overall wellbeing and their futures as parents, partners and participants in civic life. The extraordinary increase in incarceration of women in the past two decades has not been accompanied by adequate examination of the impact on sexual and reproductive health. The results of this review demonstrate unmet sexual and reproductive health service needs, inadequate access to care, and poorer perinatal outcomes for people who have ever experienced incarceration. This should cause health care providers, policy leaders and researchers to question current practices in both assessment and care in prisons for women, and the acceptability of incarceration of women when legal requirements for health services cannot be met.

### 2.4 Summary of the Literature and Perceived Gap in Research

These three reviews synthesize what has been studied with respect to the sexual, reproductive and perinatal health outcomes of people incarcerated in prisons for women and among participants in mother child programs. The international reviews of maternal health outcomes and health outcomes associated with mother child programs did not find any studies set in Canada; the Canadian review found sexual and reproductive health studies focused on HIV. Available evidence relevant to this study demonstrates incarceration in Canada is associated with unmet contraceptive needs, barriers to reproductive health care, inadequate prenatal care, and neonatal complications. Overall, the limited literature on health outcomes associated with incarceration in the perinatal period and during early parenting, vis-à-vis participation in a mother child program or not, underscores a significant gap in evidence. This lack of data limits the opportunity for health care providers and decision-makers to formulate and follow best practices in care

for this population. Prison abolition encourages creative solutions outside of carceral logics of punishment and control. The lack of evidence of the impact of incarceration on perinatal health in Canada is not only reason to call for enhanced research attention to prisoner health in this period; but for the study of alternative responses. This research study aims to understand how pregnancy and early years of parenting are experienced by people incarcerated in federal prisons for women and to speak to both these gaps.

# Chapter 3: Environmental Scan

One of the complications of studying the reproductive health of people experiencing incarceration is that so many different jurisdictions and systems are involved. Although women are the fastest growing population in prisons, they remain a small subset of the overall incarcerated population and are often incarcerated in facilities that are largely designated for the incarceration of men. No document or database exists with a comprehensive synthesis of all the relevant facilities. Without this information, it is difficult to form a picture of gendered incarceration in Canada, let alone the potential impact of mother child programs. This chapter includes an environmental scan conducted to identify all the facilities in Canada designated for the incarceration of women and girls, across the thirteen provinces and territories and the federal system, and including immigration detention centres, youth detention facilities, and forensic institutions. Once these facilities were identified, each was contacted to ask about the presence of a mother child program. Additionally, the distance from each facility to the nearest perinatal hospital was calculated to illustrate differences in geographic access to care.

## 3.1 Invisible Women: Correctional Facilities for Women Across Canada and Proximity to Maternity Services

The work in section 3.1 also appears in: **Paynter, M.J.,** Bagg, M.L., & Heggie, C. (2020) Invisible women: Carceral facilities for women and girls across Canada and proximity to maternal health care. *International Journal of Prisoner Health. 17,(2), 69-86.* https://doi.org/10.1108/IJPH-06-2020-0039

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### 3.1.1 *Background and Purpose*

Canada has one of the highest rates of incarceration in the Western world, at 136 people in prison per 100,000 population (Malakieh, 2019). People incarcerated in facilities for women are the fastest-growing population in Canadian corrections (Public Safety Canada, 2019). Currently, there is no central inventory of all the correctional institutions for women in Canada. For health researchers, prison rights advocates and policymakers to identify and respond to sex and gender differences in health indicators, access to services and supports for the children of incarcerated women, a clear picture of where women are incarcerated is required. The incarceration of women threatens reproductive health service access and reproductive autonomy (Sufrin, 2018). One critical aspect of reproductive health-care is hospital maternity services: birth is the most common reason for hospitalization in Canada (Canadian Institute for Health Information, 2020). Increasing numbers of incarcerated women, most of whom are mothers, also have significant harmful impacts on children (McCormack et al., 2014). Residential programmes for mothers to keep their children with them when incarcerated are one approach used to address that harm (Elwood Martin et al., 2012).

**3.1.1.1 Overview of Canadian Correctional Facilities.** In Canada, incarceration can be divided into four main categories, namely, federal corrections; immigration detention; provincial/territorial corrections; and youth corrections. Correctional Services Canada (CSC) governs federal institutions under the Minister of Public Safety. A sentence of two years or more results in federal incarceration. Immigration detention is the purview of the Canada Border Security Agency, also under the Minister of Public Safety. Each province and territory have their own correctional systems. Provincial/

territorial facilities include remand/pretrial custody and provincial sentences of up to two years less a day. Youth incarceration is also under provincial jurisdiction.

**3.1.1.2 Incarcerated Women in Canada.** Although the overall number of people experiencing incarceration in Canada has declined over the past five years (Malakieh, 2019), the number of women experiencing incarceration is increasing. The population in federal prisons for women increased by 32.5% from 2009 to 2019 (Office of the Correctional Investigator (OCI), 2020). Women form a small proportion of people experiencing incarceration: 7% of the 14,742 people in federal prisons and 16% of the 25,405 people in provincial custody (Reitano, 2017). This works out to about 4,065 people in provincial facilities for women. On a given day, Public Safety Canada reports 676 women on average are federally incarcerated (Public Safety Canada, 2019). On a given day there are 792 youth experiencing incarceration, 24% of whom are girls (Malakieh, 2019). Incarceration is a gender-enforcing system (White Hughto et al., 2018). Recent policy shifts have supported some trans and nonbinary people to be incarcerated according to gender identity or individual assessment Correctional Services Canada (CSC, 2017). The available research and statistics in Canada on the health of people in prisons for women does not distinguish between cisgender and transgender women. There is a serious and troubling gap in information about and services for trans and nonbinary people experiencing incarceration.

A history of colonialism and racism in Canada results in the disproportionate incarceration of Indigenous people. Although only 4.9% of the general population (Statistics Canada, 2016a, 2016b), Indigenous women represent 42% of women admitted to provincial/ territorial facilities (Malakieh, 2019) and 41.4% of women in federal

prisons (OCI, 2020). Federal incarceration of Indigenous women increased by 60.7% from 2008–2018 (Public Safety Canada, 2019). As Smylie and Phillips-Beck (2019) have discussed, colonial and racist policies have resulted in differential and inhumane treatment of Indigenous women with respect to reproductive health care, including the dismantling of traditional maternity care practices. Incarceration is described as having replaced the Residential Schools regime as a colonial system to separate Indigenous people from their communities (MacDonald, 2016) and over-incarceration as a public health crisis (Singh et al., 2019).

An inventory of facilities in which women are incarcerated is required to compare health status and access indicators across systems of corrections. There are five federal prisons for women, as well as one large and one small healing lodge (CSC, 2020b). In the federal system, women may also be co-located with men at psychiatric facilities. The three federal immigration detention centres hold men, women and children, approximately 8,781 in total per year Canada Border Services Agency (CBSA, 2020). In provincial and territorial systems, women may be co-located with units for men.

**3.1.1.3 Health Care in Correctional Facilities.** Health-care is among the most frequent concerns expressed by people in prison (Public Safety Canada, 2019). The United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the "Bangkok Rules"), adopted unanimously by the United Nations General Assembly (UNGA) in 2011, outline international responsibilities for the treatment of incarcerated women [United Nations General Assembly (UNGA), 2011]. These rules recognize that women experiencing incarceration have different needs

from men and require access to appropriate health services to meet those needs (United Nations General Assembly [UNGA], 2011).

In Canada, hospital and physician-based health services are publicly funded and administered (Canada, 1985). Provincial and territorial governments have responsibility for the health services of people experiencing provincial incarceration (remand and sentences). Health service arrangements across the adult and youth facilities in the provincial and territorial systems may be provided by provincial and territorial Departments of Justice, provincial health authorities, contractors and other bodies. The federal government is responsible for health-care delivery for those serving federal sentences. Health-care professionals working in federal prisons are used by CSC (CSC, 2020b). Health services available in immigration detention centres are the responsibility of the Canada Border Services Agency (Global Detention Project, 2018a).

The high health needs of women experiencing incarceration are well-documented. Most women in prisons in Canada have experienced childhood abuse (Bodkin et al., 2019), mental illness and substance use disorder (Farrell MacDonald et al., 2015). Women in prisons have high rates of chronic illness (Nolan and Stewart, 2017), blood-borne and sexually transmitted infectious disease (Kouyoumdjian et al., 2016; Kronfli et al., 2019) and PTSD (Jones et al., 2018).

Although most women incarcerated in Canada are of child-bearing age (Malakieh, 2019), an extensive narrative review of health research among people in prison in Canada has found little specific to reproductive health (Kouyoumdjian et al., 2016). Only two studies, Carter Ramirez et al. (2020a) and Carter Ramirez et al. (2020b) address perinatal and neonatal health outcomes of incarcerated women in Canada, both finding poorer

outcomes than are observed in the general population. In a survey of 89 provincially incarcerated women in Ontario, Liauw (2016) found 82.4% reported having ever been pregnant.

**3.1.1.3.1** ***Maternity Services for Incarcerated Women.*** The increasing number of incarcerated women heightens the need for the provision of gender-specific reproductive health care including contraception, abortion and maternity care. While prison pregnancy and reproductive health statistics are unavailable in Canada, a major recent initiative in the USA to capture such data found 3.8% of women newly admitted to prisons to be pregnant (Sufrin et al., 2019). Of these 1,396 pregnancies, 92% resulted in live births, 6% in miscarriages, 1% in abortion, 0.5% in stillbirth and 0.2% in newborn death.

Like most facilities in which women are incarcerated are co-located with men, and approximately 10 times as many men are incarcerated as women, prison health services are unlikely to be operationalized to provide gender-specific services including reproductive health care. For people in prisons, access to care can be hampered by security concerns (Olds et al., 2016) staffing issues (Morgan et al., 2007) and communication barriers between corrections and health-care providers [World Health Organization (WHO), 2014]. Poor access to reproductive health services can result in disease transmission, unwanted fertility, inadequate prenatal care, as well as maternal and neonatal complications (Stover et al., 2016).

Most incarcerated women in Canada have elevated health service needs; women who are incarcerated in the perinatal period have additional and significant needs that must be met to ensure the health of their children (Knittel and Sufrin, 2020). Health care is often in conflict with security operations in prisons: people may be strip-searched

before and after appointments, triggering PTSD (Human Rights Law Centre, 2017); transport to and from the prison to the hospital may involve the use of restraints and be forced to wear humiliating orange jumpsuits (Van Veeren, 2015); and access to care may be interrupted due to security lock-downs (World Health Organization, 2014). When care is necessary but not emergent such as routine prenatal assessment and ultrasound, it is vulnerable to being overlooked in the chaotic, violent and stressed context of prisons, particularly those populated mostly by men. Furthermore, security-related delay or denial of care can cause significant harm to both mother and infant. Longer distances to the hospital are associated with higher rates of maternal and neonatal mortality (Ravelli et al., 2011).

**3.1.1.4 Mother-Child Programmes in Correctional Facilities.** Available research demonstrates most incarcerated women are mothers of children under the age of 18 (Glaze and Maruschak, 2010). To reduce the harm to children associated with the incarceration of their mothers, many jurisdictions have residential programmes in which children can live with their mothers inside the prison (Paynter, Jefferies, McKibbon, Martin-Misener, Iftene, & Tomblin Murphy, 2020). In 2015, 70% of federally incarcerated women in Canada reported being mothers to minors under the age of 18 (Sapers, 2015). There is no reliable provincial/territorial data about the numbers of people reporting to be mothers or parents.

CSC policy stipulates that the mother-child programme must be offered to all federally incarcerated women (CSC, 2016). The eligibility requirements for full-time participation require participants to be classified as minimum or medium security and be willing to involve Child Protection Services in their families, and children must be under

the age of five (CSC, 2016). Brennan (2014) found the programme to be underused due to access barriers including prison overcrowding and the increasingly strict eligibility to participate. Over the past 17 years, only 125 women have applied to the programme, with 108 applications accepted (Office of the Correctional Investigator [OCI], 2019). Participation information is not published by CSC.

The only provincial institution with a full-time residential mother-child programme is the Alouette Correctional Facility in British Columbia. This programme was closed from 2008–2016, reportedly because of administrative concerns that children could be endangered by the prison environment (Inglis v BC, 2013, BCSC 2309). It reopened after a 2013 ruling that its closure was unconstitutional (Inglis v BC, 2013, BCSC 2309), however, there remain concerns that it is infrequently used (Stueck, 2015). In 2013, an international roundtable was convened to develop guidelines for the mother-child programme to support maternal-child bonding (CCPHE, 2015).

**3.1.1.5 Objectives.** The authors of this paper are volunteers with a non-profit organization in Canada that provides support, education and advocacy for the reproductive health of people experiencing criminalization. The organization has found the lack of publicly available information and research about the maternity care experiences of women experiencing incarceration, their children and their access to health care and support services impedes the organization's service delivery and advocacy efforts.

The purpose of this scan was to create an inventory of correctional institutions for women that identifies access to maternity care and mother-child programmes. This project begins to fill the significant gaps in our knowledge about the health and parenting

experiences of incarcerated people. Our aim was to create a baseline from which to build future policy, research and advocacy initiatives to enhance health care for people experiencing criminalization. In this project we asked four overarching questions:

- Where are incarcerated women and girls incarcerated?
- Who provides their health care?
- How physically close are these facilities in relation to maternity hospital care? And
- Do these facilities allow mothers and infants to remain together at the facility after birth in a residential mother-child programme?

### 3.1.2 *Methods*

This scan was conducted in partnership with a volunteer, community-based, non-profit organization. The organization works to advance the rights of women experiencing incarceration to health. In conducting this scam, we are informed by the values of that organization. We valued different types of knowledge, including knowledge provided by people with lived experience of incarceration, institutional staff and community volunteers. The environmental scan was conducted by a research intern for the non-profit organization.

**3.1.2.1 Methodology.** Environmental scans allow for the collation of various types of sources of knowledge (Graham et al., 2008). The environmental scan method we used is described as Searching (Choo, 2001). This method relies on the assumption that the environment is analyzable, the search requires an investment of resources and that the scan actively intrudes on the environment. From a broad search involving detailed questions in a formal process, the output is described as Discovery (Choo, 2001). The

goal of the scan is to make sense of the objective reality of the environment and to shift organizational processes in response to this new knowledge. For the non-profit organization supporting this scan, these shifts in organizational processes could include: referring to, imitating or advocate against the approach to maternity services taken in a jurisdiction; or collecting data about how a particular health concern differently affects women experiencing incarceration. We sought information from internal and external sources using our existing relationships with stakeholders in the fields of women's health, prisoner rights, prison health research and by forging new connections. We did not concern ourselves with organizational hierarchies but rather sought our answers directly from representatives of these public institutions. We maintained an audit trail of contacts made and responses.

**3.1.2.2 Content.** For this active environmental scan, we sought to create an inventory of institutions where women are incarcerated in Canada, including the following details: name, type of facility (federal, provincial, territorial, immigration detention, psychiatric and/or youth), the province or territory where it is located, whether the women's unit is co-located with men, total capacity (number of people the institution can incarcerate), capacity for women, presence of a mother-child programme, government body responsible for health care and distance to the nearest hospital with maternity services.

**3.1.2.3 Process.** The first step in the environmental scan was to sketch out what we already knew from our experience in this sector. For example, we knew that every federal prison for women must, according to policy, include a mother-child programme (CSC, 2016). Then, working from the federal to the provincial level, we conducted an

online search of the CSC website(s) (CSC, 2020b) and the websites of the Provincial and Territorial Ministries or Departments of Justice (BC, no date; Alberta, 2020; Manitoba, 2020; Saskatchewan, 2020; Ontario, 2020; New Brunswick, 2020; PEI, no date; Nova Scotia, 2020; Newfoundland and Labrador, 2020; Office of the Auditor General, 2015; Northwest Territories, 2020; Yukon, 2020). The degree of detailed information available about each facility varied according to jurisdiction. Few websites clearly stated which institutions were designated women-only or in which women were co-located with men, and few stated facility size. None of these websites stated which government department was responsible for health care in the facilities. Addresses and phone numbers for the facilities were readily available.

The next step in the environmental scan was to contact employees of CSC and the responsible Provincial and Territorial Ministries or Departments by phone and email. In every instance, the request for information by phone was redirected to a different person. Responses to queries varied by jurisdiction. Some employees returned calls and emails, answered all the questions and sometimes even volunteered supplementary information. In other cases, no response was provided despite repeated attempts and leaving several messages.

In cases where it was impossible to reach a representative of correctional services for jurisdiction, we contacted the local Elizabeth Fry Societies. Elizabeth Fry Societies are dedicated to supporting women and girls who experience criminalization and involvement with the justice system (CAEFS, 2018). Services offered to vary by society. When contacted, these employees were well informed about prisons in their areas and were generous in sharing that information.

To determine how far women experiencing incarceration must travel for maternity care services we used the correctional facility addresses and Google Maps to determine nearby hospitals. Whether the hospital provided maternity services was determined by visiting the individual hospital websites and verifying their services, and telephoning the hospital if necessary.

### 3.1.3 *Results*

**3.1.3.1 Correctional Facilities for Women.** In total, the scan includes 72 facilities across the country in which women are incarcerated (Table 4). There are seven federal facilities for women including two healing lodges; none of these are women co-located with men. There are two federal psychiatric facilities, in Saskatchewan and Quebec, with capacity for both women and men. The three facilities specifically dedicated to immigration detention in Canada are located outside Montreal and Toronto and at the Vancouver Airport. The latter may hold people for up to 48 h. In each of these facilities, children are also held. There are 44 adult provincial facilities in which women are incarcerated; of these, 34 (79%) are co-located with men. Ontario has the most provincial/territorial facilities in which women are incarcerated, at 15.

There are 16 provincial/territorial youth facilities, all generally are coed. We did not include Paul Dojack Hall's youth facility in Saskatchewan because we learned through discussion with a nurse there that girls are all sent to Kilburn Hall (personal communication, staff nurse, Sept 30, 2020). The Manitoba Youth Centre specifies that it reserves 45 spaces for girls out of the total capacity of 150. Individuals in youth facilities may be older than 18 if they are serving a sentence that would take them beyond 18 years of age. Youth in custody are sometimes handled by different departments than adults in

custody. For example, in Ontario, the Ministry of the Solicitor General is responsible for the custody and supervision of adults (18 and over years of age) who are serving a sentence of up to two years less a day or who are awaiting criminal proceedings, while the Ministry of Children, Community and Social Services (MCCSS) is responsible for youth in custody (12 to 17 years of age).

The process of conducting the scan demonstrated that women are an invisible population in the corrections landscape. Many facilities do not disclose their specific capacity for women. A very small unit for women may be connected to larger facilities for men, as in the Cape Breton Correctional Facility, which houses 96 men and "also operates, as needed, a fourbed dorm for adult women and a six-bed temporary detention facility for youth" (Nova Scotia, 2013). The Calgary Youth Centre is attached to the Adult Female Annex.

In some provinces, no list of facilities for women was available. In the case of Ontario, it was necessary to contact the Ministry of the Solicitor General to receive a complete list. In the case of Newfoundland and Labrador, repeated attempts at contacting government officials failed. We learned from the Elizabeth Fry Society of Newfoundland and Labrador that women are being incarcerated in Her Majesty's Penitentiary, a provincial corrections facility for men, due to lack of space in the women's facility, the Newfoundland and Labrador Correctional Centre for Women. This was also reported in the news several years ago (The Canadian Press, 2016).

**Table 4**

*Correctional Facilities for Women, Proximity to Maternity Services, and Presence of Mother-Child Program*

| Name | Type | Province/ Territory | Co-located with men? | Total capacity | Capacity for women | Who provides health services? | Distance to maternity services hospital (km) |
|---|---|---|---|---|---|---|---|
| | | | Federal institutions | | | | |
| Nova Institution for Women | Federal | Nova Scotia | no | 99 | 99 | Correctional Services Canada | 1.5 |
| Joliette Institution for Women | Federal | Quebec | no | 132 | 132 | Correctional Services Canada | 4.7 |
| Grand Valley Institution for Women | Federal | Ontario | no | 215 | 215 | Correctional Services Canada | 7.3 |
| Edmonton Institution for Women | Federal | Alberta | no | 167 | 167 | Correctional Services Canada | 6.4 |
| Okimaw Ohci Healing Lodge for Aboriginal Women | Federal | Saskatchewan | no | 60 | 60 | Correctional Services Canada | 132 |
| Fraser Valley Institution for Women | Federal | British Columbia | no | 112 | 112 | Correctional Services Canada | 3 |
| Buffalo Sage Wellness House | Federal | Alberta | no | 16 | 16 | Correctional Services Canada & Native Counselling Services of Alberta | |
| | | | Immigration detention centres | | | | |
| Toronto Immigration Holding Centre | Federal | Ontario | yes | 125 | | Canadian Border Services Agency-third party service vendor | 2.9 |
| Laval Immigration Holding Centre | Federal | Quebec | yes | 109 | | Canadian Border Services Agency | 14.9 |
| Vancouver immigration Holding Centre | Federal | British Columbia | yes | 24 | | Canadian Border Services Agency | |

| Name | Type | Province/ Territory | Co-located with men? | Total capacity | Capacity for women | Who provides health services? | Distance to maternity services hospital (km) |
|---|---|---|---|---|---|---|---|
| | | | Federal psychiatric treatment centres | | | | |
| Regional Psychiatric Centre | Federal | Saskatchewan | yes | 204 | | Correctional Services Canada | 6.5 |
| L'Institut Philippe-Pinel of Montreal | Federal | Quebec | yes | | | Correctional Services Canada | 12.2 |
| | | | Provincial/territorial institutions | | | | |
| Central Nova Scotia Correctional Facility | Provincial | Nova Scotia | yes | 370 | 48 | NS Health Authority | 12.9 |
| Cape Breton Correctional Facility | Provincial | Nova Scotia | yes | 96 | 6 | NS Health Authority | 4.2 |
| New Brunswick Women's Correctional Centre | Provincial | New Brunswick | no | 56 | 56 | Horizon Health Services | 8.4 |
| Newfoundland & Labrador Correctional Centre for Women | Provincial | Newfoundland and Labrador | no | 26 | 26 | Department of Justice and Public Safety- Corrections and Community Services | 0.65 |
| Her Majesty's Penitentiary | Provincial | Newfoundland and Labrador | yes | 145 | | Department of Justice and Public Safety- Corrections and Community Services | 4.4 |
| Provinical Correctional Centre, Charlottetown | Provincial | Prince Edward Island | yes | 124 | | Department of Justice | 12 |
| Centre de détention Québec (secteur feminin) | Provincial | Quebec | no | 50 | | Integrated health and social services centres and Integrated university health and social services centres | 11.8 |
| Etablisement de detention Laval (Leclerq de Laval) | Provincial | Quebec | | 250 | | Integrated health and social services centres and Integrated university health and social services centres | 14 |

| Name | Type | Province/ Territory | Co-located with men? | Total capacity | Capacity for women | Who provides health services? | Distance to maternity services hospital (km) |
|---|---|---|---|---|---|---|---|
| Algoma Treatment and Remand Center | Provincial | Ontario | yes | 104 | 21 | Correctional Services Division of the Ministry of the Solicitor General | 1.2 |
| Vanier Centre for Women | Provincial | Ontario | no | 124 | 124 | Correctional Services Division of the Ministry of the Solicitor General | 5.1 |
| Central East Correctional Centre | Provincial | Ontario | yes | 1,184 | 49 | Correctional Services Division of the Ministry of the Solicitor General | 5.1 |
| Monteith Correctional Complex | Provincial | Ontario | yes | 232 | 16 | Correctional Services Division of the Ministry of the Solicitor General | 61.4 |
| Elgin-Middlesex Detention Centre | Provincial | Ontario | yes | 450 | 42 | Correctional Services Division of the Ministry of the Solicitor General | 14.2 |
| Ottawa-Carleton Detention Centre | Provincial | Ontario | yes | 585 | 56 | Correctional Services Division of the Ministry of the Solicitor General | 7.2 |
| Quinte Detention Centre | Provincial | Ontario | yes | 228 | 43 | Correctional Services Division of the Ministry of the Solicitor General | 38.5 |
| Thunder Bay Correctional Centre | Provincial | Ontario | yes | 132 | 28 | Correctional Services Division of the Ministry of the Solicitor General | 17.1 |
| Hamilton-Wentworth Detention Centre | Provincial | Ontario | yes | 560 | 52 | Correctional Services Division of the Ministry of the Solicitor General | 8.1 |
| South West Detention Centre | Provincial | Ontario | yes | 315 | 42 | Correctional Services Division of the Ministry of the Solicitor General | 9.2 |
| Fort Frances Jail | Provincial | Ontario | yes | 23 | 4 | Correctional Services Division of the Ministry of the Solicitor General | 0.5 |
| Kenora Jail | Provincial | Ontario | yes | 105 | 30 | Correctional Services Division of the Ministry of the Solicitor General | 4 |
| North Bay Jail | Provincial | Ontario | yes | 121 | 8 | Correctional Services Division of the Ministry of the Solicitor General | 6.4 |

| Name | Type | Province/ Territory | Co-located with men? | Total capacity | Capacity for women | Who provides health services? | Distance to maternity services hospital (km) |
|---|---|---|---|---|---|---|---|
| Sarnia Jail | Provincial | Ontario | yes | 101 | 8 | Correctional Services Division of the Ministry of the Solicitor General | 1.8 |
| Sudbury Jail | Provincial | Ontario | yes | 185 | 17 | Correctional Services Division of the Ministry of the Solicitor General | 4.3 |
| Brandon Correctional Centre | Provincial | Manitoba | yes | 252 | 8 | Manitoba Justice Corrections Division | 3.4 |
| The Pas Correctional Centre | Provincial | Manitoba | yes | 114 | 4 | Manitoba Justice Corrections Division | 1.9 |
| Winnipeg Remand Centre | Provincial | Manitoba | yes | 289 | 8 | Manitoba Justice Corrections Division | 2.8 |
| Women's Correctional Centre | Provincial | Manitoba | no | 196 | 196 | Manitoba Justice Corrections Division | 18.9 |
| White Birch Female Remand Unit | Provincial | Saskatchewan | no | 16 | 16 | Ministry of Corrections and Policing | 13.7 |
| Pine Grove Correctional Centre | Provincial | Saskatchewan | no | 320 | 320 | Ministry of Corrections and Policing | 6.5 |
| Calgary Correctional Centre | Provincial | Alberta | yes | 427 | not specific | Alberta Health Services | 17.9 |
| Fort Saskatchewan Correctional Centre | Provincial | Alberta | yes | 546 | not specific | Alberta Health Services | 1.7 |
| Lethbridge Correctional Centre | Provincial | Alberta | yes | 395 | not specific | Alberta Health Services | 6.8 |
| Peace River Correctional Centre | Provincial | Alberta | yes | 249 | not specific | Alberta Health Services | 15.2 |
| Calgary Remand Centre | Provincial | Alberta | yes | 684 | not specific | Alberta Health Services | 18.1 |

| Name | Type | Province/ Territory | Co-located with men? | Total capacity | Capacity for women | Who provides health services? | Distance to maternity services hospital (km) |
|---|---|---|---|---|---|---|---|
| Edmonton Remand Centre | Provincial | Alberta | yes | 1952 | not specific | Alberta Health Services | 13.4 |
| Medicine Hat Remand Centre | Provincial | Alberta | yes | 103 | not specific | Alberta Health Services | 3 |
| Red Deer Remand Centre | Provincial | Alberta | yes | 146 | not specific | Alberta Health Services | 2.4 |
| Alouette Correctional Facility | Provincial | British Columbia | no | 315 | 315 | BC Provincial Health Services Association | 11.1 |
| Okanagan Correctional Centre | Provincial | British Columbia | yes | | 15 | BC Provincial Health Services | 34.4 |
| Prince George Regional Correctional Centre | Provincial | British Columbia | yes | | 25 | BC Provincial Health Services | 5 |
| Fort Smith Correctional Complex | Territorial | Northwest Territories | yes | | | Health and Social Services- Government of Northwest Territories | Midwifery care only in Fort Smith |
| Whitehorse Correctional Centre | Territorial | Yukon | yes | 190 | 33 | Yukon Department of Justice | 6.1 |
| Nunavut Women's Correctional Centre | Territorial | Nunavut | no | 8 | 8 | Nunavut Department of Health | 2.3 |
| | | | Youth detention centres | | | | |
| Isumaqsunngittukkuvik Youth Facility | Territorial | Nunavut | yes | 16 | not specific | Nunavut Department of Health | 2.3 |
| Nova Scotia Youth Centre | Provincial | Nova Scotia | yes | 60 | | IWK Health Services | 16.7 |
| Newfoundland and Labrador Youth Centre | Provincial | Newfoundland and Labrador | yes | | | Department of Justice and Public Safety- Corrections and Community Services | 91.9 |

| Name | Type | Province/ Territory | Co-located with men? | Total capacity | Capacity for women | Who provides health services? | Distance to maternity services hospital (km) |
|---|---|---|---|---|---|---|---|
| PEI Youth Centre | Provincial | PEI | yes | 16 | | Health PEI | 3.4 |
| New Brunswick Youth Centre | Provincial | New Brunswick | yes | | | Horizon Health Services | 8.4 |
| Centre Jeunesse de Laval | Provincial | Quebec | yes | | | | 14 |
| Roy McMurtry Youth Centre | Provincial | Ontario | yes | 192 | | Ministry of Children, Community and Social Services- Youth Justice Service Division | 12.5 |
| Near North Youth Centre | Provincial | Ontario | no | | | Ministry of Children, Community and Social Services- Youth Justice Service Division | 4.4 |
| Manitoba Youth Centre | Provincial | Manitoba | yes | 150 | 45 | Manitoba Justice Corrections Division | 7.1 |
| Burnaby Youth Custody Services Centre | Provincial | British Columbia | yes | | not specific | BC Provincial Health Services | 15.4 |
| Prince George Youth Custody Centre | Provincial | British Columbia | yes | | not specific | BC Provincial Health Services | 10.9 |
| North Slave Correctional Complex - Youth Unit | Territorial | Northwest Territories | yes | | | | 1.4 |
| Yukon Young Offenders Facility | Territorial | Yukon | yes | | | Yukon Department of Justice | 1.7 |

**3.1.3.2 Mother-Child Programmes.** Each of the federal prisons for women reportedly has a mother-child programme, however, it was not clear how many children participate. There is a programme in only one provincial/ territorial facility, the Alouette Correctional Centre in BC. Two provinces responded to our questions about mother-child programmes. Manitoba Justice reported the Province's Women's Correctional Centre had instituted a mother-child programme in the past, but it was cancelled before any child participated, due to lack of referrals. They did not clarify how referrals are made or eligibility criteria. A representative of the Nunavut Department of Justice stated there was no mother-child programme at Nunavut Women's Correctional Centre because they "have yet to see a need for it" (J. Deroy, personal communication, March 26, 2019).

**3.1.3.3 Health Services.** Responsibility for providing health care to people in prison varies across jurisdictions. CSC is responsible for providing health care to people experiencing federal incarceration (CSC, 2020a). In Nova Scotia (Nova Scotia, 2020), New Brunswick (Personal communication, R. Ritchie, Superintendent of the New Brunswick Women's Correctional Centre, October 10, 2019), British Columbia (British Columbia, 2017) and Alberta (Personal communication, T. Grzech, Alberta Corrections, April, 2019), the provincial health authority uses the healthcare providers who care for people in provincial prisons. In some cases, the shift of responsibility to the health authority is recent and in response to concerns about the quality of care (Metcalfe, 2018). Newfoundland is amid a shift in responsibility (Personal communication, S. Michellin, Assistant Superintendent, NL Correctional Centre for Women, July 4, 2019). In Prince Edward Island health-care providers collaborate with Health PEI, the health authority, but are used by Community and Correctional Services (Personal communication, S. Ellis,

Manager, October 7, 2019). In Ontario, health staff is used by the Ministry for Community Safety and Correctional Services (personal communications, Ministry of the Solicitor General, April 8, 2019). Manitoba Corrections uses a health-care staff for its facilities (Personal communication, E. Klassen, Director of Operations, April 1, 2019). The Department of Justice is responsible for the provision of health services in facilities in the Yukon (Personal communication, T. Murray, Deputy Superintendent, Whitehorse Correctional Centre, April 1, 2019). Health care for youth may be different still: in Nova Scotia, the health services for provincially incarcerated adults are provided by the provincial health authority, while health services at the Youth Centre are provided by the IWK Health Centre, a different authority specific to pediatric and maternity services (IWK Health Centre, 2020).

The distance between the facilities and the nearest hospital with maternity services varied considerably. For example, it is only 1.5 km from the Nova Institution for Women federal prison to the Colchester East Hants Hospital in Truro, Nova Scotia, while it is over 132 km from the Okimaw Ochi Healing Lodge in Maple Creek, Saskatchewan to the nearest maternity hospital, located in Medicine Hat, Alberta.

### 3.1.4 *Discussion*

**3.1.4.1 Where the Women Are: Invisibility and Co-location.** In most provincial institutions, women are co-located with men. In some cases, the capacity for women in these facilities is quite small. For instance, two Ontario jails have the capacity to house eight women each, with a total population of over 100. Being one of a small number of women in a large facility imprisoning a larger men's population can be isolating and may result in inadequate access to women's health services (Braithwaite,

Treadwell and Arriola, 2005). Co-locating a small women's population with a larger men's provincial facility may create unique problems. Health-care staff may lack specialization in women's health matters (Besney et al., 2018). Even with awareness of women's needs and histories of trauma, attempts to adjust prison spaces to address them may be futile due to the overarching hostility of the environment (Jewkes et al., 2019). A comprehensive list of facilities designated for women may allow researchers and advocates to further investigate the influence of these types of concerns.

Despite increasing attention to immigration detention in the USA (Cho et al., 2020; Von Werthern et al., 2018) the policies and practices in Canada are poorly understood. Immigration is one of the most complex areas with respect to governance and health oversight, making health research with this population challenging. We were unable to find sex or gender-disaggregated data about populations kept in immigration facilities, nor their predominant health concerns and maternity care needs.

Youth is a very small population of incarcerated people in Canada and girls makeup only 24% of girls experiencing incarceration (Malakieh, 2019). There are facilities that incarcerate girls in each province and territory, however, only one, the Manitoba Youth Centre, specified the percentage of its capacity dedicated to girls: 30%. Manitoba is a troubling outlier with respect to the incarceration of youth. Despite only 4% of the population of children 15–19 years of age living in Manitoba (Statistics Canada, 2016a, 2016b), the province has 24% of the youth experiencing incarceration in the country (Malakieh, 2019). While nationally 35% of incarcerated youth identify as Indigenous (Department of Justice, 2018), in Manitoba, that number is 80% (Grabish and Monkman, 2018). Incarceration of youth has lifelong consequences: incarceration as a

youth is associated with mental health issues as an adult (Barnert et al., 2017) and many youth who experience convictions are at risk of experiencing conviction again as an adult. Therefore, the disproportionate criminalization of Indigenous youth is a harmful practice that requires urgent attention.

There are no reliable statistics on pregnancy rates among incarcerated youth in Canada. A recent study in Georgia in the USA found 25.5% of girls experiencing incarceration had ever been pregnant (Gray et al., 2016). In Canada, the rate of adolescent pregnancy is approximately 14 per 1,000 or 1.4% (Fleming et al., 2015). While unfortunately not disaggregated by sex or gender, a 2013 study found 35% of youth experiencing incarceration in British Columbia had "been pregnant or caused a pregnancy" (McCreary Centre Society, 2014, p. 29). Of youth in the study who reported being sexually active, 67% had more than 6 partners. More than 65% had never used a condom during sexual intercourse. Clearly, girls experiencing incarceration face far greater sexual health risks and risk of unplanned pregnancy than the general population. It is critical that researchers examine the health needs of girls experiencing incarceration, and that they receive sexual and reproductive health-care that not only meets professional standards of acceptability but is culturally safe.

**3.1.4.2 Mother-Child Programmes.** As we expected, we found only one provincial prison that operates a mother-child programme, at Alouette. In Inglis v BC (2013), Madam Justice Ross ruled the decision to close that programme in 2008 violated the women's and their children's constitutional rights to equality and liberty. The ruling also recognizes that separation from their incarcerated mother is not in the Best Interests of the Child [United Nations General Assembly (UNGA), 1989]. The reinstatement of the

mother-child programme at Alouette did not result in the creation of programmes in other provinces/territories. Reinstating a programme is a different hurdle than creating a new one; Justice Ross' decision was based on the unfairness of the decision to close the programme, not the unfairness of a general practice in women's prisons to separate mothers and children. Despite its reinstatement, the Alouette programme is infrequently used. As in the federal programme, strict eligibility criteria and increased surveillance required of participants are disincentives to participate (Miller, 2013).

Prisons in Canada do not routinely collect information about women's children; it is not known how many incarcerated women have pre-school age children that could participate in the mother-child programme, how many pregnant incarcerated women give birth and lose access to their children or how many of these children end up in foster care. The incarceration of women in Canada is a continuation of colonial, racist attitudes towards Indigenous mothers and of systemic state interference in their families and communities (National Inquiry into Murdered and Missing Women and Girls, 2019). Rather than advance mother-child programmes, the risks of maternal incarceration to child well-being should prompt exploration of alternatives to prisons.

**3.1.4.3 Responsibility for Health Services.** At the federal and provincial/territorial levels, legislation stipulates that governments are responsible for the health of people in prison. The United Nations Standard Minimum Rules for the Treatment of Prisoners (the "Mandela Rules") (UNGA, 2015) and Bangkok Rules both require governments to provide people in prison with health-care equal to those found in the community. Oftentimes, to advocate for a type of care in a facility it is necessary to demonstrate it is available elsewhere. For example, advocacy for curative Hepatitis C

virus treatment in provincial facilities argues that the federal service provides this care (Kronfli et al., 2019). Understanding what health services are available and where is limited by the heterogenous responsibility for health in prisons across Canada.

People experiencing incarceration are indisputably a population with high health-care needs, experiencing backgrounds and histories of deprivation, abuse, poverty, trauma, homelessness, substance use and mental and physical illness (Kouyoumdjian et al., 2016). Poor prisoner health has negative repercussions for the health of the community at large (Restum, 2005). While health services are a minor determinant of health, varying access and policies across jurisdictions impede understanding of health services and experiences.

There is no evidence that health service provision under Justice versus Health departments (or vice versa) ameliorates outcomes, nor has there been much research to measure any differences in health outcomes based on Ministry responsible. Reportedly, complaints have fallen in British Columbia's provincial jails, as the health services were transferred from a private contractor to the province's health authority in 2017 (Metcalfe, 2018). As services shift from one department to another such as is currently underway in Newfoundland, measuring changes in outcomes, even as basic as complaints, may be illustrative.

**3.1.4.4 Maternity Services.** Our review finds that people incarcerated in prisons for women in Canada face distances of up to 132 km to a hospital with maternity services, putting these women and their infants at elevated risk of negative outcomes. The studies by Carter Ramirez et al. (2020a) and Carter Ramirez et al. (2020b) provide the first quantitative evidence in Canada of the harm of incarceration to perinatal and

neonatal health. There are no known guidelines for the perinatal care of incarcerated women in Canada (Alirezaei and Roudsari, 2020). The inventory we created here can be used to support data collection and guidelines development across jurisdictions and enhance our understanding of sexual and reproductive health experiences and care for populations experiencing incarceration.

**3.1.4.5 Inconsistency and Opacity.** This scan demonstrates inconsistency across the institutions or their governing departments with respect to access to basic information. As public institutions, there must be greater accountability from prisons to inquiries about this information. Incarcerated people are members of the public and must be part of our efforts to monitor and address public health.

### 3.1.5 *Limitations*

This inventory is a starting point and has several limitations. Several times during the compilation of the institution inventory we stepped back and evaluated the kinds of institutions to include. Our goal was to build a picture of where and under what conditions women and girls are being incarcerated in Canada. We found that it was necessary to broaden our scope to include many different types of institutions, including immigration detention centres and youth correctional facilities. However, we did not include police lockup, courthouse cells or involuntary psychiatric units. We are not able to track to what extent women may be held unofficially in prisons designated for men such as is the case at Her Majesty's in Newfoundland. Although non-citizens may be held in provincial facilities (Bensadoun, 2019; Global Detention Project, 2018a, 2018b), we do not know their numbers by sex or gender.

Although we attempted to include all facilities designated for women, there is no statistical reporting available regarding trans and nonbinary people in these sites. We did not include the facilities designated for men in which trans and non-binary persons are held. Trans and nonbinary populations experience layers of social oppression, including the potential harm of incarceration in an institution that is not gender-affirming. Their needs for inclusive healthcare are inadequately addressed in Canada, and no information is available regarding their health experiences in Canadian correctional facilities. There is a need for additional research and improved reporting for these populations.

The lack of clarity regarding where and how women are incarcerated across the country limits researchers and advocates the ability to systematically survey or assess women's health or any other aspect of women's experience of incarceration. We may be missing something because of the lack of a database with which to compare. There are urgent questions we failed to ask: how many segregation cells or "secure intervention units" are in each facility? How does each facility allocate maximum, medium and minimum-security levels? To what extent does overflow occur or the practice of "double-bunking"? What are the sex and gender differences in rates of remand/pretrial custody in provincial facilities? As this project was conceived as an environmental scan to gather basic information to support future research, ethics approval was not sought. Future research could involve surveys and interviews with facility representatives and women experiencing incarceration, with ethics approval.

Because of the complexity of the issue and its multi-jurisdictional and multi-departmental nature, no one had created such an inventory before and it is unclear who is optimally suited to maintain it. It is likely to shift regularly. New jails are already being

built: Prince Edward Island is constructing a women's facility and the Government of Nova Scotia plans for a new jail on Cape Breton Island.

### 3.1.6 *Conclusion*

The objective of this environmental scan was to create a comprehensive inventory to fill a practical gap in knowledge of where women were incarcerated in Canada, who was responsible for their health services and where they could seek maternity services. Our intention is for the inventory to power advocacy, research and policy efforts. Although this scan is an important first step towards this objective, the data we have collected, particularly on co-location and capacity, must be enhanced.

With increasing numbers of incarcerated women, it is also important to examine how women experiencing incarceration access health services. This inventory is a first step to collect sex and gender-disaggregated information related to the health of people in prison across jurisdictions. Further research is needed on the health team composition in each site such as the inclusion of doulas, midwives, nurse practitioners and other providers with sexual and reproductive health specializations; access to culturally safe and traditional care; and policies and procedures governing transport and personal searches of people in prisons to health-care services.

The invisibility of women in prisons across Canada at all levels of government impedes women's equal access to health and other services. This invisibility also limits researchers, health professionals and advocates' ability to understand and assess the experiences of women in prisons in Canada. Identifying where women are and what they do or do not have access to is but a bare minimum step to exploring inequities and solutions such as community-based alternatives to incarceration.

### 3.1.7 *Building a Framework to Address the Invisibility of Incarcerated Women's Health*

While it is essential to know where women, trans, nonbinary people and girls are situated in Canada to be able to address their health needs, a feminist abolitionist framework can be used to discern sexed and gendered impacts of incarceration on health and develop interventions to improve sexual and reproductive health outcomes. The next step in the dissertation was to develop a feminist abolitionist approach for nursing, explaining the relevance of abolition to nursing practice, the foundational role of feminist thought in abolitionist theory and organizing, and the applicability of abolition feminism to address the harms of maternal incarceration.

# Chapter 4: Feminist Abolitionist Nursing

Over the course of this doctoral project, a grounding principle in the methodological approach- abolition, the idea that prisons and the current criminal justice system is ill-equipped to address social problems- gained acceptance among the general public as people grappled with the ethical and clinical threats of COVID-19 in congregate living environments. At the same time as, and often because of COVID-19, police violence- particularly against Black, Brown and Indigenous people and against people experiencing homelessness- met increasing popular resistance. In June 2020, with two co-authors Keisha Jefferies and Leah Carrier, we prepared a manifesto committing nurses to abolitionist action in the COVID-19 era. The manifesto, published in *Public Health Nursing* (Paynter, Jefferies, & Carrier, 2020), was translated into French, Spanish and German, and received over 1000 signatures online. Over time, with these co-authors and Dr. Lorie Goshin, a US-based nursing leader in the study of maternal incarceration and its impact on children, this short manifesto was expanded into a conceptual framework to govern nursing practice, policy, teaching and research. This is the methodological approach in which the dissertation is grounded.

The manuscript beginning at 4.1 also appears in: **Paynter, M.,** Jefferies., K., Carrier, L., & Goshin, L. (2022). Feminist Abolitionist Nursing. *Advances in Nursing Science. 45*(1) Published online ahead of print. DOI: 10.1097/ANS.0000000000000385

## 4.1 Introduction

The twinned crises of COVID-19 outbreaks in prison and jails and racist, lethal police violence in spring 2020 briefly normalized public conversations about defunding police and abolishing prison systems in Canada and the United States. The pandemic

exposed how custody facilities including prisons and jails are hotbeds for the transmission of infectious disease among incarcerated people and staff alike. People in prison are likely to experience chronic illnesses that increase their susceptibility to infection.[1] The prison environment itself exacerbates risks as it is unhygienic, crowded, and poorly ventilated. Prisons are also characterized by constant transport of people in and out, facilitating infection transmission. As of December 2020, a total of 210 000 people in US prisons had contracted COVID-19 and more than 1800 had died.[2] In February 2021, a total of 5550 cases of COVID-19 were linked to prison and jails in Canada.[3]

As Boyd described in the Lancet, "Police killing black Americans is one of the oldest forms of structural racism in the USA. The act traces its roots to slavery."[4](p258) The murders by police in spring 2020 of Black medic Breonna Taylor, asleep in her bed, and of George Floyd, who witnesses videotaped being asphyxiated for more than 8 minutes, crossed a line in public consciousness and prompted international response. At the same time, across the United States and Canada, we saw efforts at "policing the pandemic"[5](p5) through ticketing the poor and unhoused for failure to stay home or social distance. Public health actions that impinge on personal liberty can be justified to protect society's most vulnerable but must respect human rights.[6] Snitch lines, fines, and criminalizing practices received widespread criticism as inappropriate, worsening inequities, exacerbating the pandemic problems of crowded jails and economic deprivation, and placing Black, Indigenous, and People of Color (BIPOC) at an elevated risk of police brutality.[7,8] Across the continent, we have heard calls for collective care and investments in community infrastructure in lieu of punitive methods.

Carceral systems include or relate to the act of imprisonment. The term "carceral" has come to encompass "forms of confinement, be they state-sanctioned, quasi-legal, ad-hoc, illicit, spatially fixed, mobile, embodied or imagined."[8](p668) Human geographers explain carcerality as extending beyond a space, to an experience of being under surveillance, policed, controlled, or punished. Nursing interacts with carceral systems not only within prison health units, immigration detention centers, and forensic hospitals but also in community hospitals and clinics, harm-reduction services, research and education, public health surveillance, and in public policy development and implementation. We argue the realities of policing and prison operations conflict intractably with nursing ethics, and, moreover, nursing ethics require us to push beyond calls for reform to demand, and participate in, sustainable transformation of carceral systems.

Abolitionism is a theory and a practice of creative and compassionate responses to social harms that do not repeat the very violence the justice system ought to remedy.[9] We focus our discussion in this article on prison abolition. While there are many possible prison abolitionist platforms to examine, it generally includes (1) releasing people who are incarcerated; (2) reducing the budgets and presence of police and military in communities; (3) decriminalizing substance use, sex work, and poverty; and (4) ensuring equitable access to housing, food, economic security, and health care. Abolitionism balances investments to prevent harm, such as in meeting basic needs, with divesting from punitive systems rather than adjusting them. Abolitionism considers how reforms to improve conditions inside carceral facilities fail to address the root problems behind escalating detention and incarceration: poverty, racism, and trauma. Reforms, such as more education or body cameras for police officers, misdirect investment into carceral

systems rather than toward upstream efforts to improve communities and reduce criminalization.

Abolitionism rejects the normalization of carceral systems in our daily lives. Hudson and Wright propose that nursing engage with abolition politics to "expand its horizon of responsibility" and enter the "realm of legal and political change-making."[10](p354) Given the pervasive harms of carceral systems, this engagement is an ethical responsibility for nurses in all areas of practice. Our embeddedness in White supremacy has prevented nursing from living up to our professional ideals. In this article, we build on the arguments of Hudson and Wright[10] to present abolition as a necessary foundation for nursing practice. As authors, our clinical and research interests include reproductive care, nursing leadership, and Black and Indigenous health and the intersection with the justice system. While we draw on examples from our respective foci, the abolitionist imperative transcends practice areas and addresses social inequities beyond health care environments. Shaped by gender bias, racism, and class oppression, policing and incarceration cumulate in poorer individual health outcomes, family disintegration, and threats to community and public health that are disproportionately experienced by groups of people already marginalized. Nursing has a long history of participation in carceral systems beyond prisons, such as eugenic control of reproduction,[11] intrusive public health monitoring, and involuntary psychiatric treatment.[12] But nursing has also long participated in action for social justice[13] and is positioned now to address social harms within and outside of carceral systems—including the gendered, raced, and classed experiences of economic deprivation, barriers

to services, deepening emotional and mental health difficulties, and increasing exposures to violence wrought by the pandemic—through abolitionist practice.

This article comprises 5 sections. First, we explain the colonial, racist origins of policing, as policing is the precursor to incarceration. Second, we outline how the lived realities of people in prison substantiate the urgent need for abolition to address public health inequities and human rights abuses. Third, we discuss the need for nursing to accelerate and deepen its engagement in political advocacy. Fourth, we critique reformism and explain political and ethical concepts foundational to abolitionist nursing. Finally, we consider how to operationalize abolition in nursing policy, research, and practice.

### 4.2 The Colonial, Racist Origins of Policing

Prison and policing systems in Canada and the United States are traceable back to the enslavement era and the beginning of colonialism. Knowing this history allows nursing to consider our complicity with policing and prison systems. Police and policing systems were first established in the colonized land that is now called Canada in 1873 as a means of controlling and punishing interference with developing the colonial state.[14] In Canada, the force's original function was to "keep order" and ensure the transfer of land from Indigenous Nations to the newly created Canadian federal government. The oppression and intergenerational trauma experienced by Indigenous peoples in Canada are directly linked to the creation of reserve lands, forced relocation of communities from their traditional territories, and the surveillance through pass and identification systems.[15] Although the pass system and the residential school regime were formally rescinded in

the 1950s and as late as 1996, respectively, colonial control of Indigenous peoples remains a contemporary issue.

In the United States, chattel slavery was a precursor to the policing and confinement of Black people.[16] Armed patrols operated from early in the 18th century in the US South to police enslaved people. Formerly enslaved or freed Black people were commonly depicted as criminals to justify re-enslavement.[14] Slavery solidified the surveillance and discipline of enslaved Africans and reduced opportunities for resistance. As depicted in the 2016 film 13th, the abolition of slavery through the 13th Amendment did not abolish racial hierarchy or discriminatory beliefs about Black people.[17] The 13th Amendment threatened the economic well-being of societies that depended on the labor of enslaved people.[16] The growing realization that Black people could potentially "be free" festered a sentiment of fear. An exaggerated association between Blackness and criminality substantiated maintenance and enhancement of surveillance and control of Black people. Pathologizing Blackness, and regarding Black people as inherently criminal, enabled creation of racist laws in the name of maintaining peace.[14] Thus, African Americans were and continue to be "re-enslaved" through the prison industrial complex, which is documented as overincarcerating Black people, exploiting labor of prisoners, as well as physical, mental, and spiritual abuse.[16,17]

Policing and prisons continue to operate as they were originally intended—to uphold and reinforce oppressive racial, gendered, and socioeconomic hierarchies. A careful examination of law enforcement, prisons, the courts, and parole boards reveals the ways in which pieces of the criminal legal system interact to exert control.[14] Abolitionist approaches enlarge our field of vision so that rather than focusing myopically on these

problematic institutions and asking how they need to be changed, we raise radical questions about the problematic organization of the larger society that relies on them.

Although we often hear about racism and policing in the United States, BIPOC are also disproportionately killed by police in Canada. Police killings of BIPOC in Canada in spring 2020 brought to the surface the contradiction of engaging police to address mental illness. These include D'Andre Campbell (Black) and Chantel Moore (Indigenous), who were shot, and Regis Korchinski-Paquet (Indigenous and Black), who fell from a balcony, all during calls to check on their mental health.

### 4.3 Lived Realities of People in Prison

The COVID-19 pandemic brought attention to long-festering problems with health services in prison institutions. People experience complex health needs and barriers to care during and after incarceration. Prisons reflect classism, racism, colonialism, transphobia, and homophobia; the most excluded populations in society are most policed and incarcerated.

#### 4.3.1 *Racism, Colonialism, and Prison*

The burden of incarceration is excessively born by BIPOC in the United States and Canada. These same populations also experienced excessive burdens from COVID-19.[18] The US rate of incarceration is 419 per 100 000 people, the highest in the world, but among Black residents the rate is 1096, more than double the average.[19] Black adults are imprisoned at 5 times the rate of White adults in the United States. In Canada, the rate of incarceration is approximately 114 per 100 000 people,[20] and yet among Indigenous people, it is 10 times higher (n = 1378).[21]

The high imprisonment rate of Indigenous people is a continuation of genocidal colonial state processes.[22] Over the course of the 20th century, hundreds of thousands of Indigenous children were forcibly removed from their homes to be sent to church-run Residential Schools, in which they were abused. In the 1960s, Indigenous children were placed in the permanent care of White parents in what is known as the Sixties Scoop, and in the ongoing Millennium Scoop, the child welfare system still disproportionately removes Indigenous children from their homes.

Roberts[23] coined the term "family policing" to describe how child welfare systems monitor and harm families. Although only 7.7% of children in Canada are Indigenous, they make up 52.5% of the children removed by the state.[24] When last studied, approximately two-thirds of Indigenous people in federal prison experienced adoption or placement outside their communities as children.[25]

Prison and child welfare are public systems that normalize state intervention and dismantling of communities. Overincarceration is both a consequence of and a pathway to child welfare system involvement. The Truth and Reconciliation Commission of Canada, examining the impact of the Residential Schools, demanded action on the overincarceration of Indigenous people, the overrepresentation of Indigenous children in foster care, and health inequity attributable to colonial, racist policies.[26] Everyone in Canada is to heed these calls, including nurses, who are specifically named in the report.[26]

#### 4.3.2 *Health*

COVID-19 transmission, as well as other infectious and chronic disease, chronic pain, mental illness, and substance use are all more common in prisons than in

community.[1] The early experience of trauma, and subsequent mental illness and substance use, can create pathways to prison. The prison environment is also a site of elevated rates of injury, violence, sexual assault, self-harm, suicide, homicide, and death.[26]

Prison is often framed as an "opportunity" to seek treatment of people otherwise excluded from health care access and that the inadequacies of prison-based health services could be remedied with more investment or oversight. Although the American Nurses Association (ANA) Code of Ethics states health is a universal human right,[27] in the United States, incarcerated people are the only ones with a constitutional right to health care (Estelle v Gamble, 1976).[28] Despite this right on paper, prisons are sites of some of the poorest health service delivery. COVID-19 exposed how prisons are antithetical to health and how the risks of prison are unevenly experienced.

### 4.3.3 *Gender and Prison*

Gender roles and discrimination cause women, transgender, and nonbinary people to experience criminalization and incarceration differently than men do. Most have experienced sexual trauma and physical abuse in childhood, economic deprivation, housing instability, unemployment, restrictions on educational, and barriers to health care.[1] In the United States, women are also burdened by the mass criminalization of male family members.[29] Abolition is a feminist issue.

Early trauma in the lives of women and BIPOC who experience incarceration is used to justify harsher punishment. Trauma continues to be applied as a dynamic factor in security-level risk assessment in Canadian federal prisons. Those who have experienced more trauma receive a higher classification score, resulting in restricted access to

programming and visiting.[30-32] This has longterm consequences, as failure to complete programming hinders eligibility for parole.

The incarceration of women has extensive family and community implications. They are more likely than men to be the primary support for children; when women are incarcerated, their children are at risk of involvement in child welfare services. Children who are removed by the state are at an increased risk of criminalization. This multisystem interference threatens reproductive health and rights broadly speaking, including the rights of people to choose when to have children, and to have safe, supportive conditions for the pregnancy, birth, and raising of children.[33]

The increasing incarceration of women exposes inadequate access to reproductive health services and harms reproductive choices, family formation, and connection to community. Prison drives reproductive oppression through institutional control of body movement, limitations on reproductive decision-making and health services for women inside carceral spaces, and separation from children and disrupted reproduction.[29] Threats to reproductive justice include lack of family contact, trauma backgrounds that interfere with parenting, ethical problems and service gaps during pregnancy, inadequate support to retain legal custody of children, and challenges with co-parenting and engagement with child welfare regimes.[34] These experiences are also disproportionately borne by BIPOC and people who identify as members of lesbian, gay, bisexual, trans, queer, and Two-Spirit communities (LGBTQ2S+).

#### 4.3.4 *Transphobia, Homophobia, and Prison*

Recent policy changes in Canada allow transgender and nonbinary people to be admitted to federal prisons for men or women according to their gender expression, not

anatomy.[35] The 2011 Adams v Bureau of Prisons decision affirmed the right to access hormonal treatment of transgender people incarcerated in the United States. Despite these changes, prisons remain institutions that enforce the gender binary. Research with people in prison is rarely trans-inclusive or specific to gender minorities, although 1 in 6 transgender people in the United States and 1 in 2 Black transgender women have experienced incarceration.[36] Furthermore, 42% of women in prison in the United States identified as sexual minorities,[37] and a recent study in Canada found 29% of women in a provincial jail identified as lesbian or bisexual.[38] Prisons are ill equipped to address the health needs of LGTBQ2S+ communities. For nursing to address the intersecting impacts of racism and colonialism, sexism, homophobia, and transphobia on the health of people experiencing incarceration, nursing must engage with political action. Our profession must reckon with its own oppressive practices.

### 4.4 Nursing, Racism, and Political Advocacy

For nursing to confront the racism, colonialism, and other systemic oppressive forces at work in carceral systems, nursing must first look inward. Nursing continues to be, as Puzan[39] articulated nearly 20 years ago, "unbearable" in its whiteness. There continues to be little to no data available about race and racism in the contemporary nursing profession in Canada. The Canadian Institutes of Health Information report Nursing in Canada 2018 does not mention race.[40] Canadian schools of nursing do not routinely collect or publish these statistics. However, racism in nursing is closely tracked in the United States, where more than 75% of nurses identify as White and only 9.9% identify as Black.[41]

Color blindness crafted through lack of data masks pernicious harm. In a 2012 qualitative study of Indigenous nurses' experiences of racism in Canada, participants described being treated as outsiders, judged, and feeling uncertain to speak up.[42] Indigenous nurses face barriers to including traditional knowledge and aspects of their identity in their practices.[43] Exclusion of Black nurses can translate into mistrust of the health system by Black patients.[44]

The racism enacted through the profession causes harm to health. The well-publicized, disproportionate burden of COVID-19 in Black, Indigenous, and other racialized communities laid bare how racism manifests in health systems. Nurses bear some responsibility for this consequence. Ruha Benjamin describes how, in response to an analysis of racism and the pandemic's impact on Black people, a self-identified White nurse insisted, "It is a choice of their own.... They damaged themselves."[45] Nursing cannot critique carceral systems while clinging to racist narratives of personal responsibility and "choice," and without understanding structures of oppression.

### 4.4.1 *Politicizing Nursing*

In response to the spring 2020 police killings of Black civilians in the United States and Canada, many nursing organizations released anti-racism statements that recognized the participation of nursing in "centuries old injustice" and called for the removal of "areas of bias that perpetuate negative behaviors and reinforce harmful stereotypes and stigmas.[46,47] This extends to those biases held by nurses.[46] The calls urged nurses to respond to racism when they saw it occur,[46] presumably in interpersonal health care interactions, but provided less clarity about how nursing could hold powerful and punitive institutions to account. Notably, these nursing organizations did not join the

calls to defund police and decarcerate prisons. Dismantling racism requires dismantling these violent systems, contemporary forms of slave patrols, and Residential Schools. But nursing works in collaboration with these institutions.

Consider a passage in Dorothy Roberts' canonical text on racism and state reproductive control, Killing the Black Body. She describes how Shirley Brown, a White nurse in South Carolina, spearheaded a campaign in the 1980s to criminalize and force treatment on Black women for prenatal drug use.[48] Now, half of US states label and prosecute drug use in pregnancy as child abuse and require health professionals report suspicions about it to child welfare agencies.[49] In Canada, pregnant people cannot be charged with child endangerment for actions during pregnancy. However, they can have their children immediately removed at birth. Nurses, other care providers, and social workers initiate "birth alerts" that notify child welfare agencies of a birth in a family already under its surveillance. In 2019-2020, 442 infants were removed from their parents in Ontario alone, with half of the referrals from health care professionals.[50] Birth alerts are widely criticized for their basis in racist and colonial belief that Indigenous mothers are unable to safely care for their babies.[51] In response to calls to end the practice, 6 provinces and territories have announced plans to ban the practice.[50] Nursing organizations have avoided political leadership in these discussions.

The disruptive political work demanded of nursing to intervene in carceral systems will not come easily.[10] Sexism, the medical hierarchy, employer nondisclosure agreements, and fear of reprisal subjugate nursing's voice and agency.[52] Nursing education and practice privilege task orientation over theory. In the COVID-19 era, nurses are exhausted and overworked by the immediate and day-to-day demands of

pandemic response. However, the pandemic has also politicized nurses perhaps more than ever. Much of this advocacy centered on the rights of nurses themselves, such as nursing unions fighting for adequate personal protective equipment and safety standards,[53] priority access to vaccination,[54] and solutions to chronic understaffing.[55] Some of the advocacy extended beyond the safety of the professional context to address social issues. For example, nursing organizations, recognizing the disproportionate burden of COVID-19 on Black and racialized communities, campaigned for improved collection of race-disaggregated data regarding COVID-19 vaccination.[56]

### 4.4.2 *Legal and Regulatory Requirements on Nurses in Carceral Contexts*

Nurses practicing in carceral contexts experience "dual loyalty,"[57] the conflict between duty to care for their incarcerated patients and duty to the carceral institution. Nurses' and correctional officers' responsibilities and goals are likely to be at odds with each other; however, nurses may want to maintain positive relationships with correctional officers to support safety within the institution and because of the nursing profession's patriarchal tradition of following orders.[58] Clinical care for the purposes of investigating patients, such as blood and urine toxicology screens, slips one role into the other.

Nurses working in carceral contexts are legally obligated to provide care at standards that are incompatible with incarceration, an ethical dilemma that itself supports an abolitionist politic. In Canada, the Corrections and Conditional Release Act requires that federally sentenced people be provided with essential health care and reasonable access to nonessential health care.[59] The Eighth Amendment to the US Constitution protects against cruel and unusual punishment and is interpreted as requiring the state to provide health services to incarcerated people.[27] The United Nations' Minimum

Standards for the Treatment of Prisoners (the Mandela Rules) state health care professionals must treat patients in prisons with the same ethical and professional standards as they do patients in community, and they are prohibited from engaging in acts of cruelty or punishment, such as solitary confinement.[60] Despite the best efforts of many health care professionals who work in carceral systems specifically to address the inhumane conditions and disproportionate burden of illness therein, ethical practice is out of reach in a fundamentally unethical context. The requirements of the Mandela Rules are aspirational, and violated routinely, undermining their enforceability and value.

Multiple nursing organizations have issued position statements regarding care inside correctional facilities. The ANA published nursing scope and standards specific to carceral settings.[61] The Association of Women's Health, Obstetrics and Neonatal Nurses issued a position statement advocating for community alternatives to incarceration and for laws against shackling of pregnant people.[62] The International Council of Nurses (ICN) endorsed the Mandela Rules.[63]

The ICN asserts prisoners' rights to health care and condemns denial of care or acts that could harm mental or physical health and requires that nurses who are aware of maltreatment of prisoners act to protect them.[63] There are many examples of courageous nurse whistleblowers who faced punishment for doing just that. Nurse Jose Vallejo was terminated after speaking out about understaffing, lack of training, and unsafe practices at an Arizona prison.[64] Nurse Dawn Wooten publicly alleged medical neglect, COVID-19 mismanagement, and forced sterilizations of women in an immigration detention facility in Georgia. Her whistleblowing came at enormous personal cost—demotion and reprimand for alleged complicity in the harms.[65]

Nurses are not routinely taught the Mandela Rules, or how to navigate real-life challenges to upholding them. Without a strong understanding of both legislated requirements and international standards for health practices in prisons, nurses risk becoming subsumed into carceral functions.

There may be individual professional consequences for nurses who do not, including civil lawsuits and discipline from regulatory bodies. Foundational nursing ethics are protective and align with abolitionism.

### 4.4.3 *Nursing Ethics*

The code of ethics for nurses in Canada describes 7 primary values to govern personal practice, beginning with "providing safe, compassionate, competent and ethical care."[66] To do so requires building "trustworthy relationships" and having the ability to intervene, report, and address unsafe and unethical conditions. The ANA Code of Ethics begins similarly with the provision, "The nurse practices with compassion and respect for the inherent dignity, worth and the unique attributes of every person," and continues "The nurse's primary commitment is to the patient."[27] Conflict is to be avoided, and when conflicts arise, nurses are required to work in the patient's best interests.

The experience of incarceration and the conditions in prisons interfere with patients' emotional and physical safety, and institutional policies often place security concerns over basic norms of compassionate care. The ethical principles of these Codes rub up against what is possible in the carceral context. Many of the other principles align with abolitionist political action, including "promoting justice" in the Canadian Nurses Association (CNA) code and "Protect human rights" in the ANA code. In Canada, this principle requires respecting the Truth and Reconciliation Commission of Canada Calls

to Action for the Rights of Indigenous Peoples and a prohibition on any form of engagement in punishment or complicity in punishment. In the United States, the provision requires nurses address social contexts where human rights are under threat or violated. These nonnegotiable stipulations in both codes of ethics are a sound foundation on which to build abolitionist practice.

#### 4.4.4 *Abolitionism as Collective Praxis*

Abolitionism may be threatening to nurses educated in systems that emphasized professionalism and clinical skills performance with individual patients above community engagement and political solidarity. Nursing's obligation to advance social justice must be borne by nursing collectively.[67] In the cases we describe earlier, it was individual nurses who bore the cost of systemic problems with prison health services. This is both unfair and ineffective. Nurses are not liable for injustice, but we are responsible. We are better equipped as a group to bring about social justice than as individuals.[67]

Nurses are an enormous social group. There are 3.8 million registered nurses in the United States[41] and more than 400 000 in Canada[40]—more than 1 in every 100 people in these countries is a nurse. This is a powerful political lobby to demand not only an end to human rights violations by police and prisons but also an end to policing and prisons as state instruments of oppression, and the alternate investment in safe, equitable, health-promoting services.

For nursing to move from acknowledgment of injustice to action is theorized by Chinn and Kramer[68] as emancipatory knowing. The need for nursing to apply criticality and take action to address social inequity may also be found in the work of Kagan et al,[69]

a volume highlighting the work of more than 40 nurse scholars to advance emancipatory frameworks. Adoption of abolitionism forces nurses to politicize outside of the prison health system, and the health system, to engage in emancipatory praxis in community. Nursing unions, schools, professional associations, regulatory bodies, and specialty organizations have a key role to play in collectivizing abolitionist nursing praxis.

### 4.5 Abolition Versus Reform

Prison health researchers, advocates, and practitioners may recommend improvements in capacity, staff, and resources inside prisons to address urgent threats to health. They argue it is necessary to match the pace of increasing rates of incarceration with increasing investment to avoid the worst human rights abuses. We argue that reforms addressing the health experiences of incarcerated people without also calling for decarceration only further entrench the normalization of incarceration. We present 4 examples that problematize reform: (1) Creating Choices; (2) Mother Child Programs; (3) harm reduction; and (4) carceral feminism.

#### 4.5.1 *Creating Choices in Canada*

The Creating Choices project is an example of how idealistic, feminist recommendations for prison reform resulted in expansion of the carceral system in Canada.[70] Creating Choices recommended closing the lone Prison for Women at the time. It introduced a new empowerment focused model that recognized the trauma histories of women experiencing incarceration, their overall low security risk, and need for support over punishment. Despite its lofty goals, Creating Choices resulted in more prison facilities, more people behind bars, and tighter restrictions. In 1991, approximately 141 women per year received a federal sentence.[71] That number has risen steadily over time,

and in 2019, a total of 357 women received a federal sentence,[72] an increase of 253% over almost 30 years. The failed legacy of Creating Choices is a powerful marker of how prison reform may result in increased incarceration.

Abolitionists conceive of the prison itself as a human rights violation, unamenable to remediation and unable to "solve the crises it creates."[73](p1) By ostracizing people who have experienced incarceration from society, prisons relieve us "of thinking about the real issues afflicting those communities from which prisoners are drawn in such disproportionate numbers."[9](p16) If we focus solely on the problems in prisons instead of the problem of prison, we risk losing our grasp on the need to dismantle punitive social systems. Nursing can address immediate threats to human rights inside while not losing sight of the greater goal of abolition.

### 4.5.2 *Mother Child Programs*

Around the world, nurseries in which children live with their incarcerated mothers are held up as a remedy to the harm of incarceration-related separation.[74] However, strict eligibility criteria result in highly unequal access. In Canada, infrequent use of and unequal access to the costly federal Mother Child Program reinforces inequity among incarcerated women.[74] Mothers may be ineligible for the program due to racism in assessments of their security risk.[32] There are only about 12 prison nursery programs in the United States, and in some of these states, women with a history of involvement with child welfare, itself influenced by systemic racism, may be restricted from participating. These inequities impact infant and maternal health. Instead of only advocating for programs inside prisons, abolitionist nursing practice works toward keeping families together within their own communities.

### 4.5.3 *Harm Reduction in Prisons*

Reforms to reduce the morbidity and mortality of substance use are becoming more common in prisons. In Canada, colonial trauma results in high rates of substance use and associated injuries. Injection drug use increases risk of blood-borne infection. While only 5% of the population in Canada, Indigenous people make up 10% of those diagnosed with HIV infection.[75] In 2018, Canada launched a prison needle exchange program (PNEP), now in 11 institutions including all 5 large women's facilities.[76] Globally, PNEP have successfully reduced needle sharing and transmission of infection among incarcerated people: "Such harm reduction programs are morally, fiscally, and pragmatically responsible and contribute to the protection of the community at large—in essence, prison health is public health."[76](p123) Nurses must not only understand the evidence behind them and support their implementation but also recognize the limitations of harm reduction. People experiencing incarceration continue to risk discipline because drug use itself is not permitted. Furthermore, PNEP does not address the harms of prison: dehumanization, isolation, and violence. PNEP does not remedy reliance on substance use for relief.

### 4.5.4 *Carceral Feminism*

"Carceral feminism" describes the reliance on prosecution, policing, and prison to address sexual or gendered violence.[77] In the age of #MeToo, the solution to sexual violence is often framed as harsher punishment and longer periods of incarceration. Forensic nursing care plays a critical role in justice seeking for survivors.[57] Despite, or perhaps because of this critical role, nursing must reckon with the fact that carceral facilities are sites of sexual violence. In 2017, the Correctional Services Canada

investigated more sexual assaults than it had in the 5 years prior.[35] In the United States, reports of sexual assault in prisons tripled between 2011 and 2015, from 8000 to 25 000.[78]

Abolition acknowledges that not only has carceral feminism failed to reduce gender-based violence but also more policing and prisons inevitably amplifies the racism and discrimination already evident in policing and prisons.[79] Police may fail to investigate reports of sexual assault, fail to make arrests, and fail to refer those arrested to prosecution, and those prosecuted are rarely convicted. Studies in the 1990s found high rates of intimate partner violence in the homes of police officers; recent data are notably sparse.[80] Officers may commit sexual assault and violence against women while on the job. Abolition recognizes policing is not an appropriate or effective pathway toward justice for survivors of gendered violence. Prevention of violence must be fundamental to nursing work.

Reform ideas, such as prisons closer to home, children inside with their mothers, harm-reduction programs, or longer sentences for sexual offenses may sound on the surface like practical solutions to gendered problems with incarceration as it stands. Reform fails to take up the problems from their roots, these suggestions with critical thinking and creative alternatives.

**4.6 Abolitionist Nursing**

Abolition is often criticized as unrealistic and idealistic. However, the abolition of slavery, for which nurse icon Harriet Tubman resolutely worked, was also considered unrealistic and idealistic. In this section, we present ideas to bring abolitionism to nursing work in policy, research, and practice.

### 4.6.1 *Policy*

Abolitionism includes not only divesting from prisons but also minimizing the possibility of criminalization. Nursing, from its historical position of White, middle- and upper-class privilege must reckon with what and who is criminalized in our society: people have experienced harm and who use substances to escape trauma and turn to theft for economic survival. We must also address violence in ways that provide true healing for those who are victimized and those who perpetrate violence. Abolitionism recognizes that the harms of policing and prison are disproportionately experienced by those who experience oppression and that criminalization is a tool of oppression. Nurses must participate in redefining criminalization, starting with calls to completely decriminalize substance use and sex work, and to divert people with serious mental illness from incarceration at every opportunity. Professional nursing bodies such as the CNA and the ANA have a role to play in advancing these calls and to advocate that public resources be directed into supportive services such as universal, publicly insured access to safe supplies of substances, to contraceptives, and to high-quality psychiatric services. Nursing regulatory bodies mandated to support public safety must recognize people who experience criminalization are part of that public.

Urgently, nursing must lead opposition to human rights abuses in contexts of policing and prisons. For example, nurses and health care providers can join the campaign to eliminate dry celling, the practice of holding an incarcerated person alone in a room without plumbing, under surveillance 24/7, until they defecate or vomit alleged contraband from their body cavities. This practice is retraumatizing and humiliating. Nurses are also well positioned to prevent shackling during clinical care, in particular the

shackling of incarcerated pregnant people. Although no Canadian law stipulates prohibition of this practice, there are now about 30 US states with anti-shackling laws.[81]

We must exercise care with efforts to augment services for incarcerated people, however. For example, there are laudable efforts in Canada and the United States to improve perinatal care and support to incarcerated pregnant women, arguably the most sympathetic incarcerated group. The first author of this article is engaged in this very work. While well meaning, these efforts inevitably increase carceral budgets and risk making perinatal incarceration more acceptable. Instead of building new prison nurseries, we could support decarceration of prospective parents. Brazil no longer allows the pretrial detention of pregnant people, and in Italy, mothers of children younger than 10 years can serve their sentences at home, effectively eliminating the need for perinatal services.[82] Family supportive housing is also being used as a custody alternative for pregnant people and women with minor children.[83] Abolition does not suggest ignoring the immediate harms people in prison face or abandoning them. It requires careful consideration of why and how we could use our political clout to create new possibilities.

#### 4.6.2 *Research*

Clinical research exploring the impact of incarceration on health experiences in Canada largely excludes consideration of reproductive health and the health of women.1 As nurse scientists, we could focus on this clinical area and petition for access to prisons for women, which may be particularly restricted to researchers. We could pilot initiatives to remedy inadequate service delivery, such as the benefits of introducing sexual and reproductive health services, staffed by nurses.[38] But these projects will not reduce incarceration.

In response to a court ruling that substandard prison care violated the rights of the incarcerated, Wang et al[84] studied the impact of a clinic for people released from prison in California. They found this successfully reached people at an extraordinarily high risk of being underserved: 86% of patients were BIPOC and 89% did not otherwise have a primary care provider. Researchers in Canada found providing permanent housing to people experiencing serious mental illness and chronic homelessness reduces their involvement with police systems.[1] Nursing research can similarly examine how introduction of accessible and appropriate health services may prevent criminalization in the first place.

Abolitionist nursing research could examine the health outcomes associated with alternatives to incarceration. For example, instead of pursuing research into the potential benefit of prison nurseries, we focus on noncarceral arrangements. There are several US examples, mostly attached to substance use treatment facilities.[81] As alternative programs grow, we can attain samples with adequate power to assess effects.

Consider Sanctum 1.5, a program created to reduce the harm of child removal from mothers who use substances or live with HIV infection. The program opened in 2018 in the province of Saskatchewan as housing with wraparound nursing support. Early findings are promising: very low rates of child removal, no vertical transmission of HIV, and overdose prevention.[85] Nurses can examine alternatives such as this to keep mother and child together outside of the prison walls.

In spring 2020, with monumental coordination, goodwill, and minimal funding, 41% of people incarcerated in the province of Nova Scotia were released to reduce the risk of a prison outbreak of COVID- 19.[86] Unfortunately, in the haste and chaos of early

pandemic response, arrangements were not made to study implications to health stemming from this intervention. Prison populations rose again thereafter. Should compassionate and prudent releases be successful again, we must seize this opportunity.

### 4.6.3 *Clinical Practice*

Nurses will encounter criminalized individuals in all aspects of practice. However, it is nurses in prisons who are most directly imposed upon by this call for abolition. Prison abolition is often met with community concerns about the economic consequences of divesting; small, often rural economies would be drained of the resources prison building and operations bring. Similarly, abolition may be perceived as a direct threat to correctional nurses. We believe that correctional nurses are motivated by interest in improving the lives of criminalized people. Just as small and rural economies can be bolstered by alternative industries, so can correctional nurses work to advance the lives of oppressed individuals in nonpunitive settings.

Consider another example. Strip searching of incarcerated people is routinely required before and after clinical encounters both within correctional institutions and when people are transported to external health centers. Visitors to institutions may also be strip-searched. The objective of strip searching is, generously, to identify contraband that could cause harm to the person or others inside the institution. Researchers in Canada have found that strip searching is used incoherently across institutions and is experienced as sexual assault.[87,88] In her autobiography, Assata Shakur describes the nurse's involvement: "The 'internal search' was as humiliating and disgusting as it sounded. You sit on the edge of this table and the nurse holds your legs open and sticks a finger in your vagina and moves it around."[89](p83) In our resistance to participating in searches for

contraband, we can advocate for decriminalization of substances and prescribe safe supplies.

We must consider how nursing invites policing into noncarceral settings, including health care institutions. Despite the intention of increasing security, placing guards and police inside health facilities risks public health and trust. Rather than liaise with or enact policing, nurses can consider how White supremacy and racism affect our interpretation of patient (or parent/spouse/visitor) distress. Instead of policing, nurses can contribute to developing policies and practices that center patient and family needs.

### 4.7 Conclusion

COVID-19 presented what could be the final breaking point in our reliance on criminalization as a response to structural inequity in Canada and the United States. Prisons and police are too harmful to public health for nurses to ignore the call for substantive change to these systems. Meaningful change will require not reform, but abolition. The patient-centered, justice-oriented, and practical orientation of nursing positions the discipline to adopt an abolitionist approach. Abolitionist practice demands reckoning with the social forces of colonialism, racism, and misogyny not only in prisons but also in nursing itself and of nursing's role in prisons and policing. Abolition honors the resistance, resilience, and power of women, gender minorities, and BIPOC experiences in carceral contexts and crafts social justice through actions and services that reduce the size and scope of the prison industry.

In policy, for nurses to take up this framework has the potential to shift belief in the appropriateness of criminalization as a response to harm and to advance conceptualizations of a broadly defined public that includes people in prison. In nursing

research, abolition can expose the consequences of incarceration to health and equity and be the very ground to propose alternatives to prison and to examine their functioning. In practice, nurses can oppose policies that violate the rights of patients, even and especially if those patients are marginalized, isolated, and imprisoned. Nurses can seek to practice in ways that recognize our connectedness and are restorative to communities experiencing marginalization and criminalization.

# Chapter 5: The Correctional Services Canada Institutional Mother Child Program—A Look at the Numbers

Early on, I planned for the dissertation to involve both interviews with formerly incarcerated mothers as well as people currently incarcerated, to enrich the variety of data sources considered in the case study. However, COVID-19 made accessing the prisons unfeasible. Fortunately, in 2018, I had submitted access to information and privacy (ATIP) requests to CSC in the hopes of acquiring updated information about participation in the Mother Child Program. It was over a year before I received the ATIP, and I scheduled several meetings with CSC representatives to understand the meaning of the results. The results of the descriptive statistical analysis of these ATIP results are not surprising- participation is few and far between, and Indigenous women are less likely to participate. This type of data collection and analysis is wanting from regular Public Safety Canada and Office of the Correctional Investigator reports and would provide invaluable insight into what is happening to mothers.

The work in section 5.1 is accepted for publication in *The Prison Journal* November 2022 issue. Co-authors Dr. Ruth Martin-Misener, Dr. Adelina Iftene and Dr. Gail Tomblin Murphy supported manuscript preparation and review.

## 5.1 Introduction

Women are the fastest growing population in prisons in Canada, with the number of federally sentenced women increasing 16.3% from 2010 to 2019 (Public Safety Canada, 2019). Women are a small subset of the total incarcerated population, representing 6% of federally sentenced people (Correctional Services Canada, (CSC), 2019). Federal prisoners have received a sentence of two years or more whereas those in

provincial institutions are either in pretrial custody or have a sentence of less than two years. Incarcerated people have complex social and health histories including childhood abuse, sexual trauma, PTSD, substance use disorder, mental illness, chronic illness, and infectious disease (Kouyoumdjian et al., 2016). They also experience high rates of unemployment, low educational attainment, and low literacy (Mahoney, Jacob & Hobson, 2011). Women's incarceration has significant implications for families, as approximately two-thirds are mothers (Mallicoat, 2014) with an average of four children (Kouyoumdjian et al., 2016). These children face intergenerational trauma (Mussell, 2020), and risk criminalization themselves (Withers & Folsom, 2007) as well as multiple health concerns and premature death (Felitti et al., 1998; Centre for Disease Control and Prevention (CDC), 2019).

In 1990, the Taskforce on the Future of Federally Sentenced Women (TFFSW) released a report called *Creating Choices* that called for the creation of environments appropriate for children to live with their mothers (TFFSW, 1990). Formally implemented across the federal system in 2001 and governed by Commissioner's Directive 768 (CD-768), the stated purpose of CSC's Mother Child Program (MCP) is "to foster positive relationships between women incarcerated in women offender institutions and units and their children and to provide a supportive environment that promotes stability and continuity for the mother-child relationship" (CSC, 2020, p.1). Mothers who have not been convicted of an offense against a child, are classified as minimum or medium security risk, and have children up to the age of six may apply (CSC, 2020). Program supporters point to evidence that keeping mothers and children together prevents psychological, physiological and developmental harm to the child (The

Collaborating Centre for Prison Health and Education, 2015). Abolitionist theorists would counter that prisons are high-risk environments, with elevated risks of disease transmission, injury and death, and the high cost of operating prison programs such as the MCP displaces funding that could be directed towards community-based solutions (Critical Resistance-INCITE, 2003; Davis, 2003; Kaba, 2021; Wilson-Gilmore, 2007). Publicly available information about outcomes associated with the federal MCP is scarce, including the number of program participants. This article begins to illuminate MCP participation.

Commissioner's Directive (CD) 768 sets out the responsibilities, eligibility, requirements and processes for the MCP (CSC, 2020). Each of the six federal facilities for women has an MCP (see Table 5). There is also a small 28-bed healing lodge for federally sentenced women that opened in 2011 and is operated by Native Counselling Services Alberta (Native Counselling Services Alberta, n.d.). In 2014, CSC added 114 minimum security beds to its facilities for women, and 15 new rooms specifically for the MCP (Hennel, 2014).

There is one provincial facility with an MCP at the Alouette Correctional Centre for Women, in Maple Ridge, BC. ACCW is a large facility with capacity for 315 women (Paynter, Bagg & Heggie, 2020). From 2004-2008, 12 women gave birth while incarcerated and kept their infants with them. In 2008, the province closed the program, which prompted a constitutional challenge by several of the women. In 2013, British Columbia Supreme Court Justice Carol Ross ruled that restricting mothers and babies from being together violated the Canadian Charter of Rights and Freedoms (Inglis v BC, 2013). Since the program reopened in 2014 there have been two participants (Minister for

Public Safety and Solicitor General Corrections Branch, 2016). No other province has started a program.

In 2019, the Office of the Correctional Investigator (OCI), the ombudsperson for federally incarcerated people, stated that 125 applications to the MCP had ever been submitted, and of those, 108 were successful (Canadian Friends Service Committee, 2019). Considering that, on average, 701 women are federally incarcerated on a given day (Public Safety, 2019), and approximately two-thirds of them are mothers, the number of applications is strikingly low. In this paper we examine available data on MCP participation in Canada.

## 5.2 Literature Review

### 5.2.1 *Other Countries*

In an international policy review, Robertson (2012) found most countries around the world allow children to live with their mothers in prison. However, the infrastructure, program elements and eligibility requirements of MCPs varied considerably around the world. Some prisons locate the MCP in a separate unit from the general population, as is the case for most of the MCPs in England (Farrell, 1998). In New Zealand, mothers and children live together in special facilities called "self care units" (Robertson, 2012, p. 22). Describing the MCP in an Italian prison, Candelori and Dal Dosso (2007) write, "The 'nursery' has all the features of a prison ward: barred windows, steel doors, locks, gates with iron bars. Even the garden-courtyard is surrounded by a high fence." (p. 61). In some of the federal prisons for women in Canada, MCP participants live apart from the general population in the Minimum-Security Unit, an apartment-building-style facility outside the gates (Paynter, 2021). Some jurisdictions include day care centres, such as the

Ohio Reformatory for Women (Inskeep, 2008). The *Creating Choices* report in Canada called for daycare in the prisons (Taskforce on Federally Sentenced Women, 1990), but in the long term this did not materialize.

Most jurisdictions place age restrictions on child eligibility. In Germany children can live full-time inside until they are school-age or about 5 years old (Robertson, 2012). In the US, the United Kingdom and many programs on continental Europe, the age restrictions are much earlier, around 18 months. Black, Payne, Lansdowne and Gregoire (2004) have criticized age limits as arbitrary and without grounding in evidence.

There are a few studies of how MCP participation supports mothers in maintaining long term custody of their children. In their US-based case-control study, Kubiak, Kasiborski and Schmittel (2010) found that a greater proportion of children of the MCP intervention group had contact with CPS than in the control group. In a study of 100 infants in an MCP, Byrne, Goshin and Blanchard-Lewis (2012) found the most common reasons for a child to be separated from their mother after participation was due to the child being removed by CPS or the child reaching the program age limit. Among the children in the French study by Blanchard et al. (2018), at discharge from the program, 40% of the children were removed from their mothers by CPS. As Haney (2013) explains, "what began as a promising alternative to punishment morphed into its own form of power and control" (p.107).

### 5.2.2 *Canada*

The federal MCP in Canada is decidedly under-researched. Paynter, Jefferies, McKibbon, Martin-Misener, Iftene & Tomblin Murphy (2020) published a systematic scoping review of the health outcomes associated with participation in MCPs around the

world. The review included 27 studies however the authors did not find any relevant studies in Canada. A small number of social science and law articles did examine barriers to MCP participation in Canada. Brennan (2014) found declining participation in the MCP from 2001-2012 to be related to: 1) changes to MCP eligibility criteria enacted in 2008 that made participation more exclusive; 2) overcrowding in the prison facilities, a result of increasing incarceration of women; 3) limitations of the physical prison environment and 4) the increasingly punitive nature of corrections.

Miller (2017) considers how CSC policies and practices create barriers to MCP participation for Indigenous women. The Custody Rating Scale used in security classification includes factors such as "employment, marital status, family situation, associates, social interaction, substance abuse, community functioning, personal and emotional orientation and attitude" (Miller, 2017, p. 12). People with higher security classification are excluded from potentially helpful programs such as the MCP and experiences of colonial harm result in elevated classification among Indigenous women. Further, Miller asserts that Indigenous women are less likely to accept the involvement of CPS, a requirement for MCP participation, because Indigenous children are more likely to be removed from their families. It is estimated that 52.2% of children in care under the age of 14 are Indigenous (Government of Canada, 2020). Fayter and Payne (2017) recount the story of a federally incarcerated woman at Grand Valley Institution who wanted to participate in the MCP. Despite "being a model prisoner" (p.16), and having received approval from the CPS, she was consistently denied the necessary security reclassification required.

In general, in the literature review we find a lack of evidence or theory governing the programs and a lack of comparative analysis between programs to determine best practices. The assumption that the MCP in Canada promotes mother-child connections should be scrutinized in the long-term.

## 5.3 Methods

This paper presents the quantitative findings about MCP participation as part of a larger program of research to examine maternal and reproductive health services for people incarcerated in prisons for women in Canada. This program of research uses a theoretical framework of feminist abolition (Davis, 2003; Critical Resistance-INCITE!, 2001). A feminist abolitionist lens critically assesses how prisons produce harm, considers alternative approaches to prisons to address social harms, and rejects the conclusion that prisons can resolve gendered violence.

### 5.3.1 *Data Acquisition*

In 2018, we submitted Access to Information and Privacy (ATIP) request to CSC for information regarding participation in the federal MCP from 2001 to the present (Set A and B). In July 2020 we submitted an ATIP request for information about MCP participants during the first wave of the COVID 19 pandemic (Set C). In late 2019, we received two data sets stemming from our first request: Set A included data from 2000-2015 and Set B from 2012-2019. We communicated with representatives from CSC's ATIP department by email and telephone to clarify information and terms used in the data set. We received Set C in September 2020. This data set includes April to August 10, 2020. We performed basic descriptive statistical analysis on the available data in each set using Excel.

### 5.3.2 *Description of Data Sets*

Set A was reportedly inputted by hand. Set B was drawn from the Offender Management System (OMS), a computerized case file management system used by CSC, on January 27, 2019. Set A and B overlapped for 2012-2015. There were discrepancies between the sets for years 2013-2015. We removed entries for years 2013-2015 from data Set A. The last year of data for Set B (2019) was only for January. Only data Set A tracks whether a participant used the program on a part-time or full-time basis. Only set B has information about Indigenous or non-Indigenous identity of the participant, and the amount of time the participant was in custody.

## 5.4 Results

### 5.4.1 *Number of Participants*

Both Set A and Set B have 67 participants in each, but because of the overlap for 2012, in total there were 133 participants in the MCP program over 19 years. When Set B was pulled on January 27, 2019, there were 21 people flagged as active participants, of which five were still incarcerated. The others were on parole or had been released at their statutory release date.

In Set A, Joliette (QC) had the most participants (31) and Edmonton (AB) the least (1). In Set B, Edmonton had the most (21) and Fraser Valley (BC) the least (6). To put this in perspective we include the (current) maximum capacity for number of women that can be incarcerated in each facility in Table 5.

Participation was higher in Set B than Set A in all institutions except Joliette and Okimah Ochi. Participation generally fell over the course of Set A and rose over the course of Set B, in keeping with Brennan's (2014) analysis that eligibility became more

restrictive in 2008, reducing participation, and then additional beds were created in 2014 to improve participation. In Set A, there was a mean of 5.2 new participants per year, and in Set B, the mean was 9.6. There were more new participants in 2016 (22) than any other year. In total over the 20 years, Joliette (40), Okimaw Ohci (27) and Edmonton Institution for Women (22) had the most participants.

Set C includes eight participants across four of the institutions: Nova (1), Joliette (2), Grand Valley (1) and Fraser Valley (4). There were no participants at Edmonton Institution for Women or Okimaw Ohci. Information was not provided regarding Buffalo Sage. See Figure 6.

### 5.4.2 *Length of Participation*

Length of participation in Set A ranged from 0 to 1513 days, and in Set B from 4 to 1201 days. The mean days of participation was 168.3 days for Set A and 241.8 days for Set B. In both Set A and Set B, six people participated for less than a week's time.

Only Set B included the amount of time in years that each participant spent incarcerated. Fifty-six of the 67 (84%) of Set B participants were no longer incarcerated on January 27, 2019. Of those who had been released, they had served an average of 1.1 years in custody.

**Table 5**

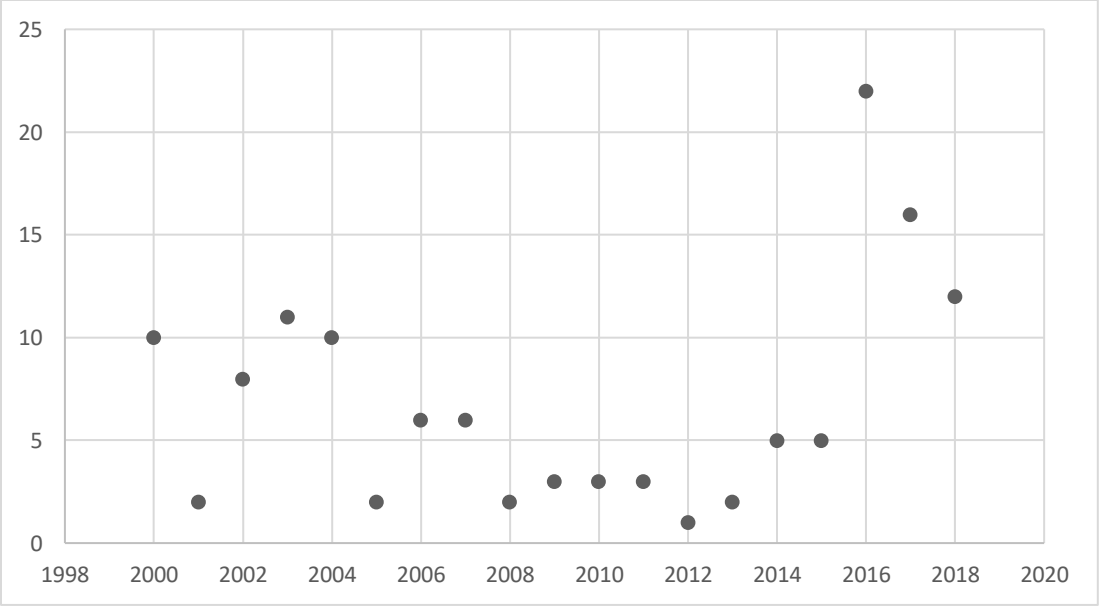
*Capacity and MCP Participants at Federal Prisons for Women*

| Name of Institution | Province | Total Capacity | Set A 2000-2012 | Set B 2012-2019 | Total 2000-2019 |
|---|---|---|---|---|---|
| Nova Institution for Women | Nova Scotia | 99 | 5 | 9 | 14 |
| Joliette Institution for Women | Quebec | 132 | 31 | 9 | 39 |
| Grand Valley Institution for Women | Ontario | 215 | 7 | 8 | 15 |
| Okimaw Ohci Healing Lodge | Saskatchewan | 60 | 20 | 7 | 27 |
| Edmonton Institution for Women | Alberta | 167 | 1 | 21 | 22 |
| Buffalo Sage Wellness House | Alberta | 28 | NA[a] | 7 | 7 |
| Fraser Valley Institution for Women | British Columbia | 112 | 3 | 6 | 9 |

[a]Buffalo Sage opened in 2011.

**Figure 6**

*New Admissions to MCP 2000-2018*




*Note*. 2019 is excluded as incomplete results were provided for the year.

## 5.5 Discussion

This paper is part of a series of research papers pertaining to the sexual, reproductive and maternal health of people experiencing incarceration in prisons for women in Canada (Paynter, Drake, Cassidy & Snelgrove-Clarke, 2019; Paynter, Jefferies, McKibbon, Martin-Misener, Iftene & Tomblin Murhy, 2020; Paynter, Bagg & Heggie, 2020; and Paynter, Heggie, McKibbon, Martin-Misener, Iftene & Tomblin Murphy, 2021). In our analysis we use a feminist abolitionist framework (Critical Resistance-INCITE!, 2003; Davis, 2003; Parkes, 2021) is critical of the suggestion that bringing children into prisons can resolve the problems of mother-child separation caused by the increasing incarceration of women. Not only is MCP participation under-researched, but there is little known about how many children are affected by parental incarceration in Canada. Their numbers are not tracked by Statistics Canada, CSC or OCI. A case review of written sentencing decisions across the country in 2016 found not one mention of the Best Interests of the Child (Canadian Friends Service Committee, 2018). There is a need to address these information gaps, beginning with counting the children who are with their mothers in Canadian prisons.

From 2005-2015, the number of new participants in the MCP was very low, between one and six per year across all federal institutions. As Fayter and Payne (2017) point out, the MCP became less accessible under Prime Minister Stephen Harper's Conservative federal government, in power from 2006-2015. For some institutions, such as Edmonton, there was only a single participant during that time. Participation overall increased in recent years, but it fell at Joliette and Okimah Ohci in Set B when compared to Set A.

There is no connection between size of facility or security levels in the facility with numbers of participants in the MCP (See Table 5). Most facilities have minimum, medium and maximum-security sections. Policies across the facilities do not differ, all are subject to the same federal Commissioner's Directives and the Corrections and Conditional Release Act (1992).

Unlike Set A, which tracked the children, Set B tracks the mothers. As a result, we do not know how many children participate in Set B, as a mother may have more than one child with her, such as twins or a toddler and an infant. It is not necessary for participants to be pregnant and give birth while federally incarcerated. Furthermore, because it is the mothers that are flagged as participants, they may be entered into the program while pregnant, before the child is born. This obscures whether the child gets to participate at all, as the child may be removed from the mother's care at birth.

Indigenous identity is based on self-report. Although more granular data about self-reported race is collected by CSC, it was not available through ATIP. Information about participants' identity as Indigenous or Non-Indigenous is not available for Set A. In Set B, 32.8% of participants identified as Indigenous. The most recent statistics show that 41.4% of federally incarcerated women identify as Indigenous (OCI, 2020). Indigenous women are underrepresented in the MCP, in keeping with Miller's (2017) analysis that racism and colonialism impact security level classification and program eligibility. Although the proportion of incarcerated women who identify as Indigenous has increased every year over the time period covered in Set B, the proportion of MCP participants who identified as Indigenous varied from as low as 0% in 2012 and 2014 to as high as 56% in 2017.

Although only Set A tracked full versus part time participation, and time "in the program", the number of days the child stays with their mother is not tracked. Mothers participating part-time could have their children with them every weekend, or only a few times a year. CSC representatives explained that it is also possible a mother was flagged as participating if her child came for a visit *once*. This is perhaps the explanation for participants with less than a week of participation.

Only Set B included information about percent of sentence served and type of release. From Set B we could discern that, for those participants who were paroled, they had spent an average of 1.1 years in custody. This is enough time to seriously disrupt their lives and leads to the question as to what purpose is served by incarcerating this population at all.

In the middle of our analysis, in March 2020, researchers, volunteers and visitors were largely locked out of federal facilities due to COVID-19. Advocacy organizations and academics around the world called for decarceration measures to prevent COVID-19 infections in prisons. This had little impact at the federal level in Canada. Outbreaks occurred in federal prisons across the country, including a large outbreak at Joliette Institution for Women (CSC, 2021; Thomas, 2020). Early in the pandemic it became apparent that pregnant people were at greater risk of contracting COVID-19 and that COVID-19 was associated with increased risk of adverse birth outcomes including prematurity (CDC, 2021). Pregnant people experiencing incarceration faced compounding risks, a context not only stressful for those inside the institutions but for their family members in community (Germano, 2020). Despite this, Set C shows eight women had their children with them in prison during the first wave of COVID-19.

In the context of a global pandemic and frequent prison outbreaks, the appropriateness of incarcerating children with their mothers can be called into question. Goshin (2015) has identified longstanding concerns with MCPs as a response to maternal incarceration, including the invisibility of children within the larger prison infrastructure, that the Best Interests of the Child (United Nations, 1989) and carceral policies do not align, and the lack of evidence-based guidelines to direct best practices. Some suggested alternatives to MCPs include "electronic tagging" such as ankle bracelets (Castello, 2015); and house arrest, as is used in Italy and Brazil for pregnant women and mothers of children under the age of 12 (Law Library of Congress, 2015). These approaches continue the carceral functions of confinement and surveillance. Supportive community-based housing models may be an alternative (Goshin, 2015). In France, alternatives must always be considered before the incarceration of pregnant women or mothers of young children (Blanchard et al., 2018).

### 5.6 Limitations

There are several limitations to our findings and the MCP data. It is a requirement of the United Nations Minimum Standards for the Treatment of Women Prisoners (United Nations, 2011), that a comprehensive health history including numbers of children be collected on a woman's admission to custody. CSC does not collect this information or information regarding maternal health outcomes such as gestational complications, breastfeeding, or peripartum depression. These data gaps impede any evaluation of the MCP, and whether it improves or worsens these outcomes.

CSC representatives expressed concerns about the accuracy of the data in both Set A and B. However, there are no alternative sources of this information. The Canadian

Association of Elizabeth Fry Societies, the national advocacy organization for people incarcerated in federal prisons for women, does not keep track. The Office of the Correctional Investigator relies on data provided by CSC for its reports. Despite its limitations, information directly from CSC is the best available. It is unclear why our data set includes more participants than were reported by the OCI in 2019, as the OCI receives data for its reports from CSC. This discrepancy speaks to the general lack of attention to clear, consistent reporting about this program.

Because the data are collected by flagging the day each new participant enters the program, there is no accurate picture of how many participants participated per year, but rather how many *new* people participated per year. Of the 67 entries in Set B, we found three instances where two participants had the exact same amount of time served in custody, to the third decimal point. While it is possible two unique individuals served such exactly similar amounts of time, it is unlikely. It is more likely that in these three instances one individual was entered twice in the system. For instance, if they were released and then were re-incarcerated, or moved from one institution to another, this would be captured as a new flagged start time.

**5.7 Conclusion**

Participation in the MCP in Canada over the past two decades was strikingly infrequent, averaging approximately seven new participants in total each year. Despite the staggering increase in the numbers of federally incarcerated women over this time, MCP participation did not similarly increase. A disproportionately low number of Indigenous women participate in the MCP. Lack of high-quality data collection about participants, both mothers and children, hinders evaluation of the program. Considering

the low numbers of participants, inadequacy of data for monitoring and evaluation of the MCP, not to mention the impact of COVID-19 on prisons across the country and around the world, there is an urgent need to re-evaluate the role of MCP and to consider investment in community-based alternatives.

## 5.8 Knowing Participation Numbers, What Do Mothers Experience With Respect to the MCP?

With a clear picture of the small size of the MCP, the next step was to understand how mothers come to participate- or not- in the program, and the implications for their health and wellbeing with respect to participation. To address these questions, the core concerns of the dissertation, a qualitative case study was designed to analyse data from interviews with both mothers with lived experience of pregnancy and parenting young children while federally incarcerated and community-based advocates with experience supporting these women through Elizabeth Fry Societies.

# Chapter 6: A Qualitative Case Study of Participation in the Mother Child Program in Canada's Federal Prisons for Women

## 6.1 The Overarching Research Question

The core concern of this dissertation is to respond to the overarching research question as to how federally incarcerated mothers experience pregnancy and parenting young children with respect to the Mother Child Program. As such, the following manuscript is the focus of the larger case study, centering the voices of mothers with lived experience. It is informed by the previous manuscripts and uses and refines a conceptual framework based on the findings in these manuscripts and on my experience as an advocate and clinician supporting and caring for people experiencing the perinatal period in prisons.

The work in section 6.2 was submitted to the *BMC Health and Justice* journal in February of 2022. Co-authors Dr. Ruth Martin-Misener, Dr. Adelina Iftene and Dr. Gail Tomblin Murphy supported manuscript preparation and review.

## 6.2 Problem

The number of people admitted to Canadian federal prisons designated for women increased 16.3% between 2009 and 2019 (Public Safety Canada, 2020). Black and Indigenous people are disproportionately incarcerated: 8% of prisoners are Black (Office of the Correctional Investigator (OCI), 2019), and 32% are Indigenous (OCI, 2021). Within the prisons designated for women the situation is worse: almost 50% of federally sentenced women are Indigenous (OCI, 2021). Increasing incarceration of women and people who can become pregnant has serious consequences for reproductive health. Studies in North America have found over 80% of incarcerated women have experienced

pregnancy, with a median number of pregnancies between 3.7 and 6 (Clarke et al, 2006; Liauw et al., 2016). Pregnancy while incarcerated is associated with inadequate prenatal care, prematurity, and low birth weight (Carter Ramirez et al., 2020a; Carter Ramirez et al., 2020b). The right to choose not to have children is restricted by limited access to abortion and contraception (Liauw et al., 2021). Further, usually separated from their families, incarcerated people face delays or interruptions in fertility, (Ross & Solinger, 2017), disrupting childrearing and kinship practices (Jones et al., 2018).

In the early 2000s, the central federal Prison for Women (P4W) in Kingston, Ontario, was officially closed and replaced by a new system of six regional facilities. At that time, Correctional Services Canada (CSC) launched the institutional Mother Child Program (MCP) which was intended to mitigate the harm of separating mothers from their children (CSC, 2020). The program has never been evaluated, internally or externally, and health outcomes associated with the program have never been investigated (Paynter, Jefferies, McKibbon, Martin-Misener, Iftene & Tomblin Murphy, 2020). The objective of this study was to examine the experiences of pregnant people and parents of young children with respect to the MCP. Note: this paper uses gender inclusive language. Where citing a source that uses the gendered terms (women/mothers), those are used.

### 6.3 Research Background

In Canada the perinatal health of incarcerated people and their newborns is under-researched. A 2019 international scoping review of perinatal health outcomes of people incarcerated in prisons for women did not find any applicable Canadian studies (Paynter, Drake, Cassidy & Snelgrove-Clarke, 2019). A scoping review of sexual and reproductive

health studies with incarcerated women in Canada included 15 studies, only two of which examined pregnancy and contraception (Besney et al., 2018; Liauw et al., 2016), and two addressed access to prenatal care and neonatal outcomes (Carter Ramirez et al., 2020a; Carter Ramirez et al., 2020b).

In their survey of 89 provincially incarcerated women in the province of Ontario, Liauw et al. (2016) found most (82.4%) had been pregnant; 77% had an unintended pregnancy, and 57% had had an abortion. In a follow up qualitative study, participants described limited access to reproductive health care, supplies and personnel; discrimination and favouritism; and a hierarchical prison structure impairing access (Liauw et al., 2021). They described traumas of separation and denial of the opportunity to become pregnant.

Incarceration involves impingements on bodily autonomy including strip searching (Balfour, 2018; Hutchison, 2019), solitary confinement (Hannah-Moffat & Klassen, 2015), and restraints (Ferszt & Clarke, 2012). Failure to attend to differences of gender, race and other health factors results in inflation of women's risk profiles by CSC, with consequent escalated restrictions on liberty (Cardoso, 2020). Studies have found experiences of childhood abuse are pervasive among people who are incarcerated, and higher rates among incarcerated women than men (Bodkin et al., 2019). Health needs such as PTSD are interpreted as security risks (Blanchette, 2004) and psychological illness is perceived as "madness" in need of coercive regulation, segregation or medicalization (Kilty 2012; Meerai, Abdillahi & Poole, 2016).

### 6.3.1 *Children and Incarcerated Parents*

Mothers separated from their children due to incarceration experience severe loss (Abbott et al., 2021; Poehlmann, 2005a). Jailed parents are three to five times more likely to experience depression compared to the norm, with higher rates among mothers (Howland et al., 2021; Milavetz et al., 2020). There are three modes of contact for incarcerated people and their children: visitation, phone, and letters/mail; in general, internet access, social media and texting are unavailable. Visitation is fraught with geographical, logistical, financial and emotional barriers, and as a result, many incarcerated people do not receive any visits with their children (Paynter, Heggie, Matheson, McVicar, Rillie, Beals, & Bray, 2022; Poelhmann-Tynan & Pritzl, 2019). In Canada, the creation of the regional prisons for women intended to reduce geographical barriers for visits, yet families are often thousands of kilometres away. COVID-19 put visitation to a halt, but accelerated access to video visits (Dallaire et al., 2021; Horgan & Poehlmann-Tynan, 2020). Frequent telephone contact- an expensive option- is associated with less depressive symptoms (Poelhmann, 2005a). Mail, the least expensive option, is beneficial and may promote literacy (Dallaire et al., 2011). Telephone and mail are largely inappropriate for building a relationship with babies on the outside.

The children of incarcerated parents in Canada are an “invisible” population (Knudsen, 2019). Their needs are unaddressed by policy, and their numbers remain unmeasured (De Saussure, 2018). While a 2007 study estimated 350,000 children in Canada were affected by parental incarceration (Withers & Folsom, 2007), there is no recent reliable research (McCormick, Millar & Paddock, 2014). Most incarcerated parents are fathers, not mothers. Who cares for children while their parents are

incarcerated in Canada is not known. A recent U.S. study found most children of incarcerated mothers live with their grandparents (Pendleton et al., 2021). In Canada, the disproportionate incarceration of Indigenous women coincides with disproportionate numbers of Indigenous children in foster care (Government of Canada, 2020).

Children of incarcerated parents experience layers of adversity, including poverty, racism, and family dissolution, making it challenging to determine what experiences result from parental incarceration alone. Children of incarcerated mothers experience increased risk of attachment disorders (Poelhmann, 2005b) and emotional difficulties (Murphey & Cooper, 2015). Lack of contact is associated with alienation from the parent (Shlafer & Poelhmann, 2010). At older ages, maternal convictions are associated with child justice system involvement (Shlafer, Poehlmann, & Donelan-McCall, 2012) and problems in school (Hagan & Foster, 2012).

### 6.3.2 *Mother Child Programs*

For over 70 years, researchers have recognized keeping primary caregivers and children together enhances childhood attachment and emotional health (Bowlby, 1952). Proponents of MCPs believe keeping the mother-child dyad together prevents psychological, physiological, and developmental harm to the child (Collaborating Centre for Prison Health and Education, 2015). International reviews of health research related to Mother Child units and prison nurseries have not included any studies based in Canada (Dowling & Fulton, 2017; Paynter, Jefferies, McKibbon, et al., 2020).

Canadian studies have examined MCP participation. Brennan (2014) investigated use of the MCP from 2001-2012, interviewing advocates working at Elizabeth Fry Societies. Main reasons for declining MCP participation included: 1) changes to

eligibility criteria enacted under the Harper government in 2008 to increase exclusivity; 2) overcrowding, a result of increasing use of mandatory minimum sentences; 3) limitations of the physical prison environment; and 4) the increasingly punitive nature of corrections. Miller (2017) explored barriers to participation for Indigenous mothers, finding gender and racism bias custody classification, resulting in higher security classification and MCP ineligibility.

Analysis of MCP participation data from 2001-2018 found only 133 participants in total, an average of seven participants per year (Paynter, Martin-Misener, Iftene & Tomblin Murphy, 2022). There was no correlation between the size of each prison and the number of MCP participants. Non-Indigenous people were more likely to participate than Indigenous people, affirming Miller's (2017) analysis.

Despite the goals of family unification, it is not clear that MCPs support family cohesion in the long term. MCP participants are subject to child protection agency surveillance. Byrne, Goshin and Blanchard-Lewis (2012) found the most common reason for a child to be separated from their mother after residing in a U.S. prison nursery was child removal due to child protection concerns, or the child reached the one-year age limit. Blanchared et al (2018) found that in a French prison nursery, 42.9% of the children were placed in foster care upon discharge.

Goshin (2015) identified several concerns with idealization of MCPs including: the invisibility of children within the larger prison infrastructure; lack of guidelines to support best practices; lack of alignment between the United Nations' Best Interests of the Child (UN, 1989) and carceral practices and policies; the lack of access and participation in MCPs due to few facilities having programs in North America and

restrictive eligibility criteria therein; and finally, the purpose of incarcerating women when most are convicted of nonviolent crimes.

In prison, parenthood is under surveillance- and constant critique. Haney (2013) conducted a three-year ethnographic study of a mother-baby program in California. She described it as layering carcerality onto the experience of motherhood, replicating heteropatriarchal, racist, classist systems of control. The mothering of some was idealized while that of others was devalued; some were subject to "near-constant public scrutiny" (p.107). People who have already experienced foster care- as children themselves or as parents- are disproportionately likely to experience incarceration. Their prior experiences with and distrust of the child protection system affect their willingness to engage with it while incarcerated.

There are alternatives to MCPs, but many extend the carceral milieu into the home. Castello (2015) remarks on "electronic tagging" such as ankle bracelets as an alternative to incarceration. Italy and Brazil have implemented house arrest for pregnant women and mothers of children under the age of 12 (Law Library of Congress, 2015). Argentina allows for home confinement when mothers have children under age five (Robertson, 2012). Suspended sentences provide a period of probation: if there are no breeches of the conditions, there is no incarceration. Kyrgyzstan uses this approach (Robertson, 2012). In Italy and France, alternatives must always be considered before the incarceration in pregnancy or for mothers of young children (Blanchard, 2018; Kebbati, 2021).

Non-custodial alternatives prioritize support over surveillance. In New York, Goshin (2015) studied a prison alternative for mothers in the form of a supportive

housing program, staffed by peers. Participants had individual units, leases, and could work, study, have visitors, and live there after the end of the term of supervision. The program fostered self-worth, independence, and parent-child connection.

To justify continuation, changes, or expansion of the MCP in Canada or elsewhere, high-quality research must inform what types of alternatives exist, examining eligibility restrictions, rates of participation, and to what extent the MCP promotes parent and child health.

### 6.4 Policy and Legal Background

Federal and international laws shape expectations for the MCP in Canada. Section 70 of the *Corrections and Conditional Release Act* (CCRA) (Canada, 1992), governing federal prisons, specifies conditions must be "healthful" (p.52). Section 86 requires provision of essential health care and reasonable access to non-essential care. Section 87 requires consideration of health in all decisions affecting prisoners. Section 77 requires programs specific to women's needs.

The federal prison system operates under policies called Commissioner's Directives (CD). CD-800 governs health and stipulates every CSC health professional will "provide health services to offenders consistent with relevant provincial/territorial and federal legislation, the provincial/territorial regulatory body's professional practice standards, as well as CSC policies and practice directives." Children appear in section 10.c: "[health professionals will] provide emergency first aid and cardiopulmonary resuscitation (CPR), according to their certification, to visitors, children who are participating in the Mother Child Program and staff until external emergency services are

available.”. Pregnancy is found in section 20: “For pregnant offenders, Health Services will ensure arrangements for childbirth are made at an outside hospital.”

Commissioner’s Directive 768 describes the purpose of the MCP is “to foster positive relationships between women incarcerated in women offender institutions and units and their children and to provide a supportive environment that promotes stability and continuity for the mother-child relationship” (CSC), 2020, p.1). CD-768 sets out the responsibilities, eligibility, requirements, and processes for the program across the six federal women’s sites. Children under five years of age can live full-time, on-site. Prisoners must not have been convicted of an offense against a child and must be classified as minimum or medium security risk (CSC, 2020). Participation depends on completing courses such as infant first aid and CPR, car seat safety, or parenting. Participants must select peer “babysitters” and have a trusted adult in the community nearby to retrieve the child in an emergency. Finally, provincial child protection services must assess the appropriateness of the parent and make a recommendation to the warden.

The United Nations (UN) *Standard Minimum Rules for the Treatment of Prisoners* (Mandela Rules) provide international standards governing the treatment of prisoners (UN, 2015). These include Rule #24: “The provision of health care for prisoners is a state responsibility. Prisoners should enjoy the same standards of health care that are available in the community” (p.12); and Rule #28: “In women’s prisons, there shall be special accommodation for all necessary prenatal and postnatal care and treatment. Arrangements shall be made wherever practicable for children to be born in a hospital outside the prison.” Health professionals must treat incarcerated people equal to those in community.

The United Nations *Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders* (Bangkok Rules) are also relevant (UN, 2010). They encourage alternatives to incarceration for pregnant women and mothers, and stipulate state responsibility for the wellbeing of children imprisoned with their mothers. Rule #10.1 specifies that prisoners are to receive gender-specific health care including access to women's health services and accommodation of pregnancy. Rule #6 requires documentation on admission of reproductive health history, including pregnancies. Rule #22 prohibits solitary confinement in pregnancy, with infants, or breastfeeding. Bangkok Rule #24 prohibits restraints during labour and delivery.

The UN *Convention on the Rights of the Child* (UNCRC) (1989) asserts a child's right "to know and be cared for by his or her parents" (Article 7). Canada ratified the UNCRC in 1991. The UNCRC sets out the principle of Best Interests of the Child. Article 24 states that children have a right to "enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health."

### 6.5 Guiding Question

In summary, the review of the literature shows that there are few studies that have evaluated MCPs. The purpose of this study was to begin to address these gaps. The research question guiding this study asks, what are pregnant people and new parents' experiences of the federal MCP?

## 6.6 Methods

### 6.6.1 *Theoretical Background*

Reproductive justice and prison abolition guide a critical examination of MCPs as a response to maternal incarceration and inform the theoretical foundation for this study. The term reproductive justice was coined in 1994 by Black feminist leaders in the United States (Black Women for Reproductive Justice, 2012). The movement reconceptualizes reproductive rights as not only the right to contraception and abortion to *not* have children, but also the right to be free from state interference in the choice to have children and to parent those children (Ross, 2018; Ross & Solinger, 2017). Incarceration impinges on this right while perpetuating cycles of racism, colonialism, and capitalism and amplifying violence and harm (Critical Resistance, 2003; Davis 2003). Federal prison is an enormous public expense in Canada- over 1.63 billion dollars/year (Office of the Parliamentary Budget Officer, 2018). Abolitionists advise redirection of investment to create systems of support, including housing, health services, food security and other types of care that prevent experiences of criminalization and avoid the need for health services within the punitive operations and infrastructure of prison (Paynter, Jefferies, Carrier & Goshin, 2021). Abolition critiques MCPs for normalizing incarceration, increasing the need for public spending on incarceration, and crowding out alternatives such as housing.

### 6.6.2 *Researcher's Position*

The first author has been deeply embedded in community work to advance reproductive health of people in prison for over ten years. They have worked closely with non-profit organizations, including the *Canadian Association of Elizabeth Fry Societies*

(CAEFS), local organizations that provide legal support, programs and housing for women affected by the justice system. The first author has facilitated reproductive health and justice workshops with CAEFS in the five English language prisons for women, with hundreds of people, allowing unique insight.

### 6.6.3 *Design*

This study uses a qualitative case study design (Yin, 2003). Case study research assumes researchers will have predetermined experience and knowledge about the phenomenon. Cases are defined by boundaries (Creswell, 2003). This case is bound by context (federal prisons designated for women), by time (since the opening of the regional facilities in the late 1990s- early 2000s) and place (the regional federal sites). Case study is a comprehensive strategy that encompasses formulation of the research question, data collection, analysis and presentation of findings. It can be used to understand complex social phenomena addressing "how" and "what" questions "when the researcher has little or no control over the phenomenon of interest" (Yin, 2003). Case Studies "provide enriched experiences of unique situations…[and] allow us to look through the eyes of the researcher" (Chesnay, 2017).

This case study began with propositions, based on existing evidence and the researcher's experience, to guide the data collection, focus the analysis, and shape the discussion (Baxter & Jack, 2008; Yin, 2003). Propositions in this study included:

1. The MCP is infrequently used (Brennan, 2014; Miller, 2017).
2. MCP participation is a positive experience for participants (Fritz & Whiteacre, 2015).
3. For incarcerated parents, separation from children is traumatic (Abbott et al,

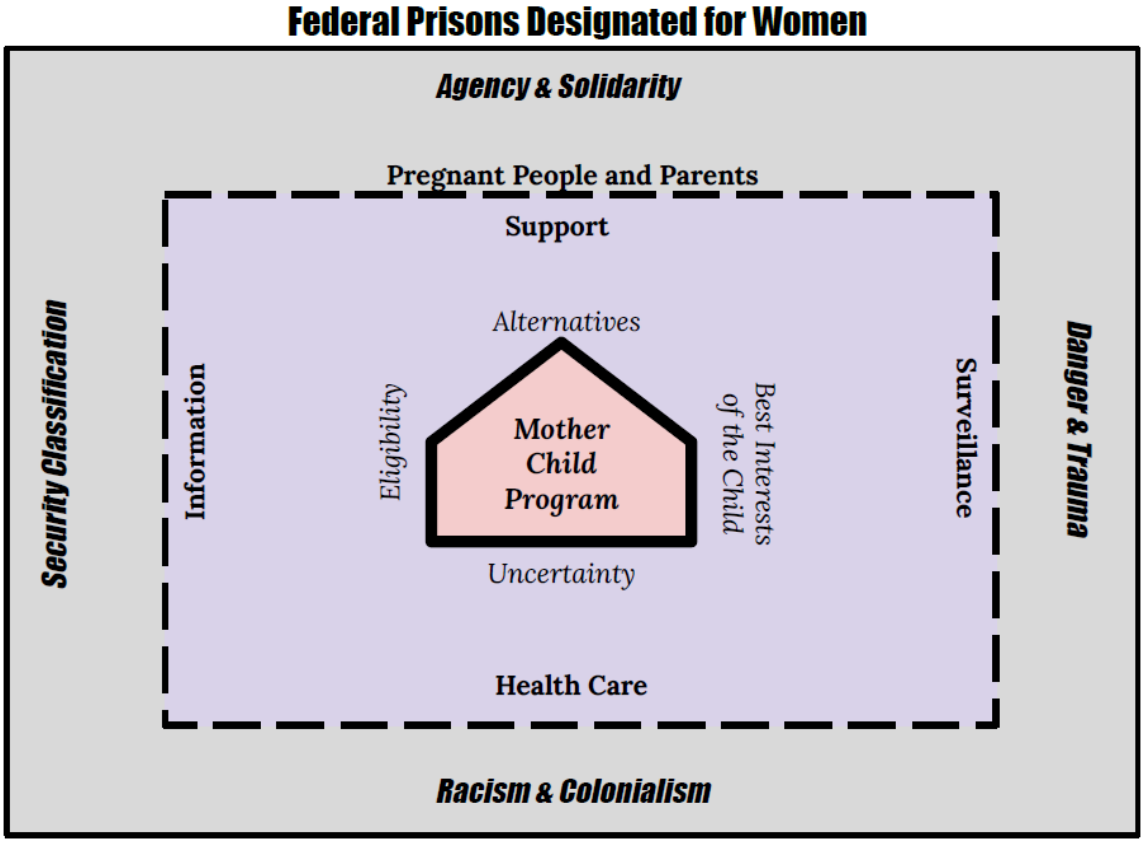
2021).

4. Perinatal health care provided by CSC is inadequate (Public Safety Canada, 2017).
5. Parents use agency and solidarity to navigate the experience

The conceptual framework developed for this study continued to be revised through the research process. It recognizes all people incarcerated in the federal prisons designated for women are subject to its systemic foundation in racism and colonialism; are exposed to danger and trauma; are classified through a security assessment; and navigate the experience through solidarity and personal agency. Within this group are a subset who identify as pregnant or parents of young children. They receive unique information, health care, sources of support, and are subject to surveillance of their parenting. The very small group who participate in the MCP do so only if eligible and if their careful calculus of alternatives – and that of provincial child protection services- determines it is the best option for their children. Participation is marked by not only the uncertainty of qualifying, but precarity of staying in the program given risks such as institutional discipline. See Figure 7.

**Figure 7**

*Conceptual Framework of Case Study of Experiences in the Federal Prison MCP*




### 6.6.4 *Setting*

The setting is the federal prison system designated for women. The six prisons are in Abbottsford, BC; Edmonton, Alberta; Maple Creek, Saskatchewan; Kitchener-Waterloo, Ontario; Joliette, Quebec; and Truro, Nova Scotia. All are subject to the same CDs.

As case studies customarily use multiple data sources, interviews were also conducted with staff of CAEFS member societies. To mitigate foreseeable challenges with recruitment, the first author collaborated with CAEFS member societies to recruit

formerly incarcerated people who experienced pregnancy or parenting young children while federally sentenced. Staff provided information to clients who could voluntarily contact the first author.

### 6.6.5 *Participants*

Participants in the broader study included a) people with lived experience of federal incarceration while pregnant or parenting young children; or b) Elizabeth Fry Societies staff who have supported federally incarcerated parents. This paper focuses on the voices of people with lived experience.

The first author is functionally bilingual, and interviews were conducted in either English or French. This study used criterion-based sampling (Sandelowski, 2000). To capture differences and similarities in experiences within the case, this study aimed to include people who did and did not participate in the MCP; who had been incarcerated in each of the six federal prisons; who had been incarcerated many years ago and recently; for brief or long sentences; in the area near their homes and at a far distance; and first-time parents and parents with other children. The number of participants was not predetermined and continued until data saturation was achieved. (Guest, Bunce, & Johnson, 2006). The broader study included 23 people: a) two parents who participated in the MCP; b) seven parents who did not participate in the MCP; c) two formerly incarcerated people involved with Elizabeth Fry Societies; and d) 12 Elizabeth Fry Societies staff. Participants varied in age, cultural background, life experience and geographic location. All identified as cisgender women.

### 6.6.6 *Data Sources and Collection*

Data collection included semi-structured interviews conducted in person or over the phone. The first author conducted all the interviews. All interviews were audio recorded and professionally transcribed verbatim. The two French interviews were professionally translated into English so that all data would be in English for the article. The interviews incorporated both open-ended and focused questions about experiences of a) participation- or not- in the MCP; b) being pregnant or having a young child while federally incarcerated; c) health care and health concerns; and d) what helped participants at that time and what they would recommend.

Documents formed a second source of data. This case study includes publicly available documents including public news articles pertaining to the MCP; CDs governing the MCP and Health services; and federal legislation governing the prison system. This case study considers the quantitative findings with respect to the MCP (Paynter, Martin-Misener, Iftene & Tomblin Murphy, 2022) and the qualitative findings from interviews with staff (Paynter, Heggie, Martin-Misener, Iftene & Tomblin Murphy, under review), published separately.

### 6.6.7 *Data Analysis*

Thematic data analysis (Clarke & Braun, 2013) was used to develop themes around MCP participation; the experience of pregnancy/early parenting in prison; health care and concerns during that time; and sources of support. The first author became deeply familiar with the data by reading all transcripts several times, creating an organized archive, and writing initial thoughts. They were reflexive about how prior

experiences and relationships prior to and after the data collection influenced interpretation by keeping a written journal and frequent team debriefing.

Using Microsoft Word and Excel applications for data management, the first author coded the transcripts to address the main concepts of the research questions. They compared different types of data with the research questions, the propositions, and conceptual framework to develop a coding matrix. A peer independently coded 10% of the transcripts using the matrix. The two coders discussed and kept notes regarding adjustments to the matrix. Themes were developed deductively and inductively, determining both data alignment with existing concepts and refining themes and developing subthemes using respondents' language. Themes were finalized through discussion with team members and incorporated into this report.

### 6.6.8 *Trustworthiness*

The first author used processes developed by well-established qualitative researchers to support trustworthiness (Nowell et al., 2017). The research question was clearly articulated, propositions were constructed, the design and sampling strategy were appropriate, data was collected and analyzed systematically. Credibility was established through prolonged engagement, data triangulation and researcher triangulation. The first author's engagement with prison systems dates to 2012 and they have a strong understanding of bureaucratic, cultural, and social factors in this environment. Interview data from formerly incarcerated people was triangulated with interview data from advocates and policy documents. The first author collaborated and debriefed with peers and supervisors in thematic analysis.

Thick descriptions of the findings, offering both description and interpretation, support transferability to other contexts and delineate limitations to that transferability. For example, there are findings relevant to the federal prison context that do not apply to other custodial contexts. Dependability is supported through extensive documentation. The first author maintained a continuous audit trail, an orderly, anonymized log of where, how and with who each interview was conducted, as well as decisions and steps taken to advance the research. The audit includes reflexive, self-critical examination of thoughts and decisions.

### 6.6.9 *Ethical Considerations*

This study was approved by the Dalhousie University Research Ethics Board #2019-4937. All participants were provided with a consent form in advance of the interview, and people who were interviewed by phone provided verbal consent.

## 6.7 Findings

### 6.7.1 *Participant Demographics*

To protect privacy, lived experience participants were not required to provide demographic information. They shared many things voluntarily, such as that they ranged in age from early 20's to into the 60's. One self-identified as Black, one as Indigenous, two as Francophone and one as 2SLGBTQIA+. Four participants had first been incarcerated at Nova Institution, and there was one participant from each of the other five facilities. One started their sentence in the 1990's, one in the 2000's, four in the 2010's and three in the 2020's.

As a case study with multiple sources of data, this study also included interviews with 14 Elizabeth Fry Societies staff. Two were from the Maritimes, two from Quebec,

two from Ontario, one from Saskatchewan, one from Alberta, and five from BC. Details from these interviews are explored in a separate publication (Paynter, Heggie, Martin-Misener, Iftene & Tomblin Murphy, under review). Findings from lived experience interviews were juxtaposed with these to develop the conceptual framework and refine themes.

### 6.7.2 *Themes*

For most respondents, participating in the MCP was out of reach, or they preferred not to and instead planned alternatives for their children's care. Even if they believed these arrangements to be in their child's best interests, they felt profound, often debilitating trauma in separation. They experienced lack of access to health services, neglect of their emotional distress was a health concern, and punitive or coercive treatment. Their self-advocacy and support from peers helped them cope. Findings are grouped into four themes and nine subthemes, see Table 6.

**Table 6**

*Themes*

| Major Theme | Subtheme | Definition |
|---|---|---|
| Reasons why—or why not—to join MCP | The lucky few | Characteristics & criteria supporting participation |
| | Prison is no place for a child | Reasons not to participate, |
| | I made arrangements | Relief at having arranged alternative custody solutions for their children |
| Mothering From Inside | Traumas of separation and incarceration | Trauma of being separated from children or other traumas experienced in the prison environment |
| | Surveillance, not support | Experiences of monitoring and policing of their actions or feelings, instead of support or care |
| | Contact with children: phone and visitation | Methods to stay connected with their children, and challenges to do so |
| Health Care | Health care in the MCP | Care experiences of the few MCP participants |
| | Care denied or pushed | Barriers to care, coercive treatment, and mistreatment |
| | Punishment instead of care | Mental health issues met with discipline e.g. solitary confinement |
| Self Advocacy and Survival | | Strategies and techniques respondents deployed autonomously and in solidarity, to get care and stay connected to kids. |

**6.7.2.1 Theme 1: Reasons Why—or Why Not—to Join MCP.** Mothers were concerned about eligibility and whether to apply to the MCP. Subthemes included "The lucky few", "Prison is no place for a child", and "I made arrangements".

**6.7.2.1.1** ***The Lucky Few.*** Only two study participants had participated in the MCP. Both had been pregnant while in a federal prison, and both disclosed they had served long sentences. Neither identified as Indigenous or a person of colour or 2SLGTBQIA+, and one was francophone. Each described encountering a handful of other women who participated in the MCP at the same time as they did. One described MCP eligibility as follows:

> It depends on your prior institutional behaviour. Yah your security level and of course you can't be in for any sexually related crime involving young children, it's automatic [disqualification]. So, they assess that and then if you have any kind of history, with some history involving neglect or abuse of a child they'll look at that, let's say you lost your child for reasons of direct neglect or abuse, they're going to be more hesitant. [P11]

While consistent with the eligibility restrictions outlined in CD-768, in practice, participation appeared to be more complicated. For instance, both MCP participants had supportive spouses living in the same town as the prison. Both felt their long sentences gave them time to get to know how to navigate the system to get their needs met. One participant had her child with her until he reached the maximum allowable age and went to live nearby with his father. He would visit on Fridays for a meal with her. She said that had her husband not lived nearby, and not sent her money to help her provide for her child while in prison, she would have struggled to provide for him, as the prison did not supply equipment or supplies for her child.

A few respondents explained that they knew they were ineligible for the MCP due to their charges/security classification, because CD-768 requires MCP participants be classified as minimum or medium security; maximum security prisoners are excluded. Several respondents said they wanted to participate and would have been eligible but did not have support in the application process. A common reason for not being supported was not having been pregnant while incarcerated. Even though CD-768 allows children under age five in the MCP, several were never offered the opportunity. As one respondent said, "I did not [participate] but I also didn't know it was available…I

probably wouldn't have [participated] only because [the child] had lots of support on the outside" [P7].

Some could not participate because their children had already been removed by child protection services prior to their federal sentence. Once COVID-19 hit, some believed the program had closed- although it had not. For these reasons, only a "lucky few" participated.

**6.7.2.1.2** ***Prison Is No Place for a Child.*** Some respondents took issue with bringing children into the prison environment which they experienced as unsafe. One mother described the conflict she felt, weighing the options and deciding what was best for her child:

> I was torn because I would have really liked to have [child's name] with me but then I thought about it, and I thought with certain people in there and stuff I'd probably rather not have my child in that environment because it's so volatile and there's certain people did certain crimes that I wouldn't want my children around. I just, you know I think it's a great program but it's also not a great program. [P9]

In 2019, Samantha Wallace, a 28-year-old mother of four, died while incarcerated at Nova Institution (Burke, 2021). Wallace's youngest child was just four months old at the time, living on the outside with her sister. For one study participant who was also incarcerated there, Wallace's experience and death were proof the prison was an inappropriate place for a child.

> [Wallace] was complaining how sick she was, why would anybody want a child in jail? You would think that would be our right to have our child with us, especially if we're minimum [security] and doing well whatever, but it kind of

> forces you not to have your child there because of all the factors. They don't have a clean space, they don't have like, they have people that are around you that shouldn't be around children for one…I don't agree with it, I really don't. So, you're kind of forced to not have your child there. [P12]

Several participants did not agree with most MCP pairs staying in the Minimum-Security Unit (MSU), which in most of the facilities looks like a low-rise apartment building and is located outside of the main fence. People in MSU tended to have served long sentences, for serious charges, and moved down through security classifications over time, eventually reaching minimum. People with short sentences for less serious offenses tended to stay in medium and not have the opportunity to move down. The MSU is small, with only a handful of residents. Participants expressed that being outside the gate, with few people for company, would be less supportive than being in the medium security space, known as "general population". One participant described "more of a family feel in general population" [P12].

Some mothers chose not to participate in the MCP because they did not want their children and their mothering to be under the level of surveillance that came with participation, not only from prison staff, but also from the provincial child protection agency. Prior to incarceration, many federal prisoners would already have experienced child protection involvement- including in their own youth, as wards of the state. Others had managed to avoid child protection up to that point and wanted to protect their families from agency involvement.

> When I had a kid, my whole life was all about her, like with her 24/7 so like that's all I know with her. And yah like Child Services has never ever popped up and

> you know I think just with that that would be an extra, that would just be an extra stress on my shoulders. Now it's like once they do get involved it's kind of hard not to have them involved and it's not something that I think that she needs to experience [P22].

Mothers worried even if they qualified for MCP, participation was tenuous. If something went wrong in the prison, your child could be taken from you. As one respondent recounted, "There was one woman…she was actually segregated for something that she didn't even start and she was actually, her child was taken out of the program." [P9]

**6.7.2.1.3** ***I Made Arrangements.*** People who did not participate in the MCP spoke about how they were fortunate and relieved to have had the power to arrange for the care of their children in community. Knowing children were safe and cared for and having had some autonomy in organizing how they would be cared for, brought participants peace, and they felt it was better for their children.

> And if you know your kids are okay then it makes it easier for you, right? … Cause a lot of people don't get that opportunity, number one, if they get arrested, they're kept in remand, so you don't, you don't even get the opportunity to try to make any kind of arrangements for your kids, the power is completely taken away from you. When you're their primary caregiver and then that power is just taken from you, and no one will explain it to them like you can as their mom, like it's not going to happen. [P7]

One mother permanently placed her child in the care of a cousin who had tried for years to have a child. To her, this was "giving back", in keeping with her Indigenous culture.

> I had every intention of bringing him into the Mother Child Program once I got to [prison] so I had my minimum security [classification], everything was good. But then I started like being really in-touch with my culture [Indigenous] and learning my traditions, doing a lot of sweats, a lot of, I moved to the healing house, did a lot of one-on-ones with [Elder name] and I came to the decision not to bring him in with me because I felt in our culture it's a lot to do with energies, a lot to do with giving back…My cousin that had taken him had just finished spending almost $60,000 on trying to have her own child…I came to the conclusion with a lot of sweats, a lot of stuff with [Elder name] that I wanted to leave him there. [p12]

**6.7.2.2 Theme 2: Mothering From Inside.** The second major theme addressed mothering in prison. Subthemes included "Traumas of separation and incarceration", "Surveillance, not support," and "Contact with Children."

**6.7.2.2.1** ***Traumas of Separation and Incarceration.*** For mothers who did not participate in the MCP, separation from their babies, isolation, and loneliness dominated their feelings. One mother described this time in her life:

> It's a very emotional and you're lonely and especially for a young mom that all she knows is her kid 24/7 and being home with her family to you know just making a mistake over one night of having fun with friends to you know not being a mom 24/7 and not being able to wake up to your kid every day. It was definitely a hard adjustment. I had no contact with anybody, like any friends at all, so for a young woman my first federal offence ever, being federally sentenced

> it was definitely a terror, was definitely lonely, it was scary, it was depressing, traumatic, it was probably the scariest time of my life. [P22]

The existence of the MCP could make the situation worse for those who didn't qualify. Seeing other mothers would prompt feelings of jealousy and pain. For some, the trauma of separation and incarceration was layered on top of difficult early lives, including childhood abuse, domestic violence, and even the death of other children. Separation could be made worse by harsh words and treatment from prison staff. As one participant described, "They kept telling me that my daughter would never be around me and that I would not have help on the outside, that I lost my daughter for good and that I will never see her again and everything." [P20]

Beyond separation, participants recounted experiences of sexual violence in police custody, provincial jail, and federal prison. One described being arrested and brought to the police station while she was breastfeeding, and having her bra forced off by the officers. Another recounted how she was sexually assaulted by a CSC officer. Several described being strip-searched, a process they said was "so dehumanizing, you feel like just an animal, right?" [P12]

**6.7.2.2.2 *Surveillance, Not Support.*** For participants in the MCP, eligibility required acceptance of monitoring by provincial Child Protection agencies. They felt their motherhood under surveillance by peers and staff.

One MCP participant described how a child protection worker questioned her maternal instincts for wanting the baby to visit with its father, as it would mean "parting with the infant", albeit briefly. That participant had to involve a lawyer and fight for four months to arrange the visit. One MCP participant described how babies' weights were

monitored weekly for the first year, and failure to gain weight consistently could result in child removal:

> At [prison] when the baby loses a bit of weight, they take him away from his mother. Even if it's just a few ounces they [Child Protection] take him away from his mother… They put them with families. And I saw a lot of mothers whose children were taken away because their weight went down a bit… maybe three to date that I've known of…They just took the child away and sent them away to a foster family [p18]

Peers would report to staff about baby's noises, or staff themselves would complain:

> Well, when the officers went by for the count they'd say, "Are you going to keep your kid quiet?" Yeah well, listen, if my child is crying it's for a reason, he's hungry, there's something. I'll feed him soon, after the count." "But are you going to shut him up?" Because he's crying. I'm not about to shut him up. I'm not going to put my hand over his mouth to shut him up. [p18]

One MCP participant had a peer try to "sabotage" her, by writing complaints to the parole board and child protection services. It took her so much strength not to lash out in anger. "Because like if I say anything, when you're the mom in the Mother/Child Program, even if you're not the one in the wrong, if you react, you'll be held responsible regardless. [P11]

As part of the prison's surveillance of MCP participants, CD-768 allows for the searching of infants, even the removal of their diapers. Infants could also be subjected to drug screening. Because of the risk of punishment or being reported to provincial child protection services, mothers would hide their needs for support from prison staff.

**6.7.2.2.3** ***Contact With Children: Phone and Visitation.*** Although contact with children, especially by phone, was a lifeline for the mothers, it was not unproblematic. Loading money onto a phone card was only permitted once monthly.

> I did two phone calls within my first two weeks there, and I had to wait a whole month and a half after that to actually be able to get money on my phone. So, I actually had no contact with my partner, with my mom, my daughter. [P22]

The calls take an emotional toll, and some mothers chose not to call anymore to avoid upsetting their children or themselves. Some children were simply too young for phone calls to be appropriate. For everyone, the calls were expensive. Working full-time in the prison, a person would make $20 biweekly, barely enough for "decent phone time to call your family." [P7]

Calls were subject to surveillance by prison staff. One respondent described how the family liaison officer would dial the number and sit next to her while she was on a call. She found this triggering, and felt it put mothers at risk, because if staff overheard something they disapproved of, they could – and sometimes did- report it to child protection services.

Most of the participants faced large physical distances between the prisons and where their children were living and were unlikely to receive visits. For those who did, it was heart-wrenching to experience them crying when they had to leave. Visitation required a lengthy approval process in which respondents had little say and requiring willingness of other family members to help. For example, one respondent's children had two different dads- she felt very lucky they both eventually gave permission for visitation. COVID-19 threw a wrench into visitation for people who lived close but did

make video visits more accessible. However, video visits required children go to a CSC-approved centre, and if that was not possible- or parole officers and institutions were not supportive- it would not happen. Despite the impact denying them would have on children, visits were treated like a privilege. One respondent described how she complained about not getting to have a birthday video visit due to staffing insufficiency, and as a result, her video visits were suspended for a month.

Another respondent described how visitation was discouraged for children in foster care, with the notion that a 'clean break' would better facilitate placement in permanent care.

> [CPS] don't want to give contact because if you get incarcerated and [CPS] do permanent care, [they]'re basically looking for how do you get a clean break. Well, you're not getting a clean break. There's no mother who's ever having a clean break from the kids and her oldest kid is ten years old, you're not clean breaking him from his mother, or any of them for that matter. There's no clean break to take a mother from her children. [P7]

**6.7.2.3 Theme 3: Health Care.** The third theme was Health care, with subthemes of "Health care in the MCP"; "Care denied or pushed," and "Punishment instead of care." These themes speak to inadequacy of care, care not meeting professionally acceptable standards, inequity, and coercion or punishment.

**6.7.2.3.1** ***Health Care in the MCP.*** A recent MCP participant described health services both prenatally and postpartum as positive and adequate: she had regular external appointments with an obstetrician, visits from Public Health nurses to the institution, and a doula. The doula would "show me how to do certain things until I felt

more secure of taking care of him alone and doing little things. Like showing me how to give him a bath and different exercises and colic relief and diaper changing and swaddling." [P11]. However, she reported that other women in the prison, pregnant at the same time but not accepted into the MCP, did not get the same level of support and that these women were angry about the different treatment they received. This participant felt positively about "never having to schedule any of the appointments", that "they had all that handled 'cause it was for security reasons." [P11]. She felt the prison staff anticipated and addressed her needs and were concerned about her wellbeing. She did not have any concerns about health care for her child, and said if she felt something was urgent, they would let her take him out for care that day.

> And I was, it was a high-risk pregnancy, so they took care of that by really checking with me, seeing a psychologist, behavioural counsellors, the nurses kept checking on me all the time, they were really good in that aspect, monitoring my wellbeing cause they know anxiety is really hard in the beginning of three months of pregnancy.... Oh yah for sure. I had to do a lot of check-ups, with quizzing and questioning. After they did a lot of, they were watching me very close after I had the baby actually. [P11]

Other respondents also recounted how they felt pregnant MCP participants received noticeably better care, resulting in feelings of jealousy from other people. The extra attention had clinical benefits. The recent MCP participant described how her doula was instrumental in shifting this mother's breastfeeding intentions, and she was allowed to breastfeed because she was 'drug free' and was able to because of support from "a

relentless [public] health nurse." [P11]. Breastfeeding mothers received more money for groceries. This respondent ended up breastfeeding the child until he was three years old.

> I didn't want to breastfeed, and the doula changed my mind. I was totally supported in doing it. Other women weren't cause someone I know that was at [PRISON] and got her baby after the fact, they took it away for a couple of months, she was in max, she wasn't supported to breastfeed because of whatever reason, they had concerns and wouldn't tell her. I think it's because [of drugs] they didn't want to let her breastfeed. But for me when I was pregnant, I was in drug-free health, I had all clean drug tests so that might have played a factor, but they never gave me a problem with breastfeeding ever. [P11]

However, the other MCP participant, in the program years before at another institution, said she received "no information" about pregnancy from the health care staff, and had to purchase her own prenatal health book. She would use maxi pads when the prison denied her access to diapers. Several months into breastfeeding, she developed mastitis, and said the health staff did not know how to help her, so she had to stop feeding her child.

Another study participant described how her friend in the MCP experienced health care. Because of security concerns, details about appointments were withheld from the women- including the date of a scheduled C-section. While giving birth, she was only accompanied by a security agent. "And I mean she was scared, it was her first child, she is 21 years old, so it was really horrible for her." [P17] She was handcuffed, during labour, and later, while breastfeeding.

**6.7.2.3.2** ***Care Denied or Pushed.*** Most participants reported mental health and stability as their main health concerns during incarceration, although several identified

significant weight gain in prison, of 80lbs or more, and one reported prolapsed uterus. They reported not receiving support for these concerns. With few exceptions, study participants described bureaucratic and operational barriers trying to access CSC health services. For example, having to wait in long lines for medication- even outdoors- while exhausted from pregnancy. Many reported issues with staff not showing up to appointments, and not providing notification:

> I make an appointment, I show up, the health care or counselling is not there. They never called me to you know follow-up to be like oh sorry I can't make it in today, it's just like you just kind of figure it out for yourself, o.k., they're not in I'll wait for a slip or a piece of paper in my mailbox for another date. It's just really slack. [P22]

To access care outside of the institution, mothers had to rely on staff to escort them, and any number of issues could interfere, such as storm days, staff illness, or short staffing. While accompanied by correctional officers, respondents faced violations of their privacy. One described the humiliation of having correctional officers present for an internal (vaginal) exam. One described the humiliating experience of being handcuffed and paraded through the hospital by two correctional officers, even though she had already received a favourable decision from the parole board and was waiting for her release.

The wait-times for speciality services, even basic mental health counselling, could be years. Many felt that the lack of access to health services was accompanied by an over-reliance on pharmaceutical treatment. While one mother recounted receiving both counselling and medication, for others only pharmacological treatment was accessible,

and they waited years for psychological counselling, if they got it at all. Some felt they were pushed into pharmacological treatment**.** Declining medications was interpreted as noncompliance, jeopardizing parole. If they refused methadone treatment, they were labelled as disobedient. When they did access care, respondents found some health care staff to be disapproving, calling them "drug seeking" [P9]. Several felt they were not believed by the nurses when they sought care. They also felt health care staff did not respect confidentiality.

> [The CSC nurses] tell your business in front of other people, they have no confidentiality… They'll tell you more or less who has HIV. Like "stay away from them," if you know what I'm trying to say, they won't say it straight out but they'll say it to you in a way, that person you know what I mean, "you've got to watch, don't do anything with them if you know what I mean." Like who says that? Even the guards, why are the guards knowing who has diseases, why do they know?" [P12].

**6.7.2.3.3** ***Punishment Instead of Care.*** The trauma and emotional distress they experienced was not interpreted as a health issue needing care but as a behaviour warranting control and punishment. The physiological or mental health issues common in the postpartum period were not on CSC's radar. As a result, the mothers did not receive assessment or diagnosis, and did not understand the emotional instability they felt. Many recounted how their experiences of mental distress were met with punitive responses.

> When the women do encounter the depression and things like that a lot of them tend to self-harm even if they weren't self-harmers in the past. They become self-harmers inside while they're incarcerated because they don't have any other

> avenue. And what's their solution to that? Put them upstairs and lock them up… they'll put them in a room on camera status, so they strip them of their clothes, they give them a little gown…and they put them in there, no mattress, no nothing…This is up in the segregation unit. [P9]

One mother described how it took years for her to stabilize on medication, and during that time she would express suicidality. She would be sent to "the hold" to be alone, without clothes. For another mother, she never wanted to express how she felt because she feared how it would be held against her. Another participant, a francophone mother first incarcerated in Ontario, described serious challenges with understanding health care staff and the materials they provided, and how the frustration she experienced caused her to lash out, and face punishment.

**6.7.2.4 Theme 4: Self-Advocacy and Survival.** All the respondents expressed pride in what they endured, organized for themselves, spoke out against, and survived through self advocacy and peer support. Participants described their strategic approaches to look out for themselves and their peers, the need for persistence to make gains, and the difference camaraderie from other women made in their lives, even if solidarity and sharing was discouraged by the institution. Long periods of institutionalization led the two MCP participants to feel they knew the system well, had developed rapport with staff, and could advocate for what they needed in non-adversarial ways. But sometimes it took knowing their rights and filing grievances, complaints, human rights cases and civil lawsuits.

Some described how the official pathways for complaint were ineffective, "I've put countless grievances in. I'm the grievance queen. Yah. I could build a house out of all

the grievances I've put in…They deny them. They say oh no it's not a founded grievance." [P9]

In some ways, being a mother was motivating for study participants to speak up when they were mistreated, and although in general they might not be the "type" to complain, in the context of separation from their children, they would. But they felt they had to be careful, to avoid punishment. One described how, "You have to take something from yourself every day to swallow your pride over and over again with people putting you down and you can't say anything because then you're being disrespectful, you're being defiant." [P12] Another said she felt the best approach was to keep her head down, avoid notice, avoid confrontation, and get through that way. She said, "I kept to myself a lot, I minded my ps and qs, I did everything I was supposed to do, I didn't start any trouble, so everything was, everything was pretty much smooth sailing for me, and I got the respect that I gave." [P22]

When asked about what would make things better, the participants had a few recommendations to improve experiences. Two recommended making the MCP more accessible- and available until children were older. The participant who had doula support recommended it for everyone. Several advocated for changes to visiting and phone policies to protect children from cancellations and to remove financial barriers. Many recommended expanding mental health supports, such as peer counsellors to help navigate the experience of separation, and improved access to professional and independently contracted counsellors.

Respondents were not optimistic it was possible to improve prison conditions to make them suitable for infants or to remedy the trauma parent-child separation. As one

MCP participant put it, “I counsel women who are pregnant to stay out of prison. Because, no, it’s not a liveable situation when you’re pregnant, being in a correctional facility.” [P18]. Instead, many expressed the belief that the answer lay outside of prison, in care, not corrections.

> Some people definitely can change without being sent to prison and having to deal with separation from their kids because can either end up, you know they’re going to turn out worse or it’s going to change them for the better. So you know there’s definitely always ways around it but yah if I could change the fact of women being incarcerated, like moms being incarcerated I would definitely choose for them not to go to jail. [P22]

**6.8 Discussion**

To our knowledge, while the provincial Mother Baby program at Alouette Correctional Centre was subject to extensive review during the *Inglis v. BC* trial in 2013, this is the first study to address experiences of pregnant people and parents with respect to the federal Mother Child Program. Findings may help to inform health professionals caring for this population about the prison context, and to identify priority areas for policy and future research. Increasing numbers of people in prisons designated for women, high parity, and high rates of unplanned pregnancy point to the importance of addressing perinatal health and planning for the care of young children when parents face federal sentences. The findings point to the urgent need to address the inadequacy of the MCP as a solution to parental incarceration; the trauma of separation and incarceration for federally incarcerated parents; and the denial of care in federal prison at professionally acceptable standards.

From a theoretical framework of reproductive justice and abolition, this study reinforces the conceptualization of incarceration as a driver of reproductive oppression (Hayes, Sufrin & Perritt, 2020; Shlafer, Hardemen & Carlson, 2019) and parental incarceration as deleterious to child and adult health (Brinkley-Rubinstein, 2013; Wildeman, Goldman & Lee, 2019). In alignment with previous scholarly work, this study identifies problems with the MCP: challenging and often opaque eligibility criteria (Goshin, 2015); surveillance of participants (Haney, 2013); and uncertain outcomes. Findings support the conceptual model, reflecting multiple impediments to MCP participation juxtaposed with parental agency and peer solidarity in resisting institutional restrictions placed on access to care and to their children.

As previous authors have found (Brennan, 2014; Miller, 2017), a small minority of federally incarcerated parents participate in the MCP. Despite the stress of surveillance, their experience was largely positive. This study found respondents were not informed of or supported to apply if they were not pregnant while in the prison. Many MCP studies focus on immediate perinatal outcomes such as birth (Fritz & Whiteacre, 2016). Pregnancy is the visible marker of parenthood; existing children of incarcerated people are invisible to the institution (Knudsen, 2019). This study found respondents chose not to participate because they perceived prison as violent and unhygienic. They reported sexual assault and strip searching by correctional officers, privacy and confidentiality violations from health professionals, and punitive surveillance of parenting by staff. Respondents engaged in a careful calculus to best protect their children during their sentences. Despite the best intentions of the MCP, it is an inadequate recourse to the damaging effects of maternal incarceration. The program is

inequitably available, qualifying is uncertain; continuous participation is precarious; and prisons are perceived as unsafe for babies.

For non-MCP participants, separation from children resulted in feelings of loss and even despair (Abbott, Scott & Thomas, 2021). Studies have predictably found separation from children to be one of the most difficult aspects of incarceration (Powell et al., 2016). Emotional responses to separation were either interpreted as behavioural problems meriting punishment, or their severity and impact was minimized. For non-MCP participants, visitation was difficult and phone contact crucial. COVID-19 presented an obvious issue however, distance from their children, custody arrangements, and the discomfort with exposing children to the prison space were all barriers to visitation (Poelhmann-Tynan & Pritzl, 2019). These findings align with results from provincial studies (Paynter, Heggie, Matheson, McVicar, Rillie, Beals, & Bray, 2022) and international studies (Booth 2020; Minson 2019). The creation of the regional facilities intended in part to address distance as a challenge to visitation. However, the six facilities remain far too dispersed geographically, and visitation policies too challenging, to make a meaningful difference.

The findings in this study indicate that health care for incarcerated pregnant people and mothers of young children is inadequate. CSC health professionals, employed by the same entity as correctional officers and subject to dual loyalty to employer and patients (Pont, Stover & Wolff, 2012), fail to adhere to professional standards of practice such as duties to protect confidentiality, dignity, and to exercise compassion (Canadian Nurses Association, 2017). CSC is failing to meet requirements of the CCRA (Canada,

1992) and the Mandela Rules (UN, 2015). There is an urgent need for research about reproductive health care services in federal prisons.

As other studies in Canada have found, the respondents demonstrated resourcefulness and persistence in efforts to assert their rights (Balfour, 2018). Sometimes they complained, sometimes they stayed silent- in both cases, they did so strategically. They carefully considered how to best protect their children and themselves and leveraged support from peers and family.

### 6.9 Limitations

There are several limitations to this study. All interviews were conducted in English or French, potentially excluding growing populations of incarcerated people who are newcomers to Canada. Due to the national scope of the project, and COVID-19 from March 2020 on, many interviews were conducted by phone and nuance, body language and depth may have been lost. Although Elizabeth Fry Societies greatly supported recruitment, the sample size is small, particularly for MCP participants. With only two MCP participants, we limited examination of diverse experiences, although these two participants were in the program in different facilities and at different time periods. Although Black and Indigenous people are disproportionately incarcerated, few study participants disclosed Black or Indigenous identity. Racism and colonialism likely affect experiences more broadly than our findings delineate.

### 6.10 Strengths

Despite limited sample size, study participants exhibit many commonalities and differences, and studying across differences enhances robustness of findings (Yin, 2003). The themes incorporate contrast and provide a start towards theoretical replication and

external validity. Interviews with Elizabeth Fry Societies staff supported data triangulation and helped the research team gain understanding of context. This study prioritizes voices of people with lived experience.

### 6.11 Conclusion and Recommendations

This study finds barriers to MCP participation include lack of information about the program, exclusionary eligibility criteria, and fear of exposing children to the prison environment. Further, respondents felt pride and comfort in the alternative arrangements they made for care of their children outside of the prison. The MCP is not a solution to escalating numbers of incarcerated parents. Incarceration exposes parents to the trauma of separation and institutional dangers including sexual violence and other threats to emotional and physical safety. Parental efforts to stay connected to their children are largely limited to telephone contact, which is heavily restricted by operational procedures and private costs. Health care may be perceived as adequate in pregnancy, but for parents outside of the MCP it involves routine violations of privacy, confidentiality, excessive waits, inadequate access to mental health services, and an over-reliance on pharmaceutical products. The emotional toll of separation is not recognized as a health care need, and outside of pregnancy or MCP participation, parents are not recognized as such. Coercion, control, and punishment interact with health care in the carceral context. Despite the strictly regulated experience of incarceration, respondents used their agency, creativity, strategic thinking, and solidarity to navigate the prison experience and support themselves and each other. Stemming from our findings, we make several recommendations:

1. *The Mother Child Program:* A formal, external, independent evaluation of the federal Mother Child Program is necessary. To facilitate this evaluation, improved data collection is necessary, beginning with data collection of the number of children affected.
2. *Mothering Inside:* As stipulated in the Bangkok Rules, suspension of custody should be considered to allow mothers to care for their children in community and avoid prison.
3. *Health Care:* Health professional educators must integrate prison health into training to prepare clinicians for the challenges of caring for incarcerated people. Health professionals must resist threats to ethical care provision in the prison context. Health professionals in community must be aware of prison procedures including strip searches, restraints, and discipline. The negative effect of parental incarceration on their health should be considered in sentencing decisions to protect parents and their children.
4. *Agency:* The impact of incarceration on both adult and child health must guide the development of meaningful alternatives to prison that recognize parental strengths and provide useful supports. As was adeptly said, "People just need help, and they need that support to get the help so you know prison definitely isn't always the answer" [P22].

### 6.12 Triangulating Lived Experience with Frontline Perspectives

The interviews with frontline service providers not only validated the findings from first voice narratives, but they provided big picture thinking about longer term patterns in MCP participation and the influences of operational differences in the prison

system across time and place. In consultation with the research team, I decided to analyse the Elizabeth Fry Society staff interview data separately.

## Chapter 7: Frontline Perspectives on the Canadian Prison Mother Child Program

This paper was submitted to *Social Science in Medicine (SSM) Qualitative Health Research* in April 2022. Co-author Clare Heggie assisted with data analysis. Co-authors Dr. Ruth Martin-Misener, Dr. Adelina Iftene and Dr. Gail Tomblin Murphy supported manuscript preparation and review.

### 7.1 Introduction

For mothers in prison, a dominant concern is maintenance of their relationship with their children (Breuer et al., 2021). Mother child programs (MCP) are often touted as solutions to the socio-psychological harms associated with increasing rates of maternal incarceration (Riley, 2019). But incarcerating children with their mothers is not a new phenomenon in North America (Yager, 2015). The well-known Bedford Hills Correctional Facility prison nursery in New York began in 1901 and continues to operate. In Canada, there is evidence mothers kept their babies with them in prisons since the 1850's (McCoy, 2016).

A national report co-published in 1990 between women's organizations including the Canadian Association for Elizabeth Fry Societies (CAEFS) and Correctional Services Canada (CSC), *Creating Choices* (Taskforce on the Future of Federal Sentenced Women, 1990), called for the creation of a federal MCP across a system of regional facilities. Established by 2000, the MCP has been subject to minimal evaluation (Paynter, Jefferies, McKibbon, et al., 2020)

Participation in the MCP requires classification as minimum or medium security; assessment and approval by the provincial child protection agency; not having a mental

health diagnosis indicative of being “incapable” of caring for a child; not being convicted of an offense against a child or endangering a child; and not subject to a court order preventing them from having custody (Correctional Services Canada, 2020). For full-time MCP participation, the child must be under five years of age.

Our earlier papers examined participation levels in the MCP (Paynter, Martin-Misener, Iftene, & Tomblin Murphy, 2022) and experiences of federally incarcerated mothers (Paynter, Martin-Misener, Iftene & Tomblin Murphy, under review). We found low rates of participation, particularly among Indigenous women. Most mothers felt participation was impossible given strict eligibility requirements, or problematic, involving the acceptance of layers of surveillance.

In this paper, we explore the experiences of staff of Elizabeth Fry Societies (community organizations dedicated to the support of incarcerated women) in relation to the MCP. With decades of experience across the country, Elizabeth Fry staff are infrequently given a platform to share their knowledge.

**7.2 Literature Review**

The association between MCPs and reduced recidivism is often cited as justification for their operation (Goshin, Byrne, & Henniger, 2014). There are also human rights arguments to support MCPs. Children have the right, enshrined in the United Nations Convention on the Rights of the Child (UNCRC) (UN, 1989) and federal laws in the US and Canada, to form secure attachment with the parent (Beit, 2020). Recent review of the evidence found methodological limitations muddied conclusiveness of these studies (Dodson, Cabage, & McMillan, 2019).

Health outcomes associated with MCPs, including maternal health, are a subordinate concern to infant attachment (Byrne, Goshin, & Joestl, 2010). In a review of MCP health outcomes, Paynter, Jefferies, McKibbon et al. (2020) found studies addressed development, infection, maternal mental health, and pregnancy. While attachment was supported, the impact on other outcomes was not uniformly positive. No study examined the MCP in Canada.

Some studies found mothers describe MCPs as empowering (Tuxhorn, 2021). Others critiqued the overly restrictive nature of the programs (Luther & Gregson, 2011), and exposed how they causes high levels of guilt and anxiety (Nuytiens & Jehaes, 2022).

Brennan (2014) and Miller (2017) explored reasons for low participation in the MCP in Canada, finding explanations include: an increasingly punitive correctional culture; race and gender bias in security assessment; rising numbers and dwindling space; and mandatory child protection surveillance. Paynter, Martin-Misener, Iftene & Tomblin Murphy (2022) found 133 mothers participated in the program from 2001-2018, with Indigenous women less likely to participate. A 2021 report found most mothers unaware of the application process, and those who did not qualify experienced extreme distress, characterizing the process as unjust and arbitrary (Paynter 2021). The Senate of Canada (2020) recommended CSC "work with the provinces and territories" to eliminate barriers of access to the MCP.

Critiques of MCPs highlight how they put mothering under discriminatory state surveillance (Haney, 2013). Goshin (2015) cautions against more use of MCPs without development of evidence-based standards, alignment with the UNCRC, and meaningful consideration of alternatives.

The United Nations Minimum Standards for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules), adopted unanimously by the UN General Assembly in 2010, set out international expectations for women's prisons. Several rules pertain to mothers and children. Rule 2 requires childcare be arranged prior to maternal incarceration, and suspension of custody be considered.

The Corrections and Conditional Release Act (CCRA) (Canada, 1992) governs federal corrections. It does not mention mothers. It stipulates policies must be gender-responsive, and CSC must consult women's organizations regarding the development and delivery of women's programs. Acknowledging disproportionate incarceration of Indigenous peoples, Section 81 of the CCRA states the CSC "Commissioner may transfer an offender to the care and custody of an appropriate Indigenous authority, with the consent of the offender and of the appropriate Indigenous authority." This provision could allow for Indigenous mothers to remain in home communities with their families, but is used infrequently (Combs, 2018).

## 7.3 Methods

### 7.3.1 *Theoretical Framework*

This study used a theoretical framework of abolition feminism (Davis et al., 2022), recognizing connections between structural inequity, discrimination against women and the violence of imprisonment. This approach, grounded in Black feminist thought, critiques incarceration as a response to social harm, and redirects focus onto underlying social issues driving criminalization: racism, colonialism, poverty, misogyny and systemic oppression. For health professionals, codes of ethics (Canadian Nurses Association, 2017), juxtaposed with health harms of prison, including increased risk of

sexual assault, injury, illness, and death, demand critical reflection about the friction between health services delivery and carceral regimes (Paynter, Jefferies, Carrier & Goshin, 2022).

### 7.3.2 *Design*

The study design is qualitative case study, appropriate for investigations of social experiences (Yin, 2003). The case explores the experience of pregnancy and parenting very young children in federal prisons designated for women in Canada. We focus on the perspectives of community-based advocates working for Elizabeth Fry Societies who have supported pregnant people in prisons and on release by providing legal services, housing, transition support, and employment. It builds on our findings from interviews with people with lived experience (Paynter, Martin-Misener, Iftene & Tomblin Murphy, under review), and on quantitative analysis of MCP participation (Paynter, Martin-Misener, Iftene & Tomblin Murphy, 2022). Case studies use propositions and illustrative conceptual frameworks to shape the design and questions of the research. In this paper, we build on those we first proposed in Paynter, Martin-Misener, Iftene & Tomblin Murphy (under review). That conceptual framework situates the MCP as a small, precarious program subject to systemic racism and colonialism.

This article analyses data from interviews with 12 staff conducted in English during January-March 2020. Using criterion-based sampling (Sandelowski, 2000), participants were selected for their roles supporting parents who had been or were federally incarcerated. Sampling intentionally aimed to include junior and senior staff from offices across the country. Recruitment and data collection continued iteratively

until data saturation (Guest, Bunce, & Johnson, 2006). All staff identified as cisgender women and included white, Black, and Indigenous people of varied ages.

### 7.3.3 *Data Sources and Collection*

Interviews with staff were semi-structured, conducted in person or by telephone by the first author, and audio recorded. A professional transcriptionist transcribed the recordings verbatim. Questions addressed staff experiences supporting people who were pregnant or had young children while federally incarcerated; their knowledge about the health of incarcerated people in the perinatal period; and thoughts about pregnancy and early parenting in the context of criminalization. As case study uses multiple data sources, this study also considered relevant publicly available documents.

### 7.3.4 *Data Analysis and Trustworthiness*

We used thematic analysis (Braun & Clarke, 2013) to analyze the transcripts. The first author repeatedly read the transcripts, developing a data archive, and generating early code ideas. The first author reflected on how relationships with participants affected the data and analysis, writing reflective memos and discussing analytic progress with the research team.

Data were managed using Microsoft Word and Excel applications. The first order of coding reflected core ideas in the interview questions. By juxtaposing staff interview data with the other data sources, the study propositions and conceptual framework, the first author formulated a coding matrix. The second author (XX) coded 25% of the staff interview transcripts using those codes. The team debriefed frequently to refine the matrix and develop themes. Detailed descriptions of the specific context our study allows

others to determine how our findings may translate in other contexts (Lincoln & Guba, 1985).

### 7.3.5 *Ethical Considerations*

The Dalhousie University Research Ethics Board approved this study in 2019 (#2019-4937).

## 7.4 Findings

### 7.4.1 *Demographics*

Although participants were not required to complete a demographic questionnaire, many shared information through their interviews. The twelve staff were based in BC, Alberta, Saskatchewan, Ontario, Quebec, New Brunswick and Nova Scotia. They included white, Black, and Indigenous cisgender women. Several identified as members of 2SLTBQIA+ communities. One identified as Francophone but conducted the interview in English. They had worked for Elizabeth Fry Societies for one to over thirty years.

### 7.4.2 *Themes*

We have grouped the qualitative findings into four themes and six sub-themes.

**7.4.2.1 Theme 1: Trauma Bond.** Describing successful MCP applications as rare, staff recounted most clients are separated from their young children while federally sentenced, developing not a maternal/parental-child bond, but what a participant named a "trauma bond":

> This is not going to help mom to not recidivate, is it not going to help mom to not turn back to substance use. We are actually retraumatizing people. And repeating these trauma bonds if you will. For a lot of women, they've had separation from

their own caregivers, their own significant others, their Indigenous communities. And we are replicating that in their lives, in new generations. [S04].

While the MCP is 24/7 co-residence with the child, outside it, contact between incarcerated mothers and their families, even by phone, is minimal because of bureaucratic barriers. One staff explained it can take 90 days to initiate phone cards. While her advocacy efforts make a difference, she explained "there are 175 women in [Prison Name] right now. I can't arrange that for everyone." [S16].

With only six prisons designated for women in Canada, travel costs, logistical and literacy barriers prevent in-person visits. Video visits require the same arduous paperwork as in-person. For a grandmother caring for multiple grandchildren while a parent is incarcerated, this is overburdensome. Furthermore, "A major problem is literacy in small towns where a lot of these families are from, way up north in northern bands" [S01].

Sending children to live with grandparents puts incredible stress on relationships, "A lot of times the families may not even be as supportive but feel like they have no choice but to take this child right? And a lot of it creates bitterness and more guilt for the mother." [S14] Family members may not be able to facilitate visitation and contact, further eroding intergenerational relationships. Mothers struggle emotionally. Eventually, as one staff explained, "They draw their line in the sand, either their child can't get to see them or it's so difficult… so they tend to sort of stop this parenting relationship and just die of guilt as a result of that" [S14]. Emotional withdrawal is misinterpreted as "bad" parenting, although it stems from the trauma of being prevented from parenting, isolation, and lack of support. Staff explained this happened systematically to Indigenous clients,

repeating the family dissolution central to the Residential School regime. Staff despaired, “It doesn’t matter what type of mom that mom was, they [children] want their mom and wouldn’t it make perfect sense to work with that mom instead of taking those children somewhere else?” [S14].

**7.4.2.2 Theme 2: Shadow Side of the MCP.** Participants’ dominant reaction to the MCP program was concern about negative impacts. Subthemes include “Hidden Requirements”, “Strategic Advocacy”, and “Adverse Effects”.

**7.4.2.2.1** ***Hidden Requirements.*** CSC stipulates MCP participants must be classified as medium or minimum security and have no history of offenses against a child. They must identify an “alternate caregiver” in the community in which the prison is located “who agrees to make decisions related to the child and/or care for the child in the event of emergency, suspension of the program and/or termination of the program.” (CSC, 2020,1). With only six prisons for women in the country, mothers are unlikely to have a strong support person nearby. That likelihood is lower for Indigenous people from remote reserves or the North.

MCP participants must select a babysitter within the institution to watch the child while they attend mandatory programs. The babysitter must meet the same eligibility requirements and complete training including First Aid/CPR. Fulfilling these criteria is not easy. One staff described the dilemma a client in the MCP faced, where she wanted to participate in a prison educational program and but did not have adequate childcare in the prison, so she sent her baby to live with its grandmother. The prison program was not offered for six months, and she missed out on that time with her infant. Yet if clients fail

to complete mandatory or recommended programs, they may not fulfill their CSC correctional plan, and lose the opportunity for parole.

Staff described how clients carefully consider how to maximize contact with children overall: quick completion of programs, or approval to participate in the MCP, but a prolonged period in custody. Having other children at home affects decision-making. Several institutions only had MCP spaces in the Minimum Security Unit (MSU). To move down from medium to minimum requires completion of programming. Instead of allowing MCP participation in medium security, or allowing participants to complete programming from the MSU, as this staff recounts, "Client [name] was also told that her child was going to be taken away from her and put into temporary foster care after she was born so she…could complete her programs and then qualify to go to the minimum security unit where the mother child program is at [Prison]" [S08].

Although the requirements for the MCP are laid out in CD-768, a publicly available document, participants described layers of subjectivity to approval between institutions, with individual wardens making the final call. Even with support people inside and outside, and with a positive assessment from provincial child protection services, the warden could, in the end, deny MCP participation, with no process for appeal. Staff found there was less flexibility and institutional support for Indigenous clients:

> We'll talk to the management team and [they're] like, "Well, she [Indigenous mom] hasn't completed program yet." And I'm like, "Well, you didn't make these other three women complete program?" Just arbitrary extra levels, layers for them to overcome that's just them treating the Indigenous moms differently." [S16]

Staff pointed out that, traumatized by separation from their newborn, parents were unlikely to successfully complete a required program:

> She doesn't qualify for Mother Child [program] so they have to take her child. Like there isn't even any kind of analysis about how that might impact her finishing her programs. Like the trauma of having your child taken whether or not you believe you'll get your child back or not, like it's not even addressed. [S13]

One staff mentioned Renee Acoby, an Ojibway woman, and the first woman to be labeled a dangerous offender in Canada. Her case was widely reported by the press (The Chronicle Herald, 2018), but articles often fail to explain how, early in her first federal sentence, Acoby's daughter was removed from her while in the MCP at Okimaw Ohci. The experience drove Renee "off the rails" [S10]. Staff felt the MCP was a vector of coercion, to "break" the mothers.

Staff felt the MCP is treated as a privilege the prison could withdraw over any infraction. Other mothers, out of resentment and jealousy, might complain about a participant's parenting. Continuous eligibility was tied up in the behaviour of others. If a participant's supports, such as the babysitter, were suddenly unavailable- for example, if the babysitter was involved in an altercation and had her security classification escalated- the mother would be removed from the MCP. There could be sudden clinical problems. For instance, a person assessed as having a high-risk pregnancy would be removed from Okimaw Ohci, because it is over five hours drive to a perinatal care centre. Although the warden at Okimaw Ohci may have approved MCP participation, the warden at the institution to which they are transferred may not. As one staff summarized:

> I think it reads very well [CD-768], I don't think it's executed very well. Oftentimes, women's access to that program to have either their newborns, their babies, or their toddlers with them was very contingent on the politics and the management at the time. And it was often presented as a carrot on a stick in that you need to be exactly this profile of "inmate" to be able to benefit from this program and then when you were in the program there was this constant fear and risk of if you do this, that or the other, we can remove you from the program [S15].

**7.4.2.2.2** ***Strategic Self-Advocacy.*** Staff described mothers' covert practice to share information about the MCP, "Women were sourcing that information from other women or asking us [Elizabeth Fry staff] because they didn't want to seem problematic by asking the prison staff about what their rights were or what the process was" [S15]. Navigating the hidden, often unfair requirements of the MCP places mothers under pressure, when they are already vulnerable to poor mental health.

Staff found mothers worried pushing prison administrators would negatively affect chances of being with their child- either in the MCP, or after release. Things had to be egregious for clients to object. One staff described helping clients file grievances when staff strip-searched their babies, a clear violation. Staff felt advocacy was imperative to be successful:

> [Name], she fights for, and she is very astute at getting what she wants. It points to self-advocacy, and if you have the strength. That she's learned from her grandmother who raised her as best she could, who is now raising her sons as best she can, with a lot of help from all kinds of organizations including me, E. Fry. I

> think that if you're a shrinking violet that can't voice your opinions, your needs, your rights as a incarcerated woman in the system…you have to be able to [use your] voice and many, many women don't have that because they've been at every corner either judged, put down, not listened to, abused in some way so they have no self-esteem, no self-advocacy happening because they, it's always been a negative experience [S01].

One staff affirmed the importance of persistence because "Once you back down, it's harder to stand up again and every time you back down it gets harder and so then you do get targeted. And in my experience the ones that the [prison] system knows will not back down, they back off of." [S10]. Mothers must be strategic and able to navigate the consequences, to "choose their battles appropriately" [S16] and manage being labelled a "troublemaker".

Advocacy could be interpreted by the institution as adversarial and indicative that a client did not "really" want to see their kids:

> For women who have stood up for what they thought was wrong or what they felt was right or, then it was like, "You don't really care about your kids do you? You're fighting with us in here, you don't really want to get out and see those kids." Like you can't win. You cannot win, you can't be an advocate, you have to be submissive and put your head down [S14].

Indigenous women's self-advocacy was interpreted differently. One staff said, "The Indigenous moms are treated more harshly than the non-Indigenous moms and that if they push back, the ones that are being told, "You are being too difficult" and "This is going to impact your correctional plan"" [S16].

**7.4.2.2.3** ***Adverse Effects.*** While some staff did have positive things to say about MCP participation, such as "The whole attitude and mood within the institution dramatically changes when a baby is present" [S06], they cautioned that is no justification for putting a baby or its mother in the prison:

> The first time I visited that jail there were a ton of kids in there, it was the most humanizing part of any jail I'd ever seen but it's exactly the same argument used to put women in prison, in men's prisons as well. That women humanize and calm down the institution. That is not a reason to put anybody in prison as far as I'm concerned, youth, women, whoever. [S10]

Staff believed positive experiences had to be compared to not only the trauma of mother-child separation, but the context of their clients' lives before incarceration:

> It [the MCP] was probably one of the best things they had to experience, because they had nothing else good to compare it to. So if you compare it to an abusive relationship in the past, so it might have felt quite comfortable for them to be part of the mother child program but that doesn't take away from its deficits, it doesn't take away from the fact that the women have to provide the necessities for baby when they are only making $5 a day or whatever it is and some of them don't have access to family members who can bring things in for them. Like ya for the ones who do, that is great, but what about everyone else? [S16].

Another pointed out how CSC staff act surprised to discover MCP participants are capable parents. Women who commit crimes are "demonized", and mothers are labelled a "Bad Mom". She said, "They just couldn't believe what a good mother she is. Of course, she should be a good mother! We wouldn't say that about other people" [S04].

MCP participation requires a provincial child protection assessment. Even if a mother is approved, and participates in the MCP, the child protection file may follow her home on release, to be scrutinized by another child protection office. They may react to the file with the assumption it is associated with abuse. In effect, participating in the MCP places the mother at risk of life-long child protection interference.

Sometimes, the MCP participant would have to restrict her child from visitation with other family members, including the child's father, grandmother or aunties, because of fear their names will be flagged by child protection. As one said,

> You have to agree, like absolutely agree, that Children's Aid is going to be in your life if you want to keep this child, or you want to have this baby. It's not like you can say no I changed my mind, I'm not going to have this baby, I'm just not going to do it, or I'm going to hold this baby till I get out, like it just doesn't work like that. And so, to me that's coercive, that's egregious, that's criminal, it's criminal that they make women do this. [S14]

Because CSC does not prepare MCP participants for life afterwards, once paroled, clients faced new issues: poverty, homelessness, and few supports for parenting. They turned to "survival crime" and were re-incarcerated. Staff found clients did better on parole if they lived at an Elizabeth Fry's halfway house that accommodates children and if they had a supportive parole officer who would come to the house rather than require a client travel with children in tow.

**7.4.2.3 Theme 3: Health Care Issues.** Within the theme of Health Care Issues, we developed three sub-themes: "The Care is Just Not There", "It's a Community," and "Security over Care".

**7.4.2.3.1** ***The Care is Just Not There.*** Unlike established relationships with correctional administration, Elizabeth Fry staff did not have many connections to CSC health services, "We never meet health care…in terms of the regular health care in my entire time with E Fry I have not met [anyone]." [S05]. Staff thought about health not only in terms of clinical care, but as whatever clients needed to be healthy- starting with food. One described people in prisons as "severely malnourished" [S16]. Another explained:

> It's hard again just to isolate your health issues from the situation that you're in you know in terms of the quality of food, there's the co-living with other women you don't know, the anxiety of losing your job, of maybe losing your home, of losing your kids. Like there's so many variables that are going to have an impact on someone's physical and mental health…How do you deliver mental health care in a system that causes mental health issues, that compromises mental health? [S15].

Staff explained pregnant clients arrive at prison with multiple disadvantages: usually very young, and unlikely to have received prenatal education. They lack continuity of care from provincial facilities, where clients are held on remand until sentencing, sometimes going months without care. Many experience substance use disorders and feel confused about the impact of substances on the fetus. Medications may be switched by CSC, without explanation- even if related to concerns about teratogenicity. Clients "just think of it as some kind of cruel and inhumane treatment of them" [S16].

Staff noted while health services were difficult to access at CSC, as marginalized, racialized, poor and stigmatized people, clients also faced difficulty accessing care in the community.

> We don't have great mental health systems across Canada so now the default is go to the prison and you can get mental health care there. And when you're in there that's the understanding, that we're giving them the counselling and the structure and the therapy and the DBT and all the things that they need to be successful in community while not acknowledging the fact that they've been removing them from community and their families, and their children is causing more significant mental health issues for the women [S15].

As CSC lacked expertise in perinatal care, patients were sent out for appointments. That presented another problem: lack of medical escorts. One staff explained,

> CSC can't recruit enough prison guards. They have a chronic employment shortage problem. So, they don't have capacity to take women out of the institution. Women's access to health care, even when there is willingness to provide access to health care, they don't have the organizational capacity to do so and the only way that women can get around that is if they allow overtime but who's going to allow that? [S04]

This was exacerbated outside of business hours, when no CSC health staff are on site, and correctional staff are unsympathetic to health issues. This could escalate into disputes, "When you're pregnant and you think there's something wrong, it has to be addressed right away" [S19].

Some recalled serious consequences to care gaps, such as two clients who had been held in segregation while pregnant, both losing their pregnancies. “There’s not that many that get documented. And so an anomalous situation “of one or two women” over a couple of years or over a decade doesn’t seem like a systemic issue.” [S10].

Elizabeth Fry staff felt CSC provided bare minimum care. “Things that we would expect for pregnant folks in the community don’t get extended into the institution because there is this idea of the bare minimum in order to fulfill legal requirements, not actually thinking about meaningful care” [S08]. Reproductive mental health counselling and postpartum support was not available: care ended at birth.

> There were so many different stories of women who right before they were incarcerated had an experience of either a pregnancy, they thought they were pregnant, or they just miscarried, or they had a stillbirth. Like, they had lived these experiences around maternal health right before their incarceration and then found themselves incarcerated and having to self-cope with not only the hormones in their bodies, like the actual physical repercussions of carrying and then not delivering or to term, but also the mental consequences of not really having anyone or anybody to talk to about that…If you’re not “pregnant pregnant” then they don’t really care about all the other states you might be in. If you’re not carrying a physical baby then all of those other experiences of maybe a false pregnancy or maybe an abortion or miscarriage, all of that, that doesn’t get you extra medical care, it doesn’t get you fast tracked to psychological or counselling services. It’s not real. Like what you’re feeling and what you’re going through. [S15]

CSC failed to support breastfeeding. Rather, women were encouraged to bottle feed: "…because of those things, it's just seen as more practical, rather than to be able to express milk and send it with the baby." [S04].

**7.4.2.3.2** ***Security over Care.*** Staff felt security dominated CSC operations. A patient might be denied an appointment because of security concerns, not even knowing about the appointment in the first place, because of a "security" restriction on knowing about it in advance. Clients cannot make a complaint about repeated cancellations they don't know about.

"Security" excuses cruel restrictions, such as access to meagre amounts of supplemental food in pregnancy being unavailable in segregation. Another example staff recounted was when a client was denied a sonogram photo for "security" reasons. A small thing, it symbolized how the person is not considered by CSC to be a "real" parent.

> You know the ultrasound scans? I've heard from a number of women inside that they didn't get the pictures of their babies or they had to fight to get the pictures of their babies, like their scan, images. It [ultrasound photos] sort of remains outstanding, like a trauma for them. Like it was withheld, you know they feel really strongly about this, like if I weren't this incarcerated person no one would ever tell you, you didn't have a right to that picture, right? But they're being actually told they didn't have a right to the scanned image, to have a copy of it. Which feels really harsh, like what's it to you? But it's meaningful to a mom, it's absolutely meaningful, and like it's just a small thing, right? But I think if you're made to feel while you're incarcerated that you're not entitled to your baby's

> scan, how can you build yourself up as a good mom? Like even in your mind, how are you going to do that? [S13].

Prioritizing security, health professionals routinely violated their codes of ethics, mistreating patients, and breaching confidentiality:

> CD [Commissioner's Directive] 800 says they have equal access to the same level of care as they would have in the community, and I wish I could say that at some level that is happening but no, it's not. And it starts, the first step is the attitude. So they [clients] are met with friction, and aggression, and lack of just respect from the health care professionals from the get go…They are told, "If you don't like it, don't come to jail." That is the first thing said by these nurses, "If you don't like how I am speaking to you, don't come to jail." And so that just sets the tone for the women, as soon as our women are treated in a nasty way, they don't have tolerance for that, and they reflect it back. And the nurses should be the ones in a professional setting to de-escalate that kind of stuff, but they are not. So then it's a relationship that is based on a lot of friction and nastiness so that's what frames their entire conversations [S16].

Unable to trust care providers to maintain confidentiality, clients refused health services. They feared providers would disclose things "that it will end up on their file when they go up for parole, it will come back to indicate they are not suitable, or something that they said indicates that they are not ready to be let out into the community" [S08].

Staff observed CSC health professionals "get contaminated by the institutional ethos" [S10]. Not only are providers confused about ethical and legal responsibilities to incarcerated patients, but patients are not aware of their rights:

> One of the women who's pregnant who's going out for regular medical appointments is routinely being taken out in shackles. She didn't know that she shouldn't be and so it'll be one of the ones that we'll see what happens, we're really monitoring because part of the problem is not only health professionals don't know the rules, but women themselves don't and you know historically advocates don't always know the rules either. [S10].

This staff asked, "how do you know someone is voluntarily coming for treatment if you're dealing with them and they're in full restraints or they've got a guard standing with them?" She suggested if care providers do not feel safe with a patient, "then you need to check that yourself, but you probably shouldn't be treating the person, pass it to somebody else who is not concerned about safety with this individual" [S10]. Having said that, she found that care providers who resisted institutionalization would be "overruled by security" and "lose their contracts" [S10]. She cautioned "One of the challenges of encouraging nurses to be advocates is what happens when they do it and they're not backed up either by the [nursing] profession or by the health community" [S10].

**7.4.2.3.3** ***It's a Community.*** Elizabeth Fry staff described how mothers cared for each other, to "make sure that that woman who's experiencing a pregnancy or a pregnancy loss, has a sense of identity as a mother despite the fucked up system that

they're in" [S15]. One described it as an "informal doula process" [S15]. Young mothers relied on the mothering of elders:

> Some of them are only I would say babies having another baby. And it's the older women that are there that I think guide them more than, because we're [Elizabeth Fry staff] only there once a month at the institution. So, it's the other women that have experience that can guide them, that guide them and give them very good information, "You have to do this, you have to call the nurse, you have to see the doctor." It's not the [CSC] staff, I can tell you right now it's not the staff, it's the other women inside that guide them [S19].

For MCP participants, a community of care envelopes the child. Babies have multiple adult caregivers, "It's a community, right? Baby has so many loving mother figures in their lives. It is really quite beautiful, if you can think past the human rights abuses of the actual institution. The babies themselves are surrounded with caring and nurturing wonderful human beings" [S16].

**7.4.2.4 Theme 4: Mom Should Be Out.** The final theme speaks to how, recognizing the problems with the MCP and health services, staff expressed complicated feelings about future directions. Some felt demoralized about how conditions had deteriorated over their careers. One, having worked in the field over 30 years, expressed regret at the outcome *Creating Choices*. Instead of actualizing its gender-responsive vision, the report was co-opted by CSC, and focus on facilitating mothering/parenting was lost.

> I believe Creating Choices is dead, died a slow and painful death. Well, a fast death actually, within two years of it being in place. And they're [CSC] not very

> happy with me saying that. And CSC take complete ownership of Creating Choices. Creating Choices wasn't theirs; Creating Choices was ours, we co-chaired that with them so it was E Fry, it was women who were formerly incarcerated, it was NWAC [Native Women's Association of Canada], it was the Women's Disabled Network, [name]. It was like this group of amazing women who conceived and put together a system that if women had to be incarcerated, that this is what it would look like, and that parenting would be first and foremost in all the systems [S14].

One staff proposed an alternative to visitation or the MCP, an external space, for mothers, children, and care. "So women would come out of the prison, and children wouldn't go in the prison. And sort of have this neutral space and that's where you could have health care because I think they would get better healthcare" [S04]. Staff felt mothers deserved dedicated services in community, "We need to have different kinds of homes. Like transitional homes where they're still in an apartment with their own, but they might have some assistance coming in." [S14]. Services had to be support-based, non-punitive, or clients would avoid seeking help.

> For them to feel like reaching out to staff, like, "I need help with this again, I need help with this again," I imagine there is a certain instinct to not be 100% truthful about what they are experiencing and what supports they could use in reality versus what they are getting. Access to parenting programs and parenting support would be I think something that we could offer the women [S03].

Some felt it was a mistake to envision a better version of prison.

> I don't want to continue to tinker in the system. I want us to work on guaranteed livable incomes, universal health care, universal mental health care, universal dental, pharmacare, education. Because if we create a more substantively equal starting point, we have fewer people, not just mothers, but fewer anybody in prison…Right now we are just loading the prisons with the least privileged and the people who have the least, and that's why women, particularly Indigenous women, are the fastest growing prison population. Not because of crime, it's got nothing to do with crime, it's got everything to do with relative lack of privilege and relative lack of opportunity. It's so discriminatory [S10].

Some, recognizing prison closure was not on the horizon, felt services inside needed to be improved to reduce immediate harms. "I'm an abolitionist, I believe that mom should be out. But if you're talking in a world where we have no choice" [S14]. One applied a harm reduction philosophy to this position:

> We need reproductive health programming in there regularly, but we also need parenting in there regularly, just women's bodily health and wellbeing programs in there regularly, and how to advocate for themselves and their human rights around their health and wellness- its all-encompassing. E Fry is not supposed to be advocating for bringing things into the prison, but we also have to take a harm reduction approach. They are not getting it, and they are not getting out to get it either, so. We have babies being born now, it's a vulnerable thing, from a harm reduction philosophy I think these things should be brought into prisons in the interim. Until we close down prisons [S16].

## 7.5 Discussion

As part of a case study of pregnancy and parenting young children in federal prisons designated for women, this article offers an in-depth exploration of the perspectives of Elizabeth Fry Society staff. While our paper highlighting the voices of people with lived experience (Paynter, Martin-Misener, Iftene & Tomblin Murphy, under review) speaks to the careful strategizing mothers engaged in with respect to the MCP, this paper provides a critical reflection on staff assessment of patterns of harm associated with the MCP and inadequate perinatal care. Our findings should give pause to policymakers, such as the Senate of Canada (2020), keen to promote the MCP as a solution to the increasing numbers of mothers in prisons.

Using a theoretical framework of abolition feminism (Davis et al., 2022), this study centres the work of grassroots organizations- and the women who run them with little funding- to protect mothers and children from carceral harms. Their expertise generates complex analyses of interlocking factors.

Many studies describe the trauma mothers feel in separation from their children while incarcerated (Clark & Simon, 2013). The findings in this paper characterize separation as not only a traumatic event, but a bond defined by trauma. Usually used to describe behaviour in abusive domestic partnerships (Hadeed, 2021), “trauma bond” similarly captures the frequent traumas mothers and their children experience- such as the repeated separation at the end of a visit or phone call. Trauma bonding extends into other familial relationships- overwhelmed grandparents, bound by ties of obligation, are burdened with childcare and responsibility to facilitate mother-child contact within complex, restrictive conditions. When mothers cannot cope with grief from these

traumas, their techniques to survive- often substance use- drive further criminalization, stigmatization of their mothering, and alienation from their families.

That the MCP is infrequently used and has overly strict eligibility criteria is well-established (Brennan, 2014; Miller, 2017). Elizabeth Fry staff shed insight on hidden requirements, as CD-768 does not capture the complexity of interdependencies that would support or preclude MCP participation. First, a mother's geographical location, and that of their support people, matters: they must be in town. Heavy reliance on support people places the mothers under extreme pressure, as supports may fail to be always available- and jeopardize the right to a participant's status in the program. Furthermore, approval from child protection services, and agreement from the warden, are unpredictable.

Navigating the MCP- and prison as a mother- relies on strategic self-advocacy: not too assertive as to prompt punishment, but enough to be visible to decision-makers. Exposed to hundreds of clients over decades of service, Elizabeth Fry staff observed Indigenous women to be discriminated against in terms of MCP eligibility and with respect to how self-advocacy was appraised. Goshin (2015) has critiqued the arbitrariness of MCP eligibility; our findings echo the concern. A program can hardly be praised for supporting mothers when it is driven by inequity.

As other researchers have found, participation in MCPs expose parents to increased surveillance (Haney, 2013). Supporting clients in transition into community, Elizabeth Fry staff attested that child protection follows clients on parole, with long-term adverse effects. MCP participants do not receive CSC support to plan for life after

release, and often experience abject poverty, homelessness, lack of health services and inadequate childcare.

While this study affirms growing evidence of inadequate reproductive health care for incarcerated people (Liauw et al., 2021), in this paper, staff emphasized the role correctional staff shortages played to limit access to external care. These interviews were all conducted pre-COVID-19; the pandemic further eroded prison staffing (The Canadian Press, 2022).

As advocates, Elizabeth Fry staff held an informed position about violations of health professional ethics. Staff named this problem not only as one of care providers succumbing to institutionalization, but simply not knowing their responsibilities under federal legislation or statutes like the Bangkok Rules. Likewise, the patient does not necessarily know their rights. Health literacy and rights education is a critical area for improvement- not only among people in prison, but among professionals caring for them. Clinical practice guidelines to address care of incarcerated people should be developed by key regulatory bodies, such as the Society of Obstetricians and Gynecologists of Canada.

Staff described clients providing each other with inter-generational peer wisdom and care, even calling it an "informal doula" service. While doula programs in prisons have received some study internationally (Shlafer et al., 2021), there is little research about how peers may formally provide this service.

Many staff openly expressed abolitionist values and envisioned shifts to wrap-around support for clients and children in community. However, most staff were very senior members of their organizations, had witnessed the promises of *Creating Choices* be co-opted by CSC, and observed deteriorating conditions in prisons over time. Their

hope was punctuated by profound disappointment about increasingly punitive environments. As these interviews were conducted before COVID-19 resulted in long-term lock-downs in prisons across the country, those conditions only worsened (Walby & Piche, 2020). While some continued to call for improved programming and services inside, other staff rejected efforts to "tinker with the system".

Finally, staff consistently identified a pattern of differential treatment of Indigenous people, including harsher assessments, quicker leaps to punishment, and exclusion from the MCP. In recent years, the genocidal consequences of Canadian colonial policies- from the Residential Schools to forced sterilization- have received increased public recognition and promises for restitution. The imprisonment of Indigenous people merits the same reckoning.

### 7.6 Limitations

All interviews were conducted in English, and no staff person was interviewed in Quebec. Elizabeth Fry staff have unique access to carceral spaces, extensive experience, and informed perspectives: they do not, however, provide first-hand, first-voice narratives.

### 7.7 Conclusions

This study explores the experiences of staff of Elizabeth Fry Societies supporting people who were pregnant or had young children while federally incarcerated. With decades of experience, and yet infrequently given a platform to share their knowledge, these respondents provide insight to complement findings from interviews with mothers. Far too often the voices of frontline service providers- disproportionately women- are ignored. Abolition feminism centres the knowledge of women resisting carceral systems

and looks beyond uncritical reforms. On the frontline of advocacy, staff have an in-depth understanding of the complex factors underlying MCP participation. They named the "trauma bond" between clients and children from repeated separation. They warned about the "shadow side" of the MCP, as it made mothers vulnerable to child protection services, and once paroled, mothers were "set up to fail". Staff had extensive concerns about prison health services - characterizing care as inadequate and problematic. Finally, staff had well-developed alternative visions for how the perinatal period should be managed, however, some had observed conditions deteriorate over time, and cynicism abutted with hope.

We offer several recommendations. 1) Health and prison policies must recognize trauma as a health outcome to be prevented and treated; 2) Inadequate access to basic perinatal care for people in prisons must be addressed, preferably by receiving care in community from independent providers who uphold duties to dignity, confidentiality, and wellbeing; 3) Inadequate data collection must be rectified to understand the number of children affected by parental incarceration and associated health outcomes. This may however increase surveillance of parents; 4) Our overarching recommendation is for caution and critical thinking, that it not be taken for granted that expanding the MCP is the best possible recourse to the trauma of maternal criminalization. As this staff person put it, maternal incarceration is fundamentally flawed social policy: "Women, who have responsibility for future generations, they should not be in prison, period" [S10].

### 7.8 Integrating Qualitative Themes Across the Participant Groups

The two qualitative manuscripts share several themes. Recall the themes from the interviews with mothers included: 1) Reasons Why- or Why Not- to Join the MCP; 2)

Mothering from Inside; 3) Health Care; and 4) Self-Advocacy and Survival. These map onto the staff themes of 1) Shadow Side of the MCP; 2) Trauma Bond; 3) Health Care Issues; and 4) Mom Should Be Out. For both participant groups, MCP participation was a rare occurrence, and the bulk of the interview data pertained to the experience of being excluded from the program.

While staff observed the cards were stacked against mothers to be approved into the MCP, and characterized participation as coercive, mothers themselves believed they made decisions about participation with thoughtfulness and considering the best interests of their children. Mothers characterized their experiences mothering from inside as traumatic, punctuated by infrequent and challenging efforts at contact. Staff described the mother-child bond as one forged in trauma and by trauma, with cascading impact on emotional wellbeing, even resulting in further criminalization. Mothers had first-hand accounts of being denied health care, being pushed to accept pharmacological interventions, having mental health distress used against them, and experiencing violations of privacy and confidentiality. Staff looked at health care from a systems perspective, observing clinician institutionalization underlying ethics violations, and recognizing access issues were tied up with security protocols and correctional staffing shortages. Mothers employed self-advocacy strategically to navigate the challenges of their incarceration and to maximize the likelihood of reuniting with their children. Staff validated the essential role of client self-advocacy in their survival but stressed the systems failures behind maternal incarceration. By interviewing both mothers and advocacy staff, this case study included individual and systems-level considerations.

## Chapter 8: Conclusion

This case study explored the experiences of federally incarcerated mothers in pregnancy and with very young children with respect to the institutional Mother Child Program, which remains out of reach for most. The chapters and manuscripts build on each other and aim to create a multidimensional understanding of maternal experiences to inform policy, clinical practice, and future research engaging this population. *Manuscripts 1, 2* and *3* (Chapter 2) are a series of scoping reviews to paint a portrait of 1) the international research on maternal health outcomes of incarcerated women; 2) the health outcomes associated with prison nurseries and Mother Child programs around the world; and 3) the sexual and reproductive health research conducted with incarcerated women in Canada. *Manuscript 4* (Chapter 3) provides an inventory of the prisons designated for the incarceration of women and girls in Canada and measures their proximity to specialized maternity services, the first time to our knowledge that a mapping of carceral spaces for women has been available. *Manuscript 5* (Chapter 4) introduces a proposal for feminist abolition as a nursing framework, grounding the theoretical foundation for the case study. *Manuscript 6* (Chapter 5) is a descriptive statistical analysis of quantitative data acquired through an Access to Information and Privacy request to reveal the limited extent of participation in Canada's institutional Mother Child Program over the past twenty years. *Manuscript 7* (Chapter 6) and *Manuscript 8* (Chapter 7) present the qualitative themes from interviews with mothers, who experienced pregnancy and postpartum while federally sentenced, and the Elizabeth Fry Society staff who provide incarcerated mothers with community-based support. These two groups of informants provide complementary insight into the challenges with

the Mother Child Program as a response to the harms of maternal incarceration. Finally, the chapter (8) describes the study's strengths and limitations, implications for policy, clinical practice, and future research.

### 8.1 Strengths and Limitations

The key strengths of this study are the application of abolition feminism as a novel approach to nursing inquiry, the multiple data sources to inform the case study, and the author's previous and ongoing experience as a community advocate for people experiencing pregnancy and postpartum in prisons. As the scoping reviews demonstrate, there is minimal Canadian content in the literature about perinatal health in prisons, and the Canadian literature about sexual and reproductive health of incarcerated women scarcely engages perinatal outcomes. What is known is that people in prisons face layers of threats to health generally, including complex comorbidities on admission, poor access to specialized services, and institution threats to wellbeing including isolation, deprivation and use of force.

The inventory of facilities designated for women shows the 72 facilities have vastly different physical access to maternity care centres, and only the federal facilities and one provincial facility (Alouette Correctional Centre for Women in BC) have residential Mother Child Programs. The quantitative dataset provides an up-to-date picture of what is generally kept invisible: participation in the MCP. Furthermore, the two sets of interviews included participants from across the country with widely different social and cultural backgrounds and provide complementary insight into the (dis)functioning of the MCP. The quantitative and qualitative data reinforce each other: low MCP participation numbers demand qualitative exploration, and the findings from

participant and non-participant interviews makes a clear case for improving the comprehensiveness of CSC quantitative data with respect to perinatal health and parenting. As a case study using multiple types of data, this study integrates dynamic data elements to offer recommendations to meaningfully direct policy, practice, and research.

The findings from this case study also have several limitations. First, each of the scoping reviews have inclusion criteria that may restrict their breadth. However, the inclusion criteria are clear, and each review involved the expertise of a medical librarian and a second reviewer. The inventory of prisons for women and girls does not include police lock up, involuntary psychiatric units, and other important spaces of confinement; it is a basic scan that does not speak to the reasons for any differences between facilities or evaluate the impact of varying distances to maternity care. Still, it is the first inventory of its kind, and arguably a necessary precursor to any future study across provincial-territorial-federal institutions with regards to maternal health.

The quantitative data were acquired through an access to information and privacy request and is severely limited in scope. That said, clarifying meetings were held with representatives of Correctional Services Canada to ensure the data were being interpreted correctly, and that manuscript was workshopped with the membership of the Health Law Institute at the Schulich School of Law to focus and improve the analysis. I am a Research Scholar member of the Health law Institute, and several times per year a member may bring a work in progress to the group for peer review prior to manuscript submission.

Due to COVID-19, it was not possible to interview anyone who was currently experiencing federal incarceration. However, the quantitative data from CSC and CSC

policies informed the case study development. Furthermore, interviews with currently incarcerated people are vulnerable to prison staff surveillance and social desirability bias and/or potentially negatively impacting participants in other ways related to the security apparatus; there is ethical and methodological value in interviewing people who have been released. The number of mothers who participated in the study- nine- is small, and only two had participated in the MCP, neither of whom identified as Indigenous. As a result, the findings may not capture nuances across time, place or groups of people. As the first study of the maternal health experiences of people experiencing federal prison, this study can (and has already) served as a model for additional research in this area.

Finally, while it is a strength of the study to bring longstanding experience in the field to the approach, it can also be a limitation. Regular engagement with the supervisory committee and co-authorship with peers mitigated bias in the findings.

### 8.2 Study Implications

The study crafts a telling picture of maternal health service access and experience in federal prisons that can inform changes to policy, practice, education and research. Contrary to the myth of prison as a health service, participants recounted not only operational barriers to accessing care- such as the limitations on staffing of medical escorts- but on the institutionalization and unethical behaviours of care providers, including routine violations of privacy and confidentiality. While the MCP on paper promises to address the harms of maternal incarceration, this study shows that mothers are largely excluded from participation, and participation itself hinges on subjection to layers of additional surveillance and risk.

### 8.2.1 *Implications for Health Policy*

These findings should prompt critical and independent assessment of CSC health services which, by law, must meet professional standards and address essential needs. That CSC health care providers are employed by the same body as correctional officers merits scrutiny. How these problems are addressed must be approached cautiously. Many provincial jails provide onsite health services delivered by provincial health authority staff rather than hire health care providers under their Ministries of Justice, and yet health professional ethics violations persist. It is also imprudent to suggest simply requiring increased use of external care providers will remedy the concerns of practitioner institutionalization, coercive or punitive treatment, and gaps in care. Many such remedies would involve increasing investment in the prison system, such as increasing funding for medical escorts to off-site appointments. This approach is contrary to abolitionist goals to improve health by reducing carceral experience. Community-based alternatives to prison would allow exploration of alternative modes of health service delivery, such as pairing access to health care provider expertise with access to safe housing, as is available at Sanctum 1.5 house in Saskatoon. Increasing use of the MCP within prisons is not recommended.

Regardless of long-term shifts in health services, as directed by the Bangkok Rules, reproductive health assessment by a clinician should be part of the CSC custody admissions process, including past pregnancies and numbers of children. Primary health outcomes in CSC- including and beyond sexual and reproductive- must be better tracked. Separation from children is a traumatic experience impacting emotional and mental

health and must be recognized as having health implications (Paynter, Heggie, Matheson, McVicar, Rillie, Beals, & Bray, 2022).

The Office of the Correctional Investigator (OCI)- the external federal prison watch dog- receives thousands of complaints from prisoners annually, with health care complaints one of the most common types. The OCI annual reports must disaggregate complaints by gender and Indigenous/ non-Indigenous complainant, wherever possible. In general disaggregation in OCI reports and Public Safety Canada's annual statistical summaries is far from comprehensive (OCI, 2019; OCI, 2020; Public Safety Canada, 2020).

Health care centres should develop policies for the care of people who are experiencing incarceration, with particular attention to factors unique to the perinatal period. Health professional regulators such as provincial colleges of physicians and surgeons, provincial colleges of nurses and provincial midwifery registrars should attend to the risks incarcerated people- who are also members of the public- may experience in the care of professionals with dual loyalties and investigate and discipline health professionals who violate those codes in prison contexts. Such disciplinary investigations have been conducted in relation to health care provider involvement in solitary confinement of prisoners (Complainant v. College of Physicians and Surgeons of British Columbia (No. 1), 2022 BCHPRB 39).

### 8.2.2 *Implications for Clinical Practice*

Evidence-based clinical practice guidelines and standards must be developed to provide direction for primary care and obstetrical health care providers in the Canadian context. The American College of Obstetricians and Gynecologists issued a committee

opinion in 2021 with respect to the *Reproductive Health Care for Incarcerated Pregnant, Postpartum and Non-pregnant Individuals* (ACOG, 2021) that emphasizes not only do these individuals have the same right to equal care as non-incarcerated people but that they face increased risks to health.

As discussed in *Manuscript 5*- "Feminist Abolitionist Nursing"- nurses are opportunely situated to promote the health and autonomy of people vulnerable to criminalization and arguably have a duty to engage with abolition as a theory and practice. Nurses play critical roles in all aspects of perinatal health- from prenatal education to operating room scrub nursing to breastfeeding support. Nurses can optimize patient experience while constrained by carceral structures through individual patient care and also advocate for alternatives in the best interest of both mother and child at a systems level.

### 8.2.3 *Implications for Health Professional Education*

In general, health professional training programs do not include prison health in the core curriculum. While social determinants of health are usually covered, there is often a failure to recognize these determinants may manifest individually- such as through higher rates of illness among individuals in certain groups- but are constituted structurally through macro hierarchies in power: white supremacy, heteropatriarchy, colonialism and capitalism. Prisons condense and repeat these hierarchies, punishing the most vulnerable. It is not enough to recommend nursing and other health professional programs introduce modules to discuss disproportionate rates of morbidity and mortality in prison settings; educators must be willing to interrogate *why*, and further, how health professionals are empowered to uphold inequity or interrogate it. It is not enough to

increase clinical placements in prisons without supporting students to recognize and resist institutionalization and encroachment of dual loyalty. These placements could be traumatizing for students without adequate support and strategies to navigate this clinical context. This case study provides a window into the complex and intergenerational implications of incarceration on reproductive health, exposing the imperative for critical and creative thinking in response.

### 8.2.4 *Implications for Health Research*

To improve understanding of reproductive health experiences of incarcerated people, prisons must be required to improve comprehensiveness and transparency regarding data collection and sharing. That the children of federally incarcerated people remain uncounted is an egregious violation of the Bangkok Rules. The Bangkok Rules provide a basic template for the types of gender-based information that ought- at minimum- be collected from people in prisons, including reproductive health histories, access to reproductive care, use of segregation, restraints, and force against prisoners in pregnancy, postpartum and lactation, etc. The Office of the Correctional Investigator must go beyond stating "women" are a priority population and conduct gender-based analyses of health experience for federally incarcerated people.

The attention in this study to the non-participants in the MCP is crucial. Research that focuses only on participants in a prison program and the impact on their health outcomes, and not on who and why people are excluded, may miss the "shadow side" of reforms. The abolitionist lens approaches reform critically. This study provides a model of application of abolition to the research process- from problem or question identification, to design, data collection, and analysis. This model can be used for further

study in the field of prisoner health and evaluation of interventions, for example, in relation to the development and implementation of community-based health services for people experiencing criminalization, such as perinatal education and supports. Sheway in Vancouver's Downtown Eastside provides an example of harm reduction-oriented, person-centred, gender transformative services in the perinatal period, prioritizing family preservation in the face of criminalization and substance use.

### 8.3 Recommendations for Future Research

This dissertation has laid the groundwork for future research initiatives, several of which I have initiated or joined. The first is to increase the collection and analysis of disaggregated data about primary health outcomes of federally incarcerated people. I have joined a research team led by Dr. Fiona Kouyoumdjian at McMaster University, supported by the Public Health Agency of Canada, to work on developing a national chronic disease surveillance system for the population in federal prisons in Canada. With this dissertation as a springboard, I am a co-PI on a CIHR-funded Indigenous-led national study, spearheaded by Dr. Jennifer Leason, focusing on the maternal health outcomes of Indigenous women experiencing federal incarceration. Both projects involve the cooperation of CSC.

The second research priority is to collect and analyze policies from hospitals identified in the inventory (Chapter 3) as being proximal to prisons, pertaining to the perinatal care of incarcerated people. With Dr. Heather Scott at the IWK Health Centre, I am co-supervising an R1 Obstetrics and Gynecology resident physician, Dr. Chloe Brown, in this project. We aim to identify policy trends, gaps, and direct policy formation

to support the dignity and confidentiality of patients and the comfort and confidence of care providers.

The third priority is to synthesize available clinical evidence internationally to create Canadian practice guidelines akin to those published by the American College of Obstetrics and Gynecology (ACOG) regarding care of incarcerated people (ACOG, 2021). The substantive differences in carcerality between the US and Canada require Canada-specific guidelines. These guidelines could then inform hospital-level policy formulation as well as shape data collection for future research about the clinical outcomes associated with incarceration. For example, if the guideline stipulated restraints are not used in labour and delivery, this outcome could then be tracked and evaluated.

The fourth priority is to understand health outcomes in provincial facilities. Although research is in some ways easier with respect to the federal system- it is one system, with far lower turnover due to the length of federal sentences. However, most incarcerated people in Canada are in provincial facilities. In tandem with this dissertation project, I led a study of maternal incarceration in the main Nova Scotia provincial prison (Paynter, Matheson, McVicar, Rillie, Beals, & Bray, 2022). This study found that brief periods of remand or provincial sentences are enough to seriously damage the health of mother-child relationships. Provincial facilities face the same obligations under the Bangkok Rules to attended to gendered health needs and include reproductive health histories in admissions assessments. In summer 2022, I plan to begin a postdoctoral study in British Columbia focused on the experiences of provincially incarcerated people accessing abortion care. The first step in this study, already in process, is a scoping

review of the international literature pertaining to abortion, contraception and incarceration.

The fifth and arguably most important priority it to invest in alternatives to incarceration and evaluate their impact. Lack of evidence of the effectiveness of alternatives does not indicate they do not hold promise, rather, it indicates a lack of imagination and experimentation and reliance on incarceration as permanent and certain. Abolition feminism allows us to look beyond the prison as a medium for addressing harm, to creative and hopeful solutions beyond the narrow vision of reform. Indeed, abolitionist nursing is a theoretical lens that can be applied and researched in other clinical areas, such as infectious disease, primary care, mental health, musculoskeletal injury, and geriatrics. As a first step in this priority area, I am working with Women and Gender Equality Canada to fund an implementation study through the IWK Health Centre and NS Health of a nurse-practitioner-led, community-based primary sexual and reproductive care clinic for people experiencing criminalization in Nova Scotia. In preparation for this initiative, we conducted an international scoping review of community-based health service interventions for people who have experienced incarceration. None of the interventions we identified through the review specifically addressed sexual or reproductive health outside of the treatment of blood-borne infections such as HIV and Hepatitis C virus, and furthermore, there was little gender-based analysis, pointing to the gap addressed by our proposed clinic.

### 8.4 Concluding Statement

This case study substantively advances what is known about how pregnancy and parenting young children is experienced by people incarcerated in the federal prisons

designated for women in Canada. The multiple methods used- including scoping review, environmental scan, theory-building, quantitative and qualitative analysis- uncover the hidden requirements for and consequences of participation in the institutional Mother Child Program. The case study reveals invisible, systemic barriers to program eligibility: dependence on hushed information sharing between peers; the imperative of just the right amount of self-advocacy to be heard but not too much as to be silenced; the need for nearly impossibly reliable, proximal and generous support people; and the willingness to submit to surveillance both within and beyond the program's bounds. It also shows the implications of inadequate or inappropriate reproductive health services in the prison system, resulting in postpartum and mental health care gaps, and professional behaviour outside of ethical norms. Abolition feminism provides a critical lens to identify the threats underlying what at first blush sounds like promising reform: the MCP creates haves and have-nots among mothers and children and fails to intercept threats to perinatal health.

This is the first study to offer detailed insight into maternal health in federal prisons from the perspective of first voice informants and frontline community-based service providers- women who are too often invisible in research. This research begins to fill a significant gap in understanding and provides a platform for extensive future research directions with respect to the reproductive health of incarcerated people. It grounds demands for hospital and health policies that attend to the reproductive health consequences of gendered incarceration; for clinical practice that recognizes and resists institutionalization; and for health professional education that not only exposes the health harms of prisons but situates those harms within systems of social oppression. It infuses

those demands with the hopeful potential of abolition theory. Most importantly, it meaningfully illustrates the conflict between incarceration and healthy maternity, and firmly insists on the humanity and dignity of pregnant people and new parents experiencing criminalization.

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## Appendix A: Search Strategy for CINAHL

S1: (MH "Postnatal Period+") OR (MH "Pregnancy+") OR (MH "Pregnancy, Multiple+") OR (MH "Pregnancy Trimesters+") OR (MH"Pregnancy, Unplanned") OR (MH "Pregnancy, Unwanted") OR (MH "Pseudopregnancy") OR (MH "Prenatal Nutritional Physiology") OR (MH "Prenatal Exposure Delayed Effects") OR (MH "Substance Abuse, Perinatal") OR (MH "Perinatal Death") OR (MH "Perinatal Nursing") OR (MH "Perinatal Care") OR (MH "Perinatal Risk (Saba CCC)+") OR (MH "Perinatal Care (Saba CCC)+") OR (MH "Disease Transmission, Vertical") OR (MH "Infant Mortality") OR (MH "Asphyxia Neonatorum") OR pregnan* OR perinat* OR prenatal* OR postpartum OR birth* OR breastfe* OR lactat* OR "peri nat*" OR "post partum" OR "breast fe*"

S2: (MH "Prisoners") OR (MH "Correctional Health Services") OR (MH "Correctional Facilities") OR (MH "Correctional Health Nursing") OR carceral OR penal OR custod* OR jail OR prison* OR incarcerat* OR penitentiar* OR detention OR inmate* OR offender*

S1+S2

## Appendix B: CINAHL Search

Tuesday, February 26, 2019

| # | Query | Results |
|---|---|---|
| S1 | (MH "Prisoners") OR (MH "Correctional Health Services") OR (MH "Correctional Facilities") OR (MH "Correctional Health Nursing") | 12,050 |
| S2 | carceral OR penal OR custod* OR jail OR prison* OR incarcerat* OR correction* OR penitentiar* OR detention OR inmate* OR offender* | 57,706 |
| S3 | mother W1 (baby OR infant OR child OR newborn) | 21,295 |
| S4 | prison W1 nurser* | 9 |
| S5 | ( "co residential" OR residential OR coresidential ) OR ( resid* OR "on site" OR onsite OR "liv* with" ) | 420,590 |
| S6 | mother* OR maternal OR antenatal OR postpartum | 158,666 |
| S7 | (MH "Mothers+") OR (MH "Mother-Infant Relations") OR (MH "Mother-Child Relations") OR (MH "Maternal-Child Health") OR (MH "Maternal Health Services+") | 63,611 |
| S8 | S1 OR S2 | 57,706 |
| S9 | S3 OR S6 OR S7 | 165,098 |
| S10 | S4 OR S5 | 420,594 |
| S11 | S8 AND S9 AND S10 | 279 |

## Appendix C: Search Strategy for CINAHL

| CINAHL Search # | Thursday, April 18, 2019 | |
|---|---|---|
| | Query | Results |
| S1 | ((women OR female* OR woman OR mother* OR pregnan*) N3 (prison* OR incarcerat* OR correction* OR offender* OR penitentia* OR inmate* OR convict* OR jail*)) | 1,905 |
| S2 | canada OR canadian OR newfoundland OR labrador OR "nova scotia" OR "new brunswick" OR "prince edward island" OR Quebec OR ontario OR manitoba OR saskatchewan OR alberta OR "british columbia" OR yukon OR "northwest territories" OR Nunavut OR "atlantic Canada" OR "atlantic province*" OR "prairie province*" OR maritimes OR "maritime province*" OR province* OR kingston OR abbotsford OR edmonton OR nekaneet OR "maple creek" OR kitchener OR joliette OR truro | 1,30,783 |
| S3 | "Nova Institution for Women" OR "Grand Valley Institution for Women" OR "Fraser Valley Institution for Women" OR "Edmonton Institution for Women" OR "Joliette Institution for Women" OR "Okimaw Ohci healing lodge" OR "prison for women" | 24 |
| S4 | ((MH "Prisoners") OR (MH "Correctional Health Services") OR (MH "Correctional Health Nursing") OR (MH "Correctional Facilities")) AND (MH "Womenþ") | 347 |
| S5 | (MH "Canadaþ") | 89,220 |
| S6 | S1 OR S4 | 2,018 |
| S7 | S2 OR S5 | 1,30,783 |
| S8 | S6 AND S7 | 66 |
| S9 | S3 OR S8 | 87 |

## Appendix D: Journal Copyright Permission Forms

| Journal | Publisher | Thesis policy/permission |
|---|---|---|
| *Advances in Nursing Science* | Wolters Kluwer | Allowed under author policies: https://www.wolterskluwer.com/en/expert-insights/authors-navigating-copyright |
| *Canadian Journal of Nursing Research* | Sage | Allowed under author policies and editor responded: https://us.sagepub.com/en-us/nam/journal-author-archiving-policies-and-re-use |
| *International Journal of Prison Health* | Emerald Group | Submitted under review or accepted manuscript only (not published version): https://www.emeraldgrouppublishing.com/publish-with-us/author-policies/author-rights |
| *Journal of Clinical Nursing* | Wiley | Rightslink and permission from individual co-authors |
| *Nursing Leadership* | Longwoods Publishing | Permission received |
| *The Prison Journal* | Sage | (In press) Allowed under author policies: https://us.sagepub.com/en-us/nam/journal-author-archiving-policies-and-re-use |
| *BMC Health and Justice* | Elsevier | (Submitted) Allowed under author policies: https://www.elsevier.com/about/policies/copyright/permissions |
| *SSM Qualitative Health Research* | Elsevier | (Submitted) Allowed under author policies: https://www.elsevier.com/about/policies/copyright/permissions |

HEALTH AUGUST 08, 2019

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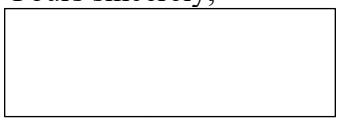

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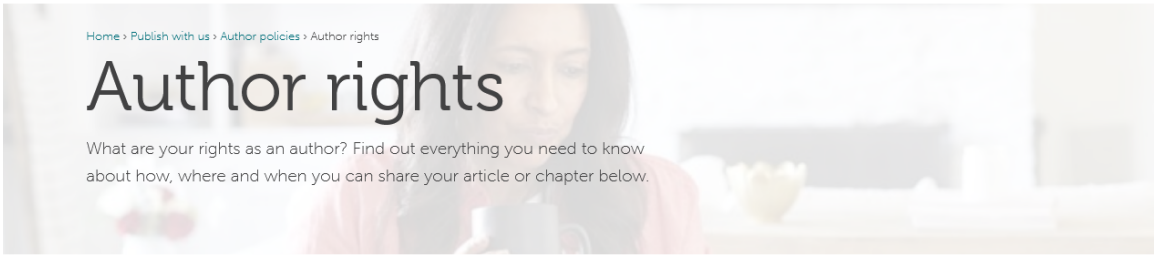



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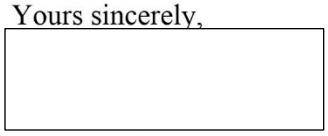

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